ITEM 02 ACTION LIST

SAINT RAPHAEL'S HOSPICE
CLINICAL QUALITY & GOVERNANCE SUB-COMMITTEE ACTION LIST
FOR APRIL 2023 MEETING

Agenda item	Action	Responsible	Timeline	Ref.
2. Minutes of previous meeting	Aim to record EDI staff training	Barry Angel	February 2023	20.01.23/01
	Consider Fundraising team and volunteer involvement in EDI Steering Group	Barry Angel	February 2023	20.01.23/02
	Share EDI training invite and content with Trustees	Barry Angel	February 2023	20.01.23/03
3. Evidence of Excellent Practice Register	Share Schwartz Round dates with Trustees	Becca Trower	February 2023	20.01.23/04
5. Clinical Quality Report	Share information on Sutton Palliative Care Hub	Dr Eva Kalmus	February 2023	20.01.23/05

St Raphael's Hospice

Meeting of the Clinical Quality & Governance Committee

Held by video call

At 9:30am on Friday 20th January 2023

Members:	Dr Carrie Chill – Board Advisor & Committee member (CC)
	Alan Cogbill – Trustee & Committee member (AC)
	Dr Eva Kalmus – Co-opted Committee member (EK)
	Norman McWhinney – Board Chair & Committee member (NM)
In attendance:	Nick Stevens – CEO (NS)
	Barry Angel – Head of HR (BA – items 1-2)
	Alex Rudkin – Head of Quality and Improvement (AR)
	Dr Naomi Collins – Consultant (NC)
	Rebecca Trower – Clinical Director (BT)
	Anna Machin (Governance – AM)

Actions arising

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The meeting began at 9.30am.

1. Welcome, apologies for absence and declarations of interest

Alan Cogbill took the Chair and welcomed Committee members and attendees to the meeting. There were no apologies. There were no declarations of interest in relation to items on the agenda.

2. Review of minutes from 21st October 2022 Clinical Quality & Governance Committee meeting, Actions List and update on matters arising

The minutes of the previous meeting were reviewed and approved as an accurate record of proceedings. The actions from previous meetings had been completed, or were on the meeting agenda.

Barry Angel attended to provide an update on Equality, Diversity and Inclusion (EDI) activities, and to share outcomes from a recent meeting with Manjit Lall (Trustee) on this topic. The Hospice's Steering Group was set up in April 2022, and a draft action plan brought together which has encompassed a range of activities. There are staff training dates in March from The Diversity Trust, which will inspire new concrete actions. The Committee suggested that training could be recorded in order to share with all colleagues. The Committee asked about the representation on this Steering Group from across the organisation and suggested adding a member from the Fundraising team alongside how volunteers can engage in this work. Trustees would receive an invite to the training alongside information on The Diversity Trust from Barry Angel.

3. Evidence of Excellent Practice Register

Committee members reviewed the Register which also includes feedback from the Medical Examiners' Office. Becca Trower shared a personal quote from a family member highlighting the Hospice's excellent care, and highlighted the strong feedback on the bereavement counselling service. The Committee received information on the student counsellors, and the weekend and evening appointments are available to fit around family members' time commitments. The Committee received assurance on the rigorous supervision given to counsellors from an external representative and input from an internal lead from amongst the Healthcare Assistants. Schwartz Rounds are also now an opportunity for colleagues to share and reflect on their practice. The future dates for Schwartz Rounds would be shared with Trustees. The roll-out of the Datix tool is also an example of excellent practice and acting effectively to enable more regular logging by staff.

4. Clinical Risk Register

The Committee noted that there are no outstanding red risks, but that the main continuing area of risk relates to staffing of the ward at night. This is being faced by other Hospices, and use of agency staff adds to budgetary pressures as internal staff now have less capacity and willingness to provide cover. There has been some recruitment to night shifts in the last quarter. The Hospice has not significantly been affected by staff absence caused by winter illnesses. Pay for all staff will be reviewed in line with the Agenda for Change

The Committee asked about the average wait time for patients. This varies according to the number of beds and the Hospice now runs twice-daily admissions meetings in order to receive feedback from the hospital and community teams more responsively. It is rare that a prospective patient is turned down because their needs are too complex.

5. Clinical Quality & Governance Report inc. Recruitment/ Staffing Update

Becca Trower highlighted key points from the report:

- The Wellbeing Service is performing well, with a high take up for services, and the complementary therapist at the Hospice making a real impact. The Men's Den site is progressing through a combination of pro bono support and paid providers.
- Hospice Neighbours relaunched in early January as Compassionate Neighbours, and the Hospice did not lose any volunteers during the transition process even though the approach has been reframed. There are a range of internal referrals coming from the Community team,.
- Workload continues to be reviewed, including the shift system and streamlining the timing of inputting bedside notes into the system at the end of the day, which is supporting morale. Tracy Young, who lead on infection control practices, left at the end of December. A staff member within the Psycho-social team has been shortlisted for a national award.

Dr Naomi Collins confirmed that the approach to sharing on-call cover with other Hospices was working effectively. The Hospice continues to engage frequently with other agencies including providing monthly supervision to the Merton end-of-life care team, and the Community team providing expert support in particular areas to care homes, such as syringe driver management. Two of the Consultants are in the examining pool for the European Certificate and participation in the CHELsea study continues. The Committee celebrated these strides to work collaboratively with partners.

It was agreed that Dr Eva Kalmus would secure information on the Sutton Palliative Care Hub to share with the team.

The Committee received assurance that the Hospice has embedded guidance on Urgent Care Plans, which is frequently referred to in meetings and internal record-keeping.

The Committee asked for more detail on the relatively higher number of incidents in October. It was confirmed that a certain number of patients had experienced pressure sores, which had previously been raised with the Committee and that there was no other underlying causal factor.

The Committee emphasised that whilst the Hospice publicising channels to make complaints and has an ethos of responding to feedback, it should also be noted that there had been no complaints received within the last three months, despite organisations in the health and other sectors experiencing a trend of rising complaints.

6. Clinical Action Plan (CAP)

The Committee noted the content of the CAP and areas that had been completed and were still outstanding. Becca Trower confirmed that individual meetings will be held in coming weeks with Heads of Department in order to plan for 2023/24. A full update will be given at the next meeting.

A 1.5-hour monitoring call was received from CQC, for which the Hospice had forward notice, and profiled the progress made since the last inspection. The outcomes of the call do not change the rating but the team believe that a range of areas of practice would meet the Outstanding requirements. There will be a new inspection framework in place from April 2023.

7. Minutes of internal meetings

The minutes of internal meetings were noted and show rigorous internal oversight and reflection.

8. Any Other Business and Dates of future meetings

There were no further items of business raised. The date of the next meeting was confirmed as Friday 31st March 2023 10am-12pm.

The meeting ended at 11.15am.

Approved……..

Date……..

Ref No.	Recorded By	Date	EXAMPLES OF EXCELLENT PRACTICE - Description	Link to evidence	PT Id	KLOE	Key Staff	Related System
2023/01	JC/AR	05/01/2023	To all the wonderful people at St Raphael's, It is our honour to make this donation in the name of Lexie (Alexia) Hennessey, with profoundly grateful thanks for all the kindness and care you showed to her earlier this year. Your compassion and empathy to us all carried us through that time and made a hideous experience overall, somewhat less hideous. After many years of tortuous medical treatment against her will, you gave her back some dignity and humanity in her final days and that meant a very great deal to us all. With warmest good wishes to you all and deepest thanks once again, from Gail and John Hennessey. (Donation sent along with note).	DATIX Feedback Module		C, R, E, W	All	
2023/02	GT/AR	06/01/2023	Email to Ginny Toubal from Alexander Filmer-Lorch (Counselling & Psychotherapy Student Volunteer) :It was you who created my placement at St Raphael's in the first place, and I will be forever grateful for that. Thank you for all the amazing support I received from you throughout the years, it really means a lot to me - you are just wonderful!	DATIX Feedback Module	n/a	E, W	Ginny Toubal	
2023/03	JC/AR	06/01/2023	Dr Paul Alford, GP of Mr Akber Noor Ali, visited reception to pass on his thanks and admiration for the way the hospice community team, Dr Strawson, Dr Tamura Rose and Dr Collins handled the patient's care. The GP considers the hospice staff in question to be amazing.	DATIX Feedback Module		C, R, E, W	Community and Medical Teams	
2023/04	GT	06/01/2023	Email from Volunteer Student Counsellor to Ginny Toubal 'It was you who created my placement at St Raphael's in the first place, and I will be forever grateful for that. Thank you for all the amazing support I received from you throughout the years, it really means a lot to me - you are just wonderful!					
2023/05	AR	27/01/2023	**Medical Examiner Feedback in October 2022** 06/10/22 : Excellent care 24/10/2022 : Everyone was wonderful, lovely and caring couldn't fault anything. Rooms were stunning. 28/10/2022 : No care concerns 31/10/2022 : Very complimentary about the staff at the hospice	N:\Managers\Feedback\MEDEX\ME Log (Community - St	n/a	S, E, R, W, C	ALL	
2023/06	AR	27/01/2023	**Medical Examiner Feedback in November 2022** 07/11/2022 : Excellent care 07/11/2022 : Very happy. Planning to make a donation. 11/11/2022 : Amazing care 16/11/2022 : Care in St Raphael's was perfect, brilliant 17/11/2022 : No care concerns 18/11/2022 : No care concerns 21/11/2022 : Hospice was absolutely wonderful, went out of their way to look after him, all needs met. Very patient, can't praise enough. Even made up a bed so that sister could stay with him for a couple of nights. 24/11/2022 : Staff at St Raphael's were exceptional	N:\Managers\Feedback\MEDEX\ME Log (Community - St Raphael's) Q3 22-23 (Oct-Dec).xlsx	n/a	S, E, R, W, C	ALL	
2023/07	AR	27/01/2023	**Medical Examiner Feedback in December 2022** 05/12/2022 : Hospice was fantastic. No concerns No care concerns x 12	N:\Managers\Feedback\MEDEX\ME Log	n/a	S, E, R, W, C	ALL	
2023/08	AR	27/01/2023	To all the wonderful staff at St Raphael's Hospice and the doctors who gave such great care and advice to make the last few years of my father's life as comfortable as possible. As a family we thank you for the amazing work you all do for those that are at the end of their lives. Please keep doing what you do so well. Many thanks to you all once again. The Ahmed family.	120		S, E, R, W, C	ALL	
2023/09	SM	03/02/2023	Positive feedback from Bereavement Support Volunteers Steve Ogden and Jackie Goodwin about their thank you lunch hosted by Steve Molyneux, Clinical Lead, Psychological Support Services on Thursday 2 February 2023	121		E,W	Steve Molyneux	
2023/10	SM	03/02/2023	Positive feedback from bereavement support volunteer Melanie Versloot re. thank you lunch hosted by Steve Molyneux, Clinical Lead, Psychological Support Services on 02/02/23.	122		E,W	Steve Molyneux	

Ref No.	Recorded By	Date	EXAMPLES OF EXCELLENT PRACTICE - Description	Link to evidence	PT Id	KLOE	Key Staff	Related System
2023/11	TC	21/02/2023	Thank you from Family : Dear Kerrie, Angela, Sam, Julie C, Joey, Cathy, Denise, Penny, Becca, Carmen, Paula, Julie Ford, Nicola, Helen, Sandy, Lisa, Aiste, Ruby, Dosia, Karen, Catherine, Gill, Jovy, Jenny, Rebecca, Hussain, Ambreen, Busi, Naomi, Marni and all the reception, facilities and cleaning staff and volunteers at St Raphael's. THANK YOU for all your hard work and support. You have doen an outstanding job looking after us all! Lots of love and gratitude form Dennis Charles & family. xxxxxx	125		C, E,W	WHOLETEAM	
2023/12	CLIN TEAM	21/02/2023	Thank you from daughter : To the palliative team : Becky, Naomi, Heather, Julie, Kevin, Katy, Gill, Myriam, Gwyn and so many more behind the scenes who helped. I just wanted to say a massive thank you for your help with my Mum Sally McGilchrist at the end of her life. Without your help she would not have been able to stay at home which I know was important to her. A massive personal thank you to Naomi & Becky for coming to see Mum at home, for telepathically knowing when she needed change/more help/change of meds and for listening to her concerns. Thank you to Gwyn for working like a yo-yo to get Mum the right equipment. Who knew there so many different commodes! Thank you Gill for being so sweet over the phone & sorry for hanging up on you. It was all just a bit too much at the time. Thank you for chasing Mum's increase in POC- it didn't happen without your input so thanks for doing this and preventing any further falls. Your current and future patients are very luck to have such a wonderful caring team. You are invaluable to so many at such a stressful time in people's lives so thank you for doing the jobs you do so compassionately. x	126		C, E,W	WHOLETEAM	
2023/13	SM	24/02/2023	Head of PS heard such glowing testimony from a patient Id 20557 and wanted to publicly commend Avril and Malin (CNSs in Community Team). This was his second visit to the patient in her home today. She lives alone, has suffered 20 years of ill health and now stoically tries to weather, as best she can, her remaining time physically, psychologically and spiritually. A sharp and intelligent woman, although housebound and immobile, she is still agile and keen of mind and discerning when it comes to the variants in the treatment allowed to her. Her GP – she can never reach on the phone, the relationship is impersonal, not felt as caring or even of particular interest. Hospitals – she loathes and fears them for a catalogue of personal horror stories stored up. Carers - come and go. She finds it hard in this frightening world she inhabits (internally and externally). And so, to have come across Malin has been a Godsend (patient's words). Malin you have clearly shown such compassion and care for this lady, engaging her in conversation (aside from what I know will have been your expert CNS role) so that you heard her likes and dislikes, her interests, passions and who she is as a person (and not just the patient). This I know because the patient has handed back to me a book you lent her (so that I can deliver it safely back to you). What a kind and wonderful, humanising gesture. This for me is symbolic of real, human engagement, going that extra mile (without want of anything in return). It meant so much to her that you shared this book with her and as she says on the note written back to you (I didn't pry – it is written on the brown paper the book is wrapped in) "Thank you, I won't ever forget this". (I will admit that hearing the patient talk so gratefully of your care of her today also repaired some of the slings and arrows I have felt today and made me, immediately, grateful for where I work and the people I work with). Avril : The patient spoke so lovingly of you today. You really made this isolated lady feel less alone, less anxious and less despondent today. You were responsive, clear, personal and kind with her on the phone and your reassurances, encouragements and also candid communication allowed her to regain some trust and hope that she isn't forgotten, that she isn't a burden and that she matters. The patient talked of the warmth in your voice, the compassion and genuine concern you showed for her, even how you sought quick clarity to provide instruction she could follow by talking with Dr Jenny on this lady's behalf. The patient sensed you were a 'young lady' from your voice and said to me – "it's nice to know there are still people like Avril in the world". From me to you both, hearing these compliments first hand – well done. I am so honoured to work alongside you both. It is written – S/He who saves one life saves the world entire. You have both done this via this patient and have made a huge and important difference in alleviating the suffering of a kind and lovely lady in our community. And so I thought it right to share. When you next have a tough day; remember this patient. What you do changes lives for the better and most of the time you won't even know it.	127		C, E,W	Avril and Malin - CNSs, Community Team	
2023/14	JF	24/02/2023	Dear SRH teams, I would like to pass on the sincere thanks and gratitude from the family of Keith Collins. Both Liz and Emma cannot thank SRH enough they felt cared for and supported before coming and whilst at the Hospice, from volunteers up wards. Liz felt our mission statement was honoured and carried out professionally. Well done Team.	130	21337	C, E,W	WHOLETEAM	
2023/15	TC/AR	15/03/2023	I would like to shine the "excellence spotlight "on Marnie Prior , who this week met Pt Id 3084 for complex ACP discussions .This gentleman has been known to the hospice for many years and situation is quite unique . Marnie 's previous ITU experience and caring for ventilated patients brought expertise to the situation however what really shines out is her desire to support the patients decision making whilst offering a truly individual plan . Marnie has been working closely with this patient , those important to him as well as the home support team from the Brompton Hospital . Thanks must also go to the whole team as they recognised the visits and the documentation would require above the normal time required and supported Marnie's workload to accommodate this. The team has a wide range of clinical backgrounds and previous experiences offering a blended experience and it is refreshing to see how this is recognised and valued by all . A sincere thanks to each and everyone of you all	134	3084	C, R, E, W	Marnie Prior	

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	JC/AR	23/03/2023	To all the staff at St Raphael's. With heartfelt thanks for your care of Ian Wright in September 2022 and best wishes for the New Year. Tamsin Wright	136				
	JC/AR	23/03/2023	To all the nurses, healthcare assistance and doctors who cared for our mother Veronica Byrne. We are so grateful for the amazing care, compassion and love you showed her and the family. Caroline, Lynda and Mandy xxx	135				
	KW/AR	27/03/2023	When CNS KW saw this patient a few weeks ago they could not speak highly enough of Mansi. They were so grateful for the support and the relationship that they had built with her. They were saying how helpful they have found the visits and also how much the patient looked forward to seeing her. This man has sadly passed away and when the CNS carried out the bereavement call they again could not thank Mansi enough for all her help and support.	140				
	EL	31/03/2023	**Message on Facebook from Rebecca McCourt** One week since my dad Tony McCourt passed, I can't thank you enough for getting the nurses out to me that desperately hard morning and somehow finding a bed for him. For making him comfortable and pain free, for supporting us in his final 6 hours. You were all amazing from the reception team letting everyone in, the CNS nurses coming to us and ward nurses especially Angela, the cleaning team a big hug from Karen, sister Ann and Father Sean visiting. It couldn't have been a better more peaceful end and that's all thanks to you. I will forever be grateful x --- My Dad was a wonderful man and a fighter to the end. He only spent a day at St Raphael's before passing away peacefully. The entire team were incredible with him and all of us, I cannot thank them enough for their support at the most difficult time, they listened to me when others wouldn't, they opened a room for dad, they cared for him beautifully, even after he passed. The support they gave and their kindness will never be forgotten. St Raphael's runs mostly on donations, they support people facing the end of life and their families every step of the way, through holistic care, support groups, counselling and more. Everyone in Dads situation should be given the chance to pass with the love and dignity and care he experienced. I know he would love to help them and thank them and so I'm doing this small thing to say thank you in honour of him. Thank you all, love Rebecca, Ella, Georgia, Serena and Joe x	https://www.facebook.com/rebecca.mccourt.9/posts/pfbid02L5eB9dNN1g2Tof5iNwhNkkDsDRLVXvc7mvEfZWnmRdQEBQJqNkvEv6UByrKBfQSUl?notif_id=1680			Angela, IPU/CNS team, Carol, reception, housekeeping, Karen, Sister Ann, Father Sean	
	RW	20/04/2023	IPU Sister would like to highlight Paula Di Palma with her thoughtful and lovely invention of a 'fake cake' for those patients who celebrate their birthday with us but are too unwell to eat/would be overwhelmed by a full cake. Paula created the cake herself after the nurses sang happy birthday to a patient who was dying and would not have been able to eat a real cake. This left the nurses wondering what could be offered instead. These little extras can mean so much to patients and truly shows the excellence in care that is given.	141		Caring Responsive Effective Well-led	Paula Di Palma	N:\Datix\Feedback - Compliments\For Datix compliments
	RT/AR	21/04/2023	**Medical Examiner Feedback in January 2023** 04/01/2023: St Raph's and RMH treatment excellent 10/01/2023: Very happy with care at St Raphael's 10/01/2023: Thought the care was excellent 10/01/2023: Very happy with care, fabulous & Very grateful 16/01/2023: Care at SRH was excellent, a better environment for everyone 31/01/2023: Care in St Raphael's was wonderful. Plus no care concerns x 6	N:\Managers\Feedback\MEDEX\ME Log (St Raphael's) Q4 22-23 (Jan-		Safe Caring Responsive Effective Well-led		
	RT/AR	21/04/2023	**Medical Examiner Feedback in February 2023** 03/02/2023: Care at St Raphael's was wonderful.t 03/02/2023: Care at SRH was lovely, couldn't fault it, lovely staff & surroundings 07/02/2023: Extremely happy with care & staff at St Raph's 10/02/2023: Hospice were amazing, no concerns 13/02/2023: Everyone was wonderful. No concerns 20/02/2023: Care was outstanding, well above & beyond. Staff, doctors, nurses, tea lady & cleaners were all wonderful 21/02/2023: Very happy with the care at the hospice. Plus no care concerns x 7	N:\Managers\Feedback\MEDEX\ME Log (St Raphael's) Q4 22-23 (Jan-Mch).xlsx		Safe Caring Responsive Effective Well-led		
	RT/AR	21/04/2023	**Medical Examiner Feedback in March 2023** 04/01/2023: St Raph's and RMH treatment excellent 10/01/2023: Very happy with care at St Raphael's 10/01/2023: Thought the care was excellent 10/01/2023: Very happy with care, fabulous & Very grateful 16/01/2023: Care at SRH was excellent, a better environment for everyone 31/01/2023: Care in St Raphael's was wonderful. Plus no care concerns x 6	N:\Managers\Feedback\MEDEX\ME Log (St Raphael's) Q4 22-23 (Jan-Mch).xlsx		Safe Caring Responsive Effective Well-led		

Serial	Cause of Risk	Description of Principle Risk to Charity	Current Controls to prevent occurance	Current Impact	Current Probability	Raw Score	Additional Controls	Residual Impact	Residual Probability	Residual Score
1.	Workforce: Registered General Nurses Recruitment of appropriately qualified nurses to support the delivery of care on the In-Patient unit.	Night duty cover remains problematic . If RGN cover on night duty not suffcient, the number of patients that can be safely supported will be affected as safe staffing is across 24hours. Increasing difficulty in recruiting Band 5 nurses for day duty - staff undertaking extra shifts to cover requirement risk burnout. Managing unexpectd sick/compassionate leave can put pressure on the staff cover.	Current qualified nursing staff levels are adequate to support 8/10 IPU beds on day duty with full current complement of staff. Significant current deficit on night duty. COVID is impacting staffing levels due to requirement to self isolate. Active recruitment of Band 5 nurses to fill permenant and Bank to support core team at times of AL/SL or increased high dependency. Requirement for continued review of night RGN cover for safety assurance. Staff flexibility from day duty to night duty- Consultation is complete and rotation has commenced.. On the job training, mentoring and educatuional support to obtain required qualifications e.g. Support of the TNA programme for HCAs Recruitment of preceptorship nurses	4	3	16	In situations where staffing levels are adversely affected there would be a managed reduction of available beds.Caveat is that even with one bed open there is a requirement to have 2 RNs on duty. Engaging with local and national training schemes to demonstrte the attractiveness of the hospice as an employer. Reviewed sickness and maternity leave policy- both amended to increase benefit October 2021 - payscale review and implementation of AfC alligned rates to remove the financial disincentive in recruitment January 2022 - bank RGN and HCA numbers increased. Agency nursing staff used when possible. Current RGN vacancy 15-18%. September 2022 -Review of shift system - introduction of 10 hour shifts January 2023 - Advert changed for night shift no longer having to rotate onto days April 2023 - Appointed new band 5 night nurse alongside bank staff to nights. Current shortage of HCAs due to sickness. Return of one staff member from long term sick leave.	4	2	12
2.	IT PAS System Failure	Inability to access contemporaneous clinical records.	Contactable team OOH (not formal contract). Back up resource - outsourced at times of AL. Back up to PAS system faciltating access to the PAS. Risk is that recent recording may not be captured.	5	2	15	Daily back up of PAS. Risk Assessment undertaken related to IT risk to PAS. Highlighting gaps. Access to OOH IT Consultant response in place.	4	2	12
3.	Bed blocking	Delay to discharge due to limited availability of CHC funded beds in the community. Limits our processing of requests for admission. Potential effect on reputation, income generation and staff morale.	Maintain relationships with Care Homes/ Sutton and Merton PLACE that have CHC funding. Completion of fast -track proficiently.	3	4	15	Screen referrals for potential impact. Dual planning with Hospital requesting admission. Consideration of CHC funded IPU beds in future. January 2023 - recent CHC claims for 2 patients April 2023 - Does fluctutae but more of an issue in the winter.	2	4	10
4.	Clinical Incidents	Patient Safety (Falls/Pressure Ulcers/Medication Errors). Risk of complaints from patients/families Requirement to report outside the organsiation to CQC Pre-empt a CQC Inspection Reputational damage	Reporting of all incidents related to clinial care Hierarchy of investigation Outputs- Learning informs improved proceedures and processes Regular review of incidents- closing the loop from reporting to action and learning Report to EXEC, Clinical Governance Committee & Advisory Committee, Dissemination to all hospice teams to inform learning	4	2	12	Continued staff training and awareness of new techniques and products. Report at Clinical HoDs. Report by manages at team meetings. Opportunity to participate in refection and sharing learning and outcomes. Feedback to complainants regarding change in practice. Encourage an environment of comprehensive reporting to support learning and quality improvement. Introduction of Datix in Q3 2021 supports reporting and monitoring.	4	1	8
5.	Corona Virus	Infection spread within hospice	All staff emails alert. Signage directing all staff & vistors to hand-washing on entering and leaving the ward / rooms and use of hand sanitiser. Staff adherence to control of infection policy. As per government guidance clinical staff that can work from home are faciltated to do so. Increased utilsation of telephone contact. Internal Lead for IPC shared amongst the link nurses on teh IPU and Community Team with oversight form ESTH IPC Team.	3	2	9	Corona Virus Policy updated on government guidance changes. PPE supplies checked. Contingency planning clarified for any identfied case within the Hospice - as per government guidance. Single room nursing. Increased telephone contact. FFP3 mask fit testing on going. Refresher PPE trainng and advice and support from PHE. LFD testing for symptomatic staff in clinical situations. Formalised SLA in place with SHH IP&C from 1 April 2022. Substantive IPC Lead role to be shared with RTH. Advert is currently out and the band advertised is for a band 7. IC Policy under review currently.	2	2	6

Serial	Cause of Risk	Description of Principle Risk to Charity	Current Controls to prevent occurance	Current Impact	Current Probability	Raw Score	Additional Controls	Residual Impact	Residual Probability	Residual Score
6.	Complaints	Rumours Local press coverage Potential for public concern Elements of public expecation not being met Loss of confidence in the service Reputational damage	All complaints both verbal and written treated with the same level of scrutiny Complaints proceedure in policy for staff to follow- escalation process Complaints documented and reported via Quality Manager Reported at Clinical Quality Improvement and Clinical Quality and Governance meetings Complainants (both verbal and written)are offered the opportunity to meet and discuss concerns with Director of Care All complaints discussed at hospice team meetings for awareness and learning across the organisation Bi-annual review by EXEC Required action taken to address concerns with staff members where individuals have been identified by the complainant File notes kept of discussions by HR	3	2	9	Use of root cause analysis for significant incidents. Feedback to complainants regarding change/improvemnt in practice. Scoping to establish all clinical staffs access to communication skills training Training on care delivery Information shared re: Duty of Candour and scope of the policy Reporting of any concerns- no blame but responsibility	3	1	6
7.	Breaches of confidentiality involving person identifiable data (PID), including data loss	If low risk breach- dealt with locally as per policy- CUI reporting More serious breach - RCA may be required- may have wider implications if data not encrypted If serious IG breach may be media coverage Potential loss of public confidence to keep PID safe	All staff paid and unpaid trained on IG on induction and annual mandatory training. Policy communicated to whole organsiation Clinical staff have nhs emials (encrypted) Regular organisational sweeps in all departments Caldicott Guardian attends regular training and presents at associated fora.	3	2	9	IT monitoring and oversight of PID in received and sent emails. Monitoring includes audit and test Phisihing emails via IT Dept. Intermittent checking in areas such as photocpier/clear desks. Established link with Capsticks solicitor who provides ad hoc advice on data access issues Annual - Information Governance Check list audit / Clinical Record documentation audit	3	1	6
8.	Corona Virus	Staff safety at work	IPU - wearing face masks for suspected or confirmed COVID+. Full PPE as appropriate. CPCT - social distancing in place in offices .	2	2	6	Infection Control link nurses in place SLA with SHH IP&C	2	2	6
9.	Lone working	Staff/volunteers work singularly in the community within referred patients homes. Risk of accident/incident in a patients home and individual risk to staff member. Risk in travel to and from home visits	Policy and proceedure in place to support community working (SOP). Supplied with a mobile phone for conatct with the hospice or other healthcare professionals. ACC informed of access and egress. Lone worker alert devices in place.	3	1	6	Lone Worker Policy informing steps to follow if a colleague does not return to base at expected time. Clarification and supported training on use of safety devices. EXEC OOH on call in place for contact and advice on further action.	3	1	6

ITEM 05

Clinical Quality and Governance Report

Contents

Aim

To update the non-executive members of the Clinical Quality and Governance Sub-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: the service remains responsive with the students input leading to low wait times for appointments. Surprisingly the Saturday appointments aren't proving particularly popular – with a low uptake, but the offer will remain in case there is a change in demand. There is some collaborative working with North Cheam Church to provide a bereavement support group for people in our community who have not been under our clinical care. Sr Anne's bereavement group continues in the WellBeing centre.

The PSS team have been managing some really difficult cases recently including young families with complex family and social dynamics. They have worked closely with the rest of the Multidisciplinary Team to achieve some very positive results.

Steve Molyneux (Clinical Lead) has also been working with other palliative care organisations to provide both clinical supervision and shared learning.

Community Engagement : Sheila Payne, our Senior Wellbeing Facilitator retired this Spring and she will be very much missed but we are so grateful for all her input and enthusiasm. Sheila supported so many of our community during Covid by providing Zoom sessions to keep spirits lifted.
Attendance at all sessions continues to increase.
Compassionate Neighbours and Wellbeing have now come together as one service – Community Engagement. This also incorporates some of bereavement support as well as The Den and Complementary Therapies. The Den is due to officially open in June – watch this space!
We have appointed Lizzie Doherty who was one of our Wellbeing Volunteers for 2 days per week. She will work alongside Katie McKenna and Simon Oliver as Community Engagement Facilitators – which means that they work across Wellbeing and Compassionate Neighbours. They are led by Roisin Yin-Poole who is our Community Engagement Lead. The team have been really creative in providing a variety of new sessions as well as advertising Compassionate Neighbours and referrals to this service are steadily growing.

Complementary therapy has now appointed 2 Reiki Volunteers, meaning that CT is now available across Tuesdays, Wednesdays and Thursdays. We are also able to offer Manual Lymphatic Drainage to some of our attendees – this is a specialist service provided on a voluntary basis each month by one of our previous Clinical Nurse Specialists Jane Gauld.

Inpatient Unit: Becca Wallis has now been the IPU sister for more than 9 months and has accepted a substantive post in this role. She has been pivotal in moving the IPU nursing team forward, morale seems high and recruitment is looking positive. The flexible shift system has proved successful in being both appealing to staff and allowing better cover across the week. We are open to 10 beds and are hoping that we can increase this to 12 over the summer months. The Bariatric/Family Suite is near completion and offers a large, airy and inviting space with accommodation for families as well as bariatic patients. There is a small kitchen, bathroom and attractive patio area.
We have appointed a Band 5 night staff nurse to work full time and also a Bank staff nurse (Miriam Wood) with palliative experience who is currently working 3 nights per week.

We are currently advertising for a shared IPC post with Royal Trinity Hospice – and a possible further job share with Princess Alice Hospice. In the meantime, St Helier continue to support us from an

infection control perspective and recent audits have been positive, thanks to our IPC Link Nurses, Cathy Foster, Sam Leech, Jill Smith and Marnie Prior.

Community Palliative Care Team – Sharon De Souza started with us in February as a Band 7 Clinical Nurse Specialist. Sharon has a wealth of experience in palliative care and is a welcome addition to our team. Naomi Stammers (Lead for Locality 3) will be going on to Maternity Leave in June and so Kate Weldon has been appointed to step into Naomi's role whilst she is on leave.
There has been some compassionate and sick leave over the last few months and the team have often been under more pressure than usual to provide their service. They have also been managing some very complex cases during this time and they have stepped up on numerous occasions to cover for one another, meaning there has been no compromise to care. Tracy Christmas has led the team with her usual 'can-do' attitude and I am extremely proud of the way in which the whole team work so cohesively and professionally.

EMIS planning and preparation has been underway over the last few months with Dr Jenny Strawson, John Groom (Director of IT and Estates) and Heather Syddall, CPCT Specialist Practitioner taking the lead in building new screens to suit our service. There are numerous training sessions for staff to attend in preparation for the transition in May.

Education/Training: Maura Flint, Palliative Care Educator, has been joined by Karen Cook in February. Karen is a trained facilitator in Advanced Communication Skills as well as a Clinical Supervisor and has a strong background in Palliative Care Education, through University Appointments and hospice roles. Between them they have been providing and planning for a whole host of education offers for 2023-2024.

Medical team involvement in an education programme has been discussed for the coming months including a Palliative Care masterclass in September 2023, input onto non-medical prescribers day, second Sage and Thyme course for staff and volunteers, Schwartz rounds, learn at lunch sessions etc.

Medical Team

On Call

On call collaboration with Princess Alice and Kingston Hospital continues, with the consultants across all 3 sites meeting every 2 months to discuss any problems arising. The consultant team continue to also participate in the executive on call. Consultants have been providing free ad hoc 1st on call support whilst covering long term sickness in first on call rota.

Engagement

Dr Tamura Rose continues to provide 1 clinical session a week to St Helier Hospital Palliative Care Team.

The consultant team host monthly MDTs for the Merton EOLC team in which complex cases are discussed, providing a form of peer support/supervision.

We contribute to the pool of examiners for the European Certificate in Palliative Care programme at Princess Alice Hospice – latest cohort commencing 17.4.23.

We typically host 4-5 medical students from St George's for one day per month and have had 2 final year medical students joining us for two and three weeks respectively during March 2023 (income generating).

