

St Raphael's Hospice
Meeting of the Clinical Quality & Governance Committee
To be held at St Raphael's Hospice with video dial-in option
At 13:00pm on Friday 8th July 2022

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)
 Dr Joy Tweed – Trustee & Committee member (JT)

In attendance: Gail Linehan – Joint CEO (GL)
 Nick Stevens – Joint CEO (NS)
 Dr Jenny Strawson – Consultant (JS)
 Alex Rudkin - Head of Quality and Improvement (AR)

Apologies : Rebecca Trower – Clinical Director (BT)
 Anna Machin (Governance – AM)

Item	Time	Description	Purpose	Lead
1.	13.00-13.05	Welcomes, apologies for absence and declarations of interest	Discussion	Chair
2.	13.05-13.20	Review of minutes from 1 st April 2022 Clinical Quality & Governance Committee meeting	Approval	Chair
		Actions List and update on matters arising Wellbeing Centre Case Studies / Video	Discussion	GL
3.	13.20-13.35	Evidence of Excellent Practice Register	Discussion	JS/AR
4.	13.35-13.55	Clinical Risk Register <ul style="list-style-type: none"> • Update on admissions refused due to staff capacity 	Discussion	JS/AR
5.	13.55-14.05	Clinical Quality & Governance Report Complaints Summary CCG Activity Data & Charts	Discussion	JS/AR
6.	14.05-14.35	Clinical Quality & Governance Objectives - Extract from Management Plan 2022/23	Discussion	JS/AR
7.	14.35-14.45	Quality Account	Approval	AR
8.	14.45-14.55	Minutes of internal meetings <ul style="list-style-type: none"> • Benchmarking of Safeguarding referrals vs other local hospices • Update on staff vaccination 	Discussion	
8.	14.55-15.00	Any Other Business & Date of next meeting	Discussion	Chair

Dates of future meetings:

- Friday 7th October 2022, 10am-12pm

ITEM 04 ACTION LIST

SAINT RAPHAEL'S HOSPICE CLINICAL QUALITY & GOVERNANCE SUB-COMMITTEE ACTION LIST FOR JULY 2022 MEETING

Reference	Lead	Description	Target Date for Completion	Comments
21/07/16-04	R Trower	Share update on equality & diversity Working Group on patient behaviour towards staff	April 2022	All members engaged and in process of 1 st meeting set up (BD-S, MB, CC, SM, RT)
21/10/29-03	Dr J Strawson	Provide update on paediatric palliative trainee post and support for younger patients	Meeting during 2022	
22/01/14-03	R Trower with colleagues	Benchmark level of Safeguarding referrals vs. other local Hospices	July 2022	Canvassed for feedback - April
01.04.22/01	Anna Machin, Eva Kalmus	Update Declarations of Interest log with Eva Kalmus' appointment	Immediate	
01.04.22/02	Gail Linehan	Evidence of Excellent Practice Register - Consider mechanisms to capture Community team feedback	July meeting	To be incorporated into the Feedback module in DATIX by September. Facilitated by the Quality Office until then. Medical Examiner's Office feedback incorporated into Excellence Register.
01.04.22/03	Alex Rudkin	Clinical Quality & Governance Report - Collate examples to demonstrate impact of audit on clinical practice	July meeting	Quality Account 2021/22
01.04.22/04	Alex Rudkin	Clinical Quality & Governance Report - Update table in Clinical Action Plan page 8 to have most recent date first	July meeting	Complete
01.04.22/05	Alex Rudkin, Anna Machin	Clinical Quality & Governance Report - Itemise Management Plan on Committee agendas and include progress summary	July meeting	

ITEM 04 ACTION LIST

Reference	Lead	Description	Target Date for Completion	Comments
01.04.22/06	Rebecca Trower	Clinical Quality & Governance Report - Bring together Wellbeing programme case studies	July meeting	Included in July meeting papers
01.04.22/07	Rebecca Trower	Clinical Risk Register - Review pre-control score for Agenda for Change	July meeting	Complete
01.04.22/08	Rebecca Trower	Clinical Quality & Governance Objectives - Share timeline for completion of key goals	July meeting	CQ&G extract from Management Plan
01.04.22/09	Anna Machin	Annual Review of Committee Terms of Reference - Update point 11	July meeting	
	Rebecca Trower	Twilight shift cover - Update on volunteer twilight shifts	July meeting	

CASE STUDY ONE:

A CARER

A is the wife of T. They have been married a long time, have a loving a supportive family and are happy and comfortably off.

T has always been a confident extrovert with a successful career. He has provided for his family and been both the major breadwinner and (along with A) decision maker. He is funny and caring.

In April last year T was diagnosed with Motor Neurone Disease. Securing the diagnosis was difficult. Early symptoms were dismissed or not detected. Covid and lockdown did not help A and T's interactions with their GP and the NHS in general.

A was referred to the WBC. She was anxious and frightened by T's diagnosis and the future. A attended all of the 8 week sessions offered by The Living Well Programme. We witnessed A grow in confidence and come out of her shell. She acquired information and skills to deal with T's diagnosis and plan for future changes. Importantly A made friends, securing significant support from people in the same position as she is – including people with MND and their carers.

At the end of the Living Well programme series that A participated in A was keen to continue to receive support. She was also keen for T to get support an in particular to have male company and to get out of the house. As T's mobility and communication skills have deteriorated he has become at risk of being socially isolated and he misses banter with male friends.

To address this both A and T attend the WBC on Thursday afternoons. A attends the ladies afternoon tea where she has fun and receives support from a diverse group of interesting ladies supported by a volunteer. T attends the Men's Den. T is a key member of the group contributing his humour and intellect to lively sessions involving a quiz, cards, pool and general chat.

T's prognosis is of course short and A is very mindful of this. The WBC cannot change the prognosis but has provided invaluable support to both A and T not only in preparing for the future but also enjoying the present.

A is a strong advocate for the WBC and has recommended us to others who also now attend.

CASE STUDY THREE:

A "PATIENT"

P, a lady in her late 70s had lived in the west country for a number of years. P lost her husband a few years ago leaving her with a grown-up daughter in Sutton.

P was diagnosed with a brain tumour. The diagnosis came as a complete shock and was a major setback for P. Prior to the diagnosis P was a confident and independent lady with very forthright opinions which she was happy to share. The diagnosis pulled the rug from under P's feet such that she had to move from the west country to live with her daughter in Sutton.

In Sutton P came under the clinical care of the hospice and was referred to the WBC for support.

It would be fair to say that initially P was rather reluctant to accept that she needed support. That reluctance soon passed and P became a mainstay of the WBC music group on Tuesday afternoons. P spent days prior to the group each week preparing for the session and very much looked forward to it. P said many times that it was the highlight of her week saying "she lived for her Tuesday afternoon music".

P enjoyed the peers support provided by the other group members and appreciated the break from home where, staying with the daughter and grandchildren (and new puppy) could sometimes be rather fraught.

P also found the Living Well session on dealing with anxiety particularly helpful as a way to adapt to her changing circumstances.

P continued to attend the music sessions until very shortly before she died making a considerable effort using public transport and taxis to get here such was her commitment.

P arranged for a donation to be made to the hospice as part of her funeral arrangements.

CASE STUDY TWO:

A BEREAVED ATTENDEE

E and J were married for almost 45 years. A long and happy marriage. J died in the hospice after a short stay and a slightly longer illness. Unsurprisingly, E was distraught.

Whilst on the surface E is a high functioning, confident lady who is very open and friendly, she has, in the past suffered from depression and low mood and in her case, appearances can be deceptive.

E's late husband, J was a lively and successful chap who traditionally took care of household finances, bills, insurance etc. J's death therefore had practical as well as emotional consequences.

E attended psycho-social counselling at the hospice which benefitted her a great deal. E also gained significant support from Sister Ann and her bereavement group. E did however need more support.

E attended a number of the Living Well programme sessions. She found the practical tips and support extremely useful at a time when she was dealing with the mechanics of J's estate. She also loved the peer support.

It emerged during her attendance at the Living Well sessions that E is a keen artist. We therefore encouraged E to attend our art group each Tuesday morning. At first E came and did her own thing but over time she has blossomed. She now joins in with confidence and vigour and laughs loudly and often.

E also attends our yoga session which she enjoys for light exercise and relaxation. Further, on Thursday afternoons E attends afternoon tea and has become a focus of that lively and supportive group. E is very careful to ensure all are included in the group taking particular care with those with cognitive issues. It has been a pleasure to see E get her confidence and purpose back.

At some point E will have the resolve to pursue her own path without attending the WBC. She will be missed of course but it is a key part of our service and ethos that we instil independence to enable people to manage on their own.

E is a strong advocate of the WBC and a generous donor.

We have a short video clip summarising E's views.

Ref No.	Recorded By	Date	EXAMPLES OF EXCELLENT PRACTICE - Description	Link to evidence	PT Id	KLOE	Key Staff	Related System
2022/05	AR/LB	21/03/2022	Outstanding RGN support demonstrated by Sandy Elderkin to a student nurse following a patient's sudden death. It was her first experience of a patient dying and she was quite shocked. The student nurse fed back to the SRH education team how supportive and caring Sandy was in looking after her and supporting her saying goodbye to the patient.	Evidence of excellence copy\2022-03-21 thank you for student support.msg	n/a	W,C,R,E	Sandy Elderkin	
2022/06	AR/RT	31/03/2022	Kate Weldon completed a virtual new assessment with Dr Busi for a gentleman who was referred to the community team. This gentleman had a trache in situ and was very symptomatic with secretions. S/N Cathy Foster (IPU) was kind enough to join us during her lunch break and offered exceptional knowledge of tracheostomy care and was able to gain information from the patient specific to his own regime for the care of his trache which was great learning going forward. Fantastic example of joint working and skill sharing for the benefit of our patients' future care.	Evidence of excellence copy\31-03-22 RE Joint Working.msg		E,C,R,S	Cathy Foster	
2022/07	AR/GT	13/04/2022	A volunteer expressed her sincere gratitude to our Main Hospice and Reception Volunteer Manager for the support she has received from her over her volunteer period and how it supported her in making application to return to paid employment : "I am so sorry to go. I have really enjoyed working under you for the last year, you have been so welcoming and encouraging and ultimately provided me with the confidence to apply for this new role. I really am very grateful and just so sorry that I have to leave you so abruptly. "	Evidence of excellence copy\2022-04-13 FW- New Job!.msg	n/a	C,W	G Toubal	
2022/08	EN	19/04/2022	Lucia followed up with a gentleman who sent a Christmas card to Nick. He is organising a big music night in July for The Royal Marsden but wanted to include us in some way as his wife died at the Hospice. Lucia met him in The Orangery and had such a great chat they were there for over 2.5hrs. He told her how appreciative he was that she had invited him in, how cathartic it was to return to the Hospice and how wonderful it was for the offer to be shown around the new ward. Julie Ford and Lucy Moore were very helpful and allowed Lucia to show him the room next door to his wife's. He was quite hesitant to return and struggled at the start but Lucia was able to take care of him and by the end he commented how much he had enjoyed it. Lucia will be attending his event and he would also like to do some more fundraising for us after this one. A good example of how beneficial it is to show our supporters around the Hospice and meet there for a coffee/chat. I also thought it demonstrated excellent communication and support from Lucia and joined up working with the help of Julie and Lucy.			C,R,E	Lucia Heard Julie Ford Lucy Moore	
2022/09	AR/GT	21/04/2022	A volunteer expressed how volunteers are valued at SRH : " VOLUNTEERS ARE NOT PAID NOT BECAUSE THEY ARE WORTHLESS BUT BECAUSE THEY ARE PRICELESS". He said it sums up beautifully the Volunteer Service's Manager and the Hospice Management Team's view of volunteers.	Evidence of excellence copy\2022-04-21 View on Volunteers at SRH.msg	n/a	W	G Toubal & SMT	
2022/10	AR/JO'G	27/04/2022	Excellent example of responsiveness and joint working : <ul style="list-style-type: none"> • HPOC received a referral on Friday 22nd, discussion was held with the referrer and family - decision was made for HPOC assessment on 25th. • HPOC called just after midday on 25th – telephone assessment identified a marked deterioration in pts condition, 7SABO. • Discussion held with CPCT Coordinators – urgent responsive visit arranged . Dr Rachel and Heather visited pt at home at 2pm – pt required s/c admission • Pt admitted to SRH IPU around 4pm on 25/04/2022. 	N:\Care Quality Commission\Excellence in Practice\Evidence of excellence copy\2022-04-27 Responsive Visit.msg	19127	C, R, E, W		
2022/11	AR/TY	10/05/2022	Over and above effort put in by Sam Leech into supporting Manual Handling Training updates and induction on the IPU.	N:\Care Quality Commission\Excellence in Practice\Evidence of excellence copy\2022-05-10 Sam Leech praise.msg	n/a	R, E, W	Sam Leech	