We continue to develop the support offered to our local prison, High Down. For the past couple of months, we have attended a weekly virtual MDT to obtain updates and provide advice for patients. The possibility of developing psychological support training for the prison chaplaincy team is being explored currently. We are signed up to a national Palliative Care ECHO group discussing strategies to improve EOLC [provision to this patient group as well as a newly commenced Quality Improvement group focussing on EOLC at High Down.

Education

The medical team continue to meet weekly for journal club/ education/ business meetings as well as joining the Monday medical teaching coordinated across Princess Alice and Woking and Sam Beare Hospices.

Dr Tamura-Rose has facilitated joint PACES teaching for medical students with St George's Hospital Palliative Care team. She has taught on the Management Course for Palliative Care registrars based at St Christopher's Hospice and presented on a virtual course for Caldicott Guardians.

We are supporting the Education team with the Lunch and Learn series with Dr Strawson updating about Schwartz rounds last month and Dr Collins due to speak about the CHELsea II study this month.

Sage and Thyme Psychological Support Level one training was held at the Hospice on 19th January 2023 with another date planned for autumn.

Supervision

The consultants continue to be actively involved in educational and clinical supervision of several trainees: Dr Gemmell Palliative Medicine ST5, Dr Woods ST7 paediatric palliative medicine and Dr Eman Maki, GP trainee.

Appraisal

Dr Strawson and Dr Tamura-Rose are trained medical appraisers and ensure all of the medical team are supported with their yearly appraisal and revalidation – all appraisals are up to date.

Audit/ Research

Hospice UK – Three posters were presented at the Hospice UK conference in Glasgow in November 2022.

The Hospice is one of 80 sites nationwide taking part in a cluster randomised trial of hydration at the end of life (CHELsea II study) being run by the Clinical trials Unit at Surrey University in which we will aim to recruit 20 patients over a 2 year study period. Three patients have been recruited to date.

Staff Wellbeing

Attention is being paid to staff wellbeing with a regular feature at the start of our business meetings focussed on highlights and achievements or more difficult experiences.

Dr Strawson is leading on the implementation of Schwartz Rounds and the first two meetings have gone well. All are welcome.

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.
On 19th December 2022, we attended via MS Teams a scheduled DMA (Direct Monitoring Assessment) by the CQC which was triggered by a change in the Registered Manager. The report indicates that we are not seen as high risk and therefore await the usual inspection at a later date. Although disappointing that the report does not reflect the huge amount of innovation, excellence and progress we have made over the past two years, we ourselves were reassured that we have so much to be proud of and look forward to really showcasing what we have achieved to date.

A working party will re-convene in 2023 and keep under review the Key Lines of Enquiry self-assessment documentation.
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 and will undertake work this year to make any alignment with the Single Assessment Framework that becomes effective from April 2023. 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 7 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	Oct'22	May'22	Jun'23
Clinical HoDs	Mar'23	Mar'23	May'23
Medical Business	Feb'23	Feb'23	May'23
Drugs & Therapeutics	Feb'23	Oct'22	Jun'23
Outcome Measurement Group	Sep'22	May'22	Mar'23
Infection Control	Mar'23	Sep'22	Jun'23
Prescribers	Mar'23	Mar'23	May'23

Effective from October 2022, the Falls Group meeting has been included into the business of the CHoDS as a bi-annual agenda item to both reduce the number of separate meetings held and guarantee attendance and subsequent cascade.

Incidents / Accidents / Near Misses

- DATIX incident reporting was implemented in November 2021. Each incident is reviewed by the line manager (HoD) and all incidents receive final approval either from the Joint CEOs (IG), the Clinical Director (Clinical), the Head of Income Generation (Retail and Fundraising) or the Head of Quality and Improvement. 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 but it is noticeable how engagement with the system continues to be healthy, from both clinical and non-clinical departments.

- An annual report for incidents will be re-introduced as part of the Management Plan objectives for 2023/24 to demonstrate the range of incidents / accidents recorded across the Hospice and to provide a useful reference point for the learning taken. We hope to produce report within Quarter 1of 2023/2024.

- Quarterly submission to Hospice UK's Quality Metrics project began in July 2017 and are on-going with the latest submission made in April 2023. The submission categories cover pressure sores, patient medication incidents and incidents of patient falls.

Quality Account

The Hospice last submitted its **Quality Account** for 2021/2022 to the NHS Choices web site in June 2022. It is also available on the Hospice's website at https://www.straphaels.org.uk/Handlers/Download.ashx?IDMF=ffdd34c4-eb3b-4f71-9d41-6188276fda30.

The next Quality Account reflecting on 2022/23 and planning for 2023/24 is expected to be submitted before 30th June 2023.

The three objectives to be chosen for inclusion in the 2022/23 Quality Account can be decided upon at the April 2023 CQ&G meeting.

Replacing Crosscare with EMIS

A project team led by John Groom, Director of IT and Estates and comprising Dr Jenny Strawson, Consultant in Palliative Medicine, Heather Syddall, Community Team Clinical Nurse Specialist, Pascale Evans, Administration Team Lead and Alex Rudkin, Director of Quality was established in the latter half of 2022 with plan to convert from the existing Crosscare, Patient Administration System to EMIS a popular primary care based system that has also been adopted by neighbouring Hospices (Princess Alice, Royal Trinity and Phyllis Tuckwell to name a few).
Implementation of the new EMIS system is scheduled for Wednesday 3rd May 2023 and the month of April 2023 has been largely given up to the training of staff in the new system.
The project is running to plan despite the loss of a member of the IT support team early on to long term sick leave.
Ensuring EMIS facilitates the data capture that supports the care planned and delivered alongside the data output that feeds into SWLICB activity review meetings is a critical objective set out in 2023/24's planning.

Clinical Audit, 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.

Review of progress with the clinical audit program and opportunity to feedback results is provided via the Clinical Audit and Activity Data forum (CAAD). Its last meeting was held in October 2022. 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 January 2023. The next forum is scheduled in June 2023 with presentations planned on CPCT clinical documentation, outpatient service, IPU referrals, IPU Satisfaction and Phase of Illness / AKPS. The forum usually occupies a lunch-time slot and is open to the clinical teams and those with an interest in topic.

A summary of 2022/2023 projects spanning, clinical audit, quality improvement and data monitoring is set out from page 10. Ownership is delegated across the clinical team and Quality office and the medical team projects have Dr Collins as medical audit and research overseer.
The Audit/Research Programme 2023/2024 with timeline is provisionally drafted and will be set out in the next report.

Data Dashboards

Clinical data dashboards that inform the service areas of the IPU, Well-being Centre, Community and Psycho-Social teams are developing. An index of tracked data that is periodically presented and communicated to the clinical team is held. It remains a challenge to find the time to keep them updated but includes such items as:-

Report Reference	**Title**	**Lead**	**Created**	**Function**	**Primary Aud.**	**Exec / CCG Interest**	**Freq**	**Resp**	**Is Data Presented?**
20/001	CMC Monitoring	BG	Jan-20	To improve CMC data capture	CPCT	Yes	Weekly	AR	Yes
20/002	NoK Details	SM	Jan-20	To improve NoK data capture	Psy / Qual / Donor Support	No	Monthly	AR	Yes
20/003	Community Team Visit Responsiveness	LB	Jan-20	To support responsiveness evidence	CPCT	Yes	Quarterly	AR	Yes
20/004	Sharing Information Consent	TC	2018	To monitor and improve Sharing Information Consent data capture	CPCT	No	Monthly	AR	Yes
20/005	Safeguarding Monitoring	RW	Feb-20	To highlight patients with safeguarding concerns and track follow up	CPCT	No	Monthly	JL	No
20/006	Referrals Monitoring	JO'G	Mar-20	To monitor and improve Referrals data capture	CPCT	No	Monthly	AR	Yes
20/007	Referral to RIP Monitoring	JO'G	Mar-20	To monitor time between referral and death	CPCT	No	Monthly	AR	Yes
20/008	Active Caseloads	NS/ GL	May-20	To monitor active caseload levels	Exec	Yes	Weekly	AR	Yes
20/009	Daily Activity Data - capacity tracker support	NS/ GL	May-20	To monitor activity recorded on Crosscare	Exec	Yes	Daily	AR	Yes
20/010	Referrals by Postcode	DN	Jun-20	To monitor referrals by postcode	Fundraising & Exec	Yes	Monthly	AR	Yes
21/001	PPoD vs Actual PoD Monitoring	RT	Apr21	To monitor PPoD achievement rates	Exec	Yes	Quarterly	AR	Yes
21/002	IPU Waiting Times / Re4quests for Admission	RT	Feb-22	To demonstrate the servicing of admission requests and profile waiting times for admission	Exec	Yes	Quarterly	AR	Yes

Clinical Quality & Governance Management Plan Objectives 2022/23

Summary

DATE	Number	Complete / on-going	As per Plan	For 2023/24
09-Jun-22	**30**	**8**	**20**	**2**
23-Sep-22	**30**	**10**	**18**	**2**
06-Jan-23	**30**	**16**	**12**	**2**
21-Apr-23	**30**	**24**	**30**	**6**

Goals Completed

Ref	Goal
3.1	All core medical team trained in advanced communication skills
3.2	Produce and maintain an audit/monitoring/research project schedule 2022/23
3.3	To maintain student counselling cohort of 8 : Appoint to an additional 0.6 Counsellor post
3.4	Re-establish Outpatient encounters / Maintain diversified offer in Wellbeing/Living Well aligned to Social Prescribing
3.5	Formalise Locality Team Lead Roles
3.6	Wellbeing – engage with external groups including social prescribers Collaborate with external groups to provide joint offers
3.7	All clinical services as required to feed into and support the clinical audit program
3.8	• Develop links and contacts to support development of local SW London Ethics Committee • Establish reflective forum for inclusion of all staff to present/ discuss clinical cases
3.9	• Open up 10 beds appropriately staffed • Review timings of admissions meeting to allow planning time for the acute sector • Streamline discharge process inc. allocated responsibility for completion of discharge process
3.10	• DATIX Feedback capture in place
3.11	• Wellbeing –The Den : Launch a diversified offer to support male patients, carers, relatives and bereaved
3.12	• Re-establish the Complementary Therapy Service / Ensure Crosscare / information collection sources are designed to support service • Review Service Policy
3.13	To support clinical reflection and supervision through introduction of Schwartz rounds
3.14	To support the transitioning of CMC to the Urgent Care Plan
3.15	• Refine existing model to play to strengths, provide professional development opportunities and meet the needs of our patient group • Transition IPU Manager role to Clinical Standards and Project Lead. • Reintroduce IPU Sister role to incorporate advanced clinical skillset • Develop our Band 6 nurses in terms of succession planning
3.17	• All Band 6 & band 7 community staff to be trained to complete VOED documentation
3.19	• Implement CSNAT in H@H / Dependency in 2023/24
3.21	• IPU : Increased Skillset of Nursing Associates
3.22	• Robust infection control practice across IPU • SLA in place with IP&C at SHH
3.24	• Develop Policy for servicing the transition of young adults (referral & working model)
3.29	Maintain CNS Development Posts
3.30	Review and revise training video to service data extraction for Xcare Produce data extract daily or as feasibly close to daily throughout the year

Objectives rolled over to 2023/24 planning consideration

3.16	• IPU Staffing • To achieve full establishment of band 5 RGNs on the IPU that services rotation across days and nights
3.18	• Referral Policy • Extend Referral Policy to capture self-referral for patients discharged from the Hospice clinical service

Clinical Quality & Governance Management Plan Objectives 2023/24

Summary

DATE	Number	Complete / on-going	As per Plan	For 2024/25
17-04-2023	**35**	**1**	**32**	**2**

Goals Completed

Ref	Goal
3.1	Community – Maintain CNS Development posts subject to availability and attrition

Extract of 2023/24 CQ&G objectives is provided within the papers.

Action : Select three 2023/24 objectives for inclusion in the 2022/23 Quality Account

Audit/Research 2022/23

Overview in April 2023

>30 projects scheduled in 2022/2023

2022/23 Listing

Project Ref.	Title	HQIP Prioritisation	Status	Lead
2022/23-01	**Community - Carer & relative questionnaires for the Hospice @ Home Service**	**• Priority 2 Internal 'must do' audit**	Ongoing - 2021 report published in Jun 22 ; 2022 report is under 'edit' and is expected to be complete with HoD feedback in May 2023	Quality Office - J Cope / A Rudkin
2022/23-02	**IPU & Community - VOICES survey of bereaved next of kin 3-6months post bereavement**	**• Priority 2 Internal 'must do' audit**	Ongoing - Latest Report for Oct 21 - Mar 22 published Apr '23	Quality Office - J Cope / A Rudkin
2022/23-03	**IPU - Patient Satisfaction**	**• Priority 2 Internal 'must do' audit**	2022 report drafted and with HoDs for comment. Expected publication in April 2023	IPU - R Wallis Quality Office - J Cope / A Rudkin
2022/23-04	**IPU – Infection Control : Environment & Hand-washing Audit**	**Priority 1 External 'must do' audit**	Quarterly production of graphical compliance for IPU display across Handwashing, Staff, Environment and Sharps commenced in Oct/Nov 2022.	IPU - S Leech Community - J Smith Quality Office - J Cope / A Rudkin
2022/23-05	**IPU - Medicines Management Audit**	**• Priority 2 Internal 'must do' audit**	Ongoing	Ashton's Clinical Pharmacist
2022/23-06	**IPU - Re- Audit against Audit NICE Guidance NG31 Care of Dying Adults at the End of Life**	**Priority 1 External 'must do' audit**	Presented at lunch time Audit Meeting - Sep 2022 ; re-audit for Oct- Dec 2022 data under analysis in April 2023	Dr Busi Da Silva

Project Ref.	Title	HQIP Prioritisation	Status	Lead
2022/23-07	**IPU : Patient Handling / Pressure Areas / Mouthcare**	**• Priority 2 Internal 'must do' audit**	Presented at lunch time Audit Meeting - Jan 2023. Re-audit of PS & MH/Falls for September/October 2023	Rebecca Wallis
2022/23-08	**Controlled Drugs Annual Audit**	**Priority 1 External 'must do' audit**	Ongoing	R Trower
2022/23-09	**OACC measures (Step 1 - Phase of Illness + Karnofsky performance status)**	**• Priority 2 Internal 'must do' audit**	Nov 2021 IPU Audit Report published in January 2023; Nov 2022 re-audit expected in May/ Jun 2023	OACC Task & Finish Group JG - IPU GT-R - Community
2022/23-10	**OACC measure (Step 3- iPOS)**	**• Priority 2 Internal 'must do' audit**	Pended to 2023/24	OACC Task & Finish Group JS - IPU GT-R - Community
2022/23-11	**Outcome measures (Step 2- CSNAT)**	**• Priority 2 Internal 'must do' audit**	CSNAT Pilot H@H Nov 2022 Crosscare window designed Data Collection on-going (13 forms as at 19-01-2023) Audit report expected in Q2 2023/24	Implementation Group MV - H@H
2022/23-12	**Referral to PS triggers**	**• Priority 4 Clinician interest audit**	Project not required.	Psychological services SM
2022/23-13	**Bereavement Questionnaire**	**• Priority 4 Clinician interest audit**	Counselling Survey designed and awaiting sign off in April 2023. For 2023/24	Psychological services SM
2022/23-14	**Non-medical Prescribing Activity Comparative : FP10.**	**• Priority 4 Clinician interest audit**	Project not required.	Community KH

Project Ref.	Title	HQIP Prioritisation	Status	Lead
2022/23-15	Advance Care Planning -(timelines) Re-audit	• **Priority 3 Specialty Priority**	Presented at lunch time Audit Meeting - Sep 2022	Community Dr G T-R TC
2022/23-16	Activity Monitoring Data CMC NoK CPCT Responsiveness Sharing Information Safeguarding Referrals Referrals to RIP Active Caseloads Daily Activity Data - capacity tracker Referrals by Postcode Community RA DoLs PPoD Wandsworth Activity	• **Priority 3 Specialty Priority**	Ongoing	Quality Office+ CAAD
2022/23-17	IPU & Community & Psychological Support Services - Activity Data Dashboards Development	• **Priority 2 Internal 'must do' audit**	Ongoing	Quality Office + CAAD
2022/23-18	**Incidents**	• **Priority 2 Internal 'must do' audit**	Ongoing Annual report included as 2023/24 objective	Quality Office + CHoDs
2022/23-19	**Falls**	• **Priority 2 Internal 'must do' audit**	Bi-annual appraisal included with CHoDs business	Quality Office + CHoDs Mtg
2022/23-20	**Complaints**	• **Priority 2 Internal 'must do' audit**	Ongoing - 2021 complaints reviewed in May 2022 ; 2022 complaints review scheduled in May 2023	Quality Office + Exec

Project Ref.	Title	HQIP Prioritisation	Status	Lead
2022/23-21	**Safeguarding Documentation**	**• Priority 3 Specialty Priority**	Data Collection (June 2021 - December 2022) Report expected in Apr/May 2023	R Wallis
2022/23-22	**Clinical Records Documentation**	**• Priority 2 Internal 'must do' audit**	Reported in Dec 2022	R Trower
2022/23-23	**Clinical Record Terminology / Subjective & Objective Review**	**• Priority 4 Clinician interest audit**	Presented at lunch time Audit Meeting - Sep 2022	IPU & Community : R Clingan / G Tamura-Rose
2022/23-24	**Outpatient Service**	**• Priority 4 Clinician interest audit**	Reported in Mar 2023	Dr J Strawson
2022/23-25	**Wellbeing Centre Service Feedback Survey**	**• Priority 3 Specialty Priority**	Reported in Nov 2022	S Payne / R Trower
2022/23-26	**GP Survey - discharge communication et al**	**• Priority 4 Clinician interest audit**	Pended for 23/24 consideration	J Strawson / A Akhtar
2022/23-27	**IPU - Mortality and Morbidity Meeting Re-Audit**	**• Priority 3 Specialty Priority**	Data collection Report in March 2023	Dr AA
2022/23-28	**Admissions Clerking Re-audit**	**• Priority 3 Specialty Priority**	Project not required	Jovy Giles
2022/23-29	**Referral to the IPU Re-Audit**	**• Priority 3 Specialty Priority**	Reported in Mar 2023	Dr J Strawson
2022/23-30	**Research Audit on Ethnicity**	**• Priority 3 Specialty Priority**	Complete - Interim results received in April 2023	Dr G Tamura-Rose
2022/23-31	**Out of Hours Calls Monitoring**	**• Priority 3 Specialty Priority**	Data Analysis Publication expected in Apr/May 2023	Dr N Collins
2022/23-32	**Spoken Language Active Referrals**	**• Priority 3 Specialty Priority**	Data cohort extracted 12-10-2022. Under analysis.	Dr G Tamura-Rose

Project Ref.	Title	HQIP Prioritisation	Status	Lead
2022/23-33	**CHELsea II examining hydration at the end of life - led by Surrey University Clinical Trials Unit : cluster randomised trial**	n/a	Data Collection	Dr N Collins
2022/23-34	**Snapshot audit reviewing Community documentation to GPs**	**• Priority 3 Specialty Priority**	Published Dec 2022	Dr G Tamura-Rose / T Christmas
2022/23-35	**Use of anticipatory medication following discharge from ESTH to Sutton community**	**• Priority 4 Clinician interest audit**	Led by PAH	PAH -led audit with participation from Dr G Tamura-Rose
2022/23-36	**Caldicott - IG Sweep**	**• Priority 2 Internal 'must do' audit**	Annual Data collection	Dr G Tamura-Rose
2022/23-37	**Liverpool University Research into Equity of Access**	**• Priority 3 Specialty Priority**	Data supplied	Dr G Tamura-Rose / A Rudkin
2022/23-38	**Discharge Planning Re-audit ??**	**• Priority 4 Clinician interest audit**	Listed as topic of interest. Not planned for 2022/23.	Med Team For new Registrar
2022/23-39	**Tissue Donation - Cornea - system / record / training ??**	**• Priority 4 Clinician interest audit**	Listed as topic of interest. Not planned for 2022/23.	Dr G Tamura-Rose
2022/23-40	**Sexual Preferences ??**	**• Priority 4 Clinician interest audit**	Listed as topic of interest. Not planned for 2022/23.	Dr G Tamura-Rose

2022/23 summary :

Projects complete = 17

Projects on-going = 14

Projects pended / not required = 9

Clinical Risk Management

Clinical Unexpected Incidents

Overview of incident data for January – December 2023 is shown below:-

2023	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2023	2022	2021	2020	2019
Admissions to IPU	**19**	**18**	**20**										**57**	**207**	**138**	**195**	**212**
Beds	**10**	**10**	**10**														
Bed Occupied Days	**296**	**204**	**242**														
Bed Available Days	**310**	**280**	**310**														
Bed Occupancy (variable beds)	**95.48 %**	**72.86%**	**78.06%**														
Bed Occupancy (10 beds)	**95.48 %**	**72.86%**	**78.06%**														
CD Medication Incident	5	2	12	0	0	0	0	0	0	0	0	0	**19**	**29**	**35**	**15**	**23**
CD Medication Near Miss	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**1**	**2**	**1**	**1**
Non-CD Medication Incident	9	1	3	0	0	0	0	0	0	0	0	0	**13**	**21**	**7**	**4**	**12**
Non-CD Medication Near Miss	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**3**			**1**
Pressure Sore on Admission	1	2	3	0	0	0	0	0	0	0	0	0	**6**	**22**	**16**	**19**	**16**
Pressure Sore during Admission	1	0	2	0	0	0	0	0	0	0	0	0	**3**	**17**	**6**	**4**	**3**
Moisture Associated Skin Damage ON Admission	0	0	1	0	0	0	0	0	0	0	0	0	**1**	**1**			
Sharps/Splash	0	0	1	0	0	0	0	0	0	0	0	0	**1**	**3**			
Infection (Near Miss)	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**3**			
Infection	0	1	1	0	0	0	0	0	0	0	0	0	**2**	**6**			
Unexpected Transfer	0	0	0	0	0	0	0	0	0	0	0	0	**0**				
Near Miss(non-medication & non-IG)	0	0	0	0	0	0	0	0	0	0	0	0	**0**		**1**	**1**	**1**
Staffing	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**9**			**1**
Behaviour (staff) : non-complaint	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**1**			
IG	2	0	0	0	0	0	0	0	0	0	0	0	**2**	**16**	**4**	**3**	
IG near miss	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**4**	**5**	**1**	
Manual Handling	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**1**	**2**	**1**	**5**
Slips, trips, falls	1	0	1	0	0	0	0	0	0	0	0	0	**2**	**21**	**19**	**20**	**21**
Falls near miss	3	0	1	0	0	0	0	0	0	0	0	0	**4**				
Verbal Violence (Pt)	0	0	0	0	0	0	0	0	0	0	0	0	**0**			**1**	

2023	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2023	2022	2021	2020	2019
Physical Violence (Pt)	1	0	1	0	0	0	0	0	0	0	0	0	**2**	**3**			
Bump	0	0	0	0	0	0	0	0	0	0	0	0	**0**				
Burn/Scald	0	1	0	0	0	0	0	0	0	0	0	0	**1**	**1**			
Equipment	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**1**			
Equipment (near miss)	0	0	1	0	0	0	0	0	0	0	0	0	**1**	**1**			
EXEC Out of Hours Call	0	1	0	0	0	0	0	0	0	0	0	0	**1**	**2**			
OTHER - Admin/Property/Documentation/ OOH Contact	2	0	2	0	0	0	0	0	0	0	0	0	**4**	**12**	**12**	**14**	**12**
MAD Alerts (re SRH)	1	0	0	0	0	0	0	0	0	0	0	0	**1**				
*** Incidents reported to Community – non-SRH**	3	1	1	0	0	0	0	0	0	0	0	0	**5**	**25**	**2**	**8**	**12**
*** MAD Alerts (incl. in Community:non-SRH)**	2	1	0	0	0	0	0	0	0	0	0	0	**3**	**12**			
Total 2023 *excluded	**26**	**8**	**29**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**63**				
Total 2022 *excluded	8	12	15	10	15	19	18	16	13	24	16	14		180			
Total 2021 *excluded	3	2	7	8	21	13	3	1	19	9	11	12			109		
Total 2020 *excluded	7	6	7	6	11	15	5	5	4	3	8	8				85	
Total 2019 *excluded	1	14	13	7	8	7	6	6	5	16	10	6					99

Incident Key

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

Falls	**Include all slips, trips and falls (inpatient unit only).** (e.g. if a patient is found on the floor, lowered themselves onto the floor, slipped from a chair, rolled out of bed, etc)
No harm	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.
Low harm	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.
Moderate harm	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.
Severe harm	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.
Death	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.
References	- National Patient Safety Agency 2010 Slips trips and falls data update NPSA: 23 June 2010. - NPSA Seven Steps to Patient Safety.

Clinical Significance	Jan	Feb	Mar	Jan-Mar	Apr	May	Jun	Apr-Jun	Jul	Aug	Sep	Jul-Sep	Oct	Nov	Dec	Oct-Dec	2023	2022	2021	2020	2019
Admissions to IPU	19	18	20	57	0	0	0	0	0	0	0	0	0	0	0	0	94	207	138	193	212
Bed Occupied Days	10	10	10		0	0	0		0	0	0		0	0	0						
Bed Available Days	296	204	242		0	0	0		0	0	0		0	0	0						
Bed Occupancy	95.48%	72.86%	78.06%		#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!	82.78%		#DIV/0!	#DIV/0!	82.78%						
Fall No Harm	1	0	0	1				0				0				0	1	15	12	14	15
Fall Low Harm	0	0	1	1				0				0				0	1	6	7	6	6
Fall Moderate Harm	0	0	0	0				0				0				0	0	0	0	0	0
Med Level 0	2	2	8	12				0				0				0	12	4	20	9	13
Med Level 1	11	1	7	19				0				0				0	19	49	20	10	21
Med Level 2	0	0	0	0				0				0				0	0	1	0	0	3
Med Level 3	0	0	0	0				0				0				0	0	0	0	0	0
Minor (No Harm or Low Harm)	10	3	7	20				0				0				0	20	65	25	15	19
Moderate (Moderate Harm)	0	0	0	0				0				0				0	0	0	3	6	2
Serious (serious Harm)	0	0	0	0				0				0				0	0	0	0	1	1
Pressure Sores	2	2	6	10				0				0				0	10	40	22	23	19
Totals 2023	26	8	29	63				0				0				0	63				
Totals 2022	8	12	15	35	10	15	19	44	18	16	13	47	24	16	14	54		180			
Totals 2021	3	2	7	12	8	21	13	42	3	1	19	23	9	11	12	32			109		
Totals 2020	7	6	7	20	6	11	15	32	5	5	4	14	3	8	8	19				85	
Total 2019	1	14	13	28	7	8	7	22	6	6	5	17	16	10	6	32					99

Clinical Complaints

- There have been 6 clinical complaints received between January and March 2023.

Complaints Overview

2023 - Complaints	CPCT / H@H Care	CPCT / H@H Comms	IPU Care	IPU Comms	IPU Care & Comms	Bereavement Comms	Reception Comms	Volunteer Services Comms	Fundraising /Shop Comms	HR	Total	Merton	Sutton	Other	UPHELD in Whole or Part
January						1					**1**	**1**			**0**
February	1	1		1			1				**4**	**1**	**3**		**4**
March				1					2		**3**		**1**		**3**
April															
May															
June															
July															
August															
September															
October															
November															
December															
2023	1	1	0	2	0	1	1	0	2	0	**8**	**2**	**4**	**0**	**7**
2022	3	0	2	3	0	0		0	0	0	8	1	7	0	6
2021	4	5	1	1	1	0		1	0	0	13	6	6	0	12
2020	4	1	2	3	1	1		0	1	2	15	6	6	0	14
2019	0	0	3	3	0	1		0	2	2	14				9
2018	2	5	10	4	1	0		0	1	0	27				19

Clinical Complaints: January – March 2023

ID	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASS	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE
2023/01	PS Client (Family Member)	06/01/2023	E-mail of dissatisfaction received from Bereavement Counselling client regarding long term counselling being withdrawn and breakdown in trust with counselling student following assumption that withdrawal of service had followed a disclosure of safeguarding information.	Bereavement Service Communications	Matter extensively investigated by Head of Psychological Support Services in liaison with Student Counsellor and Clinical Director. Letter dated 12 January 2022 explained the counselling we offered to you was Bereavement Counselling and an extension was warranted due to your particular situation regarding the grieving process (namely, that you had lost your mother, and then brother in short succession. Your elderly father was also ill and a third death was therefore being anticipated). The counselling we provide to all relatives is always focussed on the grieving process (be it pre or post-bereavement) and so although the client felt that her counselling was "initially bereavement", the focus and aims of the work was always in this regard. SRH does not offer 'life therapy' but is a specific, specialist service. The client's situation was complex and so an extension to the regular 12-week contract was given – but the work is never open-ended and so SM extended apology if she did not understand this fully. The client's counselling was not withdrawn and it certainly was not due to the Safeguarding concern she had disclosed to her counsellor and that we, in turn, reported to your local Safeguarding Team. The bereavement issues this client had initially presented with, had by the end of 2022 been worked through (the counselling being complimented by the EMDR sessions we provided her with) meaning the ending was appropriate clinically and her counsellor had included her in this decision-making process. In total she attended 17 face to face counselling sessions and received 4 EMDR sessions with us. SM expressed his regret that she felt, and named, that trust had been lost in the relationship with her counsellor and us as the provider due to us having to report her Safeguarding disclosure. He assured her that the contract was not cut short nor terminated by us. The student counsellor had collaboratively contracted with her for an additional 6 sessions to the end of January 2023, he had talked with her about and supplied her with details of onward referral options so that she could engage with an agency that delivered longer-term work and 'life-therapy'. Her last session was 6 January 2023 but this was of her choosing, as she explained to the student counsellor that she did not want to continue with the service any longer, as she sadly felt that an alliance rupture had happened and that reparation could not be achieved. He expressed if he can be of any further help in this, or any other matter, please do not hesitate to contact him.	Not Upheld

ID	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASS	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE
2023/02	Patient's wife	10/02/2023	Planned review call by CNS . No answer on pt.'s mobile, called land line. Wife answered. Wife informed that husband died last week and she is shocked we had not been informed as she came into hospice the other day and informed reception of his death. Apologised the message had not been passed on. Condolences given. The death was unexpected and sudden and CPR was attempted. Again condolences and apologies for lack of communication Informed of available bereavement service but encouraged to call hospice at any time if she felt she wanted to talk about husband's death	Reception Comms	Investigation failed to identify individual receptionist but collective reminder sent to all reception staff reminding them of the importance of passing all messages on to the relevant dept immediately. 16/02/2023 Letter of apology sent to complainant by Clinical Director.	Upheld
2023/03	Patient's sister	10/02/2023	Pt died at home. Call into triage from patient's sister later that morning: She expressed her frustration that "things weren't in place". She describes a collective failing for patient between the hospital, the GP and ourselves and expected "more to be done". Her expectation of SRH was as follows: 1) We should have visited sooner for 1st assessment. She called SRH to request the booked first assessment be brought forward and she feels this should not have been their responsibility to chase us and stress again their concerns about her brother. 2) When we visited we had "little documentation about him". The patient's sister acknowledges, however, that we would only have access to the information that had been provided to us by the hospital. She spoke about her feeling that the healthcare services supporting her brother are not "joined up". She used an example of his medications being sent to Boots pharmacy in Sutton but he was being unable to get there to collect them.	Joined up working across the community - care	CNS assured her that her concerns have been heard and apologised that we have not met their expectations. She thanked me for listening and provided her consent for me to raise her concerns as a complaint. - Explained our bereavement follow up should they wish to engage with this - Encouraged her to call us any time for advice or support if required Comm Service manager examined patient record and response / clinical input appeared appropriate and timely. Patient contacted by HPOC telephone within 48 hours of referral received and visit arranged for 5 days later (8th) with Hospice Dr. HPoC safety netted advising to phone hospice sooner if concerns . Sister phoned Triage on 6th highlighting general deterioration and visit B/F to then 7th Discussed at Mortality and Morbidity meeting Complaint followed up with a telephone call from the CD. CD conversation with patient's sister - listened to her concerns and her feeling that her brother didn't receive enough support. She acknowledged that he had capacity to make a decision to refuse care but equally was frustrated at the lack of joined up working between services - including running out of medications but not being able to get to the chemist to pick up more medications. Also, some confusion regarding changing GP and who was taking responsibility for that. Finally, felt frustrated because the MCCD couldn't be written as GP hadn't seen her brother since last year. Our doctor was on leave. CD	Upheld

ID	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASS	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE
			3) We should have implemented care support sooner. She recognises that her brother had declined a package of care but she cannot understand why this was not put in place regardless as it was clear he had a care need. She asked why we did not do this. We spoke about mental capacity and her brother's right to make what we may deem to be an unwise decision. She acknowledged that her brother could be "difficult". He reportedly felt that he could manage himself but she could see that he could not. She does not feel he was able to think clearly and rationally enough to make an informed decision "it was not his decision to die is an much pain". 4) We should have symptom managed him better. She reports his pain was significant "you wouldn't treat a dog the way he was treated". She used the term "negligence". She feels he was left to die - she spoke about his weight loss, and nutrition in the form of supplement drinks or IV Glucose that were not provided. She wonders if his symptoms were better controlled whether he would have been able to have further treatment. 5) We should have visited him last night. Our team delivered a DNACPR form to the house yesterday. The family reportedly invited the clinician into the house to see the patient but we reportedly declined. She feels if we had seen the patient we would have recognised his deterioration. Explored what she would have hoped for from a review - she acknowledged that even if her brother had been taken to A&E the outcome may not have been different.		spoke with coroner and we agreed that STHH medical should be approached to complete the MCCD. This has now been done. Complainant has said she will send complaint in writing and agreed to come in to discuss this with us if she feels at some point that it would be helpful. Outcome of Clin Director's follow up fed back to staff.	