Ref No.	Recorded By	Date	EXAMPLES OF EXCELLENT PRACTICE - Description	Link to evidence	PT Id	KLOE	Key Staff	Related System
2022/12	AR	19/05/2022	Additional Feedback via Medical Examiner's Office 09/01/2022 : Excellent care received & no concerns 18/01/2022 : Happy with Hospice care 18/01/2022 : Family reported the care in the last 2 weeks has been "OUTSTANDING". The care at the hospice has "blown us away" with the compassion shown - not only to M but also to the family as a whole. They expressed "absolute satisfaction" for the entire process, including the ME call. They felt all the literature, pamphlets provided were incredibly helpful. "Every single staff member has been outstanding" and they specifically commended: Dr Strawson Dr Fletcher Dr Jovy The family have made a donation to the hospice and we encouraged them to also email/feedback to the hospice directly, as they were so impressed with the care and the service. 27/01/2022 : She was comfortable. SRH - Beautiful place. 27/01/2022 : Care described as "phenomenal" "second to none" from all staff 30/01/2022 : Hospice were fantastic. 03/02/2022 : Hospice - "could not have hoped for a better place for her to be". 05/02/2022 : Very good care at the hospice. 10/02/2022 : Hospice - "amazing, considerate & nothing was too much trouble." 10/02/2022 : Hospice care was excellent - staff all very caring. 17/02/2022 : Cannot fault the hospice staff - excellent care. 24/02/2022 : Cared for G very well in the hospice. 27/02/2022 & 10/03/2022 : No concerns about the Hospice. 27/02/2022 : Hospice care was excellent, no care concerns at all. Fantastic care for mother & the family as a whole. 15/03/2022 : Brilliant care from all staff to deceased and family members 17/03/2022 : Beyond doubt the care at SRH was "amazing" 21/03/2022 : Hospice were amazing. Every single nurse was "outstanding". "best decision we made"		n/a	S, R, E, C, W		
2022/12	JS	25/05/2022	Team response to accommodate a patient with a tracheostomy on the IPU - excellent joint working between community and IPU team - hospice at home and consultant performed a responsive urgent visit, then Tracheostomy lead nurse Cathy Foster did a responsive home visit to assess the tracheostomy and current care plan , Ward Sister Becca Wallis and the Education team Laura Briant and Maura Flint rapidly brought together a list of training competencies a training rota and staff training led by Cathy Foster (including outside of her normal shifts) was commenced using 'Kerry' to allow high fidelity simulation to practice the necessary skills required to care for the patient before his arrival.			S,E,R,W	Cathy Foster, Rebecca Wallis, Alison, Maura, Laura	
2022/13	JS	24/05/2022	IPU team facilitated a relative to visit from prison			C, R	IPU team	
2022/14	JS	18/05/2022	SW input on facilitating a complex discharge, which involved flat clearance			C,R	Elisa	
2022/15	AR	27/05/2022	Annual Complaints Review Meeting for 2021/22 held with the Executive Team showed allowed for review of individual complaints that highlighted a variety of practice changes / learning that have been enacted/effected that included: - 1. Patient's partner feedback informed process of bereavement information literature review and was happy to be included in our literature review process. 2. Informed communications training program in explaining rationales behind decisions. 3. Reflection has supported decision to remodel the single community team into three smaller groups, increasing familiarity for patients and their families and reducing the need to repeat information as frequently. 4. Informed Information leaflet and website review 5. Informed communications training in that expectations should not be raised if they cannot be met. 6. Informed the value of routine phone call before visit. 7. Hospice neighbours service is planning to transition to Compassionate Neighbours that will aim to provide more support in the patient's home. 8. Reflection on video link consultation and its effectiveness / appropriateness. 9. Continuation of efforts to examine new ways of working in the community during the day and overnight to increase our responsiveness. 10. Education program continues to expand to teach all professionals working in the community about common symptoms experienced at the end of life, including the management of pain and agitation and the need to escalate or change medication if needed. 11. Re-enforced value of face to face visiting.	N:\Minutes of Meetings\Complaints Review Meeting\2022\Apr 21 - Mar 22 Review Meeting summary.pdf	n/a	C, R, E, W, S	All Hospice Staff and Volunteers	Complaints Management

Ref No.	Recorded By	Date	EXAMPLES OF EXCELLENT PRACTICE - Description	Link to evidence	PT Id	KLOE	Key Staff	Related System
2022/16	LB	12/05/2022	International Nurses' Day was celebrated at the hospice. A study was facilitated by the Education team on palliative care emergencies- sessions were relevant and evidence based- teaching provided by Laura Briant, Maura Flint Jovy Giles and Ambreen Ahktar. Corporate fundraiser Emma Burns arranged for ballon arch buy Bella Blue Events as well as flower wall and cupcakes donated by a local bakery for nursing staff. Lush porducts were donated and distributed amongst nursing staff. Ewan Lavender (comms) took photos and videos throughout the day. Ginny Toubal arranged for 3 volunteers to support with catering; serving teas and coffees. Paula Di Palma and Kerrie Weare purchased and prepared sandwiches- going to several stores on the day when the orginal order was not fulfilled. The whole day was a success and an excellent example of team working amongst different departments in the hospice.					
2022/17	JS	20/06/2022	We all discussed as a team the wonderful support you offered a patient and her Mum over the weekend, taking a truly holistic approach and offering your skills in light touch to calm a very difficult situation.	19178	19178	C,R	AG (CNS)	

Serial	Cause of Risk	Description of Principle Risk to Charity	Current Controls to prevent occurrence	Current Impact	Current Probability	Raw Score	Additional Controls	Residual Impact	Residual Probability	Residual Score	Monitoring Process	Date Action Required By:	Who is responsible for action	
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 sufficient, 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 unexpected 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 permanent 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 educational support to obtain required qualifications e.g. Support of the TNA programme for HCAs	4	4	20	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 demonstrate 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 aligned 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%.	4	3	16	Recruitment rates			CD
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 facilitating 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				IT/CD
3.	Clinical Incidents	Patient Safety (Falls/Pressure Ulcers/Medication Errors). Risk of complaints from patients/families Requirement to report outside the organisation to CQC Pre-empt a CQC Inspection Reputational damage	Reporting of all incidents related to clinical care Hierarchy of investigation Outputs- Learning informs improved procedures 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 managers at team meetings. Opportunity to participate in reflection 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	Review of Data and subsequent themes.	ongoing		CD & Head of QI
4.	Staff Resilience negatively impacted during long pandemic	1. Inability to continue delivering service to the desired standard. 2. Consequential impact on EVE	1. Peer Support implemented for managers- aim to equip staff effectively. 2. HR proactive and available to hear and escalate issues 3. HR Mental Health Helpline. 4. Regular and open communication from Senior Team. 5. Weekly testing for clinical and main Hospice building staff. 6. Vaccine roll out to most staff	2	2	6	1. Continue to provide some other welfare benefits to acknowledge difficulties i.e. social meal cost contribution. 2. Supportive communication across teams. 3.Access to vaccinations improved. 4. Regular review of organisation support for staff sickness / isolation to ensure staff resilience and service provision	1	2	3	Manager feedback			EXEC
5.	Corona Virus	Infection spread within hospice	All staff emails alert. Signage directing all staff & visitors 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 facilitated to do so. Increased utilisation of telephone contact.	3	2	9	Corona Virus Policy updated on government guidance changes. PPE supplies checked. Contingency planning clarified for any identified case within the Hospice - as per government guidance. Single room nursing. Marginally reduced face to face visiting dictated by urgency. Increased telephone contact. FFP3 mask fit testing complete. Refresher PPE training and advice and support from PHE. LFD testing for all staff in clinical situations or in the hospice building. Formalised SLA in place with SHH IP&C from 1 April 2022	2	1	4				CD
6.	Complaints	Rumours Local press coverage Potential for public concern Elements of public expectation 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 procedure 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/improvement 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		Ongoing		CD
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 organisation Clinical staff have nhs emails (encrypted) Regular organisational sweeps in all departments	3	2	9	IT monitoring and oversight of PID in received and sent emails. Monitoring includes audit and test Phishing emails via IT Dept. Intermittent checking in areas such as photocopier/clear desks. Established link with Capsticks solicitor who provides ad hoc advice on data access issues January 2022 - Information Governance Check list audit / Clinical Record documentation audit	3	1	6				IT/CD

Serial	Cause of Risk	Description of Principle Risk to Charity	Current Controls to prevent occurrence	Current Impact	Current Probability	Raw Score	Additional Controls	Residual Impact	Residual Probability	Residual Score	Monitoring Process	Date Action Required By:	Who is responsible for action
8.	Corona Virus	Staff safety at work	IPU - wearing face masks at all times as difficult to maintain social distancing in environment. Full PPE as appropriate. CPCT - social distancing in place in offices . Admin Corridor : staff using available office space to meet social distancing.	2	2	6	Infection Control Lead in place SLA with SHH IP&C	2	1	4			CD
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 procedure in place to support community working (SOP). Supplied with a mobile phone for contact 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	On going		CD
10.	Risk of medication shortages via suppliers	Required medication (opioids, neuropathic agents, anti seizure etc.) not available in specified dose ranges to support symptom management. Impact on patients.	Liaison with clinical pharmacy Ashtons - Reassurance that adequate supplies in stock.	2	2	6	Regular updates from clinical pharmacist. Communication with wider CCG pharmacy colleagues.	2	2	6			CD

ITEM 05

Clinical Quality and Governance Report

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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

Update on Organisational Response to the Covid 19 Pandemic

We continue to monitor and adhere to government guidance around Covid to ensure we remain as safe as possible. Our Service level agreement with the Infection Prevention and Control (IPC) team from St Helier Hospital became formal from 1 April and Tracy Young, our Clinical Standards and Project Lead is now the Infection Control Lead for St Raphael's.

Covid numbers are low amongst our patients and staff

Mask wearing away from the clinical area remains optional and testing continues to be mandatory on a regular basis for those in clinical situations or who have a presence in the hospice building.

HoDs continues on a monthly basis to ensure that information is shared and communication is effective.

Clinical Services

We have successfully appointed to the role of Patient and Family Counsellor/Psychotherapist within our **Psychological Support Team** ; we had a high number of excellent applicants and the final decision was not easy. The successful candidate, Cecilie Sasu will work across 3 days per week.

Steve Molyneux, Clinical Lead, has submitted an extract to Hospice UK for the conference later in the year, detailing the benefits of the Student Counsellor roles so we are keeping our fingers crossed for a successful outcome.

Both Diana (Counsellor) and Elisa (Social Worker) have been managing some very challenging cases over recent months. Many of the clients referred for counselling have more complex needs secondary to the pandemic and the multi-faceted issues it has brought as well as trying to plug gaps in external psychological services. Elisa has been working across the community and IPU, supporting both patients and family needs including housing issues, school support and financial concerns.

The bereavement support group run by Sr Anne continues as a rolling programme of eight weeks, allowing the Clinical Lead and core team to focus on patient work and the more complex cases.

The **Wellbeing** service has been incredibly busy over the past few months. We are now receiving a number of referrals from social prescribers within our catchment; attendees who have previously been unknown to our service, and the variety of therapeutic offers are proving popular.

The team have been working closely with Age UK as well as networking on a regular basis with Wellbeing Leads from other hospices via Zoom. Sheila Payne, our Senior Wellbeing Facilitator has visited The Rowans Hospice Wellbeing centre in Portsmouth and the team are always open to trying new ideas and ventures that may appeal to our local community.

Dying Matters week in May was particularly busy – the team held a Self-care Workshop with Sutton and Merton Uplift and spent a day at Morden Hall Park, promoting the Wellbeing service to the public.

Medical and nursing students spend time in the Wellbeing centre as part of their secondments to SRH, in order to help them gain an understanding of the benefits of reaching people with life limiting or chronic illness, earlier on in their disease trajectory.

The Platinum Jubilee kicked off with a super 'Street Party' outside the Wellbeing Centre in the sunshine. The attendees were entertained by the Epsom Male Voice Choir (including our very own Rod and Bernard) and much fun was had by all.

The Men's Den is nearing completion – attention is now being given to the internal structure to ensure comfortable social spaces. We are extremely grateful to AJ Building Group for their generosity with this project and are really looking forward to opening up the space to meet the needs of the 'missing men' in our community – there is documented evidence that men are less likely than women to seek emotional support. We are hoping that our 'Den' will encourage men to meet together and support one another in ways that they find comfortable, such as through social interaction.

Complementary therapist – Laura Janowski is already very busy providing complementary therapy sessions to patients, carers and wellbeing attendees. Jane Gauld, one of our CPCT CNS', has now begun offering manual lymphatic drainage to service users on a monthly basis.

Roisin Yin-Poole, Compassionate Neighbours Lead, has been successfully developing the hospice neighbour service as well as networking with other hospices to learn about the Compassionate Neighbours Model. Referrals for hospice neighbours have been increasing and we are hoping to transition to the Compassionate Neighbours model over the coming year to eighteen months.

Our **IPU** now has 10 beds open – this is a great achievement, considering the low numbers of staff and we are hugely grateful to everyone for their flexibility and hard work which has enabled this to happen. Our IPU and hospice video is due to be filmed on 28 June all being well – it will be really helpful to be able to show the video to patients and families as well as healthcare professionals.

Rebecca Wallis moved into her new role as IPU sister at the beginning of May. She has spent the first few weeks settling in and getting to grips with the different processes on the ward. She will be helping to upskill and develop the nursing staff in a variety of ways, focusing on different areas including staff competencies. She is also intending to review the shift system to see how we might be able to increase the flexibility of shifts, in order to increase the appeal to external applicants.

We have appointed two new IPU members of nursing staff -Nursing Associate Angela Durrant (full time) and Band 5 Staff nurse Silvane Gabriel (part time).

Tricia Wass, an external Management and Leadership Facilitator, is running two team days in June for the IPU staff. This is to focus on their vision of the IPU – how they would like to see it develop and how they can engage, to take the vision forwards. There will be a follow day later in the year.

Tracey Young has now stepped into her new role of Clinical Standards and Project Lead. This is an exciting role which will allow Tracey to further enhance her skillset through leading on projects either jointly or independently. She will be taking on IPC over the longer term and has already engaged with the StHH team to ensure our practice remains of a high standard. Tracey will also be involved further implementation of OACC – a suite of outcome measures that help to demonstrate the effectiveness of what we do and she will also help to support the introduction and embedding of the new electronic records system EMIS over the coming year.

The **CPCT** Locality Team Lead roles have been formalised - Naomi Stammers has stepped into a twelve month LTL role whilst Rebecca Wallis works on the IPU. Naomi is an experienced paramedic who has been working within the CPCT for the past year.

The team have been working more closely with Sutton Palliative Care Coordination Hub to review patients and ensure there is no duplicity whilst identifying the most appropriate service. Historically there has been some confusion externally about which patients should be referred to either service – a flow chart has now been developed in collaboration with the hub and this should clarify criteria and lines of referral going forward.

Further written guidance has been produced to support patient to understand which service to contact, depending on the need. There are also now pain diaries and medication charts for patients to use and feedback to date has been positive.

The CPCT have submitted two poster extracts for the Hospice UK conference – one details the CPCT locality model and the other describes the benefits of appointing paramedics into the team. We await the results to hear whether we have been successful.

We also have three new members of staff: two new CNS'; Bev Mc Dermott (Band 7 CNS) and Katie White (Band 6 training post) and Mansi Bravery who is a HCA joining our Hospice at Home team.

Medical Team

The Medical Team hosted the first Consultant led MDT for the Merton EOL team on Monday 20th June which was well received. The Merton team have requested monthly input which will be facilitated by the consultant team. The meetings serve to discuss complex community cases, deliver education and as a form of peer support/supervision.

On call collaboration with Princess Alice and Kingston hospital continues to work well, with the consultants across all 3 sites meeting every 2 months to discuss any problems arising.

The consultant team continue to actively partake in the executive on call alongside their clinical duties.

As part of our endeavours to engage with other key local end of life care providers the consultant team met with Dr Eva Kalmus to discuss current ways of working and any challenges. We discussed our hope to broaden our offer of education opportunities to GPs and other key EOL partners and we have been invited to attend the next GP EOL meeting, where we hope to advertise our Palliative Care Masterclass sessions.

We continue to receive regular requests from fellow hospices to update them on the role of the Physician Associate, and Jovy and the consultant team have recently spoken with St Christopher's hospice team and St Helena's hospice.

Dr Strawson was able to act as an examiner for the first time on June 15th for the European certificate in Palliative Care at Princess Alice.

The medical team continue to support education across the team regularly delivering teaching to The Wellbeing Centre as part of the living well program, as part of our Monday medical teaching with Princess Alice and Woking and Sam Beare hospices and weekly journal club. Dr Collins as lead for

education continues to organise and facilitate medical students from SGH for one day placements on Tuesdays and Thursdays – their feedback has been consistently positive.

The consultants are actively involved in education and clinical supervision of several trainees: Dr Clingan Palliative Medicine ST5, Dr Woods ST7 paediatric palliative medicine, Dr Luke Hollingworth ST2 GP trainee. The consultant team have also taken the lead on supervising Dr Kris Ray Psychiatrist. We have also hosted a number of junior doctors from F1s to anaesthetic trainees from St Helier hospital on the IPU and within the community team.

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.

The audit program continues to be proactively pursued – with ongoing work around the End of life audit (with plans in progress to develop a specific EPR screen for priorities of care at the EOL) and our first audit looking at the OACC criteria and how it has been implemented. The hospice took part in a national audit on Wednesday the 22nd of June looking at how we record ethnicity and whether this accurately reflects how the patient identifies themselves, this was led by Dr Tamura Rose and Dr Clingan.

Dr Strawson is leading on the implementation of Schwartz Rounds and hopes to launch the first Round by January 2023. All members of the hospice will be invited to attend.

Education/Training

Our Palliative Care Educators have embarked on the first quarter of their education calendar by launching and facilitating a monthly Multi-Disciplinary Team Journal Club. They have also set up 'Learn@Lunch' which is a monthly session open to all staff to discuss popular topics across the organisation. This provides a great opportunity for us all to understand what others do or the experience that they have such as learning about legacies or completing a Will.

During Dying Matters week in May, Laura and Maura gave a talk on Palliative Care at Roehampton University. This was well received by the students and they have been asked to return on other occasions to provide further teaching. This also provides us with an opportunity to advertise any clinical vacancies at SRH.

On 12th May it was International Nurses Day where we celebrated at St Bede's with nursing staff from St Raphael's and the local community. It was a fascinating day, educational and much enjoyed by everyone, and topped off with a visit and thank you from Bernard Marley one of our Trustees.

Capacity Tracker

Work that serviced our inputs into the NHS capacity Tracker that aligned to the HUK grant from Treasury continues as part of the data integrity assurance that supports our activity data. Requirement to submit activity/capacity data to Hospice UK ceased on 31st March 2022 alongside the grant funding.

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 8 clinically focused forums that currently feed into the CQ&G Sub.