ID	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASS	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE
2023/04	Patient	21/02/2023	NIC was asked to see the above patient who wished to make a verbal complaint regarding the night nurse caring for him on the night of 20/02 - 21/02. The patient was unhappy about the attitude of the nurse giving him his night time medication. He felt she was rude and belittling. Statement received from nurses on duty	IPU RN Comms	**Investigator Action Taken** Dealt with by SSN Julie. Patient wished to discuss matter however did not want to take it any further. All staff members reflected on incident and nurse involved reflected on the fact she could have ended the conversation sooner. No further action needed, no other concerns and complaints from patient. **Lessons Learned** To continue to reflect on how staff behaviour can affect a situation with a patient. To continue to ensure we have an open and honesty culture with the staff and patients, to allow all those who work or are patients at the hospice to speak up if they have concerns or complaints	Upheld
2023/05	Patient	24/02/2023	Patient complained about emotional distress caused by first visit when I called as routine follow up to the visit. She said she would have written to complain but did not have the energy but did want nurse to know about distress caused. Felt visit was very negative, left her in tears, and she felt she had to push to end the visit, wanted the nurse to leave. See below description of telephone call taken from patient record: TC to patient, follow up after 1st visit. Attempted to call- answered on 3rd call. Introduced myself. Patient was immediately very angry/upset, asking why we were calling. Explained that it was just a follow up call to check in with her following the visit 4 weeks ago. Patient said she did not appreciate the first visit or this call. The visit had upset her greatly, left her in tears. She explained that she felt the whole focus of the visit was about 'death and dying', found this very upsetting. She did not want to talk about this, she feels fine at the moment and wants to look forwards to having chemo again this week.	Community CNS Comms	CNS taking call to patient/complainant apologised for upset caused. Discussed way forward. Agreed and delivered TC in 6wks. Patient did want feedback given to nurse who made first visit, as she had been so upset. Noted patient doesn't wish to be contacted regarding the concern ALERT added to patients record. Note: Would prefer not to discuss EOL issue, wants to focus on ' life' and treatment Plan Discuss with CNS who visited Discussed with Band 6 Nurse H@H who was initially very upset at the feedback as the intention was never to cause distress. The feedback was given thought and we discussed how the situation should be approached differently. We discussed that every situation is unique and patients / those important may not always gives us the clues that we need for communicating sensitive subjects.	Upheld

ID	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASS	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE
			Apologised for her experience. Explained that this would not have been intentional, and we try to support people at all stages of their journey. We would want to support with any symptoms whilst she has treatment. And we are happy to be led by her as to what she needs to talk about. She explained she was very shocked by visit and discussions, her husband had died of MND and received care from St Raphael's which she had been extremely happy with. Initially said she did not want us any more, after some conversation I asked how she would like to proceed. If a telephone call in a few weeks would be okay or would she prefer to be discharged from St Raphael's, and could access support rom other teams or be referred again at a later date? She did not want to be d/c. Offered a call and she accepted this- agreed on approx 6wks time, but reassured she could contact us if she would like support before. Says pain controlled when asked. Note: Would prefer not to discuss EOL issue, wants to focus on 'life' and treatment Call booked. CNS taking call to patient/complainant apologised for upset caused. .			

ID	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASS	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE
2023/06	RN at Orchard House Nursing Home	03/03/2023	Orchard House Nursing Home RN unhappy that they had not received information on discharge from IPU that a patient had head lice. They had been sent the shampoo but nothing documented.	IPU Discharge Communications	Investigated by IPU Sister. On reviewing discharge paperwork headlice was not mentioned on the nursing or doctors discharge summary however it was on the nursing medication list as last used on the 2/2 and it was documented on the joint assessment form sent to social services. I called manager at Orchard House - I apologised that this was not on the discharge summary. I explained it was on the nursing medication list however I appreciate there was no other mention of it. She pointed out it hadn't been used since the 2/2. I explained I believed that was because the headlice was improving and they were combing her hair daily. NH RN reported she does have the headlice back now. Again, apologised for this and advised I would be highlighting this to the team. Email sent to the medical team highlighting the error as the medicated headlice treatment was not on the TTO list. Nursing team to be reminded to include all nursing treatment on nursing discharge letter via weekly newsletter.	Upheld

Records – Access Requests

Between January and March 2023, we have had no access to health records requests.

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

Notifications

Between January and March 2023 there have been 3 serious injury notifications made to the CQC all concerning pressure sores grade 3 or above.

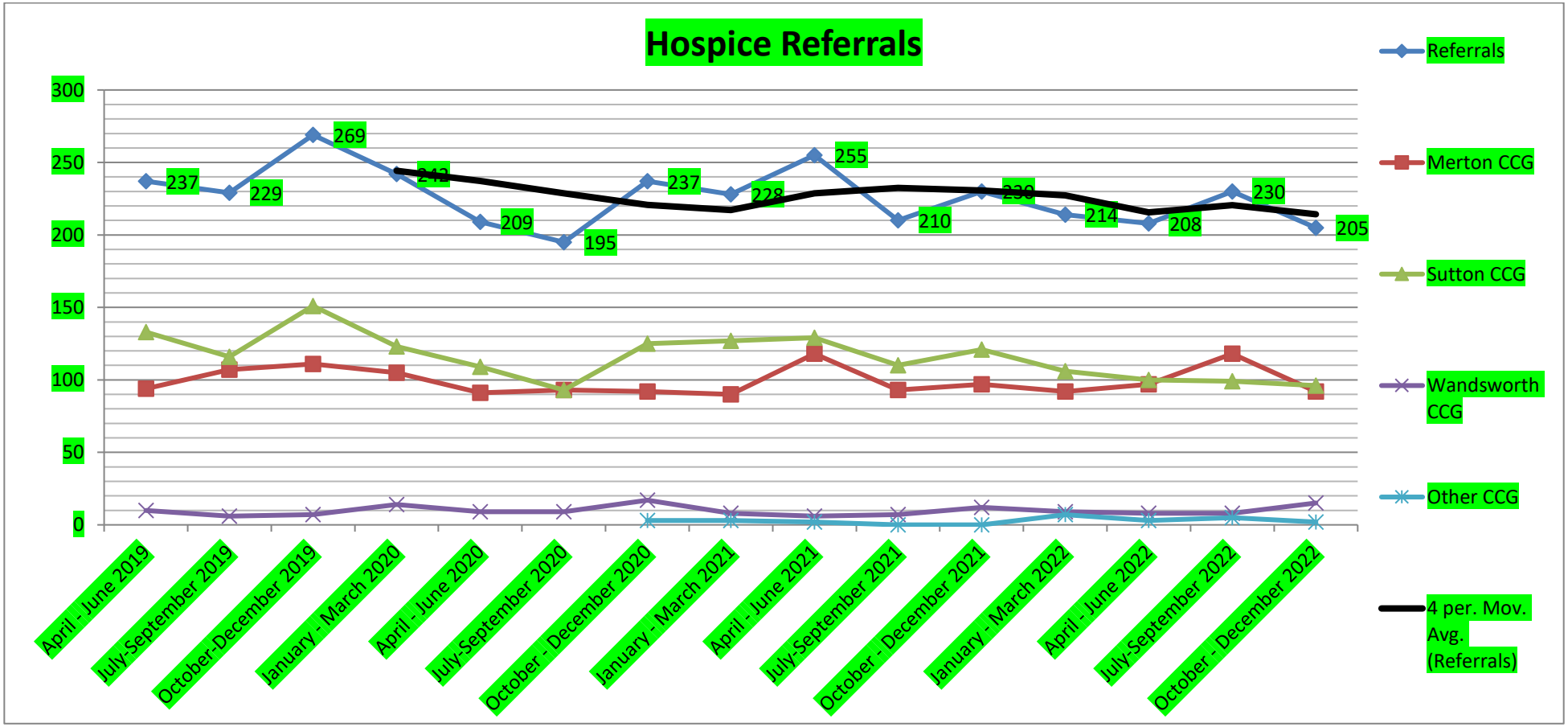
Between January and March 2023 there have been 4 safeguarding notifications made to the CQC: 2 concerning friends of patients, 1 concerning a patient's daughter and 1 concerning DN carers. All were reported to the local safeguarding teams. Of the 4, 3 have been triggered by report from the Community Team and 1 by the Inpatient Unit Team.

	Serious Injury	Safeguarding
2023 Jan - Mar	3	4
2022	9	21
2021	10	19

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.

Hospice Referrals



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

Management Plan 2023/2024

Section 3 – Clinical Quality and Governance Objectives' Extract

	Target Date	Area of Development	What will we do?	How will we know?	Lead(s)	KLOE	RAG	Notes
3.1	Apr-2023	Community	Maintain CNS Development posts subject to availability and attrition	Staffing profile CQ&G Minutes	TC/RT	Well-led Effective		• In place for 2023/24
3.2	May-2023	Clinical Audit/Quality Improvement & Research	• Produce and maintain an audit/monitoring/research project schedule 2023/24	• CQ & G Minutes • Audit report library • Audit progress/results summary report • Clinical Audit Program & Timeline	AR	Well-led Effective Safe Caring Responsive		• N:\Clinical\Clinical Governance\Clinical Audit
3.3	Jun-2023	Psychological Support Services	New literature to be produced on EMDR, Financial Support and Services for Children and Young Adults.	Leaflets and website copy to be live and available in print and online formats	SM	Well-led Effective Responsive		
3.4	Jun-2023	IPU	Develop a robust approach to Infection Control across the IPU • Appointment of IPC lead for the hospice • Ending agreement for IPC support with SHH. • IPC link healthcare professionals supported to continue leading on audits	• Infection rates remain low across the IPU • Staff feel confident and competent in managing infection prevention and control in line with mandatory training information and Infection control policies • Relevant audits are undertaken in a timely manner and reflect best practice	RT/SHH	Safe		• SLA in place with IP&C at SHH 'til June 2023 ; 3 month notice clause in-built • Joint IPC lead appointment with RTH in development early 2023

	Target Date	Area of Development	What will we do?	How will we know?	Lead(s)	KLOE	RAG	Notes
3.5	Aug-2023	Clinical Risk Management	• Create an annual incident review report that extracts learning and staff/service development	• Incident Report	AR	Well-led Effective Safe Caring Responsive		
3.6	Sep-2023	IPU	Achieve full establishment of band 5 RGNs on the IPU	• Reduced agency usage • Increased bed availability • Staffing profile	RT	Well-led Effective Safe Responsive		
3.7	Sep-2023 Mar-2024	Clinical Activity Data	• Create training video to service daily activity data extraction for EMIS • Produce data extract daily or as feasibly close to daily throughout the year	• Continued circulation of activity data / as close to daily as feasible	AR	Well-led Effective Responsive		• Video to be produced once reports production is stabilised • Data extraction has supported allocation of government funding 2020-2022. • Data extraction supports data integrity process
3.8	Nov-2023	Electronic Patient Record System - EMIS	• Support the design, implementation, training, use, integrity and output of the EMIS system	• EMIS project team • CHoDS minutes	RT JS RW TC SM	Well-led Effective Safe Caring Responsive		
3.9	Nov-2023	Psychological Support Services	Hospice UK Conference Presentation on EMDR.	Hospice UK offer of a presentation slot	SM	Well-led Effective Responsive		

	Target Date	Area of Development	What will we do?	How will we know?	Lead(s)	KLOE	RAG	Notes
3.10	Dec-2023	Activity Data	• Embed quantitative clinical activity data into clinical service reflection via CAAD meetings	• CAAD minutes	AR	Well-led Effective		
3.11	Dec-2023	Supporter Care	• Develop and substantiate communication links between patient and carer feedback and supporter development	• Supporter team feedback on relationship engagement	AR / BW/ TCSupporter Care Lead	Well-led Effective Responsive		
3.12	Dec-2023	Psychological Support Services	Maintain student placements at 8 with the potential to expand should satellite clinics be secured.	Continuation of reduced need for counselling by the Head of PS. Increased availability of counselling environments Counselling student numbers. Shorter waiting list	SM	Well-led Effective Responsive		
3.13	Dec-2023	Psychological Support Services	Expand provision of Bereavement Support Work: • continue with quarterly structured and facilitated group • establish drop-in group in partnership with Wellbeing Centre and North Cheam Church.	Monitor user uptake/referrals, attendance and evaluate via qualitative feedback.	SM	Well-led Effective Responsive		

	Target Date	Area of Development	What will we do?	How will we know?	Lead(s)	KLOE	RAG	Notes
3.14	Dec-2023	Psychological Support Services	Increase delivery of Trauma Specific Work (EMDR).	Activity Data	SM	Well-led Effective Responsive		• CS and DB qualified to deliver this innovative treatment.
3.15	Dec-2023	Community Team - H@H	• Establish H@H HCA access and engagement with the Universal Care Plan (UCP)	• Staff confidence and completion	TC/MV	Well-led Effective Safe Caring Responsive		
3.16	Dec-2023	Medicines management Non-medical prescribers (NMP) – joining the hospice Newly qualified NMP supervision / support	Review CLIN 33 Develop Non-Medical Prescriber checklist for Practice Review Scope of practice document Continue Royal Pharmaceutical Society (RPS) prescribing competency annually	• Clin 33 reflects current practice • Increase NMP activity – prescribing log data / EPACT data	TC / KH	Well-led Effective Safe Caring Responsive		

	Target Date	Area of Development	What will we do?	How will we know?	Lead(s)	KLOE	RAG	Notes
3.17	Dec-2023	IPU	Enhance the discharge process by the:- • Weekly allocation of 2 members of staff to lead on discharges • Creation of a document with a process map and all contact details for CHC discharges and social services discharges • Holding family meetings one week after admission to discuss discharge • Creating and using an EMIS discharge planning template	• Staff are more confident and competent with discharge planning and paperwork • Discharge document created that is user friendly and helpful • Staff and those important to the patient feel informed about discharges • Information about discharge is all kept on EPR system and easily accessed and used by all those in the MDT	BW/Med Team	Well-led Effective Safe		
3.18	Dec-2023	Outcomes	• Embed CSNAT within the H@H service and translate its outcomes into service delivery / development	• OMG Minutes	OACC T&F Group Comm – NC/MV	Well-led Effective Responsive		
3.19	Mar-2024	Joint working with SWL ICB Specialist & Generalist Palliative Care Providers (Acute Sector & Hospices)	• To maintain the development of joint-working across the clinical areas	• CQ&G Minutes • CHoDs Minutes • Education Initiatives • IPC Joint Position with Royal Trinity	RT GT-R TC	Well-led Effective Safe Caring Responsive		

	Target Date	Area of Development	What will we do?	How will we know?	Lead(s)	KLOE	RAG	Notes
3.20	Mar-2024	Patient Safety	• Evaluate the Patient Safety Incident Response Framework and position the Hospice accordingly	• Incident management developments • CQ&G Minutes • Health & Safety Minutes • CHoDs Minutes	AR	Well-led Effective Safe Caring Responsive		
3.21	Mar-2024	Psychological Support Services	Increase the availability and accessibility of Counselling in the Community	Exploration of options leading to Satellite Counselling Clinics from GP Surgeries and/or our Hospice Charity Shops. Trial 2 external sites and monitor uptake from clients as well as feedback from counsellors and site managers. Shorter waiting times.	SM	Well-led Effective Responsive		
3.22	Mar-2024	Community Team	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	• Observation • Appraisal • Reduction in Community Manager responsibilities	TC	Well-led Effective Responsive		• JDs reviewed and updated to reflect role responsibilities • Management Training

	Target Date	Area of Development	What will we do?	How will we know?	Lead(s)	KLOE	RAG	Notes
3.23	Mar-2024	Community Team / H@H	Increase SRH presence in the Merton Borough via:- • Collaboration with MEoLCT – identifying patients for H@H • Daily referrals meeting • TC to work with H@H and HPOC lead maximising opportunity • Extend Referral Policy to capture self-referral for patients discharged from the Hospice clinical service	• Referral data • Staff awareness and confidence • CLIN09 Referral Policy • CLINSOP48 Community	TC /MV / Med Team	Well-led Effective Safe Caring Responsive		• TC updating CLINSOP48
3.24	Mar-2024	IPU	• Open up to 12 beds including the family suite appropriately staffed • A more responsive and active IPU	• 12 beds open 90% of time as a minimum • Datix data demonstrates no increase in incidents/accidents that can be related to inadequate staffing numbers	RW/ /Med	Well-led Effective Safe Responsive		

	Target Date	Area of Development	What will we do?	How will we know?	Lead(s)	KLOE	RAG	Notes
3.25	Mar-2024	IPU	Move IPU towards a model of Excellence and a role model for other hospices by • Refining existing model to play to strengths, provide professional development opportunities and meet the needs of our patient group • Developing our Band 6 nurses in terms of succession planning • Discussing in-house management course for band 6s with no previous training.	• Band 6 nurses leading on specific areas of development and utilizing management skills effectively. • Band 6s to lead the ward in the absence of ward sister ensuring safe working of the ward and completion of management tasks • Reduced responsibilities of the IPU Sister	BW/RT	Well-led Effective Safe		
3.26	Mar-2024	Increase the skillset of nursing team in the community and on the IPU	• 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.	• Demonstration of competence and training attendance • Ongoing review of service requirements and development needs • Improved patient outcomes, e.g. through the development of nurse led assessment. • Stable and satisfied workforce (HR evidence/staff survey/appraisal)	BW / MF KC	Well-led Effective Safe		

	Target Date	Area of Development	What will we do?	How will we know?	Lead(s)	KLOE	RAG	Notes
3.27	Mar-2024	Outcomes	Plan implementation and timeline for CSNAT on the IPU and Community CPCT post consolidation/learning exacted from H@H	• OMG Minutes	OACC T&F Group Comm – NC/BW	Well-led Effective Responsive		
3.28	Mar-2024	Bereavement / Fundraising	• Develop the Memory Pathway Project	• Closer working between clinical and non-clinical • CQ&G Minutes • CHoDs Minutes	RT KB-W	Caring Responsive		• Bereavement support administrator to be appointed by June 2023
3.29	Mar-2024	Compassionate Neighbour Service	• Volunteer Training • Volunteer Office Drop-Ins • Increase number of CN Volunteers to support increase in service delivery	• Attendance at courses • Attendance at Office Drop-Ins • Increase in CN volunteers • Response time to referrals • Review at Volunteer Strategy Meetings	RYP	Effective Well-led Safe Caring Responsive		• Aim to increase number of Volunteer Compassionate Neighbours trained to support patient and community member referrals. • Seeking further funding for extension of service to evenings and weekends. (Shirley Illsley).

	Target Date	Area of Development	What will we do?	How will we know?	Lead(s)	KLOE	RAG	Notes
3.30	Mar-2024	Compassionate Communities	• Develop the compassionate community's model • Learn from other Hospice organisations that have developed this model • Work in collaboration with the Wellbeing Centre to communicate and inform about CC • Recruit volunteers to support CN • Potential to work collaboratively with other voluntary sector organisations such as Age UK, Sutton/Merton Carer Centres.	• Increase in numbers of Volunteers • Monitor number of referrals for the service • Diversification of what volunteers do to support those people referred	RYP	Caring Responsive		• CC will be a service that will grow slowly & take time to embed. It is a long-term project which is hoped will have wide impact and support engagement with SRH.

	Target Date	Area of Development	What will we do?	How will we know?	Lead(s)	KLOE	RAG	Notes
3.31	Mar-2024	Community Engagement – Increase reach for Complementary Therapy service	• 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. • Offer complementary therapies in the Den. • Attend the needs of the IPU by offering 'aromastick' inhalers and short treatments with the assistance of volunteers. For example: develop a "prepare to sleep" program for patients and carers in IPU with the help of a nurse and an HCA champion.	• Attendees will understand and utilise the benefits of the approaches we teach and we will receive positive feedback to demonstrate this. • We will have increased therapeutic interventions	AA	Effective Well-led Caring Responsive		
3.32	Mar-2024	Community Engagement – increase complementary therapies offer	• Recruit more volunteer therapists via advert in social media (liaison with Comms) • Liaise with other therapists	• We will have a positive response to our advertising campaign • We will have a higher number of volunteer Comp Therapists	AA	Effective Well-led Caring Responsive		

	Target Date	Area of Development	What will we do?	How will we know?	Lead(s)	KLOE	RAG	Notes
3.33	Mar-2024	Community Engagement – Wellbeing Activity	• Double our morning and afternoon sessions on Tuesdays, Wednesdays and Thursdays using both The Den and The Wellbeing Centre. • 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). • 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. • Reinstate carers lunches • Cntinue to run trips to galleries/theatre/museums • Use facilities in The Den to bake biscuits / pizzas / other simple dishes	• A growing trend in WB attendance with a growing number of new service users • Observe the confidence of our service users grow and we will demonstrate this through feedback mediums • Increase in our number of carer attendees and demonstrate the benefit through a variety of feedback mechanisms	R Y-P /SO/KM/ LD	Effective Well-led Safe Caring Responsive		

	Target Date	Area of Development	What will we do?	How will we know?	Lead(s)	KLOE	RAG	Notes
3.34	Oct-2024	Community Engagement – CT feedback	• Developing a survey with the Comms Team • Asking patients for feedback via email.	• We will be able to demonstrate the response to our service and what actions we have taken to respond to service user need	AA	Effective Well-led Safe Caring Responsive		
3.35	Mar-2025	Outcomes	• Implement Step 2 of OACC – iPOS on the IPU and in the Community • Policy / Documentation • System / Capture • Education • Implementation • Audit	• OMG Minutes	OACC T&F Group IPU-RW ; Comm - TC	Well-led Effective Responsive		• Pended to 2024/25 unless feasible in 23/24

ell
Meeting: **Clinical HODs Meeting**

Date: 13.03.23

Chair: Rebecca Trower Minutes: Lynn Jackson

Present: Tracy Christmas, Dr Gaby Tamara-Rose, Alex Rudkin, Rebecca Wallis, , Maura Flint, Steve Molyneux

Apologies: Dr Jenny Strawson, Dr Naomi Collins, Karen Cook

Agenda item	**Discussion**	**Actions & by whom**	**Anticipated date for completion**
Review of previous minutes	Accurate		
Matters Arising	Potential Source of Funding - Discussion was held with regards to this at the executive meeting no decision made at present on bid for funding		ongoing
Topic			
Infection Control	IC Champions – IPU – Cathy Foster/Sam Leach, CPCT – Jill Smith/Marnie Prior		
	STHH IPC team will be attending the IPC meeting scheduled for 14.03.23		March 23
	RW is awaiting guidance on Immune-compromised patients with regards LFT's.	RW	March 23
	Yearly FFP3 mask fit testing by STHH is to begin week 20.03.23. 35 Staff have been allocated time slots – there will be 7 per day – 1 hr per person. There will be "mop up" sessions available for staff not allocated at present – this will be delivered by SRH staff. On Call Drs to provide their own mask through own organisatio ?? Dr Gaby to email PAH to check.	Clinical staff/MF/ Dr GTR	March 23
	Advert for 0.8 Band 6 Infection Control Lead is being advertised. This is a joint post with RTH .A possible 0.2 joint post for PAH – making a full time position	RT/PAH	March 23

Medical Devices	Mortuary trolley has been delivered but there are some issues with its capabilities. Steve C is dealing with this. Family/Bariatric Room is near completion – there has been a delay due to modifications/alterations having to be made. Room yet to be named but Family Suite is a favoured option. GTR & TC have had initial meeting to discuss sub-cut medication administration by informal carers in the community. It is a substantial/complex piece of work to be undertaken. Once complete this will mean good governance is in place for the future but not a priority at the moment. The delayed Micrel Syringe Driver will now be trialled in May 23. Refresher training to arranged. The SOP is complete.	RW//SC John G/RT/RW GTR/TC MF/KC	Ongoing Ongoing June 23
Medicine Management	A meeting with Ashtons is scheduled for 24.03.23 to look at any service issues Prescribing palliative oxygen in the community was discussed. TC highlighted that this is a prescription and therefore can only be ordered once discussed with a prescriber. Dr Naomi is to review the policy. Medicine management update to be given this week CPCT have 8 non-medical prescribers. The policy is to be reviewed.	RT/RW/Ashtons Dr NC/TC/RW MF/KC/IPU /Jovy G TC/Kevin H	March 23
Incidents & Accidents/RCAs	AR shared January/February incident report data. Increase in non-CD medication incidents reported. There is a healthy culture amongst the staff to report. Difficult to benchmark due to the discrepancies and anomalies in reporting culture and processes amongst fellow hospices,	AR/Staff	Ongoing
Complaints & Compliments	Compliments & feedback are being given to both CPCT & IPU. Please send any received to AR &/or add to DATIX feedback module & Excellence folder . AR & MF informed group that Jonathan C & volunteer admin could help with the input if needed. Email compliments should also be captured by adding to DATIX feedback module & Excellence folder Complaints discussed included multi agency working and the difficulties a patient and family experienced due to miscommunication external to SRH. 1 complaint has been received from a relative with regarding emotional distress.	All staff/AR RT/RW/TC	Ongoing April 23

	Both of these complaints are being dealt with at present. 1 complaint received from IPU patient has been reviewed & staff reflections have been made. MkAD alerts are being made but staff felt that there is little learning shared and a question was raised regarding the usefulness of the reporting.TC to email AR with concerns.	 RT/TC/AR	 Ongoing
Health & Safety	Crash mats have been delivered H & S committee has been held in February	RW/IPU	
New Policies/ Guidelines	Dr GTR has completed the Opioid Use Dependant Management policy. This has to be finalised before publishing Prison SOP has been reviewed by Dr NC/HS. This has been finalised & sent to AR to publish Well Being Centre Operational Guidelines are to be completed Psychological Support Services SOP to be reviewed IPU admission SOP & the trial of IPU Dependency Score has been trialled & is to be reviewed. AR to send out policy updates shortly including CD policy	GTR/AR NC/AR RT/WBC SM/RT RW/IPU AR	April 23 March 23 April 23 March 23 Ongoing March 23
Documentation/ Crosscare	EMIS – launch scheduled for May 2023 – Staff Training schedule has been emailed out to staff & booking has been made. 2 extra dates have been allocated for 'Mop Up' sessions & for night & bank staff. Patient Letters – discussion was had regarding the terminology & to whom letter is written – the patient or GP ? RT to ask other Hospices how they write their letters. It was discussed that this topic should possibly have its own SOP?	JG/MF/PE RT/AR/TC	June 23 April 23
Audit/Research	CSNAT – pilot has begun with H@H initially implementing the pilot. Review TBA Caldicott sweep has been carried out by Dr GTR – To be presented at future Audit meeting CHELSEA study continues. 2/3 recruited. 20 required over 2 years Dr NC/AR to review medical engagement	NC/MV/H@H GTR Dr NC/IPU Dr NC/AR	March 23 June 23 Ongoing Ongoing

	RW/AR to review IPU engagement Voices survey data to be published shortly- return rate 27-32% (9 month turnaround noted by group) 2022 IPU is to be published shortly TC/RW due to have a meeting/SRH visit with Rebecca Dicks -SGH PCT. A discussion note to be made with regards hospital discussions with patient/family/carer awaiting IPU admission & expectations.	RW/AR AR AR/RW TC/RW	Ongoing April 23 April 23 April 23
Education/Training Reflective Forums	Micrel Syringe driver training – May Equality & Diversity training is currently being delivered by The Diversity Trust. Next session due 23 March Karen Cook Education Facilitator began her role 23.02.23 The following training has taken place face to face – VOED/ HCA 2nd Checker- IPU/medicine management Advanced Communication training is to be arranged for September 23 Education are receiving numerous enquiries for placements/visits from both medical students & outside agencies. Maura is aware of the amount of students each department can accommodate at one time. Roehampton Uni have invited Maura & Karen to present to their students on EOL care – date TBC	MF/Clinical staff MF MF/KC MF/KC MF/KC	May 23 March 23 Sept 23 Ongoing TBA
Recruitment/ Staffing	Band 5 Night staff post interview to be held shortly Psychological Support Services – 1 interview carried out & SM informed group an appointment has been made – now at full capacity in terms of students. Well Being Centre & Compassionate Neighbours to merge & be known as Community Engagement from 01.04.23. Roisin has been appointed Community Engagement Lead Simon & Katie have been appointed Community Engagement Facilitators An advert is to be posted for a 0.4 Engagement Facilitator An advert is to be posted for 0.6 Bereavement Journey Facilitator	RW/RT/HR HR/RT/ RYP HR/RT	March 23 May 23 May 23

	An advert is to be posted for Social Work Support - TBA RT to email staff lists to CHODS to check with regard to staff who have left etc. & list Facilities hold for Access cards Fundraising have now moved into the old training room at the main site. Kate Billingham Wilson has started her role as Fundraising Director	RT/CHODS/ Facilities	May 23
CQC	Nothing to report		
Clinical Management Plan	Briefly discussed but will be discussed in depth at next meeting. CHODS to email AR their plan or add to plan themselves in next 2 weeks ready for Alex to present at April Board Meeting – AR to send GTR link for plan.	AR/RT/ CHODS	March 23

AOB			
	Nothing further from CHODS		
	Dates of Meetings Every 6 weeks on Mon, 9 occurrence(s) Apr 24, 2023 01:30 PM Jun 5, 2023 01:30 PM Jul 17, 2023 01:30 PM Aug 28, 2023 01:30 PM Oct 9, 2023 01:30 PM Nov 20, 2023 01:30 PM Jan 1, 2024 01:30 PM Join Zoom Meeting https://us06web.zoom.us/j/85638592795?pwd=MFROZGxId3lvOWhwMVg4S2JDaEFpQT09 Meeting ID: 856 3859 2795 Passcode: 976968		

Date next meeting: 24th APRIL 2023

Equitable Care for All Ethnicities audit

Individual site report: St Raphael's Hospice

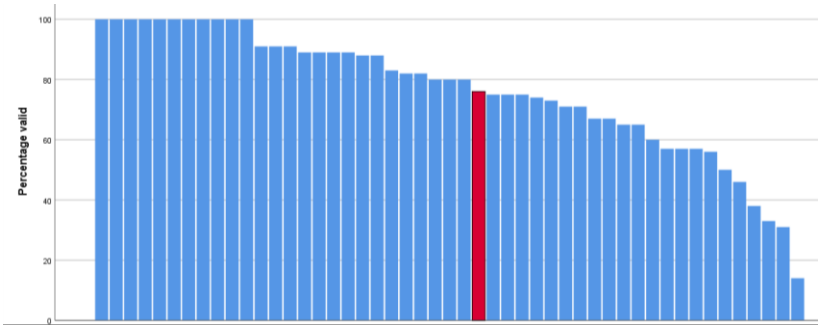
Summary: Fifty-one sites participated in ECAE nationally, returning 1179 lines of data overall.

Your site audited three databases: Crosscare, EMIS and Hospital records. The primary database selected was: Crosscare. Your site returned 43 lines of patient data, 25/43 consented to participation in the full audit (58%).

Reasons for non-inclusion at your site were: patient did not have capacity (14%), patient was too unwell/clinically inappropriate (23%), patient refused (5%).

Audit measure 1: Validity

Validity in the primary database: The graph below shows the % of valid ethnic groups in the site-identified primary database for each site. Your site is the red bar. The table compares your site to the ECAE data overall.



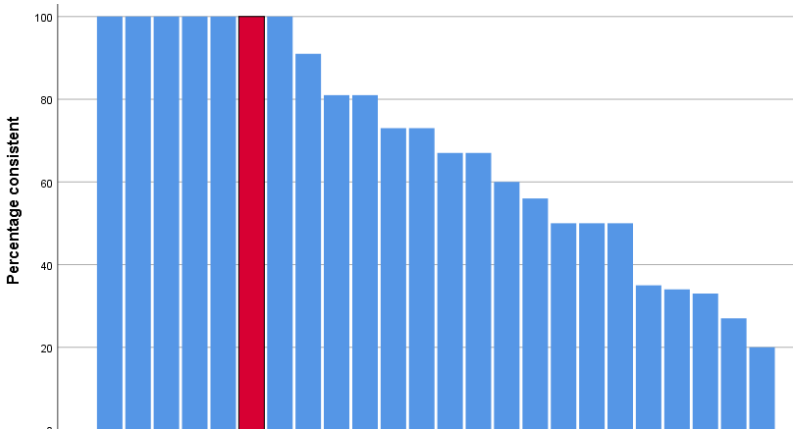
	ECAE national average N=725	Your site N=25
Valid	73%	76%
Mismatch	10%	16%
Not recorded or missing	17%	8%

Validity by ethnic group for each database: The crosstab below illustrates validity by patient self-selected ONS group for each database at your site. The table compares each database at your site to the ECAE overall national average for the primary database.

	Valid matches % ethnic group in DB, (N)				Mismatch % ethnic group in DB, (N)				Not recorded or missing % of the ethnic group in DB, (N)			
	ECAE DB1 N=530	Your site DB1 N=19	Your site DB2=1	Your site DB3=1	ECAE DB1 N=68	Your site DB1=4	Your site DB2=0	Your site DB3=0	ECAE DB1 N=127	Your site DB1=2	Your site DB2=0	Your site DB3=0
White UK	79%	88%, (15)	100%, (1)	100%, (1)	3%	0%, (0)	0%, (0)	0%, (0)	17%	12%, (2)	0%, (0)	0%, (0)
White Other	44%	50%, (1)	-	-	37%	50%, (1)	-		19%	0%, (0)	-	
Mixed/ Multiple	44%	-	-	-	33%	-	-	-	22%	-	-	-
Asian	68%	75%, (3)	-	-	20%	25%, (1)	-	-	13%	0%, (0)	-	-
Black	53%	0%, (0)	-	-	27%	100%, (1)	-	-	21%	0%, (0)	-	-
Other	43%	0%, (0)	-	-	43%	100%, (1)	-	-	14%	0%, (0)	-	-

Audit measure 2: Consistency

Consistency between two databases: The graph below shows the % of consistent ethnic groups between the site-identified primary database and the second database listed. Consistent matches of an incorrect ethnic group or those with no ethnic group were excluded from this measure. Two cases only at your site had data for the first and second database. Your site is the red bar. The table below compares your site to the ECAE data overall.



	ECAE national average N=296	Your site N=2
Consistent	60%	100%
Inconsistent	3%	0%
Not recorded or missing	39%	0%

Consistency by ethnic group across two databases: The table below illustrates consistency between the first two databases by patient self-selected ONS group.

	Consistent % ethnic group, (N)		Inconsistent % ethnic group, (N)		Not recorded or missing % ethnic group, (N)	
	ECAE N=176	Your site N=2	ECAE N=8	Your site N=0	ECAE N=112	Your site N=0
White UK	60%	100%, (2)	1%	-	38%	-
White Other	31%	-	6%	-	63%	-
Mixed/Multiple	33%	-	33%	-	33%	-
Asian	69%	-	7%	-	23%	-
Black	78%	-	0%	-	22%	-
Other	0%	-	100%	-	0%	-

Other measures: Missing data

The table below shows recorded and missing data in the site-identified primary healthcare database for consenting patients.

	ECAE national primary database N=739	Your site primary database N=25
Code present	82%	92%
Marked as not recorded or missing by auditor	14%	8%
Missing data unknown reason	3%	0%

Site acknowledgements: This audit would not have been possible without the support and contribution of local clinical and administrative teams. Thank you to the audit site local lead *Dr Gabrielle Tamura Rose* for supporting, organising and undertaking ECAE at this site, and thank you to all those involved at this site. Local site leads will also receive named acknowledgements in the main ECAE report, available later this year.

An audit looking at referrals to the Hospice Inpatient Unit

1.0 Introduction

This audit looked at all referrals made to the inpatient unit from 13th April to the 14th June 2022. During this period of time the IPU had increased its occupancy to 10 inpatient unit beds, with some flex in keeping with daily staffing levels. This compares to the previous audit period from 2nd Feb to 4th March 2022 when the IPU was operating on a flexible bed capacity ranging from 6 to 9 inpatients (out of 12 available beds). Another change introduced since the previous audit period was to introduce an afternoon admissions' meeting as well as the usual morning meeting. The idea of this was to allow patients to be pre-booked, especially with hospital patients in mind, to ensure transport is booked and paperwork and medication organised in a timely way before transfer.

2.0 Aim of the Audit

1) To audit the number of referrals to the IPU and the number of patients accepted and cared for on the IPU from 13th April to 14th June 2022 and compare this data to the previous audit period of February 2nd to March 4th 2022.

2) To audit where referrals are coming from (home/nursing home versus hospital) and to review waiting times in relation to the referrer's triaging of urgency (emergency within 24 hours, urgent within 48 hours, routine within 5 days).

3) To audit the use of the admissions' score sheet.

3.0 Methodology

Retrospective collection of data from the hardcopy admissions' book updated daily by the consultant team, with reference to the EPR/Crosscare. We decided to extend the audit period to 2 months for the re-audit to capture more data.

4.0 Standards

The hospice aims to admit patients to the IPU within the time frame specified by the referrer (emergency same day, urgent within 48 hours, routine within 5 days) on the admission's score sheet. See admissions policy for more details.

RESULTS

5.0 NB previous audit data is in blue to allow comparison

We received 37 admission requests between 13th April and 14th June (63 days total, 37/2 = 18.5 per month, 0.58 referrals a day, 4.1 a week).

26 referrals were marked as urgent, 10 marked as routine, 1 marked as an emergency.

Compared with 28 admission requests to IPU between 2nd Feb and 4th of March 2022. (31 days, 0.9 referrals a day, 6.3 a week, 28 per month).

Place of care at time of referral:

Home = 21/37 (57%) (20 patients own home, 1 Nursing Home).

Hospital = 16/37 (43%) (SGH: 8/16, SHH: 8/16).

Place of care at time of referral:

Home = 13/28 (46%).

Hospital 15 = 54% (SGH 7/15, SHH 5/15, Croyden 1/15, Springfield 1/15, William Harvey hospital Kent 1/15).

Number of patients admitted to SRH IPU =31/37=84%

- 13/31 (42%) from hospital
- 18/31 (58%) from home/NH

Number of patients admitted to SRH IPU =15/28=54%

- 4 (27%) from hospital
- 11 (73%) from home

Number of patients not admitted to SRH = 6/37 = 16%

- 1 died whilst awaiting a bed (1 at SGH, waited 5 days from referral)
- 1 pt was too unwell for transfer at time bed available (SHH, waited 3 days)
- 1 clinically improved and returned home from hospital (SGH, but referred back by community CNS 5 days later)
- 1 pt was referred to PAH as required trachy care and SRH nurses not trained at this time, but then stabilised and stayed at home
- 1 pt was admitted to hospital via RMH outpt clinic 2 days after hospice referral and later died in hospital
- 1 pt stabilised at home so was taken off the list, asymptomatic but PPD hospice

Number of patients not admitted to SRH = 13/28 = 46%

- 6 died whilst awaiting bed (5 in hospital, 1 at home)
- 2 too unwell for transfer (both hospital)
- 3 admitted to Trinity (all hospital)
- 1 clinically improved and returned home from hospital
- 1 stayed at home as symptoms improved following community management

Number of score sheets completed: 31/37 = 83%

Not completed: 6/37 (2 community referrals, 4 hospital referrals)

Average score patients at home: 6.7

Average score patients in hospital: 6.3

Number of score sheets completed: 22/28 = 79%

Not completed: 6/28 (3 community referrals, 3 hospital referrals)

Average score patients at home: 6.5

Average score patients in hospital: 7

SEE RESULTS TABLE in Appendix 1

Pt was admitted within referrer triaged time frame i.e emergency within 24 hours, urgent within 48 hours, routine within 5 days: 21/37 = 57%, home 14, hospital 7

Pt was admitted but not within referrer's triaged time frame: 10/37 = 27%, 4 home, 6 hospital

Pt died before bed available or too unwell to transfer at time of IPU bed availability: 2/37 = 5%, 2 hospital

Pt taken off waiting list = 4/37 = 11%

- 1 hospital pt: no bed immediately available decision to return home, rereferred to IPU from home 5 days later
- 3 at home: 1 pt needing trachy care, then stabilised and later died at home (PPD), 1 was admitted to RMH from outpt clinic and died later at SHH, 1 pt stabilised, reason for referral was hospice as PPD, no complex symptoms supported by H@H.

Average waiting time for patients referred and admitted to the hospice: 4,6,0,7,1,6,5,0,1,0,1,1,1,1,1,2,1,0,1,1,4,1,1,1,0,6,10,0,12,6,4 /31 = 2.7 days (range 0 to 12 days).

Average waiting time for patients referred from home and admitted to IPU = 4,6,0,1,6,5,0,1,1,1,1,1,4,1,1,1,0,0 days/18 = 1.8 days (range 0 to 6 days).

Average waiting time for patients referred from hospital and admitted to IPU = 7,0,1,1,1,2,0,1,6,10,12,6,4 days/13 = 3.9 days (range 0 to 12 days). NB Outliers 10 days and 12 days waiting, Jubilee BH and ward full with 10 beds for a period without movement. Removing these wait time = 2.6 days.

5 patients admitted on the same day as the referral i.e wait time = 0 (3 home, 2 SHH hospital).

Pt admitted within referrer triaged time frame (12/28 = 43%, 9 home, 3 hospital)

Pt was admitted but not within referrers triaged time (3/28 = 11%, 2 home, 1 hospital)

Pt died before bed available or too unwell to transfer at time of IPU bed availability (8/28 = 28%, 7 hospital, 1 at home)

Pt taken off waiting list/admitted to alternative hospice =5/28= 18%

- 4 hospital (3 accepted at Trinity: 2 patients offered alternative hospice as limited bed capacity at SRH, one patient required NIV/AGP and SRH staff not fully fit tested at this time, 1 pt improved and was discharged home from hospital)
- 1 home: symptoms improved following community interventions

7 patients admitted as a same day emergency admission (all patients at home)

Average waiting time from referral to IPU admission all patients (excluding those not admitted) = 1.9

Average waiting time for patients referred from home and admitted to IPU = 17days/11= 1.5 days (range 7 to 0 days)

Average waiting time for patients referred from hospital and admitted to IPU = 11 days/4 = 2.75 days (range 1 to 4 days)

6.0 **Discussion:**

This audit period shows that 84% of patients referred to the IPU were able to be admitted to the hospice. This compares to 54% in the previous audit period. Only 2 patients in hospital died whilst awaiting a hospice bed in comparison to 6 patients during the previous audit period. This may reflect the increase in the number of beds open to admissions to 10 on average from the previous 6-9 beds open. However, this requires interpreting with caution as the number of referrals during the previous audit period during one month was 28 versus 37 during this 2 month audit period i.e 28 per month (6.3 a week) versus 18.5 per month (4.1 a week).

In terms of number of admissions achieving the urgency time frame standard, 57% achieved this standard during this audit period versus 43% during the previous audit period. 70% of referrals were triaged as urgent with the current standard aiming to admit these patients within 48 hours. Of note only one of the 31 patients was admitted on a weekend. Our current on call SOP, with one first on call doctor covering 2 hospice sites, allows only the admission of emergencies over the weekend period. Discharges are also not planned over the weekend and rarely on a Friday, due to limited community support during OOH/weekend periods and a limited pharmacy service from Ashtons. These factors are likely to have impacted our ability to meet the urgent triaging standard, alongside the limited number of inpatient beds with demand out stripping this provision.

Examining the source of referrals there is a slight fall in referrals from the hospital 43% versus 54% in the previous audit period. This may suggest that the hospitals had fewer referrals due to the declining Covid numbers or conversely this may reflect pressure within the palliative care team, who may have been unable to assess and refer as many patients as usual. There were an equal number of referrals from St George's hospital and St Helier hospital during this audit period.

While this audit continues to demonstrate more patients are admitted from the home environment (58% home vs 42% hospital) this proportion has significantly decreased compared to the previous audit period (73% home vs 27% hospital). This prioritisation is also reflected in the average wait time for a bed, 1.8 days at home versus 3.9 days if in hospital. I note the hospital data is

somewhat skewed by 2 particularly long waits of 10 and 12 days. These waits were impacted by the long Jubilee bank holiday and a period when the ward was full with 10 inpatients and little movement. Removing these gives a hospital to IPU admission wait time of 2.6 days. As previously explored patients at home are often prioritised due the social pressures and lack of care in the home environment versus the hospital environment, often referred to as a 'place of safety'.

Admission Score sheets are used to help in the triaging of patients, in the context of multiple bed requests and often only one bed available. This audit period showed a slight improvement in number of completed scoresheets 83% completed versus 79%. The average score for patients referred from home was 6.7 out of 9 (cf 6.5) and for patients referred from hospital the average score was 6.3 (cf 7). The score continues to act as a helpful objective numerical value when the team tries to triage multiple competing referrals when only one bed is available.

Reflecting on the patient who could not be admitted due to his tracheostomy care requirements, following this referral, the IPU nursing and medical team were urgently trained in tracheostomy care with the education team and ward sister creating a competency document and training delivered by our nurse tracheostomy champion via simulation. We are now able to admit patient who require tracheostomy care and have successfully done so since.

7.0 **Conclusions**

7.1 Increasing the number of available beds to 10 allowed 84% of patients referred to the inpatient unit to be admitted, versus 54% during the previous audit period, however this requires interpreting against a reduction in overall admission requests during the 2 audit periods. Examining the IPU length of stay data may be of interest as despite having 10 beds open the waiting time for an IPU bed increased to 2.7 days compared to 1.9 days, however it is reassuring to note that there was a significant reduction in the number of patients who died before a bed was available. Anecdotally during this period there were longer than average delays in finding appropriate nursing homes with the skills required to look after our patient group e.g those able to manage a syringe pump and this is likely to correlate with a longer than average length of stay.

7.2 The hospice response to the tracheostomy training need, demonstrates the team's drive for excellence and motivation to be as responsive as possible to the needs of our patients.

8.0 **Recommended Actions:**

8.1 Continuing to aim for all 12 beds, plus the new family suite, to be opened for admissions remains key to allowing all patients referred to the hospice to be admitted. Ongoing staff nurse recruitment is required to achieve this goal. Remaining flexible in the contracted hours offered may help to achieve this going forwards, as well as continuing to develop the skills of Nursing

Associates to support the Staff nurses and recognising the particular needs of the night team. Improving wellbeing support and ensuring fair renumeration and benefits (sick pay, maternity pay etc) for all staff, may allow the current workforce to feel supported in the work they do and may ensure retainment of the current workforce, reduce sickness and incentivise recruitment.

8.2 Continuing to work closely with commissioners/EOLC partners to ensure rapid access to NHS CC funded care at home, or in a nursing home with appropriately trained staff is vital to ensure we can move patients on from the IPU once they have stabilised.

8.3 Continuing to work closely with our local hospitals is key to ensuring hospital referrals are appropriately triaged and prioritised. In particular it was noted that the two patients who were able to access a bed on the same day came from St Helier hospital where we have close shared working. As a counterbalance to this we must ensure that all patients from the other referring hospitals (St George's, RMH, Croyden) are given equal access to our inpatient beds based on clinical need.

8.4 Meeting 100% of the urgency time frame currently specified in our admission's policy may be an over optimistic goal. However, we did see an improvement during this audit period and this standard may continue to act as an important motivation to continue to try and improve our responsiveness to the community we serve.

8.5 Of note 6 patients were pre-booked for admission following our introduction of the afternoon admission's meeting and will have allowed patients and families some time to prepare for transfer and is likely to have led to earlier IPU admission times, which impacts the patient and family experience, nursing and medical working hours and wellbeing. Continuing with the afternoon admissions meeting should continue to allow some admissions to be pre-booked as appropriate.

8.6 Increasing the number of beds available may contribute to a feeling of less pressure to discharge and also less time to focus on discharges with more patients to look after. Continuing to train the whole team in discharge management is vital in order to ensure flow through the IPU in order to allow the whole community access to inpatient beds, when they need them most.

9.0 Appendix 1, Results table

Crosscare number	Referrer, place of care	Date of referral And time	Urgency of referral	Admission score	Date and day of admission and any comments	Number of days on the waiting list	If not admitted/taken off the list reason why
18032	CNS/P home	12/4/22 12.25	urgent	9	16/4/22 Saturday	4	
18891	CNS/P home	13/4/23 1552	urgent	4	19/4/22 Tuesday	6	
16959	SGH/CNS	14/0/22 1630	Urgent	4 then increased to 8		6	Taken off list 20/4/22 went home from hospital
16959	Home CNS	25/4/22 11.30	Urgent	7	25/4/22 Monday	0	
19092	SGH/ CNS	15/4/22 am	routine	6	22/4/22 Friday	7	Admission prebooked 21/4/22
18655	SHH	22/4/22 1430	urgent	7	Monday Offered 25/4 too unwell to transfer	3	Fri pm referral
12629	Home/ CNS	26/4/22 2pm	urgent	7	27/4/22 Wed	1	
18825	SGH CNS	27/4/22 am	urgent	9	R.I.P 1/5/22	5	
18365	Home, CNS	27/4/22 1600	routine	8	2/5/22 Mon	6	
17746	Home, CNS	29/4/22 Saturday	urgent	6	3/5/22 wed	5	Saturday referral
18311	Home, CNS	3/5/22	emergency	Not done	3/5/22 Tues	0	
18487	Home, CNS	11/5 4pm Thurs	urgent	6	12/5 Thur	1	
19035	SHH, CNS	12/5 8am	urgent	6	12/5 Thur	0	
16548	Home CNS	12/5 11am	routine	5	13/5 Fri	1	
Xcare no	**Referrer, place of care**	**Date of referral And time**	**Date and day of admission**	**Urgency of referral**	**Admission score**	**Number of days on the**	**If not admitted/taken off the**

			and any comments			waiting list	list reason why
19297	SHH, CNS	16/5/22	17/5/22 Tues	urgent	No score	1	Prebooked day before
18925	Home, SpR CNS	16/5/22 4pm	17/5/22 Tues	urgent	7	1	
1829	SGH CNS	16/5/22 pm	17/5/22 tues	urgent	8	1	
19306	SHH CNS/SpR	17/5/22	18/5/22 wed	urgent	No score	1	Prebooked day before New referral
19304	SHH	17/5/22 pm	19/5/22 Thurs	routine	4	2	Notes mention dual planning for NH
19236	Home, Dr	17/5/22	18/5/22 wed	urgent	8	1	Prebooked for 18/5
15915	Home, Dr	18/5/22	N/A	urgent	9	N/A	Unable to offer trachy care at time of referral, referred to PAH no beds, then stabilised and stayed at home
18402	Home CNS	19/5/22 No bed	n/a	urgent	Not done	N/A	Admitted to RMH following outpt, t/f to SHH and died there on 24/5
19340	SHH CNS, SpR	18/5/22 Late pm	19/5/22 thurs	urgent	4	0	
19363	SGH, CNS	23/5/22 5pm	25/5/22 wed	urgent	6	1	Prebooked transport 24/5
14068	Home. H@H nurse	25/5/22 3pm	26/5/22 thurs	routine	5	1	Prebooked 25/5
12629	Home, SpR	26/5/22	30/5/22 Mon	routine	6	4	
18988	Home, CNS	29/5pm	30/5/22 Mon	routine	7	1	
17797	home	30/5/22	31/5/22 Tues	urgent	8	1	

19079	NH, CNS	30/5/22 5pm	31/5/22 tues	urgent	7	1	
17837	Home, Dr	31/5/22	31/5/22 tues	urgent	7	0	Arrived 1830
19401	SGH, Dr	31/5/22 2pm	6/6/22 Monday	urgent	6	6	Note only 8-9 inpatients on the ward on 1-6/6 staffing?
19418	SHH, CNS	31/5/22 4pm	10/6/23 Fri	5 days	6	10	2-5thJune BH Jubilee
18248	Home, H@H	6/6/22	6/6/22 Mon	urgent	Not done	0	
19465	SHH, CNS	8/6/22 wed	20/6/22 Mon	routine	7	12	Ward full 10 pts
19160	SGH, CNS	10/6/22	16/6/22 Thurs	urgent	6	6	
18368	Home, CNS	10/6/22	N/A taken off list as stabilised 20/6	routine	6		PPD hospice
19499	SGH	10/6/22	14/6/22	urgent	Not done	4	

10.0 Actions Completed

11.0 HPoC/IPU staff Comments

11.1

SAINT RAPHAEL'S HOSPICE

MINUTES OF THE MEDICAL BUSINESS MEETING
Held on 1st February 2023

In attendance:	Gaby Tamura-Rose	Consultant (Chair)
	Ambreen Akhtar	Speciality Doctor
	Naomi Collins	Consultant
	Rebecca Gemmell	StR
	Jovy Giles	Physician Associate
	Eman Maki	GP trainee

Apologies for Absence

Jenny Strawson and Busi Da Silva

Minutes of the Last Meeting

Checked and no issues raised.

Welcome to Eman, joining the team today!

Team Wellbeing

All shared.

Rota / staffing for the next few weeks

Rebecca shared the rota for the next four weeks.

Eman will be with us Mondays, Wednesdays and Thursday mornings.

Jovy has started her Friday Morning sessions with community palliative care team (CPCT) but the timing of this may require to be reviewed in light of staffing. EM would like to do some work with the CPCT during her placement.

Clinical Challenges

Discharge of complex cases from the IPU into the care of the CPCT are to be discussed at the morning CPCT meeting to promote better transfer of information and coordinated care. Names can be added to the CPCT MDT list.

Infection Control

Sharps policy completed.

Recent case of C Diff. Barrier nursing took approx. 12 hours to implement as some confusion as to status/ risk. Rebecca Trower is developing information leaflets on various infections eg C Diff, MRSA which may be helpful for relatives particularly.

Jovy due to offer Fit testing to staff once solution available.

Joint infection control post (0.8 WTE, Band 6) being advertised between Trinity Hospice and StRH; the post holder will hopefully be able to take on ongoing Fit testing in due course.

Education

First Schwartz round held with good turnout. One meeting to be held monthly on different days/ times.

Sage and Thyme course held 19.1.23.

Basic life support training held. Future dates postponed from April in light of EMIS roll out.

EMIS training will need to be done April 2023 with everyone attending 2-3 sessions.

Audit and Research

Chelsea Study: One patient completed. Second patient in progress currently.

Audit: Naomi thanked everyone for the good work on audits and encouraged that current audits are completed if possible in current year. Eman keen to do an audit/ quality improvement project and Rebecca keen to supervise an audit project. To try and identify topic of interest in near future.

Caldicott Sweep – Gaby has completed her annual inspection of the Hospice. Medical office generally good, and improved from last year 😊 Report to follow. GTR

NC

Any other business:

Jovy asked about planning for attendance at future conferences. Plan to discuss at next meeting and to come with dates of PCC, Guildford course, Hospice UK, Oxford Course etc

Dates of future meetings:

Date	Event	Venue/Time
01.03.2023	**Medical Business Meeting**	14.00 – 15.00 Training Room

Outpatient service activity

AUDIT

1.0 Introduction

1.1 In June 2022 the hospice outpatient service was re-introduced. It was recognised that some patients prefer having a choice of where they are reviewed, some preferring the outpatient setting to their own home and indeed since working practice shifts as a result of the Covid-19 pandemic, some preferring virtual face to face reviews. As a hospice we are keen to ensure patients and families are given the choice of where they are reviewed and so a room was identified for use, positioned next to the CPCT and consultant office, decorated and fitted for purpose (computer, couch, chairs, blinds installed). The outpatient room was added to the Crosscare diary to allow clinicians to book the room. Following this a decision was made to audit outpatient activity since the launch of the service.

2.0 Aims

- To quantify how many outpatients have attended the hospice between July and December 2022, as the outpatient service has just been reintroduced.
    - To understand the patient characteristics of those attending outpatients (New referral, follow up, AKPS,POI)
    - Who booked the patient into outpatients – HPOC, CNS/P, doctor
    - To quantify the frequency of non-attendance.
    - Are these patients also attending other hospice based services e.g counselling, well-being.

- **Methodology**: Retrospective data collection, patients were identified using the Crosscare diary. Data collected from 4th July to 9th December 2022. Data was anonymised using the Crosscare number, no individual staff were identified within the results.

- **Standards:** Patients who are able to attend outpatients should be offered this as an alternative to home visiting. This supports patient choice and may also allow the team to be more responsive as the clinician is not required to travel so is likely to be able to see more patients in this setting.

3.0 RESULTS

3.1 14 outpatient appointments were booked between 4th July and 9th December (over 115 working week days, 1 outpatient booked every 8 working days) for 11 different patients - 4/14 of these appointments were attended by the same patient. (See table below).

3.2 5 were First assessments (4 CNS, 1 dr) booked by HPOC, the remaining 9 were follow up appointments, 6 booked by the CNS team and 3 booked by the medical team, 4 appointment were with CNSs and 5 with doctors.

3.3 There was one DNA(Did Not Attend), when the patient was phoned he had forgotten about the appointment as he had had a busy week attending haematology outpatient appointments. A home visit was rebooked 2 weeks later.

3.4 The AKPS of patients ranged from 80% (Normal activity with effort, some signs or symptoms of disease) to 60%(Able to care for most needs but requires occasional assistance) with an average of 70% (Cares for self, but unable to carry on normal activity or do active work, 72.14 rounded to nearest AKPS score).

3.5 The Phase of Illness(POI) of patients ranged from unstable to stable(3) to deteriorating(1), with unstable (10) being the most common POI.

3.6 The average age of patients attending was 59, with a range of 37 to 81 years.

3.7 Of those 11 different patients attending outpatients 5 were already known to the wellbeing centre, complementary therapy or counselling team at time of outpatients booking. Of those booked for outpatients who were not already known to these teams, the reason for booking an outpatient was based on an assessment of good mobility and overall function, a chance for them to visit the wellbeing centre during the visit as they showed an interest over the phone, or the fact that they were already attending hospital outpatients such as oncology.

4.0 Discussion

4.1 This audit demonstrates that since the outpatient service was reintroduced and the outpatient room was made available for bookings, that outpatient appointments are being offered to patients for both first assessment through HPOC and follow up, with only one DNA (did not attend).

4.2 The results demonstrate that currently the service is offered to those who remain mobile with good function, demonstrated by the average AKPS of 70% and to those who are already known to hospice outpatients services such as wellbeing or those who show an interest in these services. Free parking on site also supports access to the outpatient room in the main hospice building.

4.3 While to be expected at the start of introducing a new service, the current number of outpatient appointments remains low and it is likely that more of

our patient group could attend outpatients, although this may not be their preference. With increasing demands on our workforce, balancing patient convenience and choice against the capacity of the team to see more patients in the outpatient setting should be considered.

4.4 There is a strong culture of home visiting as the norm in community palliative care team services and moving towards more outpatient working requires a significant shift in behaviour, particularly as the patient group we serve changes with referrals often being made earlier in the disease trajectory, in line with the enhanced supportive care movement in oncology.

4.5 Some palliative care clinicians feel seeing a patient in the outpatient setting does not allow an assessment of the home environment as part of the social and spiritual review, often felt to be key to the holistic palliative care assessment. While as a counterpoint to this some clinicians feel that allowing patients and families to visit the hospice site may help to de-stigmatise their view of the hospice**,** especially if they are considering this location as their PPC/PPD (preferred place of care/death).

4.6 The outpatient setting can also be a useful environment for clinicians in training, as they can assess patients independently with the safety net of having a senior clinician/MDT close by for support +- patient review if required.

5.0 **Conclusions :**

6.0 Following the introduction of the outpatient service, this audit demonstrates that 14 outpatient appointments were offered during a 5 months period (115 working days Mon-Fri, 1 appointment offered every 8 days) as an alternative to home visiting, following an assessment that the patient was physically able to travel or if they were already visiting the hospice outpatient services such as wellbeing and counselling. This audit was not able to capture the number of patients who were offered an outpatient appointment and declined, preferring the convenience of a home visit.

7.0 Continuing to promote and expand the outpatient offer may allow us to further increase out responsiveness, as the time saved travelling will allow clinicians to see more patients, whilst recognising that a significant number of our patients are unable to travel due to their deteriorating functional status and common symptoms such as pain and nausea which makes travelling burdensome.

8.0 Working towards a hybrid model of both outpatient and home visiting may strike the necessary balance required to ensure the best, most responsive and holistic care for our patients and those important to them, whilst promoting patient choice, alongside the increasing demands on our service.

9.0 Recommended Actions

9.1 Continue to promote the outpatient service within both HPOC and the wider community team and to offer the outpatient service as an option to all patients who are able to travel (AKPS 60% or above).

9.2 To consider the number of rooms available for outpatient bookings if the service continues to grow over time.

9.3 To consider the option for other outpatient settings that may be more convenient for patients and promote visibility and engagement with primary care such as satellite clinics within GP surgeries.

HPoC/IPU staff CommentsCrosscare number	Date/day of outpt visit and type of clinician making the booking	1st assessment/follow up, clinician (CNS, practitioner, dr)	Age/AKPS/POI	Comments e.g non attendance, visiting other onsite hospice service
20706	6.12.22 Tuesday, booked by HPOC	1st assessment, CNS review	61yr old, AKPS 80%, Unstable (not recorded, auditor interpretation of text)	HPOC picked up pt's interest in attending WBC
19203	8.12.22, Thurs, Booked by CNS	Follow up, CNS	61 yr old, 70%, stable	Pt already attending comp therapy in WBC
20750	9.12.22, Fri, Booked by HPOC	1st assessment, CNS review	63 yr old, 60%, unstable	HPOC felt the pt may only need one off assessment and onward referral to EOL team, may eb interested in WBC
16432	18.11.22, Friday, booked by HPOC	1st assessment, CNS review	78 yr old, 80%, unstable	Function assessed over the phone by HPOC 'fully mobile and driving'
20254	15.11.22,Tues, booked by CNS	Follow up, CNS	37, not recorded at time of visit, on next visit AKPS 80%, unstable (28.11.22)	Plan to meet psychosocial team member at during the visit to SRH
18730	2.11.22, Wed, booked by CNS	Follow up, doctor	66, 70%, unstable	Pt booked into wellbeing centre/comp therapy on the same day

17302	22.9.22, Thursday, booked by HPOC	1st assessment, CNS review	41, 80%, unstable	HPOC note she is attending oncology outpts for clinical trial
16819	9.8.22, Tuesday, Booked by Dr	Follow up, pt keen to catch up with consultant after counselling session	54yr old, 70%, stable	Already attending counselling as outpt and weekly WBC sessions
18526	3.8.22, wed,CNS	Follow up, CNS	55,unstable, 60%	Previous inpt and known to wellbeing team
19777	3.8.22, Wed, HPOC	1st assessment, Dr	49, 80%, unstable	HPOC note that pt is still working and functioning well
16819	2.8.22., Tuesday, booked by Dr	Follow up, Dr(Keen to catch up with Consultant whilst visiting)	54 yr old, 70%, stable	Already attending counselling as outpt and weekly WBC sessions
16819	26.7.22, Tuesday, Tuesday booked by Dr	Follow up (keen to discuss trial drug with consultant, ACP started), Dr	54 yrs old, 70%, deteriorating	Already attending counselling as outpt and weekly WBC sessions

Prescriber's Meeting 9th March 2023

Present – Kevin Hobson, Tracy Christmas, Jill Smith, Katie White, Kate Larkin, Dr. Gaby Tamura Rose, Kim Smith, Dr. Busi Da Silva,

Minutes

Previous meeting minutes

Reviewed and agreed by team

- Kevin and Avril to look at auditing ? anti-emetics s/c requests (? Dr. Naomi can advise)

Prescribers Competencies

- RPS competencies and Intention to Prescribe forms are due to be completed again. The RPS competency forms are on computer =

N drive - Clinical – CPCT- NMP'S Competencies - with each individual prescribers name ready to be completed.

- Intention to Prescribe form is on =

N drive - Clinical – CPCT – Nurse Independent Prescribers – Appendix 1 Intention to Prescribe

- Tracy and Kevin will be reviewing and updating CLIN33 Non Medical Prescribers Policy to include guide / list for all Prescribers.

Prescribing Governance

- ClinSOP 09 - 'Safe & Secure Management of NHS Prescription Stationary' has been updated by Tracy. New instructions about returning / destroying FP10's and failure of the safe in CPCT office. Please read.

- All Independent Nurse Prescribers should continue to keep personal log of all prescriptions issued plus record on Excel - there is a tab for each prescriber! =

N Drive – Clinical – CPCT – Nurse Independent Prescribers – Prescribing Log – Current Prescribing Log

- Tracy will email SWL Lead pharmacist re current budget for St.Raphael's Non Medical Prescribers – we have historically been told not to worry as we have always been under budget. However, we now have a high proportion of NMP's in the hospice (which is great!) so would be useful to know if there is a limit set.

- CLINSOP 24 – Transportation of Medicines has been updated (in particular Procedure for collecting and transporting medication from the community pharmacy to take to patients home) – please read

Nutritional Guidelines

- Sutton lead dietitian has reported that there has been a number of inappropriate requests for supplements prescriptions to G.P's - officially nutritional supplements should only be prescribed after review by dietitian (this can be a lengthy process!).
- Michelle Philpot (Sutton dietitian) has kindly sent info pack re home made supplements / nourishing snacks / prescribing guidelines. Now printed off and supply kept on Info leaflet stand in CPCT office – also available on N drive in Forms

Medicines Alerts

- Alex continues to forward Alerts from MRC ? Whole team have responsibility to check which is relevant to them / their practice.
- Recent alerts include Methadone supply having incorrect info leaflet and there being an unstable supply of Levothyroxine at large.

- Haloperidol was discussed due to recent costings of drug. 0.5mg tablets cost £222 for pack of 28 whereas 1.5mg tablets are £2.18. Kevin will send out reminder to CPCT team re requesting Haloperidol from G.P.'s – Advise to request Haloperidol 1.5mg tablets when able, however if this dose is too high for patients then consider Haloperidol oral solution (5mg/5mls) which cost £7.08 for 100mls.

- Jenny recently highlighted the availability of immediate release Morphine prep (Actimorph tablets) available in 1mg & 2.5mg. They may have a place for pt's with swallowing difficulties, however is more expensive than oral Morphine solution (Oramorph) – and not yet on SWL prescribing formulary.

Community Prescribing practices in last few months

Continues to be mainly at weekends or Friday afternoons!
Since last meeting Kevin has prescribed –

- MST
- Oramorph
- Butrans patches
- Nystatin x 2

Jill has prescribed –

- Haloperidol & Morphine injection
- Oramorph x 2

Lorraine has prescribed –

- Senna tabs
- Omeprazole
- N. Saline nebs

Bernie has prescribed –

- Oxycodone oral solution x 2
- Paracetamol Supps
- Haloperidol 1.5mg tabs & oral solution
- Midazolam & Morphine & Glycopyrronium injections
- Butrans patch x 3
- Lorazepam tablets x 2
- MST 30mg tabs

AOB

- Kim reminded team that Rapid Response team can assess pt' for antibiotics
- Busi – Template for writing letters to G.P's have been sent out incomplete – can look unprofessional! Kevin will send out reminder to team re deleting sections of letter not needed.
- Tracy will look at issue of prescribing Oxygen – whether NMP's are happy to prescribe / including in competencies.
- There have been inconsistencies regarding amounts of ampoules for anticipatory s/c meds requested to G.P. Kevin will ask Pascal to remove current amounts from request template we send out to G.P's to allow for individual assessment of amounts needed.

Next meeting we will aim for early June (Kevin will let you know!)

Clinical Records Service Evaluation– Clarity, Accuracy and Relevance

1.0 Introduction

1.1 Keeping clear and accurate records relevant to the area of practice are key principles for healthcare professionals to ensure effective communication and best support patient care [The Medical Defence Union (1); The Nursing and Midwifery Council (2)]. This is clearly outlined within St Raphael's Hospice Policy (3). It is best practice and an essential part of good governance to undertake a service evaluation of clinical record keeping on a regular basis to ensure that policy is adhered to and standards are maintained.