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

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

Governance Meetings - Clinical	Date last held	Date of Last Minutes Reviewed at CQ&G Sub	Next meeting
Clinical Audit and Activity Data	May'22	May'22	Jul'22
Clinical HoDs	May'22	May'22	Jul'22
Medical Business	Jun'22	Jun'22	Jul'22
Drugs & Therapeutics	Mar'22	Mar'22	Jun'22
Falls	Dec'21	Dec'21	Jul'22
Outcome Measurement Group	May'22	Nov'21	Jul'22
Infection Control	May'22	May'22	Sep'22
Prescribers	Mar'22	Mar'22	tba

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 remains healthy, particularly from the non-clinical area of Retail – the reported numbers of which have increased since the introduction of the electronic report format.
- Quarterly submission to Hospice UK's Quality Metrics project began in July 2017 and are on-going with the latest submission made in June 2022. The submission categories cover pressure sores, patient medication incidents and incidents of patient falls.
- All falls are reviewed at meetings of the Falls Group. Its last meeting took place in December 2021 and its next meeting is scheduled for July 2022. The Falls Policy was last reviewed and re-published in October 2020.

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 January 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 held in March and April 2022. Presentations topics have included Safeguarding Audit, IPU Discharge Correspondence Re-audit, Timing of IPU Admissions, Mortality & Morbidity Meeting, Record Keeping, Discharge Planning and DNACPR Documentation. The forum occupies a lunch-time slot (12.45-2pm) and is open to the clinical teams and those with an interest in topic.

The Audit/Research Programme 2022/2023 with timeline is set out from page 10. It itemises 30 projects spanning, clinical audit, quality improvement and data monitoring. Ownership is delegated across the clinical team and Quality office and the medical team projects have Dr Tamura-Rose as audit overseer.

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 presented and communicated to the clinical team is held and 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

Quality Account

The Hospice last submitted its **Quality Account** for 2021/2022 to the NHS Choices web site in June 2022 and is included with papers. 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.

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.

An expanded working party periodically populates and keeps under review the Key Lines of Enquiry self-assessment documentation.

The CQC have published Temporary Monitoring Arrangement KLOEs that underpin their support calls that are expected more frequently than previously as part of their relationship building and assessment program. Last submission to support the latest telephone monitoring call was on 23rd February 2021 and was included in the papers for the February CQ&G Sub-committee meeting.

The self-assessment against the KLOEs will support our preparation for an inspection. We understand that the CQC have abandoned the requirement for completion of a Provider Information Return with inspection methodology expected to embrace unannounced inspection. Allied to the workings of this group has been the creation of a depository for evidence of excellence that is included as an Agenda item for the CQ&G Sub. We hope our KLOE work will support our evidence base to achieve an 'Outstanding' rating at our next inspection and maintain it in the future.

The last TMA telephone catch up was held by Gail and Becca with Renae Clews, our CQC Relationship Manager, in March 2022.

Clinical Quality & Governance Management Plan Objectives 2022/23

Summary

DATE	Number	Complete / on-going	As per Plan	Behind Plan	For 2023/24
09-Jun-22	30	8	20	0	2

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
3.7	Engage with external groups including social prescribers Collaborate with external groups to provide joint offers
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

Audit/Research 2022/23

Overview in June 2022

30 projects scheduled in 2022/2023.

2022/23 Listing

Project Ref.	Title	HQIP Prioritisation	Lead	Status
2022/23-01	Community - Carer & relative questionnaires for the Hospice @ Home Service	• Priority 2 Internal 'must do' audit	Quality Office - J Cope / A Rudkin	Ongoing
2022/23-02	IPU & Community - VOICES survey of bereaved next of kin 3-6months post bereavement	• Priority 2 Internal 'must do' audit	Quality Office - J Cope / A Rudkin	Ongoing - Latest Report for Apr-Sep 20 published 20-12-2021
2022/23-03	IPU - Patient Satisfaction	• Priority 2 Internal 'must do' audit	IPU - T Young Quality Office - J Cope / A Rudkin	Ongoing for review with TY in July 2022
2022/23-04	IPU – Infection Control : Environment & Hand-washing Audit	Priority 1 External 'must do' audit	IPU - S Dunmall Community - J Smith Quality Office - J Cope / A Rudkin	Ongoing for review with TY in July 2022
2022/23-05	IPU - Medicines Management Audit	• Priority 2 Internal 'must do' audit	Ashton's Clinical Pharmacist	Ongoing
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	Dr Busi Da Silva	Data Collection Phase
2022/23-07	IPU : Patient Handling / Pressure Areas / Mouthcare	• Priority 2 Internal 'must do' audit	N:\Clinical\Clinical Governance\Clinical Audit\Audits - project folders\2021-22\IPU Risk Assessment	IPU - TY, RW, PJ, JF, HA, PH 2021 report – IPU comments awaited – feed into education – re-audit early 2023
2022/23-08	Controlled Drugs Annual Audit	Priority 1 External 'must do' audit	R Trower	Ongoing
2022/23-09	OACC measures (Step 1 - Phase of Illness + Karnofsky performance status)	• Priority 2 Internal 'must do' audit	OACC Task & Finish Group JG - IPU GT-R - Community	2021 Report due by July 2022

Project Ref.	Title	HQIP Prioritisation	Lead	Status
2022/23-10	OACC measure (Step 3- iPOS)	• Priority 2 Internal 'must do' audit	OACC Task & Finish Group JS - IPU GT-R - Community	Pended to 2023/24
2022/23-11	Outcome measure (Step 2- CSNAT)	• Priority 2 Internal 'must do' audit	OACC Task & Finish Group MV - H@H	Research / license process
2022/23-12	Referral to PS triggers	• Priority 4 Clinician interest audit	Psychological services SM	Pended for discussion for 2022/23 tba
2022/23-13	Bereavement Questionnaire	• Priority 4 Clinician interest audit	Psychological services SM	Pended for 2022/23 tba
2022/23-14	Non-medical Prescribing Activity Comparative : FP10.	• Priority 4 Clinician interest audit	Community KH	Agreed for pursuit in 2022/23. To discuss with R Wallis post August 2022
2022/23-15	Advance Care Planning -(timelines) Re-audit	• Priority 3 Specialty Priority	Community Dr G T-R TC	Data Collection Phase for 2021 Data
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	• Priority 3 Specialty Priority	Quality Office+ CAAD	Ongoing
2022/23-17	IPU & Community & Psychological Support Services - Activity Data Dashboards Development	• Priority 2 Internal 'must do' audit	Quality Office + CAAD	Ongoing
2022/23-18	Incidents	• Priority 2 Internal 'must do' audit	Quality Office + CHoDs	Ongoing
2022/23-19	Falls	• Priority 2 Internal 'must do' audit	Quality Office + Falls Mtg	Ongoing
2022/23-20	Complaints	• Priority 2 Internal 'must do' audit	Quality Office + Exec	Ongoing
2022/23-21	Safeguarding Documentation	• Priority 3 Specialty Priority	Rebecca Wallis	Data Collection (June 2020 - December 2021)

Project Ref.	Title	HQIP Prioritisation	Lead	Status
2022/23-22	Clinical Records Documentation	• Priority 2 Internal 'must do' audit	R Trower	See Outcome of Clinical Record Audit – 2022/23-23 first
2022/23-23	Clinical Record Terminology / Subjective & Objective Review	• Priority 4 Clinician interest audit	IPU & Community : R Clingan / G Tamura-Rose	Data Collection
2022/23-24	Outpatient Survey	• Priority 3 Specialty Priority	J Strawson	TBA
2022/23-25	Wellbeing Centre Service Feedback Survey	• Priority 3 Specialty Priority	S Payne / R Trower	TBA
2022/23-26	GP Survey - discharge communication et al	• Priority 4 Clinician interest audit	J Strawson / A Akhtar	Discharge comms under review by Med Team
2022/23-27	IPU - Mortality and Morbidity Meeting Re-Audit	• Priority 3 Specialty Priority	Dr AA	Re-audit October 2022
2022/23-28	Admissions Clerking Re-audit	• Priority 3 Specialty Priority	Jovy Giles	Re-audit October 2022
2022/23-29	Referral to the IPU Re-Audit	• Priority 3 Specialty Priority	Dr J Strawson	Data Collection
2022/23-30	Research Audit on Ethnicity	• Priority 3 Specialty Priority	Dr G Tamura-Rose	Complete

Clinical Risk Management

Clinical Unexpected Incidents

Overview of incident data for January – December 2022 is shown below:-

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	22	21	20	19
Admissions to IPU	12	18	14	21	25								0	138	195	212
Beds	8	9	8	10	10											
Bed Occupied Days	203	216	221	270	206											
Bed Available Days	248	252	248	300	310											
Bed Occupancy (variable beds)	81.85%	85.71%	89.11%	90.00%	66.45%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!				
Bed Occupancy (10 beds)	65.48%	77.14%	71.29%	90.00%	66.45%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%				
CD Medication Incident	0	3	0	1	4								7	35	15	23
CD Medication Near Miss	1	0	0	0	0								1	2	1	1
Adverse Reaction (Opioid Toxicity)	0	0	0	0	0								0	0	0	1
Adverse Reaction	0	0	0	0	0								0	0	0	0
Non-CD Medication Incident	2	2	2	1	0								7	7	4	12
Non-CD Medication Near Miss	1	1	0	0	0								2	0	0	1
Pressure Sore on Admission	1	0	2	2	2								7	16	19	16
Pressure Sore during Admission	0	2	1	2	1								6	6	4	3
Sharps	0	0	0	0	0								0	0	0	0
Infection (Near Miss)	1	0	0	0	0								1	0	0	0

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	22	21	20	19
Infection	0	0	6	0	0								6	0	0	0
Readm <7days	0	0	0	0	0								0	0	0	1
Unexpected Transfer	0	0	0	0	0								0	0	0	0
Near Miss(non-medication & non-IG)	0	0	0	0	1								1	1	1	1
PE	0	0	0	0	0								0	0	0	0
Staffing	0	0	1	0	0								1	0	0	1
IG	1	3	2	1	2								9	4	3	0
IG near miss	0	0	0	1	0								1	5	1	0
Manual Handling	0	0	0	0	0								0	2	1	5
Slips, trips, falls	0	0	0	0	1								1	19	20	21
Verbal Violence	0	0	0	0	0								0	0	1	0
Bump	0	0	0	0	0								0	0	0	0
Other - Admin/property/Documentation/Clinical	0	3	2	1	1								7	12	14	12
* Incidents reported to Community – non-SRH	1	2	8	3	4								18	2	8	12
* MAD Alerts (incl. in Community:non-SRH)	0	1	7	2	0								10			
Total 2022 *excluded	7	13	16	9	12	0	0	0	0	0	0	0	57			
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.