2.0 Aims

1. To promote and maintain effective clinical record keeping in line with professional guidance and standards.

2. To identify areas of concern or areas for improvement.

3. Increase and retain confidence in appropriate record sharing with third parties as required.

3.0 Methodology

3.1 Ten clinical records sampled from EPR (Crosscare) system in line with the following criteria:

- Active within the last 2 months
- From all CPCT locality caseloads
- At least 2 records to include IPU stay
- To include multi-professional entries
- Patient to be primary subject of the record

3.2 First assessment and most recent assessment to be reviewed.

4.0 Criteria

There are no specific standards set but guidance is provided. Therefore, criteria have been set from the guidance provided by the Medical Defence Union (1) and NMC: The Code (2):

1. Consent for records to be shared – specific, clear and easily visible
2. Report/record decisions made and rationale for those decisions
3. Demonstrate patient involvement in decision making where possible
4. Are records objective?
5. Do records contain jargon or meaningless phrases or irrelevant speculation?
6. Is third-party information relevant and appropriate?
7. Are they succinct?
8. Comments

5.0 Results

First assessment: Most recent assessment

:

1. Consent for records to shared – specific, clear and easily visible	• 90% documented consent for sharing of records/ 10% (1 record) no evidence of consent – patient too poorly to discuss but patient representative not asked about consent according to records. • 20% identified HCPs and specific family members with whom information could be shared.	• 30% documented that consent to share had been revisited.
2. Report/record decisions made and rationale for those decisions	• 100% • 30% included more detail such as declining discussion re CPR due to wanting more chemo/detail re ACP and rationale for not wanting discussion at this point	• 100% • 20% provided specific detail such as not wanting ACP discussions until RMH can no longer offer treatment/'has capacity regarding health and wellbeing today and not

		consented to FT application'.
3. Demonstrate patient involvement in decision making where possible	• 100% (detail of one patient lacking capacity on this occasion)	• 100% of patient had capacity and this was recorded.
4. Are entries objective?	• 100%	• 100%
5. Do records contain jargon or meaningless phrases or irrelevant speculation	No	No
6. Is third-party information relevant and appropriate?	• 100%	• 100%
7. Are entries succinct?	• 80% succinct • Two records unnecessarily wordy, overly descriptive	• 80% succinct • Two records unnecessarily wordy – one with excellent assessment
8. Comments	• HPOC noted that a patient hadn't consented to our input so asked referrer to double check and patient initially responded that she didn't want SRH input.	

5.1 Summary of results

1.Consent for records to shared – specific, clear and easily visible ***90% (100% last year)***

2.Report/record decisions made and rationale for those decisions ***100% (100% last year)***

3.Demonstrate patient involvement in decision making where possible ***100% Nearly all patients were able to actively participate in decision-making. One patient lacked capacity on the first assessment and this was recorded.***

4.Are records objective? ***100%***

5.Do records contain jargon or meaningless phrases or irrelevant speculation? ***No – 100%***

6.Is third-party information relevant and appropriate? ***100%***

7.Are they succinct? ***Two sets of records were unnecessarily wordy – different authors. One was a thoroughly recorded assessment but the same information could have been provided in a shorter narrative. This is both time consuming for the author and a member of staff needing to access information.***

8.Comments: ***All records were informative and demonstrated compassion and sensitivity. Occasional spelling errors. Most used full names for HCPs***

6.0 Discussion

The majority of records were clear. All had rationale for actions documented. Two records were particularly wordy and would have been easier to read had they been shorter and to the point. Some of the description did not add to the quality of the information. The records demonstrated individualised care with attention to detail where relevant. As previously, there are a number of abbreviations in the text but these are commonly used such as BNO and HNPU and easy to interpret.
On occasion the notes referred to a colleague in a familiar way rather than using the full name. This has happened previously and again requires address.

7.0 Conclusion and Action Plan

Results are once again positive with very few areas for improvement or focus. However, this is a very small sample and does not necessarily bear out all the issues for consideration.
The results will be shared at CHODS as well as the Clinical Quality and Governance Committee. Managers will cascade to their teams.
Staff will be reminded to use full names when referring to colleagues in the clinical record.

Rebecca Trower
Clinical Director
January 2023

References

1.https://www.themdu.com/guidance-and-advice/guides/good-record-keeping
2.NMC (2015), The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates
3.St Raphael's Policy Manual (2020); Creating and Maintaining the Clinical Record; OP31 – Records Management Policy.

VOICES QUESTIONNAIRE

2021-2022

Compiled by: Quality Office

INDEX

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 1st October 2021 to 31st March 2022 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 2021/22 dataset with earlier audit from 2021.

Executive Summary

a) The number of returned questionnaires has increased to 27% in 2021/22 (c.f. 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 12).

c) Definite assertion of the adequacy of inpatient emotional support greatly increased to 93% in 2021/22 from 2021's 64% (page 13), whilst definitive assertion of the adequacy of inpatient religious/spiritual support has decreased to 67% from 2021's 86%.

d) Inpatient support regarding financial concerns or other practical problems was considered to be of greater need – 6 respondents (33%) in 2021/22 (c.f. 18% in 2021). That need was considered to have been definitely met by 6 (100% in 2021/22 c.f. 67% in 2021).

e) Definite assertion that symptoms other than pain in the IPU had been relieved has decreased to 77% (c.f. 83% in 2021) and 100% recorded either definitely or to some extent in 2021/22 (c.f. 100% in 2021).

f) Support regarding family concerns was considered to be of greater need – 50% in 2021/22 (c.f. 41% in 2021). That need was considered to have been definitely met by 78% in 2021/22 (c.f. 71% in 2021).

g) Pain relieved completely, 'all of the time' has maintained at 71% in 2021/22 (c.f. 71% 2021), 'some of the time' has decreased to 0% in 2021 (c.f. 18% in 2021) and 'partially' has increased to 18% in 2021/22 (c.f. 6% in 2021) (Page 14).

h) Significant shift in the number of family members from being always kept informed to only being 'usually' kept informed of the patients' condition - 78% in 2021/22 (c.f. 88% in 2021) being always kept informed. 22% considered family members were usually kept informed (c.f. 6% in 2021). 0% considered family members were only sometimes informed (c.f. 6% in 2021).

i) The percentage of respondents who considered the language used by doctors and nurses to explain the condition to be 'very easy' to understand decreased to 72% in 2021/22 (c.f. 76% in 2021) (Page 15) with a slight decrease in 'fairly easy to

understand' responses to 22% in 2021/22 (c.f. 24% in 2021). 6% reported that they 'never spoke' to staff about the patient's condition (c.f. 0% in 2021).

j) The number of respondents that felt that decisions were made about the patients' care/treatment that they wouldn't have wanted has increased to 11% in 2021/22 (c.f. 0% in 2021).

k) Doctors and nurses 'always treating patients with respect and dignity' remained the same for doctors and nurses – 94% for nurses and 100% for doctors (c.f. 94% for nurses and 100% for doctors in 2021).

l) Definite assertion that the Hospice worked well with patient GPs and other external services has increased to 71% in 2021/22 (c.f. 50% in 2021). 0% of respondents (c.f. 0% in 2021) felt that they didn't work well together and 12% in 2021/22 that didn't know (c.f. 13% in 2021).

m) A larger proportion of respondents regarded that being able to stay overnight in the Hospice was important – 60% (c.f. 41% in 2021) (page 16, Question 11).

n) There has been a decrease in respondents considering that they had 'definitely received sufficient emotional support from the hospice team' whilst an inpatient – 72% in 2021/22 (c.f. 76% in 2021) (page 17), with an increase in emotional support not being required – 6% in 2021/22 (c.f. 0% in 2021). Taken together the adequacy of emotional support as either definite, to some extent or not required has increased to 100%.

o) Respondents were asked to rate care given to inpatients by doctors and nurses and the responses in 2021/22 show a shift to 'Exceptional' up from 'Excellent' and 'Good.' 71% considered doctor care to be 'Exceptional' (c.f. 53% in 2021),' 24% considered it to be 'Excellent' (c.f. 40% in 2021) and 0% considered it to be 'Good' (c.f. 7% in 2021) and 6% considered it 'Fair' (c.f. 0% in 2021) and 0% recorded 'Don't Know' (c.f. 0% in 2021). Taking 'exceptional' and 'excellent' together there is a small increase in 2021 – 95% (c.f. 93% in 2021). Responses relating to nursing care show a shift to 'exceptional' from 'excellent': 78% rating nursing care as 'Exceptional' (c.f. 59% in 2021) and 11% as 'Excellent' (c.f. 41% in 2021) and 6% as 'Good' (c.f. 0% in 2021) and 6% as 'Fair' (c.f. 0% in 2021) (Page 17). Taking 'exceptional' and 'excellent' together, this has decreased in 2021/22 to 89% (c.f. 100% in 2021).

p) Regarding the food provided on the IPU in 2020/21, there was a decrease in 'Exceptional' responses: 21% rated the food as 'Exceptional' in 2021/22 (c.f. 40% in 2021), 43% 'Excellent' (c.f. 40% in 2021), 7% 'Good' (c.f. 10% in 2021), 14% 'Fair' (c.f.

0% in 2021), 0% 'Poor' (c.f. 0% in 2021) (Page 18) and 14% recorded 'Don't know' (c.f. 10% in 2021). Combining 'exceptional' and 'excellent' ratings there has been a decrease in 2021/22 – 64% (c.f. 80% in 2021).

q) 89% of respondents rated the patient bedroom as 'Excellent' which is a large increase from 71% in 2021. The en-suite bathrooms were rated 'Excellent' by 94% in 2021/22 (c.f. 65% in 2021) (Page 19) which is a very great 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 is slightly decreased – 84% (c.f. 85% in 2021); 'Yes definitely' answers for emotional support have increased – 58% (c.f. 51% in 2021); Religious or spiritual support have increased to 62% (c.f. 46% in 2021), but that question has a smaller data cohort, since fewer respondents consider religious/spiritual support to be necessary.

s) A higher proportion felt that the patient required help with urgent problems during the evenings, between 5pm and 11pm, – 75% (c.f. 62% in 2021) and of those, an increased proportion – 65% (c.f. 52% in 2021) felt definitely that enough support had been received. (page 22)

t) A higher proportion felt that the patient required help with urgent problems during the night (7pm – 9am) – 75% (c.f. 66% in 2021) and of those, a higher proportion – 65% (c.f. 61% in 2021) felt definitely that enough support had been received.

u) A slightly lower proportion of respondents considered that the patient's pain had been completely relieved all of the time by the CPCT – 38% (c.f. 40% in 2021) (page 22). [Note – complete pain relief on the IPU has maintained the same result during this audit period – it was 71% (c.f. 71% in 2021)]

v) A lower proportion in 2021/2 – 82% (c.f. 85% in 2021) 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 slightly: 'Very easy' to understand increased very slightly to 71% (c.f. 70% in 2021) and 'fairly easy' increased very slightly to 26% (c.f. 25% in 2021).

x) Care received from the CPCT altogether saw an increase to 53% rating it as 'Exceptional' (c.f. 48% in 2021), 0% rated it as 'Poor' (c.f. 5% in 2021) (Page 24). Overall care as a whole provided by the CPCT shows a slight increase on 2021 with either 'Exceptional', 'Excellent' or 'Good' yielding 97% (c.f. 95% in 2021).

y) CPCT involving family/carers in decisions about the patients' treatment has maintained at 88% in 2021/22 (c.f. 88% in 2021).

z) Patient's explicit statement on their preferred place of death once again indicates that it is usually their home or the Hospice: Home – 67% (c.f. 77% in 2021) Hospice – 33% (c.f. 18% in 2021).

aa) 87% of respondents believed the patient died in the right place (c.f. 89% in 2021) (page 28).

bb) 69% felt the patient achieved their preferred place of death (c.f. 68% in 2021) (page 26).

cc) Bereavement support for those whose loved ones died in the Hospice was considered definitely enough by 80% - a decrease from 2021's 92% (page 29).

dd) 94% felt able to talk to someone from the Hospice as soon as they wanted about their bereavement (c.f. 71% in 2021) which shows a substantial increase. 0% wanted it sooner (c.f. 24% in 2021).

ee) Following receipt of the bereavement leaflet – a slightly decreased proportion - 65% found it either definitely helpful or helpful to some degree (c.f. 66% in 2021). 24% did not receive the leaflet (c.f. 26% in 2021).

ff) The proportion of respondents that considered contact from the bereavement team was either definitely helpful or helpful to some degree has increased to 81% (c.f. 69% in 2021). 0% felt the contact was unhelpful (c.f. 5% in 2021). Responses stating that contact wasn't received decreased to 10% (c.f. 15% in 2021).

gg) Responding to the Friends & Family question, all 48 recorded an answer and 40 (83%) rated the hospice as 'Very Good' (c.f. 77% in 2021), 8 (17%) rated the hospice as 'Good' (c.f. 17% in 2021), 0 (0%) rated it as 'neither good nor poor' (c.f. 2% in 2021). 0 (0%) rated it as 'Poor' (c.f. 0% in 2021), 0 (0% c.f. 4% in 2021) rated it as 'Very Poor,' and 0 (0%) did not know the answer to this question (c.f. 0% in 2021). Taken together, 100% rated the Hospice as either 'Very Good' or 'Good' in 2021 (c.f. 94% in 2021).

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%. Utilising email or our website as potential complementary or primary communication route for the survey will be a consideration going forward. **LEAD : Alex Rudkin, Director of Quality & Governance**
b) Open a new and enlarged family room that will service bariatric admissions as its primary function but will otherwise provide overnight accommodation for family members. **LEAD : Becca Trower, Clinical Director**
c) Review the demand for advice out of hours and its impact upon staffing. Already created a flowchart to support the inpatient nurses with the management and triage of OOH calls to lessen any distress or undue burden they may have been causing. **LEAD : Dr Naomi Collins, 2022 Audit Report**
d) Review the process of distribution/receipt of the bereavement literature to highlight potential gaps in provision. Already improved our capture of NOK details so that we can write to the majority within the one month post date of death – only 10% of respondants did not receive information about support services**. LEAD : Alex Rudkin, Director of Quality & Governance**
e) Review the 'spiritual' offer on the IPU and how spiritual needs on the IPU are addressed (An item of note in the IPU feedback questionnaires in 2022 also). **LEAD : Becca Wallis, IPU Sister**
f) Already adopted a more proactive engagement of patients with those important to them, especially during discharge planning.

g) Already identified through discussion at a doctors journal club regarding the use of language by doctors has led to a change to the style of our discharge summaries, inspired again by the results of another internal audit.

h) Already identified joint working with GPS and other HCPs as an area for improvement. Initiated various new models of working (daily MDTs with Merton End of Life Care Team (MEOLT) and Sutton Hub, supervision for MEOLT, more joint visits with GPs etc).

i) Already, the nursing and medical teams on the ward are now arranging family meetings 5 to 7 days post admission to try and improve family member feeling less informed during an IPU stay.

j) Already the housekeeping staff have been very responsive to the dietary needs of patients over the previous few months, creating a vegetarian and halal menu.

k) Already incorporated into the education programme in 2023/24 is communication training and extending the offer to a wider group of staff.

Update on Last Report Actions : April 2021 – September 2021

a) Source funding for the acquisition of 'Z' beds for family member use in the patient bedrooms. 'Z' bed provision in place.

b) To consider if and how 'respite care' should be referred to in its patient information literature as a service that the Hospice does not offer. Patient information literature reviewed

c) To utilise the IPU Survey to inform review of the menu offer on the IPU to assure that personal and dietary needs are accommodated alongside adequate choice. IPU Survey in place

d) VOICES survey questions to be expanded for Bereavement Service feedback for mailing from March 2023 for October 2022 RIPs onward. Bespoke Counselling Survey in development.

OVERVIEW

In October 2021 – March 2022, there were 176 questionnaires mailed and 48 questionnaires returned, providing a return rate of 27% (c.f. 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:

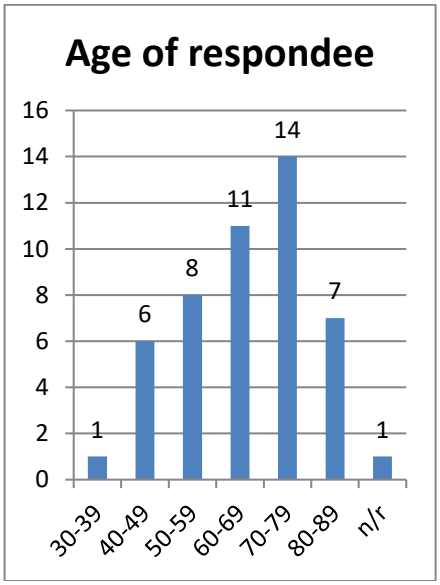
Gender of Respondent

Period	Male	Female	*n/r*
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*

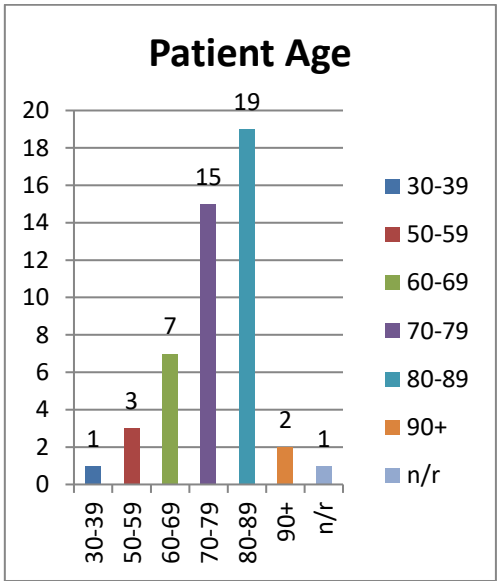
Gender of Patient

Period	Male	Female	*n/r*
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*

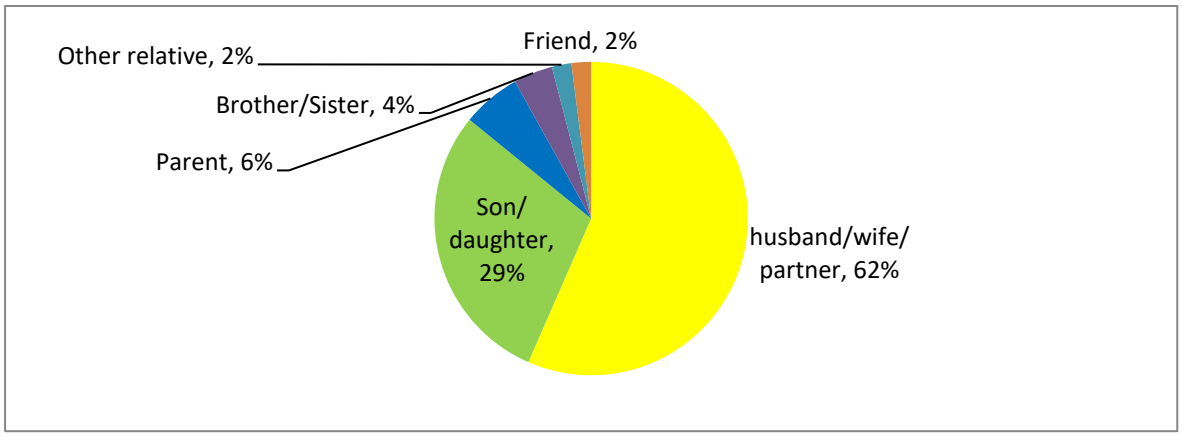
Age of respondent



Age of deceased



Respondent's relationship to patient

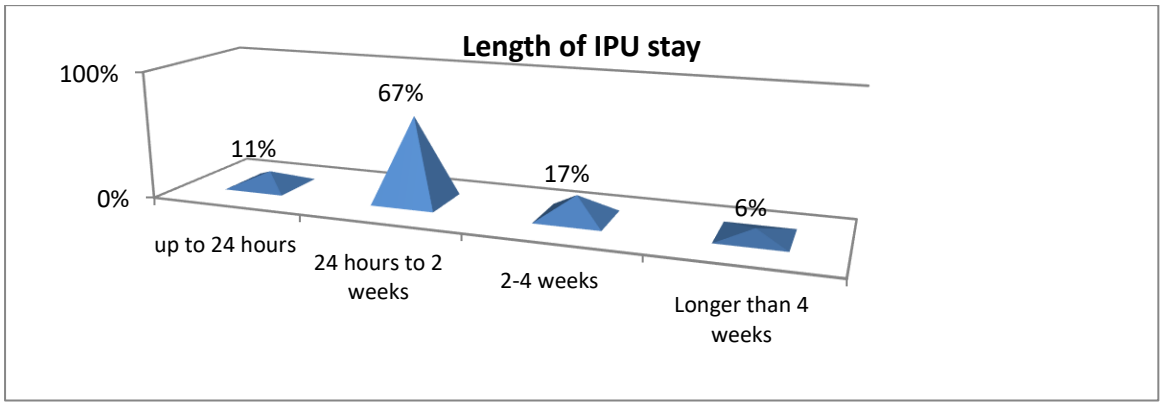


42 (88% c.f. 90% in 2021) of the 48 respondents who answered the question identified themselves as being 'White' (British/Irish/Other) with the remaining 6 (12%) identifying themselves as "Asian Indian," "Asian Other," "Black Caribbean," "Black African" and "Chinese." 41 (87% c.f. 92% in 2021) of the 47 patients who had the question answered on their behalf were identified as being white and the other 4 (13%) as 2 "Asian Indian," 2 "Asian Other" 1 "Black African," and "1 Black Caribbean."

Inpatient Care on Hospice Ward

Inpatient Stay

Q2) 18 (38% c.f. 35% in 2021) of the 48 respondents stated that the patient had stayed in the IPU at some point. Of these, 12 (67% c.f. 47% in 2021) had stayed between 24 hours and two weeks, 3 (17% c.f. 29% in 2021) stayed between two and four weeks and 1 (6% c.f. 12% in 2021) stayed for longer than 4 weeks. Two (11% c.f. 12% in 2021) stayed for less than 24 hours. None (0% c.f. 0% in 2021) did not record an answer.



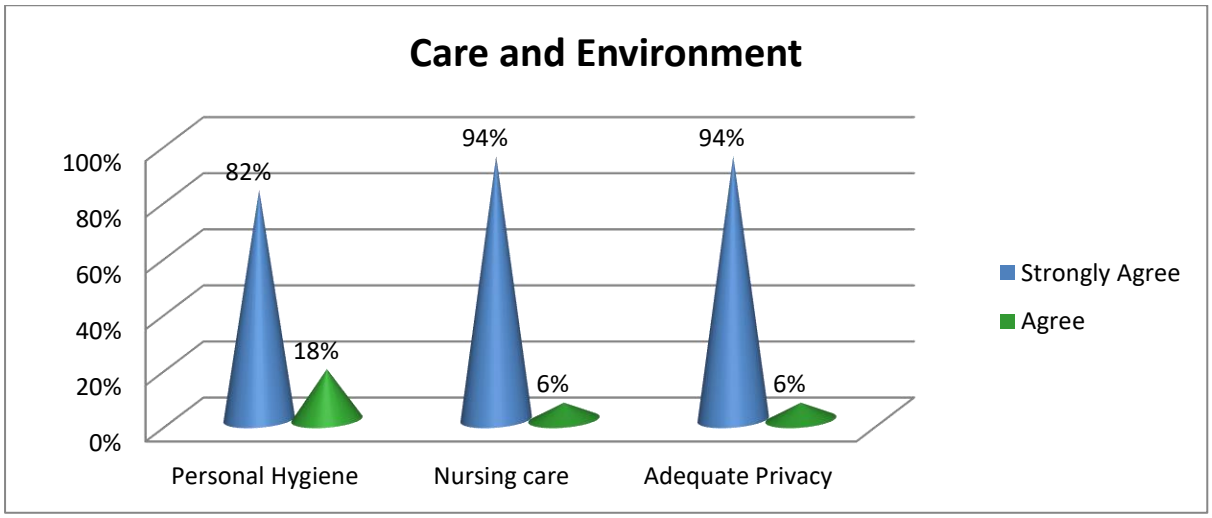
Care and Environment

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) 82% 'strongly agreed' that there was enough help with personal care such as washing, personal hygiene and toileting needs (c.f. 94% in 2021), 18% 'agreed' (c.f. 0% in 2021) and 0% (c.f. 6% in 2021) neither agreed nor disagreed.

Q3B) 94% '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. 88% in 2021), a further 6% 'agreed' (c.f. 12% in 2021) and none (c.f. none in 2021) 'Neither agreed nor disagreed.

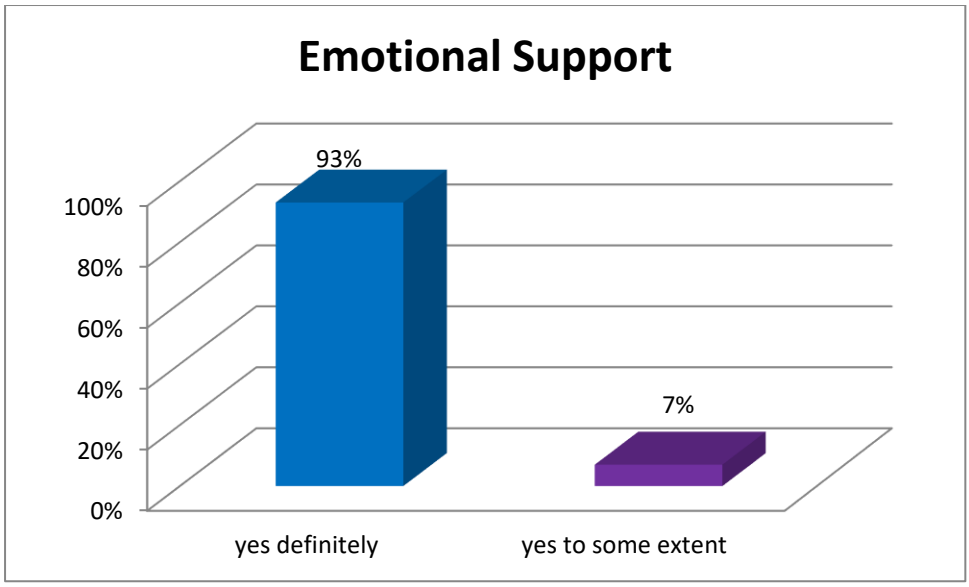
Q3C) With regards to the surrounding environment and bed area providing adequate privacy 94% 'strongly agreed' (c.f. 100% in 2021) and 6% 'agreed' (c.f. 0% in 2021).



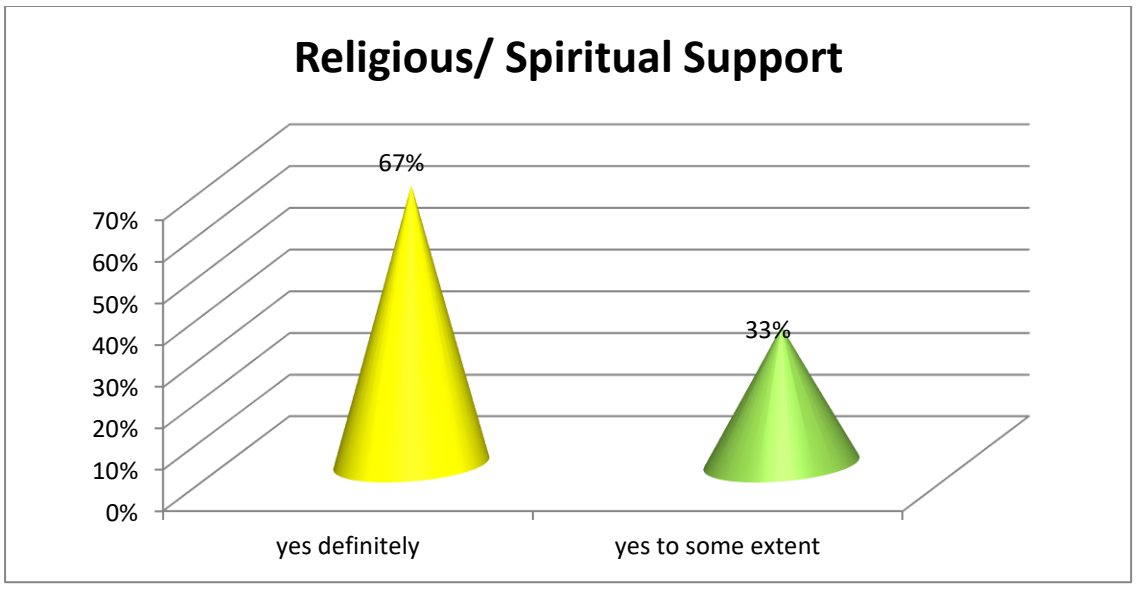
Support

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, 83% of respondents responded with a definite yes/no answer (c.f. 82% in 2021). Of these, 93% responded 'Yes definitely' (c.f. 64% in 2021) and 7% responded 'Yes to some extent' (c.f. 36% in 2021). 0% (c.f. 0% in 2021) responded 'No.'



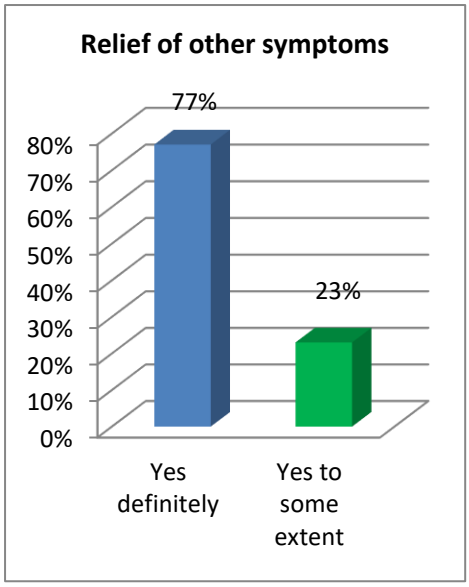
Q4B) Nine respondents felt the patients required religious/spiritual support. In answer to whether they received enough, 67% replied 'Yes, definitely' (c.f. 86% in 2021) and 33% replied 'Yes, to some extent' (c.f. 14% in 2021).

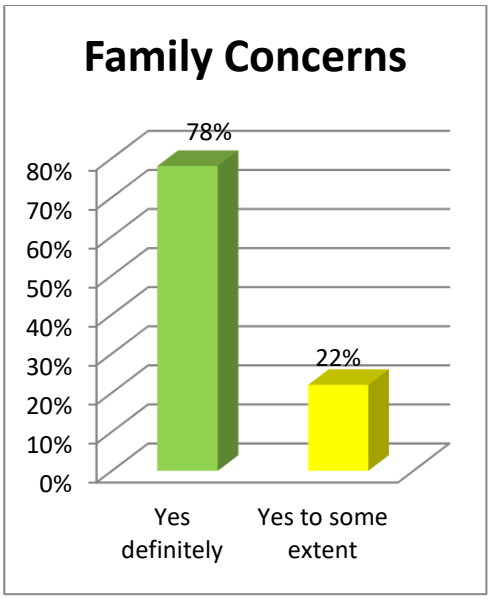


Q4C) 6 (33% c.f. 18% in 2021) respondents considered the patient to be in need of support regarding financial concerns or other practical problems. 6 (100% c.f. 67% in 2021) believed there was definitely enough support available and 0 (0% c.f. 33% in 2021) believed there was some support available.

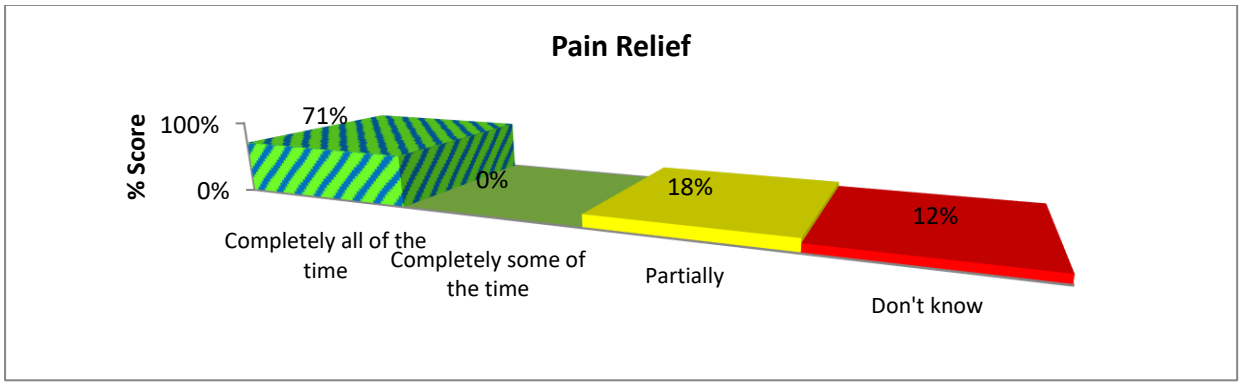
Q4D) With regard to enough support for relief of symptoms other than pain, 72% of respondents responded either 'Yes' or 'No' (c.f. 71% in 2021). Of these, 77% considered there to have definitely been enough support (c.f. 83% in 2021), 23% answered 'Yes, to some extent' (c.f. 17% in 2021) and 0% answered 'No, not when needed' (c.f. 0% in 2021).

Q4E) 50% of respondents considered that there was a need for support in family concerns (c.f. 41% in 2021). Of these, 78% considered there was definitely enough support (c.f. 71% in 2020-21) and 22% replied 'Yes, to some extent' (c.f. 29% in 2021).





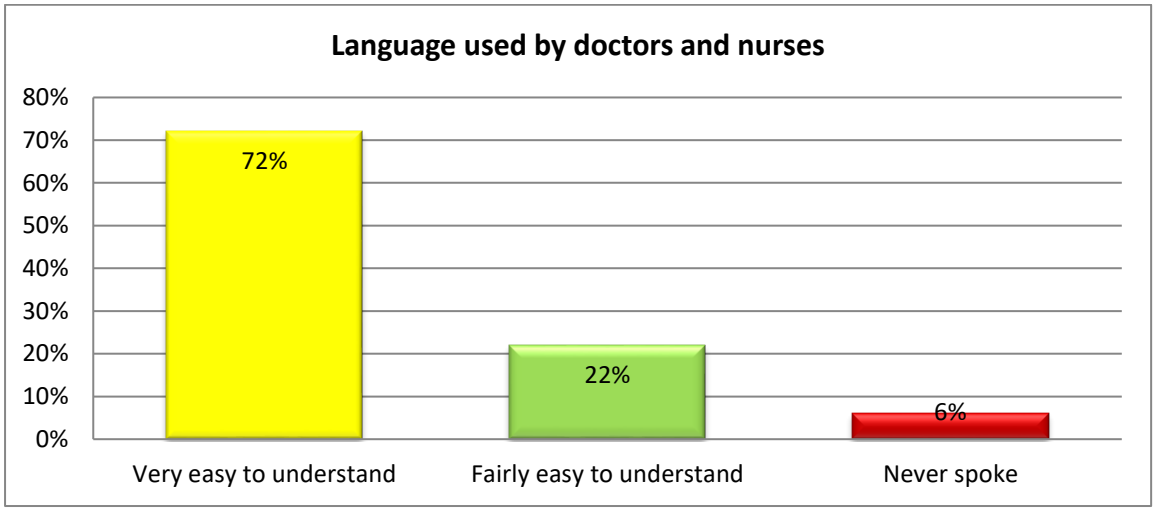
Q5) Respondents were asked how well the patient's pain was relieved during their inpatient stay. 1 (6% c.f. 0% in 2021) said that the question did not apply because the patient had no pain. Of the 17 inpatient respondents who answered the question, 12% did not know the answer (c.f. 6% in 2021), 71% replied that the pain was relieved completely all of the time (c.f. 71% in 2021), 0% that it was relieved completely some of the time (c.f. 18% in 2021) and 18% considered it to have only been partially relieved (c.f. 6% in 2021).



Communication and involvement

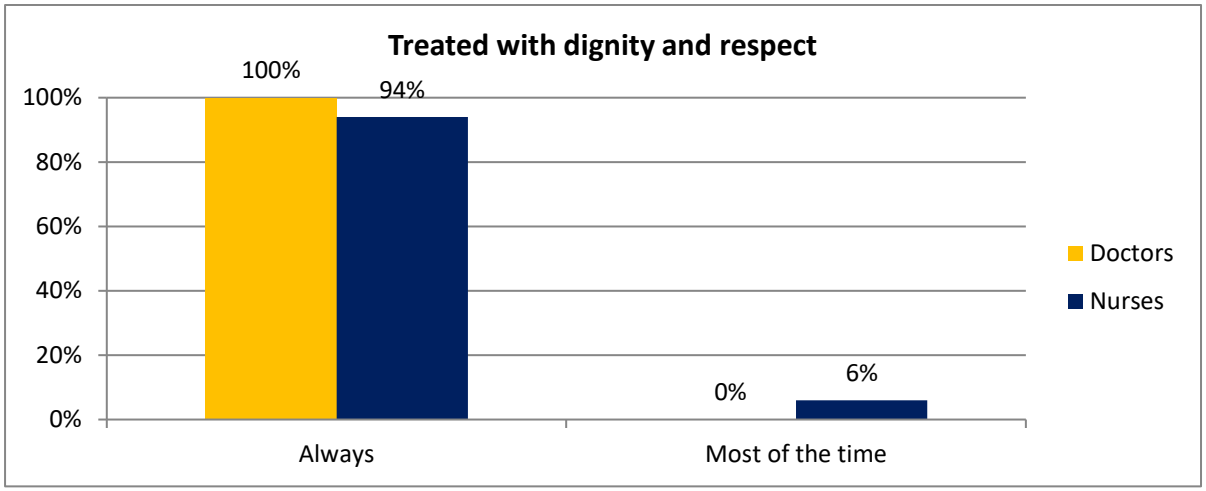
Q6) Relevant to 18 patients who stayed in the Hospice inpatient unit. 14 (78% c.f. 88% in 2021) reported that family members were always kept informed of the patient's condition, 4 (22% c.f. 6% in 2021) responded that this was usually the case and 0 (0% c.f. 6% in 2021) responded that this was sometimes the case.

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 72% of respondents (c.f. 76% in 2021), fairly easy to understand by 22% (c.f. 24% in 2021). None found them fairly difficult to understand (c.f. 0% in 2021). 0% (c.f. 0% in 2021) responded that they never spoke to a doctor or nurse and 6% (c.f. 0% in 2021) responded that the doctors and nurses never spoke to them.



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?" 67% responded with a positive 'No' (c.f. 88% in 2021), 22% replied that they did not know (c.f. 12% in 2021) and 11% replied with a negative 'Yes' (c.f. 0% in 2021).

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 2020-21). For the nurses, 94% stated Always and 6% stated 'most of the time.' (c.f. 94% stated 'Always' and 6% stated 'most of the time in 2021.')



Q10) Answering the question as to whether the respondent felt that the Hospice worked well with the patient's GP and other external services : 71% stated 'Yes definitely' (c.f. 50% in 2021) and a further 18% agreeing 'Yes to some extent' (c.f. 38% in 2021). 12% answered 'Don't know' (c.f. 13% in 2021), 0% recorded 'No' (c.f. 0% in 2021) and 0% recorded that they did not work together (c.f. 0% in 2021).

Comments on hospice working in collaboration with GP practices:

'As far as I am aware but only admitted at 11.30 AM. Died at 5.15 PM the same day.'– Daughter of patient

'St Helier Hospital' – Wife of patient

'Not quite sure of this answer' – Mother of patient

Q11) Being able to stay in the Hospice overnight with their loved one was seen as important to 60% of respondents who recorded an answer (c.f. 41% in 2021). Of these, 67% were able to stay, and of these 67% who did get to stay, 83% found it helpful (c.f. 100% in 2021).

Comments on the subject of staying overnight:

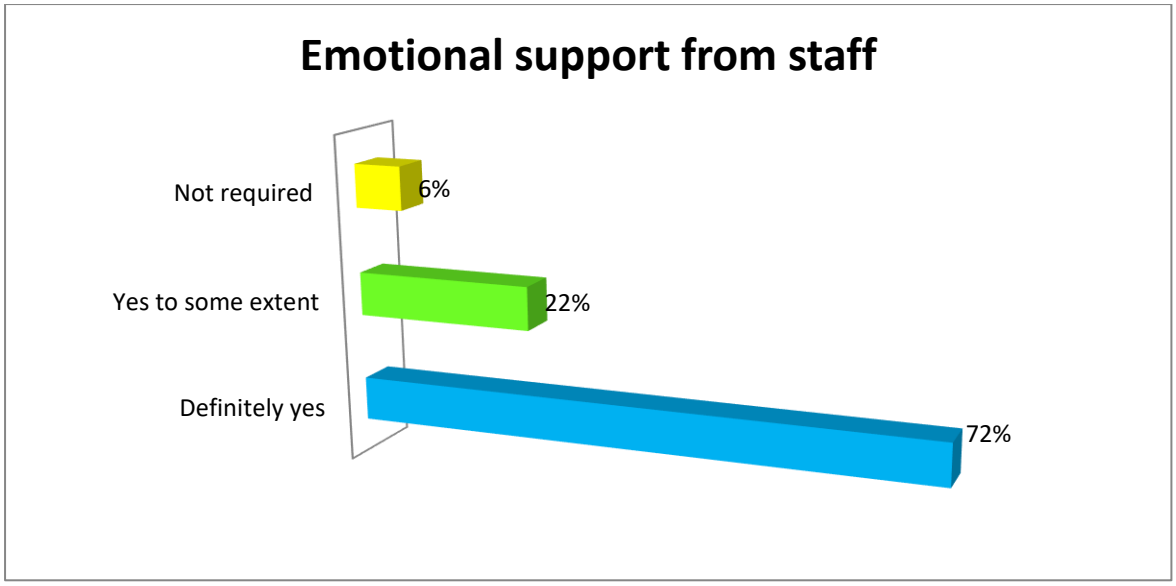
‘My cousin's daughter stayed’ – Other relative of patient

‘I only stayed one night but a nurse came in and we prayed together which was a great help to me.’ – Parent of patient

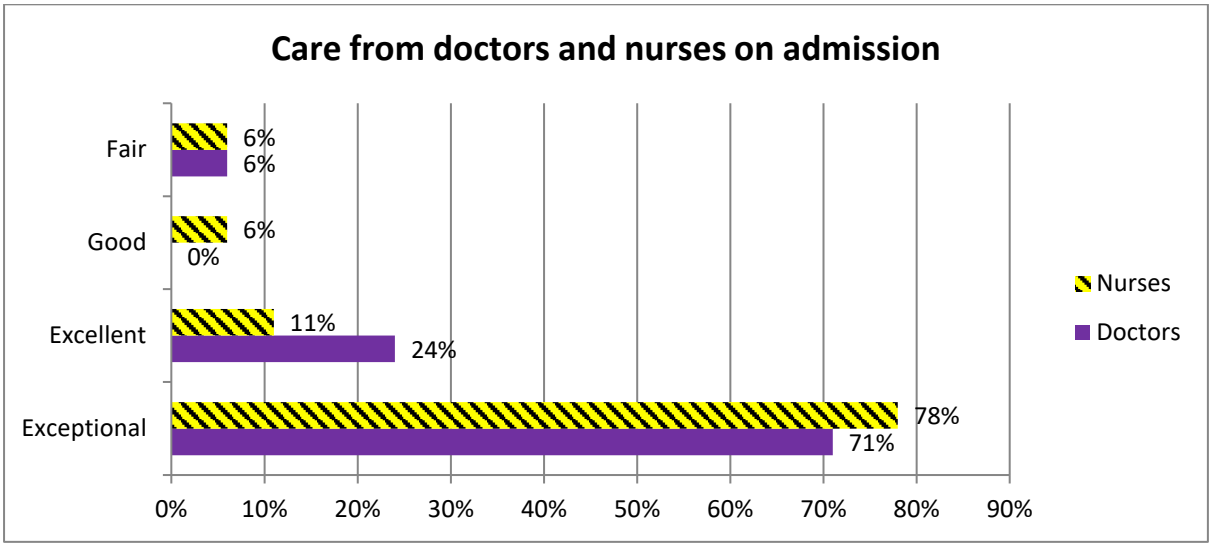
‘His daughter stayed overnight’ – Wife of patient

‘Daughter died before evening on day of admission so I did not stay.’ – Mother of patient

Q12) Respondents were asked whether they felt that they had received sufficient emotional support from the Hospice staff. Responses showed 72% answering ‘definitely yes’ (c.f. 76% in 2021), 22% answering ‘yes, to some extent’ (c.f. 18% in 2021), and 6% replying that they did not require this kind of help (c.f. 0% in 2021). 0% (c.f. 6% in 2021) responded ‘no.’ 0% (c.f. 0% in 2021) recorded that they did not receive this kind of help, despite requiring it. 0% (c.f. 0% in 2021) 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. 71% considered doctor care on admission to be ‘Exceptional’ (c.f. 53% in 2021), 24% considered it to be ‘Excellent’ (c.f. 40% in 2021), 0% considered it to be ‘Good’ (c.f. 7% in 2021), 6% considered it to be ‘Fair’ (c.f. 0% in 2021) and 0% recorded ‘Don’t Know’ (c.f. 0% in 2021). Responses relating to nursing care were higher, with 78% rating nursing care as ‘Exceptional’ (c.f. 59% in 2021), 11% as ‘Excellent’ (c.f. 41% in 2021), 6% as ‘Good’ (c.f. 0% in 2021), 6% as ‘Fair’ (c.f. 0% in 2021) and 0% recorded that they did not know the answer (0% in 2021).



Food and Catering

Q14) It should be noted that 22% 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. 29% in 2021). Of those who replied that their loved one did partake of hospice food, 21% answered that the food was 'Exceptional' (c.f. 40% in 2021), 43% that it was 'Excellent' (c.f. 40% in 2021), 7% that it was good (c.f. 10% in 2021), 14% that it was 'Fair' (c.f. 0% in 2021), 0% that it was 'Poor' (c.f. 0% in 2021) and 14% of the respondents (c.f. 10% in 2021) did not know what rating to give it.

Two of the three general written comments about the Hospice IPU was altogether positive:

'I could not have wished for better treatment from anyone. They were everything I could have wished for under the difficult circumstances.' – Mother of patient

'We received sufficient emotional support from the nurses after my daughter died. They were able to stay with us for a couple of hours. There were five of us. ' – Mother of patient

There was one comment that was neither outright praise nor criticism:-

> ‘Patient was not with you long, but I think that he should have been with you longer/ been admitted sooner.’ – Father of patient

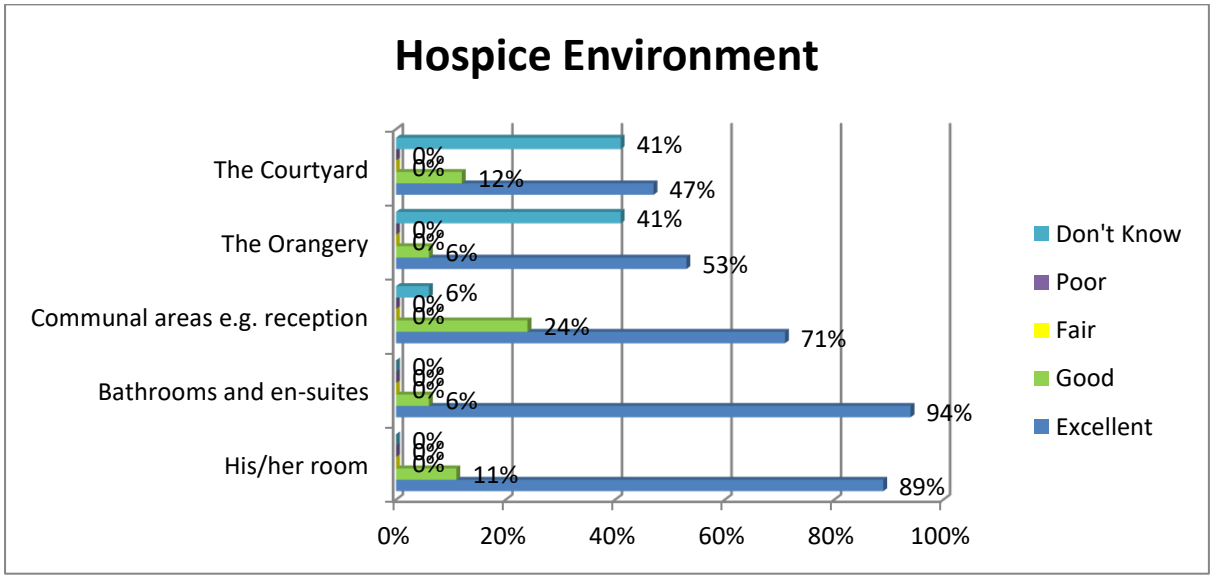
Q15 A-E) Respondents were asked to comment on different aspects of the Hospice.

The patient’s room was considered to be ‘Excellent’ by 89% (c.f. 71% in 2021) and the remaining 11% rated the room as ‘Good’ (c.f. 24% in 2021). 0% considered it to be fair (c.f. 0% in 2021) and 0% did not know (c.f. 6% in 2021). 94% of respondents considered the en-suite bathrooms on the IPU to be ‘Excellent’ (c.f. 65% in 2021), 6% rated them as ‘Good’ (c.f. 24% in 2021), 0% rated them as ‘Fair,’ (c.f. 6% in 2021) and 0% did not know the answer (c.f. 6% in 2021).

When asked to rate the communal areas of the Hospice, such as the Reception, 71% of respondents rated them as ‘Excellent’ (c.f. 50% in 2021), 24% rated them as good (c.f. 19% in 2020-21), 0% rated them as fair (c.f. 6% in 2021) and 6% recorded ‘Don’t Know’ (c.f. 25% in 2021).

When asked to rate the Orangery, 53% rated it as ‘Excellent’ (c.f. 29% in 2021), 6% rated it as ‘Good’ (c.f. 7% in 2021), 0% rated it as ‘Fair’ (c.f. 0% in 2021) and 41% answered that they did not know (c.f. 71% in 2021).

When asked to rate the courtyard, 47% rated it as ‘Excellent’ (c.f. 36% in 2021), 12% rated it as ‘Good’ (c.f. 0% in 2021), 0% rated it as ‘Fair’ (c.f. 0% in 2021), 0% rated it as poor (c.f. 0% in 2021) and 41% did not know how to rate the courtyard (c.f. 64% in 2021).



St Raphael's Community Services

Q16) 37 of the total 48 respondents, 77% (c.f. 82% in 2021) stated that the patient received care from the St Raphael's Hospice Community Palliative Care Team's (CPCT) Clinical Nurse Specialists, four were unsure whether they had or not, six answered 'no' they had not, and one simply left the entire section blank. The following data is extracted from responses relating to the 37 patients (77%) who were recorded as having definitely received care. The total number of respondents varies slightly per question, since not all respondents answered every question.

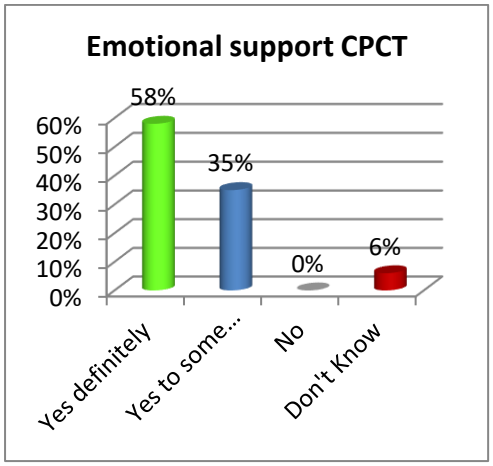
Responsiveness

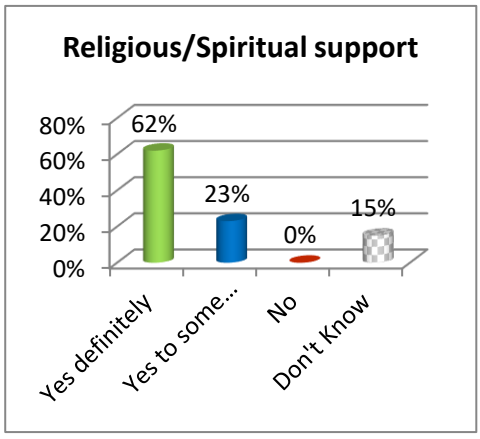
Q17) Most respondents felt that the team visited as often as needed - 84% (c.f. 85% in 2021) and 9% felt that the team 'only sometimes' visited as often as needed (c.f. 8% in 2021), 3% replied 'no' (c.f. 5% in 2021) and 3% replied "don't know" (c.f. 3% in 2021).

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, 31 (94% c.f. 90% in 2021) of the 33 respondents who answered the question acknowledged that the patient had a need for emotional support and of these, 58% replied 'Yes definitely' (c.f. 51% in 2021), 35% 'Yes to some extent' (c.f. 40% in 2021), 0% recorded 'No, not when needed' (c.f. 6% in 2021) and 6% recorded 'Don't know' (c.f. 3% in 2021).

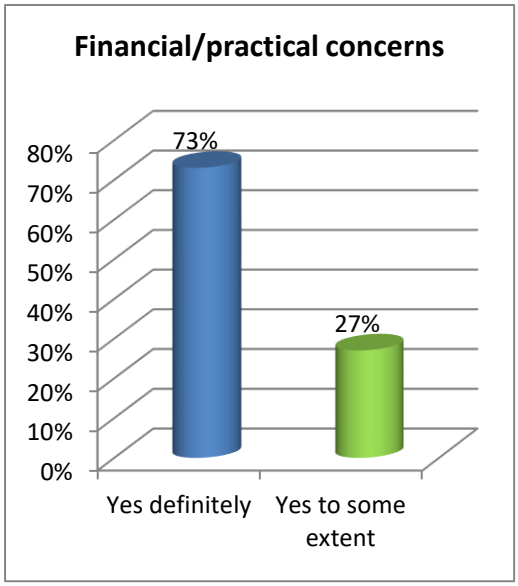
Q18B) 13 (39%) of the 30 respondents who answered the question stated that the patient did require some kind of religious or spiritual support. In response to whether they received enough religious or spiritual support from the CPCT, 8 of these (62% c.f. 46% in 2021) answered 'Yes definitely' and 3 (23%) replied 'Yes to some extent' (c.f. 23% in 2021), 0 (0%) replied 'No, not when needed' (c.f. 15% in 2021) and 2 (15%) replied 'Don't Know' (c.f. 15% in 2021).

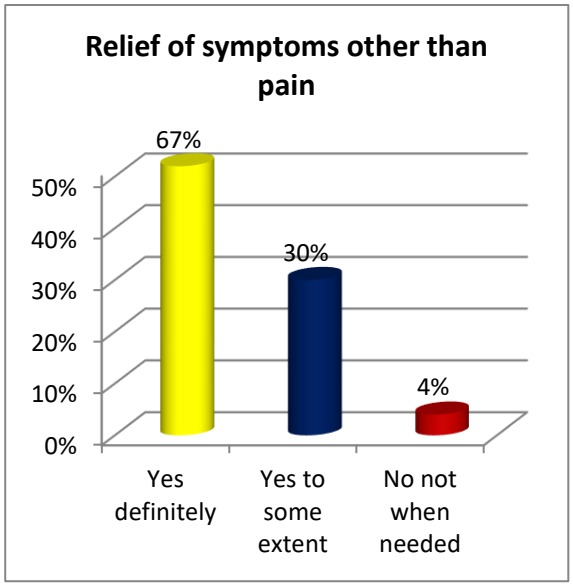




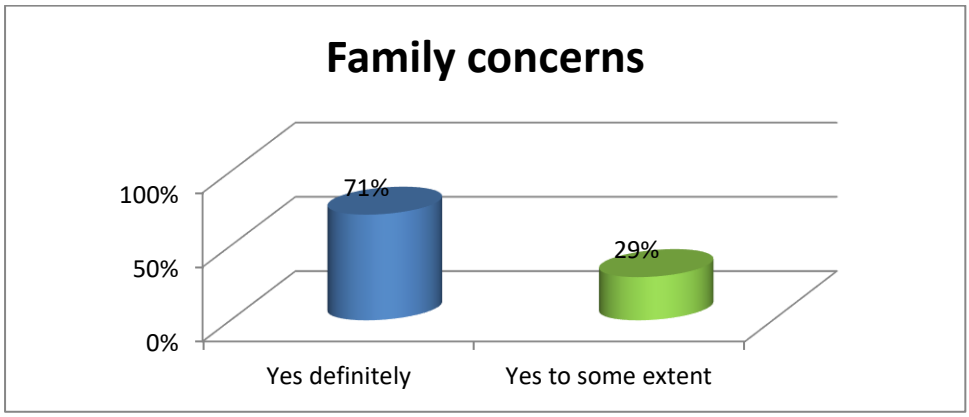
Q18C) 45% of respondents felt that the patient did not require help with financial concerns and other practical problems (c.f. 77% in 2021) and 6% respondents (c.f. 8% in 2021) did not know. Only 15 respondents felt that this support was needed and, of these, as to whether enough support was received, 73% replied 'Yes definitely' (c.f. 67% in 2021), 27% 'Yes to some extent' (c.f. 33% in 2021) and 0% 'No not when needed' (c.f. 0% in 2021).

Q18D) 10% of respondents felt that the patient did not require help with relief of symptoms other than pain (c.f. 15% in 2021) and one respondent (3% c.f. 5% in 2021) did not know. 27 respondents felt that this support was needed and of these, as to whether enough support was received, 67% replied 'Yes definitely' (c.f. 61% in 2021), 30% 'Yes to some extent' (c.f. 26% in 2020-21) and 4% 'No not when needed' (c.f. 13% in 2021).

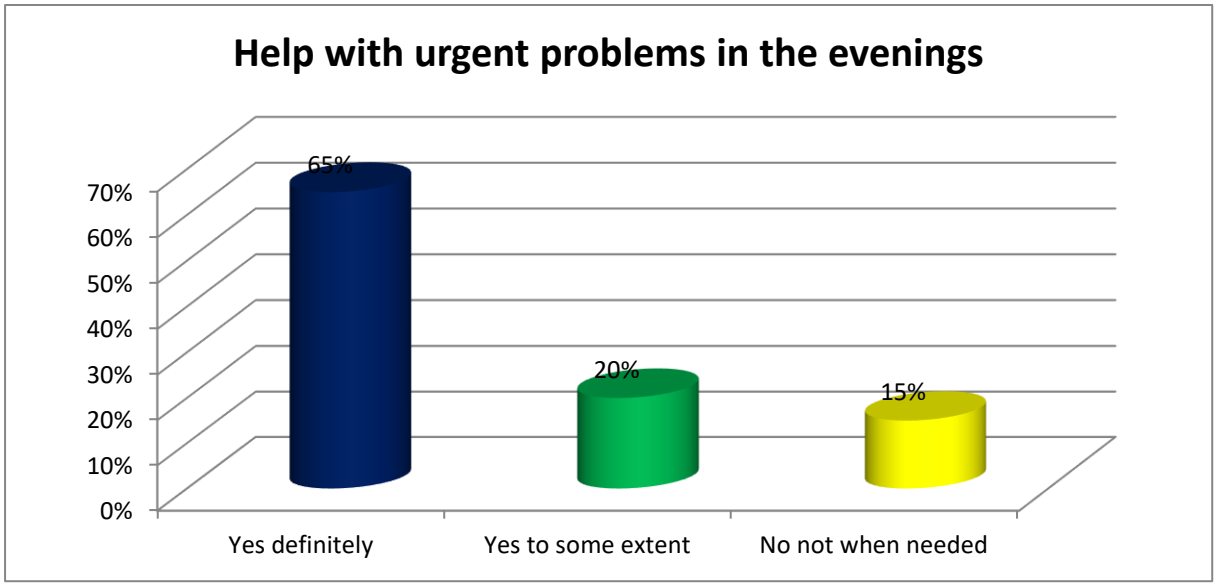




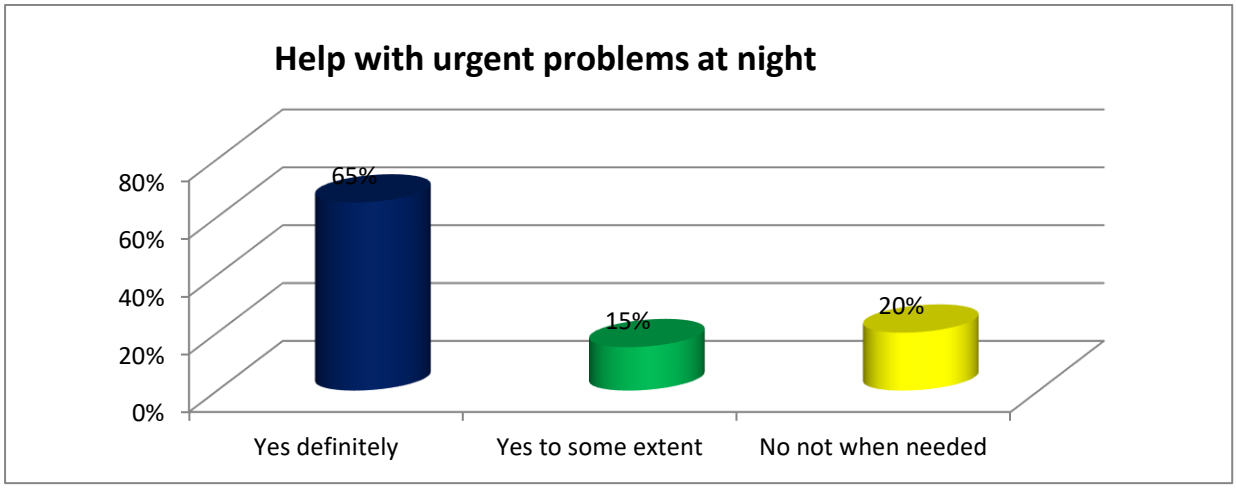
Q18E) 43% of respondents felt that the patient did not require help with family concerns (c.f. 58% in 2021) and three respondents (5% c.f. 5% in 2021) did not know. 14 respondents felt that this support was needed and of these, as to whether enough support was received, 71% replied 'Yes definitely' (c.f. 50% in 2021), 29% 'Yes to some extent' (c.f. 43% in 2021) and 0% 'No not when needed' (c.f. 7% in 2021).



Q18F) 25% (c.f. 38% in 2021) of respondents felt that the patient did not require help with urgent problems during the evenings (between 5 PM and 11 PM) and 13% did not know (c.f. 3% in 2021). 20 (63% c.f. 59% in 2021) respondents felt that this support was needed and of these, as to whether enough support was received, 65% replied 'Yes definitely' (c.f. 52% in 2021), 20% 'Yes to some extent' (c.f. 35% in 2021) and 15% 'No not when needed' (c.f. 13% in 2021).

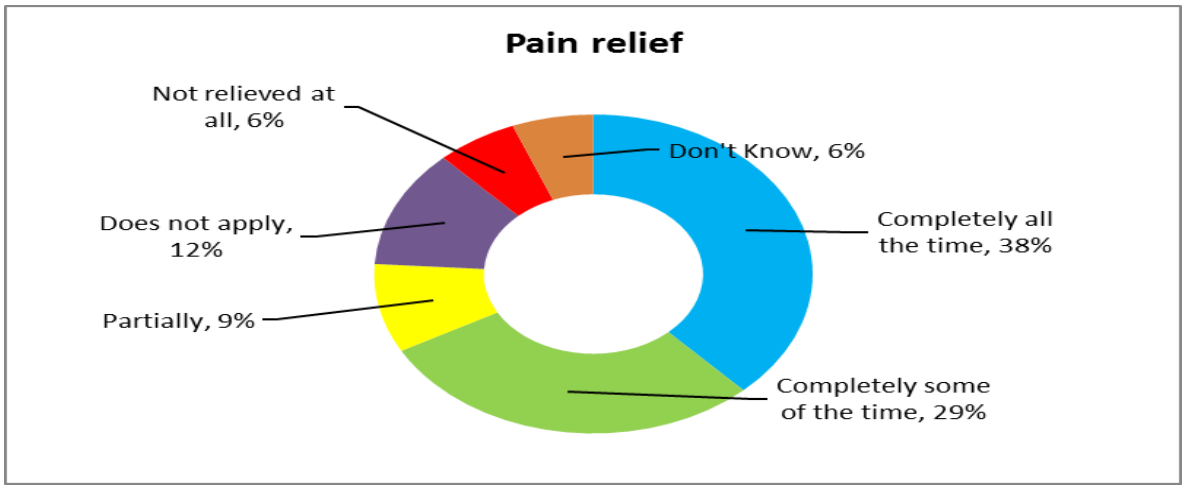


Q18G) 25% of respondents felt that the patient did not require help with urgent problems during the nights (between 7 PM and 9 AM) (c.f. 34% in 2021) and 13% respondents (c.f. 5% in 2021) did not know. 20 respondents - 63% (c.f. 61% in 2021) felt that this support was needed and, of these, as to whether enough support was received, 65% replied 'Yes definitely' (c.f. 61% in 2021), 15% 'Yes to some extent' (c.f. 22% in 2021) and 20% 'No not when needed' (c.f. 17% in 2021).



Q19) 34 respondents answered the question relating to their loved one's pain relief provided by the CPCT. 38% reported that the pain was relieved 'Completely all the time' (c.f. 40% in 2021), 29% 'Completely some of the time' (c.f. 30% in 2021) and a further 9% considered that pain was only ever partially relieved (c.f. 15% in 2021). Two (6% c.f. 0% in 2021)

replied that the pain was not relieved at all. Furthermore, 6% did not know (c.f. 0% in 2021) and 12% responded that this did not apply because the patient had no pain (c.f. 15% in 2021).



Q20) 34 of the 37 respondents answered the question relating to whether they and their family got enough help and support from the Hospice CPCT. See table below.

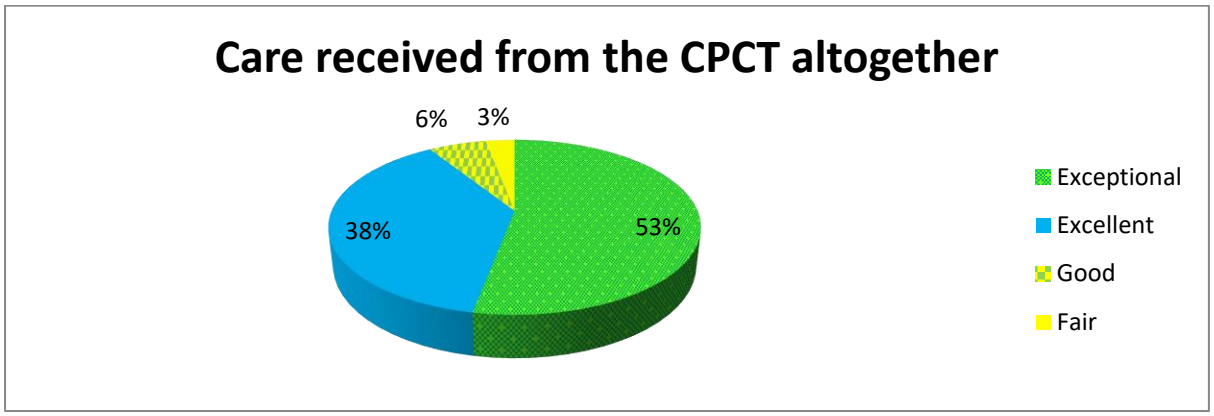
	2021-2022	2021	2020-2021	2020	2019-20	2019	2018-19	2018	2017-18	2017
Yes as much as we wanted	82%	85%	81%	85%	89%	82%	85%	79%	78%	83%
Yes, some, but not as much as we wanted	9%	5%	9%	8%	8%	9%	8%	12%	7%	17%
No, tried to get more	3%	5%	7%	3%	3%	6%	2%	4%	6%	0%
No, did not ask for more	6%	5%	0%	5%	0%	3%	4%	5%	7%	0%
Did not need	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 71% of respondents (c.f. 70% in 2021) and 'fairly easy' by 26% (c.f. 25% in 2021), 'fairly difficult' by 0% (c.f. 0% in 2021) and 0% recorded that they did not explain anything (c.f. 5% in 2021). One (3% c.f. 0% in 2021) recorded that they never spoke with the team. 34 of the 37 answered this question.