<i>Clinical Significance</i>	Jan	Feb	Mar	Jan-Mar	Apr	May	Jun	Apr-Jun	Jul	Aug	Sep	Jul-Sep	Oct	Nov	Dec	Oct-Dec	2022	2021	2020	2019	2018	2017
Admissions to IPU	12	18	14		21	25											90	138	193	212	211	214
Bed Occupied Days	203	216	221		270	206																
Bed Available Days	248	252	248		300	310																
Bed Occupancy	81.85%	85.71%	89.11%		90.00%	66.45%																
Fall No Harm				0		1											1	12	14	15	21	
Fall Low Harm				0													0	7	6	6	10	
Fall Moderate Harm				0													0	0	0	0	1	
Med Level 0	2	1		3													3	20	9	13	6	
Med Level 1	2	5	2	9	2	4											15	20	10	21	37	
Med Level 2				0													0	0	0	3	10	
Med Level 3				0													0	0	0	0	3	
Minor	2	5	11	18	3	4											25	25	15	19	38	
Moderate				0													0	3	6	2	21	
Serious				0													0	0	1	1	3	
Pressure Sores	1	2	3	6	4	3											13	22	23	19	27	
Totals 2022	7	13	16	30	9	12											57					
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		
Total 2018	21	14	11	46	10	18	24	52	15	8	13	36	16	17	9	42					176	
Total 2017	13	11	19	43	15	15	17	47	12	2	16	30	16	15	12	43						163

Clinical Complaints

Review of complaints received in 2021/22 was undertaken with the Executive Team on 27th May 2022. Review of individual complaints highlighted a variety of practice changes / learning that have been exacted/effected that included: -

1. Patient's partner feedback informed process of bereavement information literature review and was happy to be included in our literature review process.
 2. Informed communications training program in explaining rationales behind decisions.
 3. Reflection has supported decision to remodel the single community team into three smaller groups, increasing familiarity for patients and their families and reducing the need to repeat information as frequently.
 4. Informed Information leaflet and website review
 5. Informed communications training in that expectations should not be raised if they cannot be met.
 6. Informed the value of routine phone call before visit.
 7. Hospice neighbours service is planning to transition to Compassionate Neighbours that will aim to provide more support in the patient's home.
 8. Reflection on video link consultation and its effectiveness / appropriateness.
 9. Continuation of efforts to examine new ways of working in the community during the day and overnight to increase our responsiveness.
 10. Education program continues to expand to teach all professionals working in the community about common symptoms experienced at the end of life, including the management of pain and agitation and the need to escalate or change medication if needed.
 11. Re-enforced value of face to face visiting.
- There have been no clinical complaints received between March and May 2022.

Complaints Overview

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

Records – Access Requests

- In January – June 2022, there have been 3 access to health records requests : 2 from Solicitors and 1 from a next of kin nok, alongside 1 sharing request from Merton Learning Disabilities.

	DSARs	Access To Health Records	Sharing
2022	0	3	1
2021	0	5	4
2020	0	3	4
2019	1	4	0

Notifications

There have been 5 serious injury notifications made in January and February 2022 to the CQC all concerning pressure sores grade 3 or above.

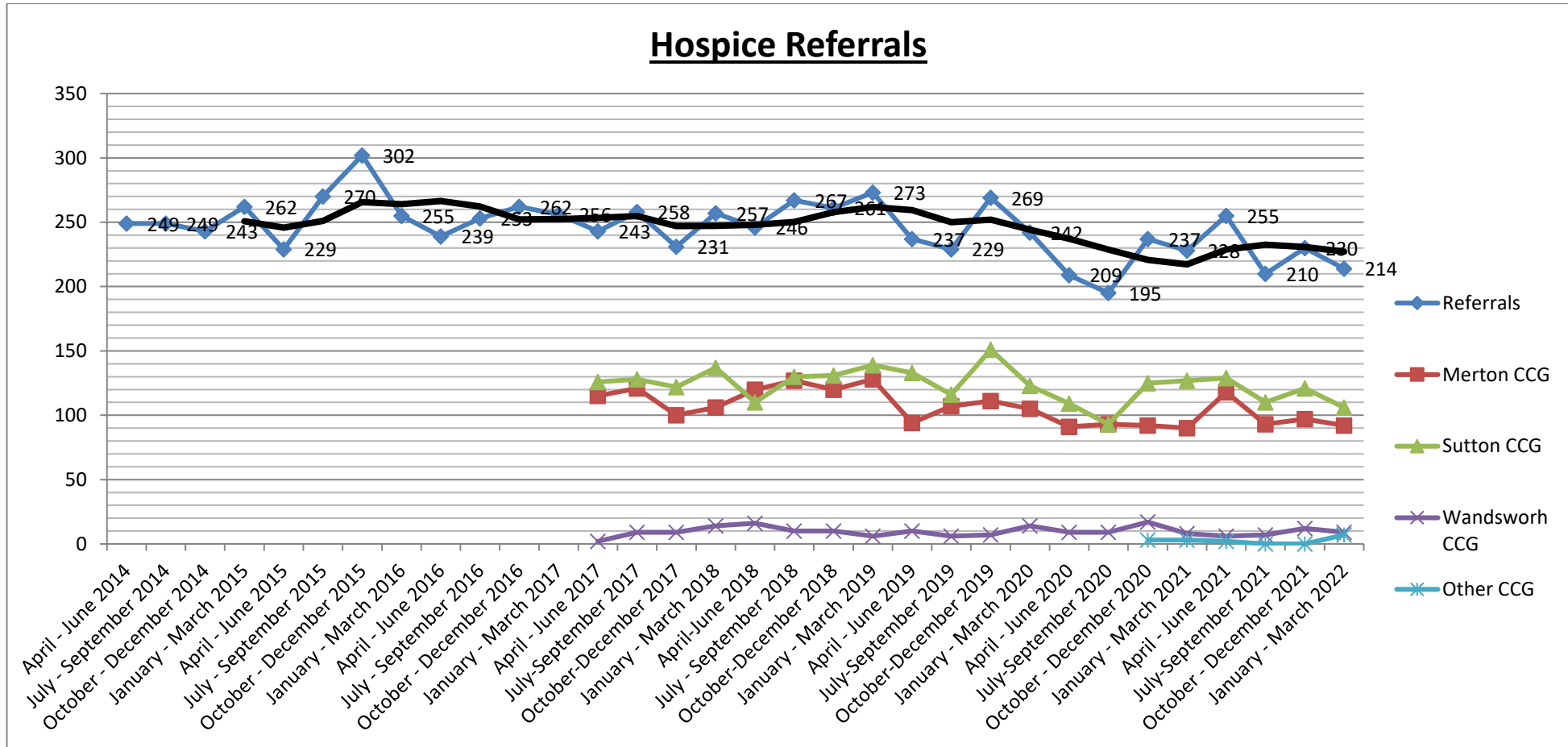
There have been 11 safeguarding notifications made to the CQC in 2022: 9 concerning individuals, 1 concerning POC and 1 concerning a care agency. All 11 were reported to the local safeguarding teams.

	Serious Injury	Safeguarding
2022 (Jan-Jun)	5	11
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. The latest data period Q4 (Q4, January – March 2022) was submitted in May 2022 and is included amongst papers. A selection of graphical representations for some of the data items produced for the SWL CCG is also included with papers.

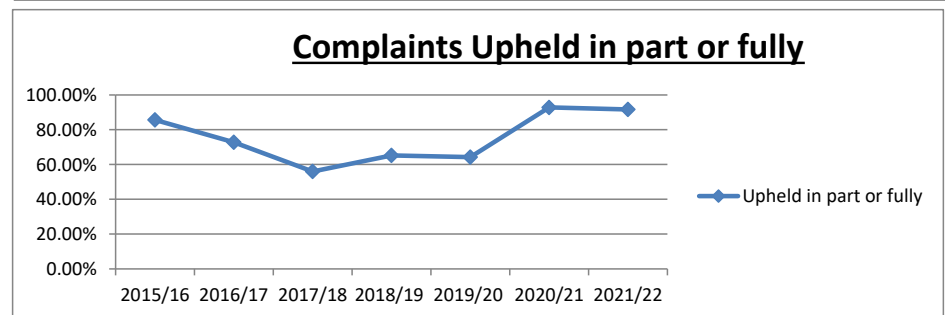
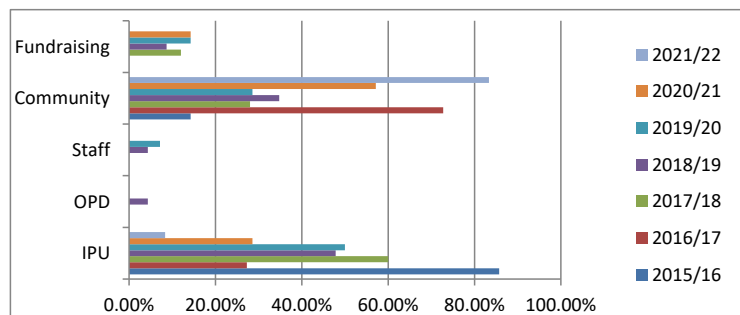
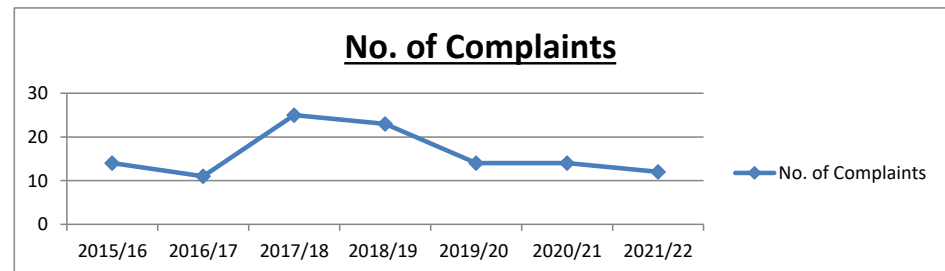
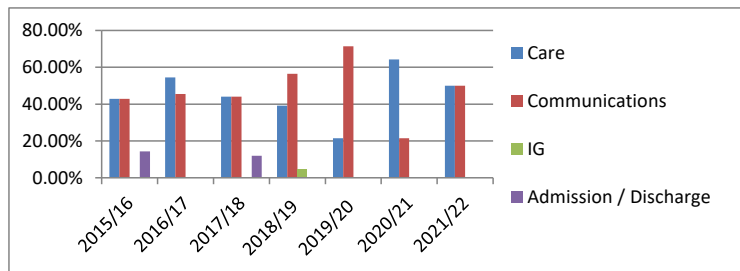
Hospice Referrals



The authors of this paper are Mrs R Trower, Clinical Director and Mr A Rudkin, Head of Quality and Improvement/ISO with inputs from clinical heads.