Q22) 32 of the 37 respondents answered the question relating to whether the CPCT team had time to listen to them and 88% responded 'Yes, all the time' (c.f. 85% in 2021) and 6% responded 'Yes, some of the time' (c.f. 15% in 2021), none (0% c.f. 0% in 2021) recorded 'No, not when needed,' and two (6% c.f. 0% in 2021) 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, 34 of the 37 respondents recorded an answer and of these, 53% recorded 'Exceptional' (c.f. 48% in 2021), 38% 'Excellent' (43% in 2021), 6% 'Good' (5% in 2021), 3% 'Fair' (c.f. 0% in 2021), and 0% recorded 'Poor' (c.f. 5% in 2021).



Q24) 34 of the 37 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. Of these, 88% recorded that they had been involved as much as they wanted (c.f. 88% in 2021), 9% recorded that they would have liked to have been more involved (c.f. 10% in 2021), 3% (c.f. 3% in 2021) recorded 'Don't know.'

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

ID	24 CPCT COMMENT
17	Yes I couldn't have received better care or support, particularly as my mother wanted to be treated at home and not moved. Thank you, you did everything you could for her and the family. (Daughter of patient)
18	Staff member was a star with the patience of an angel. My friend was a very unreasonable patient. (Friend of patient)

And then there were six comments that were equivocal or ambiguous or mixed praise and criticism:

ID	24 CPCT COMMENT
5	Q19 that was during the past few days. (Wife of patient)
10	COVID and refurbishment obviously was a problem at times. COVID caused a shortage of staff. (Wife of patient)
13	Cancer progressing, so pain relief was always increasing. (Daughter of patient)
22	The care my mum was given when she was admitted to the hospice was exceptional, however prior to that she received hardly any medical/ nursing visit by the team when she became very poorly and we had to desperately seek out help on our own. (Daughter of patient)
27	I found that we had a catalogue of issues that I recognised were worrying but when raised in isolation perhaps not considered as bad… (Daughter of patient)
43	On day admitted we had a meeting with DNs and nurse which explained what I needed to know. Shame my daughter only lasted a few hours in your care. Had to call district nurses to give pain relief. (Mother of patient)

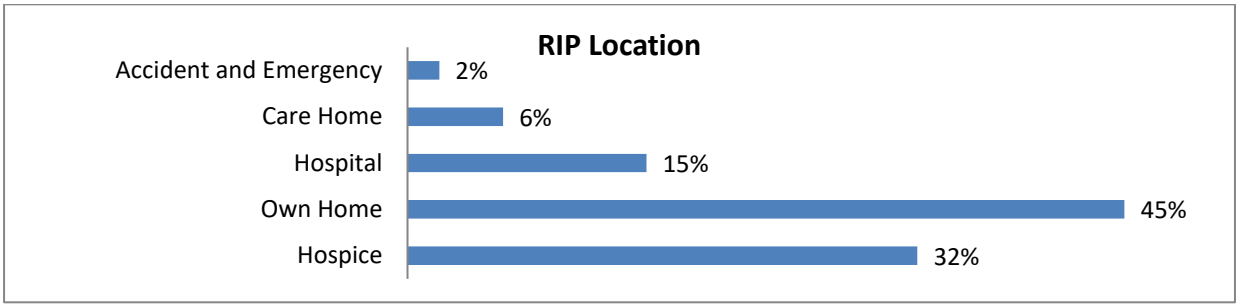
St Raphael's Hospice Wellbeing Centre

Q25) & Q26) 3 of the 48 respondents said that the patient had visited the Wellbeing Centre (c.f. 1 of the 49 in 2021) and all three said that the patient always benefited from attending**.**

Circumstances surrounding his/her death

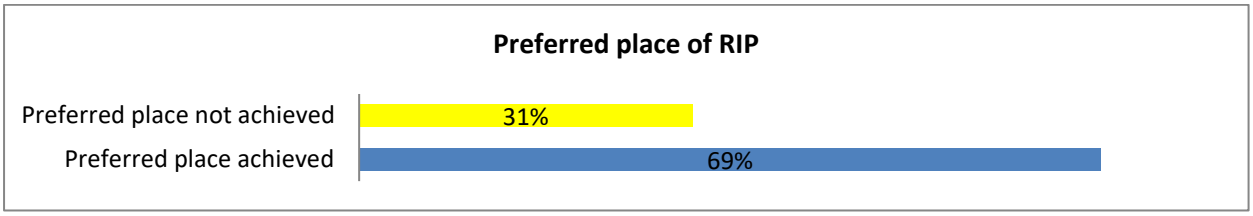
This section presents the views of the respondents regarding the circumstances of the patient's death and any expressed wishes. The questions were asked of all respondents.

Q27) Of the 48 respondents, one did not record an answer to this question. Of the remaining 47, 32% reported that their loved one died in the Hospice (c.f. 27% in 2021), 45% that they had died in their own home (51% in 2021), 15% that they had died in hospital (c.f. 16% in 2021), 6% that they had died in a care home (c.f. 4% in 2021), 2% that they had died in Accident and Emergency (c.f. 0% in 2021) and 0% that they had died in the home of a family member or a friend (c.f. 2% in 2021).



Q28) 36 respondents said that their loved ones explicitly stated where they wanted to die, 6 did not say, 3 recorded no answer and 3 replied that they were 'Unsure.' Of the 36 who recorded that the patient stated their preferred place of death, 12 – 33% said they preferred a hospice (c.f. 18% in 2021) and 24 (67% c.f. 77% in 2021) their own home.

Q29) Of the 36 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 (69%) of cases (c.f. 68% in 2021).



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

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

Q30) Respondents were asked whether their loved ones had enough choice about where they died. Of the 36 that did say where they wanted to die, 3 did not record an answer. Of the other 33, 25 – 76% reflected their loved one had had enough choice about where they died (c.f. 83% in 2021), 15% were 'Unsure' (c.f. 3% in 2021) and 3 (9% c.f. 14% in 2021) said they did not have enough choice.

Actual place of death	Yes	Unsure	No	*N/R*
Family/Friend Home	0	0	0	*0*
Hospice	7	3	0	*2*
Hospital	0	0	0	*0*
Own Home	18	2	3	*1*
Total	25	5	3	*3*

One of the respondents who believed the patient did not have enough choice recorded comments:

30 COMMENT ON ENOUGH CHOICE
We were in the process of arranging to bring him home but he passed away in hospital. (Wife of patient)

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

30 COMMENT ON ENOUGH CHOICE
At one time I think she may have felt she would be better off as an inpatient - this passed, though it was offered. (Husband of patient)
It was his wish to die at home. (Wife of patient)
Unfortunately she was too unwell to die at home. (Mother of patient)
Unfortunately he never made it to the hospice as he was too weak to be moved there from the hospital ward. (Wife of patient)

Three of the respondents who were unsure recorded this comment:

30 COMMENT ON ENOUGH CHOICE
Because his death was quick there was no time (Wife of patient)
He wanted to die at home, but agreed to the hospice as we were unable to give sufficient care. (Wife of patient)
Due to COVID there was no space at the hospice which was sad. (Daughter of patient)

Q31) On balance, when responding to the question of whether the patient died in the right place, 46 answered the question and of these, 40 replied that they did – 87% (c.f. 89% in 2021), 3 (7% c.f. 4% in 2021) were unsure, and 3 – 7% replied that they did not (c.f. 7% in 2021).

Actual place of death	Yes	Unsure	No
Care home	1	1	1
Accident and Emergency	1	0	0
Hospice	14	0	0
Hospital	3	2	2
Own home	21	0	0
Total	40	3	3

Two of the three respondents who felt their loved ones died in the wrong place recorded comments.

31 COMMENT ON PLACE
I would have loved him to be taken to the hospice but no beds were available. (Daughter of patient)
I was not happy with Orchard House care home - level of skill and communication. (Daughter of patient)

One of the three respondents who were unsure whether their loved ones died in the wrong place recorded a comment:

31 COMMENT ON PLACE
Reason being he wanted to go the the hospice, but he was cared for and looked after in hospital. (Wife of patient)

Two of the 40 respondents who believed the patient had died in the right place recorded comments:

31 COMMENT ON PLACE
My husband was always anxious to come home when in hospital so i'm sure he was in the right place at the end. (Wife of patient)
Would have prefered to be in India. Didn't have any remission in nearly six months nhs care and treatment. (Husband of patient)

Bereavement Support

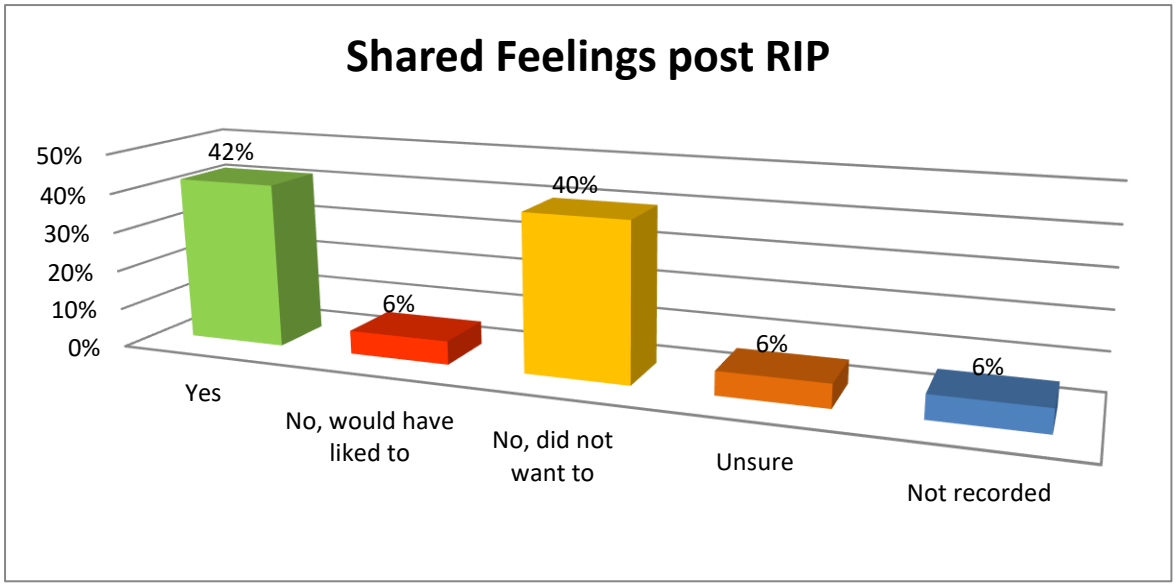
Q32) All 15 respondents who stated their loved ones died in the Hospice recorded an answer, and of these 80% felt that they were definitely given enough support by staff (c.f. 92% in 2021), 20% replied 'Yes, to some extent' (c.f. 8% in 2021), and 0% responded 'No, not at all' (c.f. 0% in 2021).

Three respondents recorded comments:

32 FAMILY HELP COMMENT
He passed very quickly so we couldn't be with him. (Daughter of patient)
We were all well supported. (Mother of patient)
Arrived three minutes after she died and was met by two doctors and two nurses. They left us with our daughter for as long as we wanted to stay. (Mother 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.

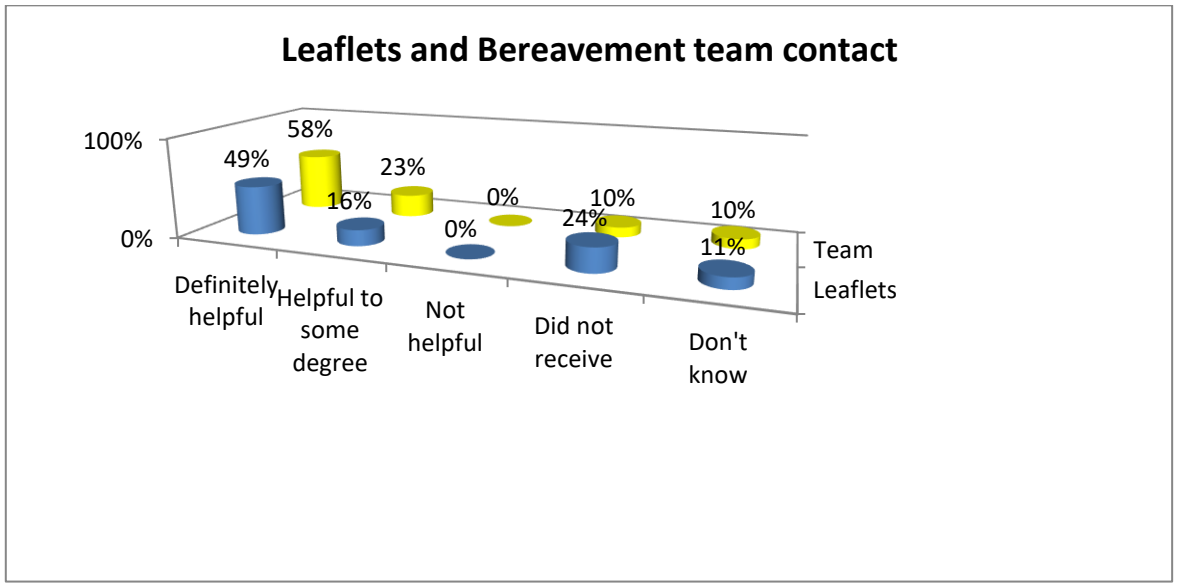
19 of the 48 respondents had not spoken to anyone, and said that it had been their choice. 3 replied that they would have liked to, 3 were unsure and 3 did not record an answer. 20 replied that they had (c.f. 23/49 respondents had in 2021). Of these 20, 6 (30%) spoke with a bereavement service volunteer, 5 (25%) spoke with a counsellor, 3 (15%) spoke with nurses, 2 (10%) spoke with a nurse and a doctor, 1 (5%) spoke with a bereavement service volunteer and a nurse, 1 (5%) spoke with a bereavement service volunteer and a nurse and a doctor, 1 (5%) spoke with 'other' and 1 (5%) 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 20 who had spoken to someone, 17 (94% c.f. 71% in 2021) responded that they had talked to them as quickly as they wanted to, none (0%) said they wanted it sooner (c.f. 24% in 2021), 1 (6% c.f. 5% in 2021) was unsure, and 2 did not record an answer (c.f. 2 in 2021).

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 45 who did record an answer, 22 (49% c.f. 47% in 2021) found it 'Definitely helpful,' 7 (16% c.f. 19% in 2021) 'Helpful to some degree,' five (11% c.f. 9% in 2021) did not know, 0 (0% c.f. 0% in 2021) found it 'Not helpful' and 11 (24% c.f. 26% in 2021) did not receive it.

Q36 B) When respondents were asked whether they had received contact from the Hospice Bereavement Team, 8 did not record an answer and of the 40 who did record an answer, 23 - 58% found it 'Definitely helpful (c.f. 37% in 2021) ,' 9 - 23% 'Helpful to some degree (c.f. 32% in 2021),' 5 - 10% did not know (c.f. 12% in 2021), none - 0% found it 'Not Helpful' (c.f. 5% in 2021) and 4 - 10% did not receive contact (c.f. 15% in 2021).



Bereavement Comments

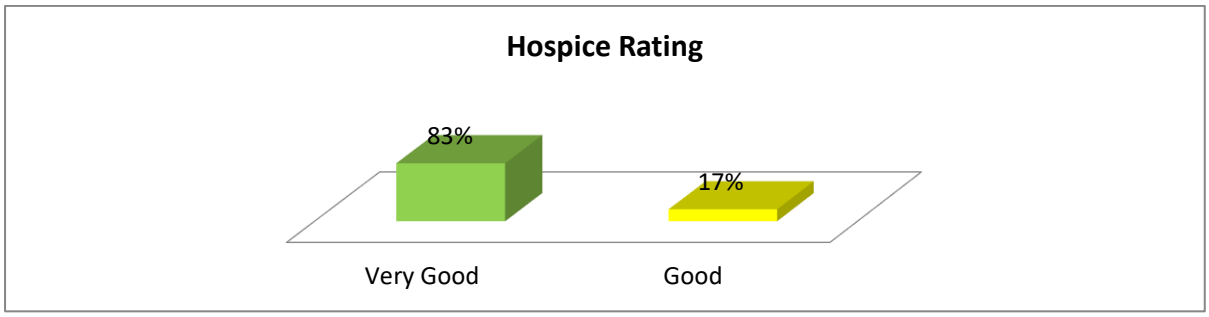
36 COMMENT
Was called, but missed the calls. Honestly didn't feel like doing anything to be fair. (Wife of patient)
Did get contact, but not needed. (Daughter of patient)
All the treatment folders still lying around. Don't know what to do with it. (Husband of patient)
I had 12 weeks of bereavement counselling and I cannot praise the young lady highly enough. (Mother of patient)
I have friends and family who supported me. (Wife of patient)

Comments concerning bereavement support were fed back contemporaneously to the Psychological Support Team Manager and relatives were contacted accordingly.

Q36 a)

Friends and Family section

When respondents were asked to rate their overall experiences of the hospice, All 48 respondents recorded an answer. Of the 48, 40 (83% c.f. 77% in 2021) rated the hospice as 'Very Good', 8 (17% c.f. 17% in 2021) rated the hospice as 'Good', 0 (2% c.f. 2% in 2021) rated the hospice as 'neither good nor poor,' 0 (0% c.f. 0% in 2021) rated the hospice as 'Poor,' 0 (0% c.f. 4% in 2021) rated it as 'Very Poor,' and 0 (0% c.f. 0% in 2021) did not know the answer to this question.



Most comments were positive:

ID	36A FRIENDS AND FAMILY COMMENTS OF PRAISE	43 YOUR RELATIONSHIP
1	All the staff. Doctors and nurses were very kind and understanding.	Husband
3	I knew very little about the hospice movement and was very favourably impressed.	Husband
5	All phone calls I made for a carer to sit for patient or to clear up checks with medicines were answered promptly and started which was very helpful.	Wife
6	Nice lady visited	Brother
8	My cousin had wonderful treatment. My husband who sadly passed away in november was coming into the hospice, but passed away. The day he was going to come into the hospice, the hospice rang me to see how I am coping. You couldn't do better. The service you provide is outstanding.	Other relative
9	When needed St Raphael's hospice staff were always on hand and nothing to offer help as requested.	Wife
10	Caring for your loved one is difficult, scary and lonely. Worry about how you are caring for your patient is overwhelming. Having your support was paramount for me.	Wife
12	When mum came home we were at a loss to call in an emergency, but once we found out it was St Raphael's, the help and information helped was amazing a heavy weight was lifted off our shoulders. For us nothing could have been donn better - you were a phone call away which was reassuring, with a calm and supportive and quick response.	Daughter
13	Communication was excellent prior to admission. Guidance given to help us help dad was excellent. We do not think anything could have been improved.	Daughter
15	Although my husband didn't really want your help (because of the reason for it) it worked well when we needed the services of the district nurses etc. in the last couple of weeks of his life.	Wife
16	My husband always said he was very happy to be in the hospice.	Wife
17	It was unfortunate on my return to full time work, I could not attend some classes at the hospice which I would have enjoyed - your team never failed to keep in touch and I'm sorry I was not always available or able to talk, but they did not give up on me! I am much better now at coping, thank you. If you feel someone else has more priority. Thank you for persistance. Sometimes people take a while to be drawn out of their numbness/ withdrawal from contact with others.	Daughter
18	Excellent and absolutely indispensible! All perfect! Do pay more to the excellent professionals you have!	Friend
19	They were so helpful, kind and caring.	Sister
20	Very professional and honest. Had confidence in their knowledge and experience. Always responded immediately to calls and when reassurance needed. Very approachable.	Wife
21	You looked after my father wonderfully. The nurses and the care could not have been any better and I am so grateful.	Daughter
22	In the hospice - her care, the medical team were exceptional. We couldn't have asked for better. They were all absolute angels and we are forever grateful to you all. They will always remain in our heart for being so compassionate,	Daughter

ID	36A FRIENDS AND FAMILY COMMENTS OF PRAISE	43 YOUR RELATIONSHIP
	sensitive and most of all caring in this awful time in our lives.	
27	Right at the very end her care was optimised, but leading up I felt she could have been more comfortable.	Daughter
28	Yes all was good. Few mishaps.	Husband
30	We thought the team members and level of care offered was amazing. They were on hand when we needed them and helped with everything required. We will be forever grateful.	Daughter
31	My daughter was in the hospice from December 30th to February 5th. I cannot praise the hospice highly enough.	Mother
32	Help was offered at the time it was needed, even if it wasn't always accepted. Visits with help and offers of help would still continue.	Son
34	All the people I met were very professional some better than others, but all great. That is why we have made an effort and made donations to keep these people.	Husband
35	My family were made very welcome and your understanding of our needs at such a difficult time. Thank you.	Father
36	Very helpful, I felt I could always ring the number night or day. I can't think of anything that could have been any better.	Wife
37	They visited and provided some aids.	Wife
39	Different people gave very good support to both myself and my husband. I was always able to telephone for advice and assistance.	Wife
40	The care given was exceptional, not only to my husband, but also to us as a family. You did everything with loving care and we will be forever grateful.	Wife
43	The nurses and doctors are great. Nurses very helpful - when our daughter died they all gave us a cuddle even though we were all crying and got us cups of tea - nothing was too much trouble for them. Nurse was great.	Mother
44	The hospice team were very helpful. I couldn't fault them. And also the support i was given as well as my partner. I don't think there was anything you could have done better.	Wife
45	Just excellent. Exceptional. Professional.	Husband
46	Everyone was really good and supportive. A nurse contacted me as soon as she knew my husband's life was ending. Not one person could have been better. Thank you.	Wife
47	The hospice's response was always prompt and appropriate. The hospice at home team were magnificent.	Husband
48	The team have prepared me well for his death. What to expect, what to look out for, and what to do thereafter. They showed great empathy.	Wife

Two comments included criticism:

ID	36A FRIENDS AND FAMILY NEUTRAL/MIXED COMMENTS	43 YOUR RELATIONSHIP
2	It was just a shame that more support could not be given around our GP surgery/ district nurses' constant struggles.	Daughter

41	My first experience of having a loved one cared for in a hospice for end of life care was good overall. However, I certainly noticed a different approach between nursing staff. Some "hit just the right note" by way of quiet caring and calmness, although two members of staff were well meaning, I found their very loud voices and general jolliness somewhat inappropriate. Patients should be called by their name, not 'darlin!' Certainly some of the staff I met had all the skills of what one would expect within a hospice setting.	Wife

What could we have done better?

ID	36A DONE BETTER	Your relationship
2	The hospice staff do their best with the resources they have, the government need to invest more money to those patients sent home for end of life care.	Daughter
3	Perhaps the liaison between hospice and district nurses could have been faster. Once or twice we had to wait 24 hours to change/increase medication.	Husband
10	Respite was my problem. I was exhausted. We came out of "lockdown" and I went into another ten months of being so restricted.	Wife
20	We possibly may have been in denial as how close the end was - would not have minded being advised objectively first how many weeks/days left. Perhaps for us to ask?	Wife
21	He passed so quickly that we couldn't get to him - we called at 6 PM and was told he was comfortable, then we were called before midnight to say that he had passed. I wish we could have been there.	Daughter
27*	It's a shame that Mum didn't die in her preferred place of death and I feel sad and guilty about that.	Daughter
34	There was a long time before hospice contacted me after the patient's death.	Husband
37	Patient wanted to die in the hospice but there was no vacancy.	Wife
41*	I certainly noticed a different approach between nursing staff. Some "hit just the right note" by way of quiet caring and calmness, although two members of staff were well meaning, I found their very loud voices and general jolliness somewhat inappropriate. Patients should be called by their name, not 'darlin'!'	Wife

*Both forwarded on to relevant senior staff members.

St Raphael's Hospice Follow Up Action

ID	SRH follow up	Your relationship
27	Followed up by bereavement support.	Daughter
41	Fed back to Ward staff by IPU Sister.	Wife

2021/2022 CEO Comments

The Voices survey provides an important insight into how the work of St Raphael's Hospice is received by those supporting and caring for their loved ones. This feedback is invaluable in helping us to shape the service going forward and, importantly, to learn about aspects that can be improved upon or where there is a gap that we need to try to fill. We would love to improve upon the **response rate** which, at 27%, is below the average level over the last five years and this **is something we will work on**.

I am delighted that the "overall experience" rating of very good (83%) or good (17%) is at the highest level it has been and the whole team of staff and volunteers can be proud of the overall impact that is made.

I note that the proportion of people who died "in their preferred place" remains at around the long-term average at 69% and would like to see that improve. However, I feel somewhat reassured that nine out of ten respondents did feel that their loved one died in the most appropriate place, even though it may not have been their original preference.

The refresh of the in-patient rooms in Summer 2021 did cause disruption and this is noted in some comments which I am sorry about. However, I am pleased that the completion of this work has coincided with an improved sense of bedroom and bathroom quality with 89% and 94% giving "excellent" ratings respectively compared with around two thirds hitherto. We want to make our patients and the ones they love feel as comfortable as possible whilst they stay with us. I note that two thirds of respondents were able to stay overnight which has improved over the last 2-3 years but which had been at a higher rate in previous years. We will **soon open a new, enlarged family room** which will aid the ability for loved ones to stay over and will also provide specialist hoists for patients who need that.

The lingering impact of the pandemic will have affected the group of patients that this Voices survey included and we can see this in some of the responses around awareness of some facilities at the Hospice. The Orangery Café was not known to 41% of respondents. This has improved from 70% over the previous covid-impacted surveys but remains significantly higher than before the pandemic. Prior to 2020 only around 5% of respondents did not know about the café. We clearly need to reconnect visitors with this beautiful facility as well as with the courtyard seating areas.

It is rewarding to read about the positive benefit our staff and volunteers provide with emotional and spiritual support. Alongside this we can see an improvement in the Bereavement support immediately after a death with 94% saying that they were able to talk with someone as soon as they wanted to. However, only around half the respondents found our bereavement leaflet useful. We have recently re-done this leaflet and will keep it under constant review. I also note that around a third of people either did not receive or were unaware of the leaflet. We still have potential to enhance awareness of the support we offer for those who would like to receive it.

As ever, funding is a constraint for hospices and we can see from this report that our service still could be extended, for example to improve evening and night support for patients in the community, if the funding allowed. St Raphael's currently receives only 25% of its running cost from the NHS and this means we need to raise over £4.5m every year, from legacies and donations, lottery players and charity shoppers, in order to remain free of charge to the people of Merton and Sutton. Each year the cost goes up and the gap that needs to be filled increases. Our specialist end of life and palliative care is fully integrated into the health system and one in every four of us will, one day, need it. Imagine the outcry if maternity services were only 25% funded and survived year by year on donations and charity shopping.

2021/2022 Clinical Director Comments

The response rate from this period (Oct 21-Mar 22) remains reasonably static at a low 27%. This may reflect survey fatigue – during the last couple of years, means of communication has relied very much upon remote responses and less personal contact. Although the value of the feedback is not diminished, it is important to consider the robustness of the information provided as an overall reflection of the services.

Treatment with respect and dignity for our patients remains a reassuring constant with the level of care being considered as exceptional demonstrating an upward trend at high level.

Close collaboration and good relationships with external services are vital in order to ensure communication is two way and effective. It is encouraging to see more than a 20% increase in the number rating this as working well, although it's important to also note a couple of comments around the delays or 'struggles' perceived by families to be felt by the District Nurses and GPs and a sense that we could have resolved these.

Responsiveness from the CPCT remains high despite this covering the winter period during higher levels of staff sickness and some of the Covid restrictions. The data regarding a need for support 'out of hours', is borne out in the recent audit on 'Out of Hours Calls to the IPU', where we have since established that specifically early evening and between 7am and 8am in the morning, there is a greater demand for support. This is an area that requires further discussion and consideration of changing some of the working hours to respond to the identified need.

Preferred place of death (PPD) might be considered somewhat disappointing with only two thirds of familes feeling that this was achieved by their loved one but it is reassuring to know that the overall majority felt their loved one died in the right place. PPD is overdue for reconsideration as an outcome measure due to the ever changing condition and symptoms experienced by the dying patient.

Our bereavement support and service remains an area for further growth and development, but the current counselling offer is proving positive and responsive to need. The hospice literature needs further review as is not particularly well received if indeed it is received at all. This is an area for development over the coming year with allotted resource to ensure that we are receptive predominantly to the needs of our service users but also to the future needs of the hospice.

2021/2022 Palliative Care Consultant Comments

The response rate continues to be relatively poor, increasing from 25% to 27%, thus continuing to make any meaningful interpretation of the results difficult. Given our previous comments, it may be pertinent to explore our process of disseminating the questionnaires/the cover letter attached to them. The representation from the BAME population also continues to be poor, again lending the question of whether or not we need to explore provision of the questionnaire in other languages to help improve the response rate.

It is worth noting that this time period, 1st October – 31st March 2022, covers a period of time when the inpatient unit was operating between 6-8 beds due to limited IPU nursing staff availability, which may account for some of the free text comments suggesting limited capacity to admit their loved one.

As anticipated, responses regarding the care and environment provided in the inpatient unit have improved since the refurbishment. 89% rating the patient bedroom as "Excellent" compared to 71% previously. It would of course be very helpful to compare these and other results to those we collect in real-time from the patients during their stay on the IPU. It was pleasing to hear that being able to stay overnight in the Hospice was a priority for relatives, as a lot of time and money has been invested in refurbishing and creating a family suite for the use of bariatric patients but also extended to others as a place to stay overnight.

What concerns me slightly is the reduction in religious/spiritual support from 86% to 67% and I am unable to comment upon why this might be. We, as a hospice however, are very mindful of being more embracing/sensitive to all religions/spiritualities.

We continued to support symptom control, financial and practical/family concerns well which is to be commended. It is easy to become complacement about these statistics / despondent about a lack of improvement, however consistently scoring above 70%, and being classed as providing "Exceptional" care is excellent given the complexities of our patient population.

Again something that we as a team have already identified through internal audits and reflections during mortality and morbidity meetings, is a need for more family involvement. This is seen here in the results, so I anticipate a marked improvement upon our latest 78% in subsequent reviews, as we have adopted a more proactive engagement of patients with those important to them, especially during discharge planning. This again should be commended, demonstrating our very reflective and proactive approach to continuous service improvement. Likewise our early identification through discussion at a doctors journal club regarding the use of language by doctors has led to a change to the style of our discharge summaries, inspired again by the results of another internal audit.

Another disappointing aspect was seeing the increase in statistics from 0 to 11% of respondents feeling that decisions were made about the patients' care/treatment that they wouldn't have wanted. But as above, I anticipate this improving since our recognition and adoption of more proactive family meetings and better use of language etc.

It was pleasing to see that there was a definite assertion that the Hospice worked well with patient GPs and other external services. Again, through internal identification and reflection, we have subsequently already identified this as an area for improvement and initiated various new models of working (daily MDTs with Merton End of Life Care Team (MEOLT) and Sutton Hub, supervision for MEOLT, more joint visits with GPs etc) which will most likely improve this statistic even further.

Again another theme identified regarding a higher proportion feeling that the patient required help with urgent problems during the evenings, has already been identified and audited by Dr Collins. The results of which are being presented at our next Hospice audit meeting. We have already however created a flowchart to support the inpatient nurses with the management and triage of these calls to lessen any distress or undue burden they may have been causing.

Interestingly, there was a shift in this cohort, of patients preferred place of death being the Hospice (increase from 18% to 33%). This may in part be due to Covid fears lessening and the visiting restrictions in the Hospice easing, thereby encouraging more to once again select the Hospice.

A reduction in the bereavement support from 92% to 80% may serve as increased fuel for the proposed bereavement journey the Hospice is keen to initiate later this year. I am however curious as to why 24% reported they did not received the bereavement leaflet, which appears to have been the case in the previous cohort, and again warrants investigation.

And finally, reflecting upon the free text comments captured, which I always find some of the most useful aspects of the report. Whilst there were many positive compliments, there was also a common theme of comments regarding patients not being in the IPU long, which could reflect late identification of specialist palliative care needs and referral, or potentially reflective of our limited bed capacity to admit during this period. Dr Strawson has recently completed an internal repeat audit reviewing our inpatient referrals and response to requests, and has found a positive and significant improvement in the 6months, and so I anticipate this to improve in subsequent surveys. Of note, as part of our strategy inparticular engagement, it was pleasing to see that from the input from our team, a relative who knew very little about the hospice movement was “favourably impressed”.

2021/2022 IPU Sister Comments

The response rate remains low so it is difficult to know how much these figures reflect the patient population however there are some positive responses including a shift from excellent to exceptional nursing care on the IPU. There has also been a large shift towards excellent responses for the IPU rooms and en-suites which shows a positive impact of the ward refurbishment. An increase in financial concerns from family member is likely a sign of the economic times and something that may become more present over the coming months. It is a shame that there has been a significant shift in families feeling less informed during an inpatient stay however the nursing and medical team on the ward are now arranging family meetings 5 to 7 days post admission to try and improve this. It is important to highlight a reduction in spiritual needs being met which has been a theme in the IPU feedback questionnaires also and something that may need to be explored further.

There may still work to be done with regards to the menu on the IPU, within the restrictions of the ward kitchen, given the reduction in 'exceptional' responses from 40% to 21% however the housekeeping staff have been very responsive to the dietary needs of patients over the previous few months, creating a vegetarian and halal menu.

It is clear that relatives feel it is important to stay with their loved ones at night with an increase form 41% to 60% and Z beds are being used on the ward. The family suite is also nearly complete which will support those important to patients to stay with them.

2021/2022 Head of Psychological Services Team Comments

I am in the process of working towards additions/ammendmants being made to the VOICES Questionnaire so that we can capture data and feedback specific to the Psychological Support Services Department and for the Bereavement Service as well as our Pre-Bereavement and Patient facing work. This will be completed by the end of March 2023.

It is encouraging that relatives felt able to talk in a timely manner post the date of death – up to 94%. This is likely due to the waiting times now being reduced massively due to the student cohort of counsellors.

The new leaflet is now in circulation so this ought to demonstrate an improvement in the feedback received going forwards.

Contact made by the Bereavement Team in a timely manner was also likely improved as we have increased the number of Bereavement Volunteers so that the support calls are made without a time lag.

We have also improved our capture of NOK details so that we can write to the majority within the one month post date of death – only 10% of respondants did not receive information about support services.

2021/2022 Palliative Care Educator Comments

Overall the impressions of our services continue to be positive with a small increase in the amount of responses. This timeframe includes a period of refurbishment for the IPU and an easing of Covid restrictions which provided a return to more normal visiting for families. The responses reflected these improvements with 89% rating the environment as excellent.

While respondents felt strongly that patients were treated with dignity and respect (94% for nurses and 100% for doctors), I note comment 41 as an example of the importance of the appropriate use of language and tone when communicating with patients and families. However, as noted in the comment, this was limited to two members of staff. As an Education Team, communication training continues to be a priority and work is ongoing to extend that training to a wider group of staff.

The Education Team will continue to develop our internal training programme to support clinical teams and drive service improvement.

2021/2022 Housekeeping Manager Comments

I am pleased that our department received positive feedback especially regarding catering.

Subject	Question	Answer	2015-2016	2017	2017-2018	2018	2018/ 19	2019	2019-20	2020	2020-21	2021	2021-22	Trends
Demographics	Respondent gender	Male	29%	35%	24%	31%	28%	36%	33%	32%	28%	41%	27%	
		Female	71%	65%	76%	69%	72%	64%	67%	68%	72%	59%	73%	
	Patient gender	Male	44%	48%	49%	54%	54%	48%	46%	49%	58%	53%	49%	
		Female	56%	52%	51%	46%	46%	52%	54%	51%	42%	47%	51%	
Inpatient stay	Inpatient stay up to 24 hours	up to 24 hours	7%	5%	4%	11%	14%	14%	6%	5%	3%	12%	11%	
	Inpatient stay 24 hours to 2 weeks	24 hours to 2 weeks	64%	68%	56%	58%	61%	67%	71%	29%	66%	47%	67%	
	Inpatient stay 2-4 weeks	2-4 weeks	21%	27%	32%	22%	18%	10%	13%	62%	13%	29%	17%	
	Inpatient stay longer than 4 weeks	longer than 4 weeks	7%	0%	8%	6%	7%	10%	6%	5%	6%	12%	6%	
		Unrecorded	0%	0%	0%	3%	0%	0%	3%	0%	13%	0%	0%	
Care and environment	Enough help with personal hygiene	Strongly agreed	82%	87%	92%	83%	71%	76%	90%	86%	71%	94%	82%	
		Agreed	11%	13%	8%	14%	25%	24%	10%	14%	29%	0%	18%	
		Neither agree nor disagree	7%	0%	0%	3%	4%	0%	0%	0%	0%	6%	0%	
	Sufficient Nursing Care	Strongly agreed	79%	78%	88%	81%	71%	76%	87%	95%	77%	88%	94%	
		Agreed	18%	22%	12%	17%	25%	24%	13%	5%	23%	12%	6%	
		Neither agree nor disagree	4%	0%	0%	0%	4%	0%	0%	0%	0%	0%	0%	
		Disagree	0%	0%	0%	3%	0%	0%	0%	0%	0%	0%	0%	
	Adequate Privacy	Strongly agreed	89%	87%	88%	92%	86%	76%	81%	95%	84%	100%	94%	
		Agreed	11%	13%	12%	8%	14%	19%	16%	5%	16%	0%	6%	
		Neither agree nor disagree	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
		Disagree	0%	0%	0%	0%	0%	0%	3%	0%	0%	0%	0%	
Support	Enough Emotional Support	Yes definitely	87%	63%	86%	90%	78%	68%	96%	69%	77%	64%	93%	
		Yes some	9%	37%	14%	10%	17%	32%	4%	31%	19%	36%	7%	
		No	4%	0%	0%	0%	4%	0%	0%	0%	4%	0%	0%	
	Enough Religious Support	Yes definitely	75%	77%	91%	73%	84%	55%	56%	56%	88%	86%	67%	
		Yes some	17%	23%	9%	27%	16%	45%	33%	33%	13%	14%	33%	
		No	8%	0%	0%	0%	0%	0%	11%	11%	0%	0%	0%	
	Enough financial support	Yes definitely	100%	67%	91%	33%	67%	33%	75%	50%	100%	67%	100%	
		Yes some	0%	33%	9%	67%	0%	67%	25%	50%	0%	33%	0%	
		No	0%	0%	0%	0%	33%	0%	0%	0%	0%	0%	0%	
	Enough relief of other symptoms	Yes definitely	92%	67%	90%	86%	73%	67%	83%	87%	79%	83%	77%	
		Yes some	4%	33%	10%	14%	18%	28%	17%	13%	17%	17%	23%	
		No	4%	0%	0%	0%	9%	6%	0%	0%	4%	0%	0%	
	Enough family support	Yes definitely	75%	58%	82%	92%	100%	90%	92%	75%	94%	71%	78%	
		Yes some	25%	42%	18%	0%	0%	0%	8%	25%	6%	29%	22%	
		No	0%	0%	0%	8%	0%	10%	0%	0%	0%	0%	0%	
	Pain was relieved	Completely all the time	72%	64%	56%	67%	54%	79%	54%	63%	70%	71%	71%	
		Completely most of the time	0%	0%	0%	0%	0%	0%	4%	0%	0%	0%	0%	
		Completely some of the time	8%	27%	36%	20%	12%	11%	29%	32%	13%	18%	0%	
		Partially relieved	12%	0%	0%	10%	19%	5%	14%	5%	3%	6%	18%	
		Not at all	0%	0%	0%	0%	4%	0%	0%	0%	0%	0%	0%	
		Don't know	8%	9%	8%	3%	12%	5%	0%	0%	13%	6%	12%	
Communication and involvement	Family informed of condition	Always	79%	91%	76%	83%	82%	80%	90%	81%	55%	88%	78%	
		Usually	21%	4%	16%	11%	7%	15%	10%	19%	35%	6%	22%	
		Sometimes	0%	4%	4%	6%	4%	5%	0%	0%	10%	6%	0%	
		Occasionally - Had to ask	0%	0%	0%	0%	4%	0%	0%	0%	0%	0%	0%	
		Never	0%	0%	0%	0%	4%	0%	0%	0%	0%	0%	0%	
		Don't know	0%	0%	4%	0%	0%	0%	0%	0%	0%	0%	0%	

Subject	Question	Answer	2015-2016	2017	2017-2018	2018	2018/ 19	2019	2019-20	2020	2020-21	2021	2021-22	Trends
	Doctors and nurses' language easy to understand	Very easy to understand	82%	70%	72%	75%	76%	55%	90%	90%	77%	76%	72%	
		Fairly easy to understand	18%	22%	24%	22%	16%	40%	6%	10%	17%	24%	22%	
		Fairly difficult to understand	0%	4%	0%	0%	0%	0%	3%	0%	0%	0%	0%	
		Very difficult to understand	0%	0%	0%	0%	4%	0%	0%	0%	0%	0%	0%	
		Did not explain anything	0%	0%	0%	0%	4%	5%	0%	0%	3%	0%	0%	
		Never spoke	0%	4%	4%	3%	0%	0%	0%	0%	3%	0%	6%	
	Any decisions made that they did not want?	No	89%	78%	72%	83%	80%	67%	87%	95%	66%	88%	67%	
		Don't know	7%	9%	24%	8%	8%	24%	0%	0%	19%	12%	22%	
		Yes	4%	13%	4%	8%	12%	10%	13%	5%	16%	0%	11%	
	Doctors treated them with respect	Always	96%	91%	96%	96%	93%	84%	97%	90%	87%	100%	100%	
		Most of the time	0%	4%	4%	4%	7%	11%	3%	5%	3%	0%	0%	
		Sometimes	0%	4%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
		Don't know	4%	0%	0%	0%	0%	5%	0%	5%	10%	0%	0%	
	Nurses treated them with respect	Always	92%	96%	96%	96%	96%	86%	100%	90%	94%	94%	94%	
		Most of the time	4%	4%	4%	4%	0%	10%	0%	10%	0%	0%	6%	
		Sometimes	0%	0%	0%	0%	4%	0%	0%	0%	0%	6%	0%	
		Don't know	4%	0%	0%	0%	0%	5%	0%	0%	6%	0%	0%	
	Did Hospice work well with patient's GP?	Yes definitely	54%	53%	68%	56%	48%	47%	45%	53%	47%	50%	71%	
		Yes to some extent	21%	21%	12%	12%	19%	35%	21%	32%	13%	38%	18%	
		Don't know	25%	21%	16%	32%	22%	6%	31%	16%	30%	13%	12%	
		They did not work together	0%	5%	4%	0%	4%	0%	3%	0%	0%	0%	0%	
		No	0%	0%	0%	0%	7%	12%	0%	0%	10%	0%	0%	
	Did carer get to stay overnight?	Got to stay	82%	100%	87%	80%	88%	50%	44%	38%	22%	71%	67%	
		Didn't get to stay	18%	0%	13%	20%	13%	50%	56%	63%	78%	29%	33%	
	Enough emotional support from staff?	Definitely yes	69%	78%	71%	80%	85%	62%	90%	45%	61%	76%	72%	
		Yes to some extent	15%	9%	13%	9%	4%	33%	7%	45%	10%	18%	22%	
		No	0%	0%	0%	0%	4%	0%	0%	0%	3%	6%	6%	
		Not required	15%	9%	17%	6%	8%	0%	3%	10%	23%	0%	0%	
		Did not receive	0%	4%	0%	3%	0%	5%	0%	0%	0%	0%	0%	
		Don't know	0%	0%	0%	3%	0%	0%	0%	0%	3%	0%	0%	
	Quality of care from nurses on admission	Exceptional	57%	70%	80%	81%	76%	57%	81%	57%	34%	59%	78%	
		Excellent	36%	30%	16%	19%	12%	38%	19%	43%	55%	41%	11%	
		Good	7%	0%	4%	0%	8%	5%	0%	0%	7%	0%	6%	
		Fair	0%	0%	0%	0%	4%	0%	0%	0%	0%	0%	6%	
		Don't know	0%	0%	0%	0%	0%	0%	0%	0%	3%	0%	0%	
	Quality of care from doctors on admission	Exceptional	61%	65%	60%	80%	64%	40%	65%	48%	34%	53%	71%	
		Excellent	36%	26%	32%	17%	24%	50%	32%	43%	48%	40%	24%	
		Good	4%	9%	8%	3%	4%	10%	3%	5%	10%	7%	0%	
		Fair	0%	0%	0%	0%	8%	0%	0%	0%	0%	0%	6%	
		Don't know	0%	0%	0%	0%	0%	0%	0%	5%	7%	0%	0%	
Food and catering	Food Quality	Exceptional	18%	53%	15%	12%	17%	12%	38%	10%	26%	40%	21%	
		Excellent	47%	13%	40%	44%	33%	65%	19%	35%	26%	40%	43%	
		Good	24%	27%	30%	24%	11%	24%	29%	40%	19%	10%	7%	
		Fair	0%	7%	5%	0%	0%	0%	5%	5%	7%	0%	14%	
		Poor	0%	0%	0%	0%	0%	0%	0%	0%	4%	0%	0%	
		Don't know	12%	0%	10%	20%	11%	0%	10%	10%	19%	10%	14%	

Subject	Question	Answer	2015-2016	2017	2017-2018	2018	2018/ 19	2019	2019-20	2020	2020-21	2021	2021-22	Trends
Hospice environment	Bedroom Quality	Excellent	75%	83%	80%	86%	62%	57%	74%	71%	68%	71%	89%	
		Good	25%	17%	16%	14%	35%	43%	26%	24%	23%	24%	11%	
		Fair	0%	0%	4%	0%	4%	0%	0%	5%	6%	0%	0%	
		Don't Know	0%	0%	0%	0%	0%	0%	0%	0%	3%	6%	0%	
	Bathroom Quality	Excellent	68%	78%	76%	78%	76%	60%	68%	62%	61%	65%	94%	
		Good	29%	17%	16%	17%	16%	35%	32%	33%	29%	24%	6%	
		Fair	0%	0%	4%	0%	4%	0%	0%	5%	3%	6%	0%	
		Don't know	4%	4%	4%	6%	4%	5%	0%	0%	6%	6%	0%	
	Communal Areas Quality	Excellent	64%	65%	60%	72%	68%	55%	61%	30%	52%	50%	71%	
		Good	32%	30%	40%	28%	32%	40%	32%	60%	26%	19%	24%	
		Fair	0%	0%	0%	0%	0%	5%	3%	0%	3%	6%	0%	
		Don't know	4%	4%	0%	0%	0%	0%	3%	10%	19%	25%	6%	
	The Orangery Quality	Excellent	59%	74%	68%	74%	64%	63%	61%	11%	20%	29%	53%	
		Good	33%	22%	28%	20%	20%	32%	32%	28%	7%	0%	6%	
		Fair	0%	0%	0%	0%	0%	0%	3%	0%	0%	0%	0%	
		Don't know	7%	4%	4%	6%	16%	5%	3%	61%	73%	71%	41%	
	The Courtyard Quality	Excellent	54%	70%	56%	77%	64%	74%	58%	26%	29%	36%	47%	
		Good	29%	26%	24%	14%	16%	16%	32%	32%	10%	0%	12%	
		Fair	0%	0%	0%	0%	0%	5%	0%	0%	0%	0%	0%	
		Poor	0%	0%	0%	0%	0%	0%	0%	0%	3%	0%	0%	
		Don't know	18%	4%	20%	9%	20%	5%	10%	42%	58%	64%	41%	
CPCT	CPCT Nurse visited often enough	Always	88%	84%	81%	80%	85%	87%	84%	74%	77%	85%	84%	
		Only Sometimes	6%	14%	10%	17%	9%	13%	8%	16%	12%	8%	9%	
		Definitely Not	3%	0%	8%	0%	2%	0%	5%	7%	11%	5%	3%	
		Don't know	3%	3%	2%	4%	4%	0%	3%	2%	0%	3%	3%	
	Enough emotional support from CPCT team	Yes definitely	55%	53%	57%	61%	73%	73%	68%	43%	61%	51%	58%	
		Yes to some extent	35%	40%	30%	35%	20%	19%	23%	40%	24%	40%	35%	
		No	0%	3%	11%	0%	5%	0%	6%	13%	10%	6%	0%	
		Don't Know	10%	3%	2%	4%	2%	8%	3%	3%	4%	3%	6%	
	Enough Religious/ Spiritual Support from CPCT	Yes definitely	60%	62%	33%	33%	71%	50%	45%	45%	25%	46%	62%	
		Yes some	40%	15%	27%	27%	17%	38%	18%	18%	13%	23%	23%	
		No	0%	8%	11%	13%	0%	0%	18%	27%	31%	15%	0%	
		Don't know	0%	15%	27%	7%	13%	13%	18%	9%	31%	15%	15%	
	Enough Financial Support from CPCT	Yes definitely	64%	78%	38%	56%	67%	63%	38%	69%	35%	67%	73%	
		Yes some	27%	11%	48%	22%	24%	38%	46%	15%	35%	33%	27%	
		No	9%	11%	14%	22%	10%	0%	15%	15%	29%	0%	0%	
	Symptoms other than pain relieved by CPCT	Yes definitely	74%	48%	49%	49%	66%	59%	68%	59%	59%	61%	67%	
		Yes to some extent	17%	52%	40%	46%	29%	37%	25%	41%	27%	26%	30%	
		No	9%	0%	11%	5%	5%	4%	7%	0%	14%	13%	4%	
	Enough support for family concerns from CPCT	Yes definitely	45%	58%	63%	68%	71%	40%	63%	41%	50%	50%	71%	
		Yes to some extent	45%	42%	26%	23%	24%	47%	32%	47%	39%	43%	29%	
		No	9%	0%	11%	9%	5%	7%	5%	12%	11%	7%	0%	
	Enough help with urgent problems evening from CPCT	Yes definitely	65%	44%	60%	70%	67%	61%	64%	58%	49%	52%	65%	
		Yes to some extent	29%	31%	27%	23%	29%	33%	27%	29%	34%	35%	20%	
		No	6%	25%	13%	7%	4%	6%	9%	13%	17%	13%	15%	
	Enough help with urgent problems at night from CPCT	Yes definitely	71%	43%	71%	69%	67%	63%	65%	62%	47%	61%	65%	
		Yes to some extent	14%	33%	18%	24%	29%	31%	25%	24%	34%	22%	15%	
		No	14%	24%	11%	7%	5%	6%	10%	14%	19%	17%	20%	

Subject	Question	Answer	2015-2016	2017	2017-2018	2018	2018/ 19	2019	2019-20	2020	2020-21	2021	2021-22	Trends
	Pain relieved by CPCT	Completely all the time	32%	28%	31%	40%	31%	27%	42%	39%	33%	40%	38%	
		Completely some of the time	22%	28%	31%	24%	33%	42%	29%	21%	32%	30%	29%	
		Partially relieved	22%	17%	18%	16%	18%	9%	8%	18%	19%	15%	9%	
		Not at all	0%	3%	2%	0%	2%	3%	3%	3%	5%	0%	6%	
		Don't know	5%	3%	4%	5%	6%	0%	3%	0%	2%	0%	6%	
		Does not apply	19%	22%	14%	15%	10%	18%	16%	18%	9%	15%	12%	
	Family got help and support from CPCT	Yes as much as we wanted	84%	83%	78%	79%	85%	82%	89%	85%	81%	85%	82%	
		Yes some	8%	17%	7%	12%	8%	9%	8%	8%	9%	5%	9%	
		No tried to get more	3%	0%	6%	4%	2%	6%	3%	3%	7%	5%	3%	
		No did not ask for more	3%	0%	7%	5%	4%	3%	0%	5%	0%	5%	6%	
		Did not need	3%	0%	2%	0%	2%	0%	0%	0%	3%	0%	0%	
	Explanation of patient's treatment by CPCT	Very easy to understand	65%	81%	57%	63%	66%	70%	61%	55%	74%	70%	71%	
		Fairly easy to understand	35%	14%	35%	32%	24%	21%	31%	38%	23%	25%	26%	
		Fairly difficult to understand	0%	3%	0%	0%	2%	3%	0%	0%	0%	0%	0%	
		Did not explain anything	0%	3%	6%	0%	6%	6%	3%	5%	2%	5%	0%	
		Never spoke	0%	0%	2%	5%	2%	0%	6%	3%	2%	0%	3%	
	CPCT had time to listen	Yes all the time	86%	78%	77%	81%	87%	84%	83%	78%	84%	85%	88%	
		Yes some of the time	14%	22%	19%	14%	9%	9%	14%	15%	11%	15%	6%	
		No not when needed	0%	0%	2%	4%	2%	3%	0%	2%	2%	0%	0%	
		Don't know	0%	0%	2%	2%	2%	3%	3%	5%	4%	0%	6%	
	Overall care from CPCT	Exceptional	33%	53%	42%	46%	48%	41%	50%	32%	35%	48%	53%	
		Excellent	56%	31%	28%	32%	38%	41%	36%	51%	40%	43%	38%	
		Good	8%	14%	21%	18%	12%	15%	11%	12%	13%	5%	6%	
		Fair	3%	3%	4%	4%	0%	0%	0%	2%	7%	0%	3%	
		Poor	0%	0%	6%	2%	2%	3%	3%	2%	5%	5%	0%	
	Involved as much as wanted by CPCT	As much as wanted	89%	94%	87%	91%	92%	88%	88%	93%	98%	88%	88%	
		Wanted to be more involved	8%	6%	8%	5%	2%	9%	6%	5%	0%	10%	9%	
		Don't know	3%	0%	6%	4%	6%	3%	6%	2%	2%	3%	3%	
Jubilee/Wellbeing	Benefited from Jubilee/Wellbeing Centre	Always	83%	33%	67%	67%	75%	80%	0%	100%	0%	100%	100%	
		Usually	0%	33%	17%	33%	0%	20%	0%	0%	0%	0%	0%	
		Sometimes	0%	17%	17%	0%	0%	0%	0%	0%	0%	0%	0%	
		Never	17%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	
		Don't know	0%	17%	0%	0%	25%	0%	0%	0%	0%	0%	0%	
Circumstances surrounding RIP	Where did the patient die?	Own Home	35%	33%	43%	32%	28%	47%	25%	51%	47%	51%	45%	
		Hospice	46%	42%	29%	48%	39%	23%	49%	27%	33%	27%	32%	
		Hospital	13%	13%	15%	16%	23%	11%	14%	10%	12%	16%	15%	
		Care Home	6%	10%	10%	3%	7%	15%	7%	6%	8%	4%	6%	
		Accident and Emergency	0%	2%	2%	0%	2%	4%	2%	0%	0%	0%	2%	
		Family/ Friend Home	0%	0%	0%	1%	2%	0%	4%	4%	0%	2%	0%	
	Where did the patient want to die?	Own Home	47%	53%	65%	60%	64%	56%	53%	59%	66%	77%	67%	
		Hospice	47%	43%	30%	31%	31%	27%	42%	33%	26%	18%	33%	
		Hospital	3%	0%	0%	2%	0%	0%	0%	0%	0%	3%	0%	
		Care Home	3%	3%	5%	2%	3%	2%	0%	0%	0%	0%	0%	
		Either Own Home or Hospice	0%	0%	0%	2%	0%	0%	0%	0%	0%	0%	0%	
		Family/ Friend Home	0%	0%	0%	2%	3%	0%	0%	0%	0%	0%	0%	
		Changed Mind	0%	0%	0%	0%	0%	5%	0%	3%	4%	0%	0%	
		Did not mind	0%	0%	0%	0%	0%	10%	3%	3%	4%	3%	0%	
		Somewhere else	0%	0%	0%	0%	0%	0%	3%	3%	0%	0%	0%	
	Preferred place of RIP achieved	Yes	82%	67%	57%	71%	62%	63%	65%	57%	76%	68%	69%	
		No	18%	33%	43%	29%	38%	37%	35%	43%	24%	32%	31%	

Subject	Question	Answer	2015-2016	2017	2017-2018	2018	2018/ 19	2019	2019-20	2020	2020-21	2021	2021-22	Trends
	Patient had enough choice about place of RIP	Yes	90%	68%	75%	85%	79%	83%	83%	69%	85%	77%	76%	
		Unsure	3%	10%	8%	9%	5%	0%	3%	8%	2%	4%	15%	
		No	6%	13%	17%	7%	15%	18%	14%	22%	13%	19%	9%	
	Patient died in the right place	Yes	90%	93%	89%	91%	82%	90%	89%	84%	81%	89%	87%	
		Unsure	2%	0%	3%	3%	3%	0%	0%	2%	11%	4%	7%	
		No	8%	7%	8%	6%	15%	10%	11%	14%	8%	7%	7%	
Bereavement Support	Enough bereavement support from staff	Yes definitely	86%	80%	83%	94%	92%	71%	96%	83%	75%	92%	80%	
		Yes to some extent	14%	20%	11%	3%	8%	29%	4%	17%	13%	8%	20%	
		No not at all	0%	0%	6%	3%	0%	0%	0%	0%	13%	0%	0%	
	Carer shared feelings after patient died	Yes	36%	15%	59%	57%	37%	58%	28%	41%	34%	53%	44%	
		Unsure	2%	4%	5%	1%	7%	0%	4%	4%	7%	7%	7%	
		No would have liked to	20%	15%	14%	10%	18%	12%	21%	37%	20%	2%	7%	
		No did not want to	43%	66%	22%	31%	37%	30%	47%	18%	39%	37%	42%	
		No - Did not elaborate	0%	0%	0%	0%	2%	0%	0%	0%	0%	0%	0%	
	Carer talked to someone as soon as they wanted	Yes	86%	100%	68%	86%	74%	71%	77%	81%	88%	71%	94%	
		Unsure	7%	0%	11%	9%	21%	19%	15%	6%	4%	5%	6%	
		Wanted to talk sooner	7%	0%	22%	6%	5%	5%	8%	13%	8%	24%	0%	
		No was not asked	0%	0%	0%	0%	0%	5%	0%	0%	0%	0%	0%	
	Leaflet on bereavement helpful?	Definitely helpful	51%	58%	39%	54%	48%	45%	67%	28%	45%	47%	49%	
		Helpful to some degree	9%	9%	21%	22%	19%	14%	14%	22%	17%	19%	16%	
		Not helpful	2%	2%	3%	2%	0%	0%	0%	0%	4%	0%	0%	
		Did not receive	31%	21%	30%	22%	22%	32%	18%	36%	28%	26%	24%	
		Don't know	7%	9%	7%	2%	10%	9%	0%	14%	6%	9%	11%	
	Contact from Hospice helpful?	Definitely Helpful	27%	28%	29%	48%	47%	40%	46%	27%	37%	37%	58%	
		Helpful to some degree	22%	18%	25%	27%	17%	26%	13%	24%	20%	32%	23%	
		Not helpful	0%	3%	13%	5%	5%	5%	0%	4%	2%	5%	0%	
		Did not receive	24%	35%	21%	17%	16%	21%	40%	33%	31%	15%	10%	
		Don't know	27%	18%	13%	3%	16%	7%	2%	12%	11%	12%	10%	
Recommend Hospice	Would carer recommend Hospice to their Friends and Family?	Extremely Likely			77%	86%	78%	77%						
		Likely			16%	10%	12%	16%						
		Neither likely nor unlikely			3%	1%	4%	0%						
		Extremely Unlikely			3%	3%	3%	0%						
		Don't know			2%	0%	3%	7%						
	Overall Experiences Rating	Very good							82%	75%	68%	77%	83%	
		Good							13%	15%	23%	17%	17%	
		Neither good nor poor								6%	6%	2%	0%	
		Poor								2%	3%	0%	0%	
		Very poor							2%	0%	1%	4%	0%	
		Don't know							4%	2%	0%	0%	0%	

Terms of Reference for Clinical Quality & Governance Committee

St Raphael's Hospice

Scope of Committee remit

1. The Board of St Raphael's Hospice is responsible for the strategic direction of the charity, and Board members hold collective legal liability for oversight of the charity. The Board are supported in their oversight of the clinical quality, governance and risk activities by the Clinical Quality & Governance Committee.
2. The Committee takes responsibility for providing assurance to the Hospice Board that the organisation has a robust framework for clinical governance that supports the delivery of safe and effective care and the management of clinical systems and processes. To achieve this, the Committee will ensure that quality is integral to the work of the Hospice and the systems and services that support that work, and that there is a robust programme that supports the monitoring of clinical performance across all clinical services. Committee members will contribute expertise, human resource capacity, and their professional perspectives to the development and successful operation of the St Raphael's Hospice clinical governance activities.
3. The charity's Scheme of Delegation outlines the key decision-making structure within the charity, including delegation from the Board to the Committee.
4. The Committee reports directly to the Board of St Raphael's Hospice.

Committee membership and composition

5. In line with the Articles of Association, the number of Committee members shall not be less than two, of whom at least one must be a Trustee of St Raphael's Hospice. It will be general practice for Committees to consist of at least three individuals, of whom two will be Trustees.
6. Additional suitable Committee members may be co-opted who, in the opinion of the Board and Committee, will bring additional relevant skills and expertise. Co-opted Committee members do not hold the same legal duties as the charity's Trustees, but are expected to uphold high standards of governance and adhere to the policies and procedures applicable to Board members.
7. At least one Committee member should have a Clinical background.
8. Committee members must be over 16 years in age and will generally be over 18 years in age, and must not be disqualified under the provisions of clause 5.6 of the Articles of Association and disqualification criteria set by the Charities Commission of England and Wales.
9. Appointments to the Clinical Quality & Governance Committee are made by the Trustees, for a period of three years. Following this first term, a Committee member may be appointed for up to two further terms of three years. This arrangement mirrors the term lengths for the St Raphael's Hospice Board of Trustees.
10. Committee members will receive no remuneration in relation to their role, and will adhere to the charity's expectations and procedures with regards to conflicts of interest and connected persons.

11. The Trustees will appoint a Chair of the Clinical Quality & Governance Committee, who shall be a Trustee. The Chairing of this Committee may rotate between each meeting, to leverage the respective expertise of Committee members.

Role and responsibilities of the Committee

12. Subject to the provisions in the charity's Articles of Association, the members of the Clinical Quality & Governance Committee take delegated responsibility on behalf of the Board of Trustees for the following high-level areas:

- Receive assurance on the delivery of a work programme on an annual basis in accordance with Hospice's strategic objectives.
- Receive assurance on the quality and safety of any service development or re-design.
- To receive reports on progress against key clinical quality and governance objectives in the Hospice's annual Management Plan.
- Receive assurance that the key critical clinical systems and processes are robust, safe and effective. These systems will include, but are not limited to clinical leadership, staffing, competency, activity, learning/ education, incident management, complaints, audit, and effective. They will also encompass the Patient and Service User Experience, compliance with the CQC Fundamental standards of quality and safety, Electronic Patient Record (EPR), Research and Development and Medicines Management.
- Receive assurance that safe and effective person-centred care is being delivered and will do this by:
    - Receive reports on clinical quality across the Hospice.
    - Ensuring mechanisms are identified to enable all clinical teams to review performance in line with national benchmarking and evidence based practice and review/agree subsequent action plans.
    - Receive assurance that that new clinical systems are implemented within a framework of robust clinical governance, improve patient care and experience.
    - Receive and review minutes from the Hospice's internal Clinical Committees.
- ~~Review the Provider Information Return.~~
- Conduct in-depth review of the Clinical Risk Register.
- Receive progress reports on the ~~Clinical Action Plan~~Clinical Quality & governance section of the annual Management Plan.
- Review Clinical Key Performance Indicators (KPIs), data and information on Clinical Complaints.
- To review and approve/ recommend to the Board other related clinical reports or publications as agreed.
- To consider how the Hospice contributes and is part of the wider health and care system.
- Have delegated authority to review progress and take decisions within a framework approved by the Board and linked to the annual business cycle.
- Assisting the Board identify the Hospice's major risks in relation to clinical quality and governance, and developing appropriate approaches to risk management. This will include periodic reviews of the Hospice's corporate risk register and insurance cover.

Access

13. Individual Committee members or managers may raise concerns with the Committee Chair at any time.

Committee Meetings

14. The Committee will meet at least four times a year. The Committee Chair may call additional meetings if necessary.
15. In line with the St Raphael's Hospice Articles of Association, the quorum for Committee meetings will be two Committee members, of whom one must be a Trustee.
16. Meetings may be held in person, or by suitable electronic means such as video conference.
17. Meetings of the Committee will normally be attended by the ~~Joint~~ CEO~~s~~, Clinical Director, the Lead Palliative Care Consultant (or nominated other) and ~~Head~~ Director of Quality ~~and Improvement~~. ~~Consultants~~ Other Hospice personnel ~~working at the Hospice~~ may also be invited to attend or present.
18. Committee members may ask any attendees who are not members to withdraw to facilitate open discussion of particular matters.
19. Any votes will be undertaken in accordance with the provisions in the St Raphael's Hospice Articles of Association.

Reporting

20. Minutes will be taken of each meeting of the Committee, by the Secretary to the Committee or another individual agreed with the Committee, and circulated to Committee members.
21. Minutes of Committee meetings will be made available to the Board.
22. Minutes will be stored for at least 10 years.

Renewal

23. The Terms of Reference will be updated every three years.

Date of last approval: March 202~~1~~3. Date of next renewal: March 2024.

St Raphael's Hospice

Meeting of the Clinical Quality & Governance Committee

To be held St Raphael's Hospice, London Road, Cheam, Sutton, SM3 9DX

At 10:00am on Friday 28th April 10am-12pm

Members: Dr Carrie Chill – Trustee & Committee member (CC)
Alan Cogbill – Trustee & Committee member (AC)
Dr Eva Kalmus – Co-opted Committee member (EK)
Bernard Marley – Trustee & Committee member (BM)
Norman McWhinney – Board Chair & Committee member (NM)

In attendance: Nick Stevens – CEO (NS)
Alex Rudkin – Director of Quality & Governance (AR)
Dr Naomi Collins – Consultant (NC)
Rebecca Trower – Clinical Director (BT)
Anna Machin (Governance – AM)

Item	Time	Description	Purpose	Lead
1.	10.00 – 10.05	Welcomes, introductions & 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 13th January 2023	Approval	Chair
		Actions List and update on matters arising	Discussion	Chair
3.	10.15 – 10.25	Evidence of Excellent Practice Register	Discussion	RT, NC, AR
4.	10.25 – 10.35	Clinical Risk Register	Discussion	RT
5.	10.35 – 10.55	Clinical Quality & Governance Report	Discussion	RT, NC, AR
6.	10.55 – 11.45	Clinical Action Plan 2022/23 round-up & 2023/24 priorities (CAP) Selection of three 2023/24 objectives for inclusion in 2022/23 Quality Account	Discussion Decision	RT, NC, AR
7.	11.45 – 11.50	Minutes of internal meetings Audit - QI reports	Discussion	RT, AR
8.	11.50 – 11.55	Annual review of Committee Terms of Reference	Discussion	AM
9.	11.55 – 12.00	Any Other Business & Date of next meeting	Discussion	Chair

Dates of future meetings:

- Friday 30th June 2023 10am – 12pm Virtual meeting

- Friday 6th October 2023 10am – 12pm In person meeting