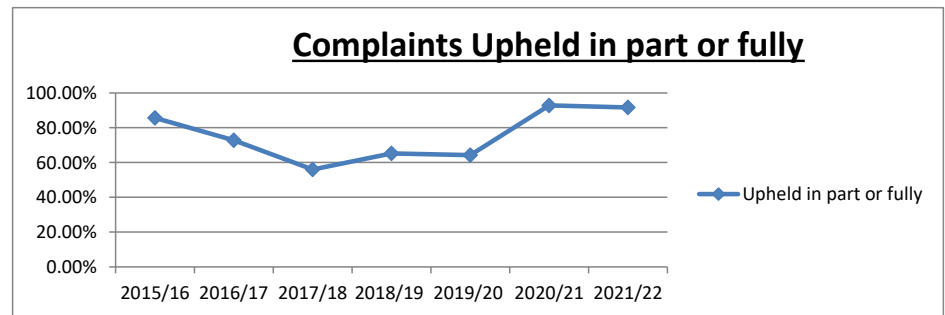
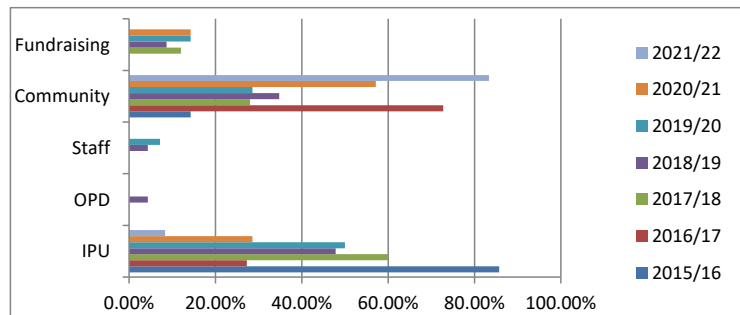
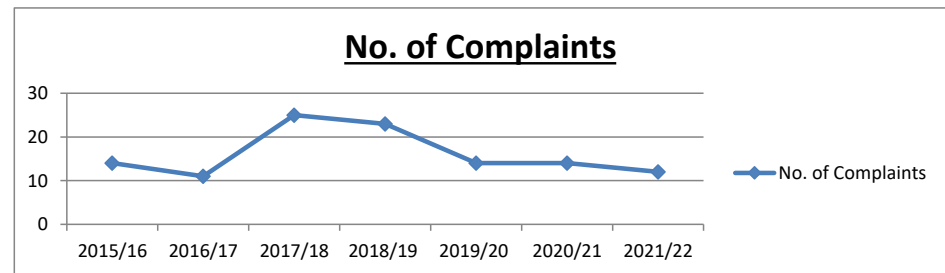
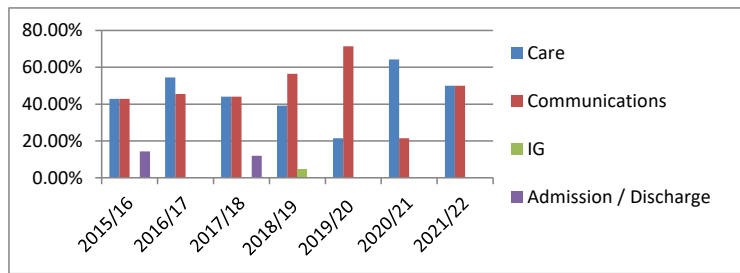
	No. of Complaints	Closed	Care	Communications	Integrity	IG	Admission / Discharge	Upheld in part or fully	IPU	OPD	Staff	Community	Fundraising
2015/16	14	14	6	6	0	0	2	12	12	0	0	2	0
2016/17	11	10	6	5	0	0	0	8	3	0	0	8	0
2017/18	25	25	11	11	0	0	3	14	15	0	0	7	3
2018/19	23	23	9	13	0	1	0	15	11	1	1	8	2
2019/20	14	14	3	10	1	0	0	9	7	0	1	4	2
2020/21	14	13	9	3	0	0	0	13	4	0	0	8	2
2021/22	12	12	6	6	0	0	0	11	1	0	0	10	0

	No. of Complaints	Closed	Care	Communications	Integrity	IG	Admission / Discharge	Upheld in part or fully	IPU	OPD	Staff	Community	Fundraising
2015/16	14	100.00%	42.86%	42.86%	0.00%	0.00%	14.29%	85.71%	85.71%	0.00%	0.00%	14.29%	0.00%
2016/17	11	90.91%	54.55%	45.45%	0.00%	0.00%	0.00%	72.73%	27.27%	0.00%	0.00%	72.73%	0.00%
2017/18	25	100.00%	44.00%	44.00%	0.00%	0.00%	12.00%	56.00%	60.00%	0.00%	0.00%	28.00%	12.00%
2018/19	23	100.00%	39.13%	56.52%	0.00%	4.35%	0.00%	65.22%	47.83%	4.35%	4.35%	34.78%	8.70%
2019/20	14	100.00%	21.43%	71.43%	7.14%	0.00%	0.00%	64.29%	50.00%	0.00%	7.14%	28.57%	14.29%
2020/21	14	92.86%	64.29%	21.43%	0.00%	0.00%	0.00%	92.86%	28.57%	0.00%	0.00%	57.14%	14.29%
2021/22	12	100.00%	50.00%	50.00%	0.00%	0.00%	0.00%	91.67%	8.33%	0.00%	0.00%	83.33%	0.00%



	No. of Complaints	Closed	Care	Communications	Integrity	IG	Admission / Discharge	Upheld in part or fully	IPU	OPD	Staff	Community	Fundraising
2015/16	14	14	6	6	0	0	2	12	12	0	0	2	0
2016/17	11	10	6	5	0	0	0	8	3	0	0	8	0
2017/18	25	25	11	11	0	0	3	14	15	0	0	7	3
2018/19	23	23	9	13	0	1	0	15	11	1	1	8	2
2019/20	14	14	3	10	1	0	0	9	7	0	1	4	2
2020/21	14	13	9	3	0	0	0	13	4	0	0	8	2
2021/22	12	12	6	6	0	0	0	11	1	0	0	10	0

	No. of Complaints	Closed	Care	Communications	Integrity	IG	Admission / Discharge	Upheld in part or fully	IPU	OPD	Staff	Community	Fundraising
2015/16	14	100.00%	42.86%	42.86%	0.00%	0.00%	14.29%	85.71%	85.71%	0.00%	0.00%	14.29%	0.00%
2016/17	11	90.91%	54.55%	45.45%	0.00%	0.00%	0.00%	72.73%	27.27%	0.00%	0.00%	72.73%	0.00%
2017/18	25	100.00%	44.00%	44.00%	0.00%	0.00%	12.00%	56.00%	60.00%	0.00%	0.00%	28.00%	12.00%
2018/19	23	100.00%	39.13%	56.52%	0.00%	4.35%	0.00%	65.22%	47.83%	4.35%	4.35%	34.78%	8.70%
2019/20	14	100.00%	21.43%	71.43%	7.14%	0.00%	0.00%	64.29%	50.00%	0.00%	7.14%	28.57%	14.29%
2020/21	14	92.86%	64.29%	21.43%	0.00%	0.00%	0.00%	92.86%	28.57%	0.00%	0.00%	57.14%	14.29%
2021/22	12	100.00%	50.00%	50.00%	0.00%	0.00%	0.00%	91.67%	8.33%	0.00%	0.00%	83.33%	0.00%



ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASSIFICATION	ACTION TAKEN SUMMARY	STAFF INVOLVED	UPHELD IN PART OR WHOLE
2021/05	ORAL	Partner	15/04/2021	CNS visited as pt hadn't had a F2F assessment for some time. Partner felt that the conversation that ensued which related to planning for EOLC (PPC/PPD) was not well timed as pt could have another '5-10 years'. She also said that pt doesn't like to talk about the future and she felt that the CNS was persistent in her questioning even though pt had indicated that he didn't want to discuss it.	Community Comms	30/04/2021 Telephone call from Clinical Director to Pt partner explaining that it can be difficult at times to know when to have these conversations particularly when we don't know the patients as well as we would like due to the a number of constraints—some people are keen to plan ahead and find this reassuring whilst others find it difficult to discuss. I explained about the CMC record and how helpful it can be at a time when someone is less well/deteriorating (often unexpectedly). Partner said that she understood this but it wasn't a conversation for her and pt at the present time and that she will have that conversation with him privately when the time is right. Pt and partner remain happy for the CNS to visit. Partner was also critical of the 'Advice and Support before and after Bereavement' leaflet stating that there was very little in the way of 'before' and that there were too many adverts for funeral directors. She provided some constructive feedback on the leaflet and provided her e-mail address if we wished to utilise her in commenting on our leaflet content review.	Jane Gauld	Upheld
2021/06	ORAL	Daughter	28/06/2021	Complaint received during a bereavement call to daughter regarding weekend contact between SRH CNS and daughter. Pt had globally deteriorated and not passed urine for 24 hours. She was agitated and confused so CNS wanting to exclude urine retention as a reversible cause of agitation and do a urinalysis at the time of catheterisation to exclude urine infection. Daughter reported that the community nurse that visited to do the catheterisation had said that Pt doesn't have to have the catheter, therefore daughter made the decision not to put pt through the insertion if it wasn't required. CNS spoke to daughter 27/06/21 and the reason why she declined the catheter for her mother was discussed. Daughter reported that the rationale for the catheter was not explained to her by SRH or the community nurses, and the call from us exploring the reason for catheter refusal made her feel guilty that she had not agreed to an intervention that was felt to be in pt's best interests. Daughter reported that she would have consented should she have understood our clinical rationale.	Community Comms	Apologised for the miscommunication between SRH, daughter and the community nurses and the upset this has caused. Offered to raise this as a complaint for our learning which daughter agreed to. Daughter consented to a follow up call from the management team anytime over the coming weeks. She is happy to be contacted on her mobile. Call to Daughter on 1 July by Clinical Director. Daughter was clear that she doesn't want to make a complaint and that she was making an observation more than anything. She felt a little 'caught in the middle' between the DN and us regarding whether or not her mother should have had a catheter in case of retention. She wishes that the DN had been insistent and catheterised her mother rather than asking Daughter to make the choice. Daughter wanted to pass on her thanks to everyone in the team and said they had all been amazing – especially Linda, one of the H@H HCAs, who was with her the day before her mum died. We talked a little about bereavement support and Daughter knows she can call us if she has any particular concerns.	n/a	Upheld
2021/07	WRITTEN	Daughter	30/05/2021	Daughter felt that the Hospice's response to her mother's needs when her health declined significantly wasn't adequate and didn't live up to the expectation that she had had. In particular, the introduction upon first assessment by the CNS that, if required, would the patient be accepting of admission to the Hospice. This had created the expectation that if things did take a turn for the worse then admission would be possible. It was not explained that an admission may not be possible due to bed availability and that alternative care i.e. nursing home may be an avenue to have explored. Whilst the patient's wish had been to die in her own home, the daughter critiqued that in making that decision her mother and father were not presented with the considerations that 24/7 clinical care could provide at the end of life. The daughter listed a number of examples of how she felt the Hospice hadn't provided enough support. These were addressed in the Clinical Director's letter.	Community Care	Daughter was telephoned by the Clinical Director and a follow-up letter sent post investigation of her complaint. A reflection had been held by the Community Team and the substance of the Clinical Director's response showed:- Continuity and communication are key in providing reassurance and seamless care for patients and we recognize that working as one large community team can mean that patients and their families often speak to a number of different people. SRH has taken this into consideration and has now remodelled the single team into three smaller groups, increasing familiarity for patients and their families and reducing the need to repeat information as frequently. SRH knows that provision of community care and services can be confusing; there are a number of different organisations providing care and support in our area and so expectations of who can provide what is unclear. SRH are reviewing our information leaflets and website messaging to better define the care that we are able to offer. SRH are unable to provide 24 hour care at home due to our staffing levels and resources but are able to provide short term hands on care at times for those in the last hours and days of life. Much of our time is spent providing expert support and advice to other healthcare professionals such as GPs and District Nurses who take the lead responsibility for patients in the community. Discussing where patients want to be at the end of life can be a difficult conversation and being able to offer the requested setting at the right time is not always possible. Apology given that we were unable to admit her mother to the hospice which we know is where she had wanted to be. And apology given that the daughter felt let down. This is a discussion we often have with our colleagues – are we raising an expectation that we may then be unable to meet. We need to ensure that we are clear at the time of this conversation and ongoing, that although a preference has been identified, it might not actually be the reality, but we will endeavour to support our patients to the best of our ability. Practicalities such as supplying of pads and ordering medications ahead of time can also seem confusing. As explained on the phone, SRH are unable to supply pads as a matter of course because we only have a small supply, and frustratingly a continence assessment in this instance would take too long, so the onus falls on the family to purchase pads. As the daughter described, this would have meant your father leaving your mother alone, and so in this instance we should have provided more pads to allow time for someone else to purchase pads on another day. The injectable medications are usually ordered in advance of need - so that they don't need to be ordered and collected during a time of crisis. This means that if medications need to be given urgently, the District Nurse or GP (or Out of Hours doctor) can administer them when making an urgent response visit. However, this meant they were sitting in your house for some time, which didn't feel comfortable for your parents. In terms of communication, SRH let you down. Our Hospice at Home nurse visited without the knowledge that your mother had already died. On reflection, we should have phoned before making the visit and asked for an update on the situation. Sincere apologies for the distress – we are truly sorry and hope that our response goes some way in assuring you that we are always keen to improve the way that we work.	Community Team	Upheld

ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASSIFICATION	ACTION TAKEN SUMMARY	STAFF INVOLVED	UPHELD IN PART OR WHOLE
2021/08	SURVEY	Daughter	09/07/2021	Daughter expected more home contacts leading to a Poor rating in her VOICES survey return.	Community Care	<p>Followed up by Community Manager who drew out the timeline of interactions by the Community Team during the pandemic and concluded that there had been continuity of staff involvement. Follow up phone call made by Clinical Director to daughter Call to daughter in response to VOICES questionnaire. Daughter was happy to talk and declined the offer to come in and discuss her concerns.</p> <p>She wanted to make it clear that when staff from SRH visited they were extremely helpful and she found them supportive. But when her mum's condition was reasonably stable, she found the regular telephone calls frustrating as she was 'always asked the same questions' and felt it was a 'tick box exercise' for our staff. 'I think they just wanted to know if she had passed or not.'</p> <p>There were times when her mum was less well and she would have liked face to face visits but acknowledged that it was during COVID and explained that all the healthcare professionals she contacted were slow to visit.</p> <p>One of the daughter's biggest difficulties is coming to terms with the cause of her mum's death. There was never a confirmed cancer diagnosis and the post mortem confirmed the cause of death as a pulmonary embolus. Daughter was instructed by a doctor (unclear whether hospital or GP) to stop her mum's fragmin injections 5 days prior to her mum's death and so she questions whether had she continued with the fragmin, her mum might still be alive.</p> <p>Discussed bereavement support and the daughter had received the letter from our PS service explaining that we are under pressure and therefore to actively contact us should she require support. She explained that she has done this and spoke to a man but has heard nothing since. Clinical Director apologised but explained that it might be that there were others also needing support and our service is limited. Daughter was very understanding of this – she has also accessed support through a work-based employee scheme but has heard nothing from them yet.</p> <p>Daughter said she is fine for the time being and Clinical Director will follow up with the team to see if they can make contact soon – the funeral was delayed for 5 months due to the PM and so the funeral was only in June.</p> <p>Clinical Director apologised on behalf of SRH that she feels as though she didn't receive support when she felt she needed it – we aim to meet the needs of our patients and their families as best we can but we have a limited resource. She said she completely understood and that talking had helped – she felt 'listened to.'</p>	Community Team	In part
2021/09	WRITTEN	Volunteer	11/08/2021	<p>Background.</p> <p>The complainant EH had attended a taster session as a volunteer in the Wellbeing Centre as a Pets for Therapy handler with her dog Poppy on July 29th 2021.</p> <p>Incident leading to complaint:</p> <p>Staff in the Wellbeing Centre(WBC) expressed concern related to an overheard conversation between EH and 3 patients attending the Younger persons day, who appeared upset and later reported they had found the comments by EH upsetting.</p> <p>The Volunteer Services Lead for the Hospice (GT) was informed and attended the WBC to meet with EH. EH had already left. GT undertook a telephone conversation with EH on the 30th July to explore and discuss the issues raised by the staff and patients in the WBC.</p> <p>The telephone call was followed up by GT with a letter dated 4th August. A formal complaint was received on the 11th August.</p> <p>The letter expressed umbrage at the tone and content of GT's letter.</p> <p>Issues highlighted were:</p> <ul style="list-style-type: none"> •No specific training or induction received •All policies were only in email format – no hard copies provided •No clear understanding of what was expected of her •In her opinion the organisation is badly organised <p>Complainant acknowledges in the letter that her skills are not well matched to hospice requirements.</p> <p>Clearly stated that she did not require/expect a reply.</p>	Vol. Comms	<p>Action: GT informed GL on 11.08.2021 of receipt of the letter. Content and context of the complaint discussed with GT for clarity on the same day.</p> <p>Outcome: No further action. No reply to be sent as per letter.</p>	GT	Not Upheld
2021/10	SURVEY	Daughter	15/09/2021	VOICES survey returned by daughter in which she regarded the overall experience of the Hospice service as Poor detailing having to chase up professionals whose focus was pain/symptom control when the family needed more support and respite/end of life bed wasn't available to give her mother a break. Patient RIP in Hospital in March 2021.	CPCT Care / Comms	<p>Investigated by Community Team Manager who noted that there were regular visits (monthly) responding to need and also regular support with triage and review calls . Most calls if not all were to a different daughter . Clinical Director telephoned the daughter and apologised if we had raised expectations that we were unable to meet and explained that we have a limited number of beds for our community caseload and therefore are unfortunately not able to offer respite. Daughter understood but said that she felt that she had to write down her feelings anyway. Also talked about the impact of Covid and how this meant that Day Hospice could not offer a FZF service. Explained that the Hospice neighbours service is being developed with a future transition to Compassionate neighbours. Daughter said that she felt this was positive and although it hadn't helped the situation with her parents, she felt it was a positive move to being able to offer support to people struggling and living at home. CD mentioned bereavement support but daughter feels that she and her family are currently experiencing 'normal' grief - she will however, be in touch should she feel they need any extra support. She thanked SRH for the help and support that they had offered her parents, despite her father dying in hospital.</p> <p>Sadly the patient was taken in to hospital as he had sustained a fracture . The CPCT were aware . The post bereavement call to the daughter with whom there had been primary contact states the death was "good" and a relief and SRH were thanked.</p>	n/a	In part
2021/11	WRITTEN	Wife	10/09/2021	Letter received from wife of patient who died at home in July 2021, by and large appreciating the care and support that the Hospice had provided her husband and in particular the H@H input at the end of life but critical of a video link consultation that her husband had experienced during COVID and earlier in his care undertaken by community team members that she felt had not been a suitable platform of engagement due to her husband's compromised capacities to interact.	CPCT Comms	Letter of response sent by Clinical Director acknowledging the challenges that had been faced during the pandemic and how the video link form of consultation had not met the needs on this occasion. Acknowledged the times that the Hospice did provide the support that she and her husband needed and further extended access to bereavement support as had been offered and appreciated by our PS service.	HCA L Mears & CNS A Gill	Upheld

ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASSIFICATION	ACTION TAKEN SUMMARY	STAFF INVOLVED	UPHELD IN PART OR WHOLE
2021/12	ORAL	WIFE	22/10/2021	Patient's wife expressed to CNS how she felt that her husband's discharge from SRH to Fieldway Nursing Home had been rushed and that she had not been given enough time to consider the NH. She stated that she had raised concern over how far away the NH was from her home and that travel with her 2 children may be difficult. However, she felt her concerns weren't listened to. She also felt that she should have been advised of the NH vaccination rules for visitors as her husband's brother couldn't visit because he wasn't vaccinated.	IPU Comms	CNS asked CHC for list of nursing homes nearer the wife's address that they would consider funding if decision is made to transfer. Explained to wife that it is government advice regarding visiting rules in Nursing Homes and that it is unlikely that any would permit entry of an unvaccinated visitor. Palliative Care Consultant (NC) telephoned wife and had a 70 minute conversation in which the wife mainly outlined her frustrations and difficulties with Fieldway NH. She does feel her husband's discharge to Fieldway Care Home from SRH was rushed but was contacted by the home before the Hospice was. She did get the chance to visit the care home prior to accepting the place. She had expressed a wish to take longer in accepting the place but was told by Hospice IPU staff that we really had to accept it. Palliative Care Consultant (NC) does not feel giving a longer time would have altered her concerns/ experience. NC tried to explore if she would wish to take the complaint to the clinical director and she said she would be happy to meet or discuss with her. NC does not think she wished that. NC advised that she can call at any time. She expressed a wish for regular phone calls like this one but NC did say it would become less and less helpful now that her husband was off the ward as NC would get less and less in touch with how he is. NC has said the Community team are going to be continuing to review the situation and suggested she await contact from CHC as CNS (RW) has emailed asking for them to be in touch with Sylvia regarding possibly alternative nursing home places. She thanked NC for the call.	n/a	In part
2021/13	ORAL	Daughter	23/12/2021	Daughter of a patient known to the CPCT is very unhappy with the care and management of patients condition. Main concerns: 1: Feels there should have been consultant assessment since the beginning of the week (had three bad nights where patient has been distressed). 2: Feels syringe driver should have been started on Saturday. 3: Feels lack of co-ordination in services. 4: Feels palliative care has been inadequate. 5: Feels there needs to be a review of the case	CPCT Care / Comms	Acknowledged her concerns and offered to raise as a complaint Spoke through with daughter about the decisions that have been made this week Explained Community Team Manager's actions today (liaised with DNs about their visit today and ensure medication was being increased in syringe driver) Explained CNS and Dr visit is planned for tomorrow Informed clinical director Clinical Director Rebecca Trower - telephoned both daughters to discuss their complaints and concerns on same day as complaint received. No further action required. On reflection, team have worked within their resource but acknowledge that it is distressing for the family to witness their mother's deterioration and agitation. CD doesn't feel that there is any action that would have been taken differently should the situation recur but family will be offered bereavement support and PS team will be updated regarding specifics re family distress	n/a	In part
2022/01	SURVEY	Son	28/01/2022	VOICES survey content reflected the son's rating of Poor for the care received by his mother from the Hospice CPCT with qualifying comment that 1. He felt her pain control poor; 2. It was very difficult to get information about likely course of his mother's condition; 3. Nobody could make his mother comfortable in the air bed at home. His overall experience of our service was rated as Very Poor and he explained that his mother was in great distress in the final few weeks of her life because a) clinicians put her in a hospital bed with an air mattress and she was extremely uncomfortable in it. Not one of the many professionals who visited his mother could make her even vaguely comfortable in the wretched bed and b) his mother was in great pain associated with her dementia. The Hospice doctors too far too long to get his mother's pain under control with the result that his mother was in unnecessary pain for many of her final few days.	CPCT Care	Records reviewed by Clinical Director, Community Services Team Manager and Hospice Palliative Care Consultant Team. Community Services Team Manager reflected: From the notes, agitation and distress was an ongoing, complex symptom and difficult to get under control despite very regular input from our medical team/ CPCT. Patient's son phoned in at regular intervals in and out of hours and the situation appears to have been responded to promptly and appropriately. There was what could be considered a delay with the DNs' setting up the initial CSCI, however contributing factors adding to this could be the time the email was sent / received (late afternoon) and therefore it would be reasonable that the CSCI was set up the following day? There were some good examples of collaborated working with the GP who the patient was well known too. Airbed – there is limited reference to this in the EPR. I note that on the 19th July that it was recommended the son reconsider replacing this as he had removed it as he felt his mum didn't like it. Son's feedback is very valuable and I'm sorry the situation was so distressing for him and his mum. It can be more challenging to manage irrefractable symptoms in the community due to care pathways and delivery. A stepwise approach to medication appears to have been taken and doses escalated inline with requirements however I recognise it took a considerable time to manage the patient's agitation which must have been very distressing for her son. Hospice Palliative Care Consultant Team : Lead Consultant telephoned son and talked through his concerns. She offered to process his feedback through a formal complaint process and he was in agreement as he hopes this will help the hospice secure more funding from the CCG in the future for community resources. She offered further bereavement support as suggested by our Head of Psychological Support Services but he has declined this. Letter sent following the conversation advising that we are trying to find new ways of working in the community, during the day and overnight, to allow us to be more responsive to the needs of future patients and families. Alongside this, we continue to expand our education program so that we can teach all professionals working in the community about common symptoms experienced at the end of life, including the management of pain and agitation and the need to escalate or change medication if needed.	n/a	Upheld
2022/02	WRITTEN	MP & Husband	15/02/2022	Complaint received from MP Siobhain McDonagh advocating a complaint sent to her from bereaved husband of patient (RIP 28/12/21) regarding end of life care at home from multiple providers. Wasn't explicitly critical of SRH but felt he and son were overwhelmed by the care needs of his wife at the end of her life.	Multi-agency care provision at home at EoL	Telephone call to patient's husband followed by letter of apology. Opportunity taken to explain SRH's remit and what was offered. Apology given for being unable to provide admission due to availability of beds.	n/a	Upheld
2022/03	ORAL	Wife	08/02/2022	Wife telephoned following receipt of a feedback questionnaire and wished to speak with a manager about her husband's care. She thought H @ H gave her a lot of support but would have liked a CNS to come in and see her husband when he was dying. She said that her husband had had a lot of secretions at the end and would have liked a CNS to come in. HCA explained that when a patient has secretions that we would phone the D/N to administer required i/v medication. Wife advised that she didn't want a counsellor, just someone to talk to about his care. She stated that she didn't want to make a complaint. Advised that a manager would call her.	Comm Care	Investigated by Community Team Manager: Patient died on the IPU as his family were distressed with his increased respiratory secretions. Secretions were an ongoing problem when he was seen by BG on the 16/08/21 and on the telephone contact (23/08/21) the wife reported that he was still symptomatic. It's probably here that a face to face should have been arranged but we gave worsening advice and arranged another telephone rv. He was admitted to IPU on 06/09/21 and died peacefully with family by bedside on 7/9/2021. Clinical Director telephoned wife who explained that she felt that her husband had been deteriorating and that she had needed someone to have that conversation with both him and her. She felt the GP had neither the experience nor the desire to do that and she would have felt more supported had we provided a face to face visit when she had called the team about his secretions on the Friday before the bank holiday weekend. She spoke very highly of all the services involved including SRH and described the staff as 'wonderful'. She wanted to make it clear that she wasn't complaining but had just identified upon reflection that she would have felt more supported by a FtF visit. She was reassured that we would be reflecting upon this. Patient case discussed at the complex CPCT M+M on the 9th of March.	n/a	Upheld

2021 - Complaints	CPCT / H@H Care	CPCT / H@H Comms	IPU Care	IPU Comms	IPU Care & Comms	Bereavement Comms	Volunteer Services Comms	Fundraising /Shop Comms	HR	Total	Merton	Sutton	Other	UPHELD
January	0	1	0	0	0	0	0	0	0	1	0	1	0	1
February	0	0	0	0	1	0	0	0	0	1	1	0	0	1
March	1	0	1	0	0	0	0	0	0	2	0	2	0	2
April	0	1	0	0	0	0	0	0	0	1	1	0	0	1
May	1	0	0	0	0	0	0	0	0	1	0	1	0	1
June	0	1	0	0	0	0	0	0	0	1	0	1	0	1
July	0	1	0	0	0	0	0	0	0	1	1	0	0	1
August	0	0	0	0	0	0	1	0	0	1	0	0	1	0
September	1	1	0	0	0	0	0	0	0	2	1	1	0	2
October	0	0	0	1	0	0	0	0	0	1	1	0	0	1
November	0	0	0	0	0	0	0	0	0	0	0	0	0	0
December	1	0	0	0	0	0	0	0	0	1	1	0	0	1
2021	4	5	1	1	1	0	1	0	0	13	6	6	1	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
	Comms		Clin. Tx / Care	Other	Policy			Fundraising / Shops	HR	Total				
2017	12		5	1	2			2		22				13
2016	6		5	0	0			0		13				9

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Classification: Restricted

Author: A Rudkin

Date Issued : 26-05-2022

2022 - Complaints	CPCT / H@H Care	CPCT / H@H Comms	IPU Care	IPU Comms	IPU Care & Comms	Bereavement Comms	Volunteer Services Comms	Fundraising /Shop Comms	HR	Total	Merton	Sutton	Other	UPHELD
January	1									1		1		1
February	2									2		2		2
March														
April														
May														
June														
July														
August														
September														
October														
November														
December														
2022	3	0	0	0	0	0	0	0	0	3	0	3	0	3
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
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April 2021 – March 2022

COMPLAINTS REVIEW MEETING

27th May 2022

Present

(NS) N Stevens, Joint Chief Executive
(GL) G Linehan, Joint Chief Executive
(RT) R Trower, Clinical Director
(S-JW) S-J Woods, Director of Income Generation
(NC) Dr N Collins, Palliative Care Consultant
(AR) A Rudkin, Head of Quality and Improvement (mins)

Apologies

(JG) J Groom, Director of IT and Facilities, (JS) Dr J Strawson, Palliative Care Consultant Lead

Introduction

To provide annual review of complaints received by the Hospice between 1st April 2021 and 31st March 2022

Aims

1. To identify underlying themes and points of learning
2. To review responsiveness to complaint

Complaints Summary

The complaints' summary document found at [Complaints Register extract of April 2021 - March 2022 Data.pdf](#) was reviewed alongside a quantitative graphical comparative overview 2016-2022 [Complaints Annual Overview 2016-2022 Graphic.pdf](#) and calendar year overviews [Jan - Dec 2021 Complaints Overview.pdf](#) , [Jan - Mar 2022 Complaints Overview.pdf](#)

There were 12 complaints received between 1st April 2021 and 31st March 2022, 100% of which are closed. It was noted that:-

- There were 11 clinical and 1 non-clinical complaints.
- Reported numbers were comparable with 2020/21(14 pa) which was a sustained figure from 2019/20 (14) and notable reductions on numbers reported between 2017-2019.

The number of complaints that have been upheld in full or part following investigation have notably maintained a high level at 92% (c.f. 93% in 2020/21. RT expressed how this should be seen in a positive manner that again supports the Hospice's receptiveness to exploring opportunities to learn and develop.

Clinical complaints are predominantly founded in the Community at 83% in 2021/22 (c.f. 57% in 2020/21) and are fairly evenly balanced between communication and care as being the underlying nature of complaint.

It was noted that, given the pandemic and the restrictions that were managed within the service, the low number of IPU complaints is extremely positive. There were no retail/fundraising complaints made in 2021/22.

Responsiveness to complaints was regarded as excellent.

Policy in place last reviewed 29/03/2021 and further review is planned this year in order to capture the DATIX module that will provide an electronic route for feedback capture (including complaints).

Review of individual complaints highlighted a variety of practice changes / learning that have been exacted/effected that included: -

1. Patient's partner feedback informed process of bereavement information literature review and was happy to be included in our literature review process.
2. Informed communications training program in explaining rationales behind decisions.
3. Reflection has supported decision to remodel the single community team into three smaller groups, increasing familiarity for patients and their families and reducing the need to repeat information as frequently.
4. Informed Information leaflet and website review
5. Informed communications training in that expectations should not be raised if they cannot be met.
6. Informed the value of routine phone call before visit.
7. Hospice neighbours service is planning to transition to Compassionate Neighbours that will aim to provide more support in the patient's home.
8. Reflection on video link consultation and its effectiveness / appropriateness.
9. Continuation of efforts to examine new ways of working in the community during the day and overnight to increase our responsiveness.
10. Education program continues to expand to teach all professionals working in the community about common symptoms experienced at the end of life, including the management of pain and agitation and the need to escalate or change medication if needed.
11. Re-enforced value of face to face visiting.

It was agreed that the Hospice's culture truly embraces the value it attaches to feedback and attention was afforded to the robust and responsive management of complaints from our Clinical Director and, particularly in 2021/22, the Community Services Team Manager (CSTM) and Consultant Medical Team. RT expressed how the reflection forums led by Tracy Christmas, were particularly impressive and could merit presentation at a future relevant conference. NS further expressed appreciation to AR for his presentation and efforts in bringing reflection on this topic amongst others to the attention of the Executive for their assurance process.

It was agreed that given the low number of complaints review will be held annually.

Action	Lead
Cascade feedback to clinical team Heads for their robust and attentive approach to complaints / feedback received.	RT
Include reference to the practice changes / learning in the Excellence Register and the next CQ&G report.	AR
Canvas other Hospices for complaints numbers	AR

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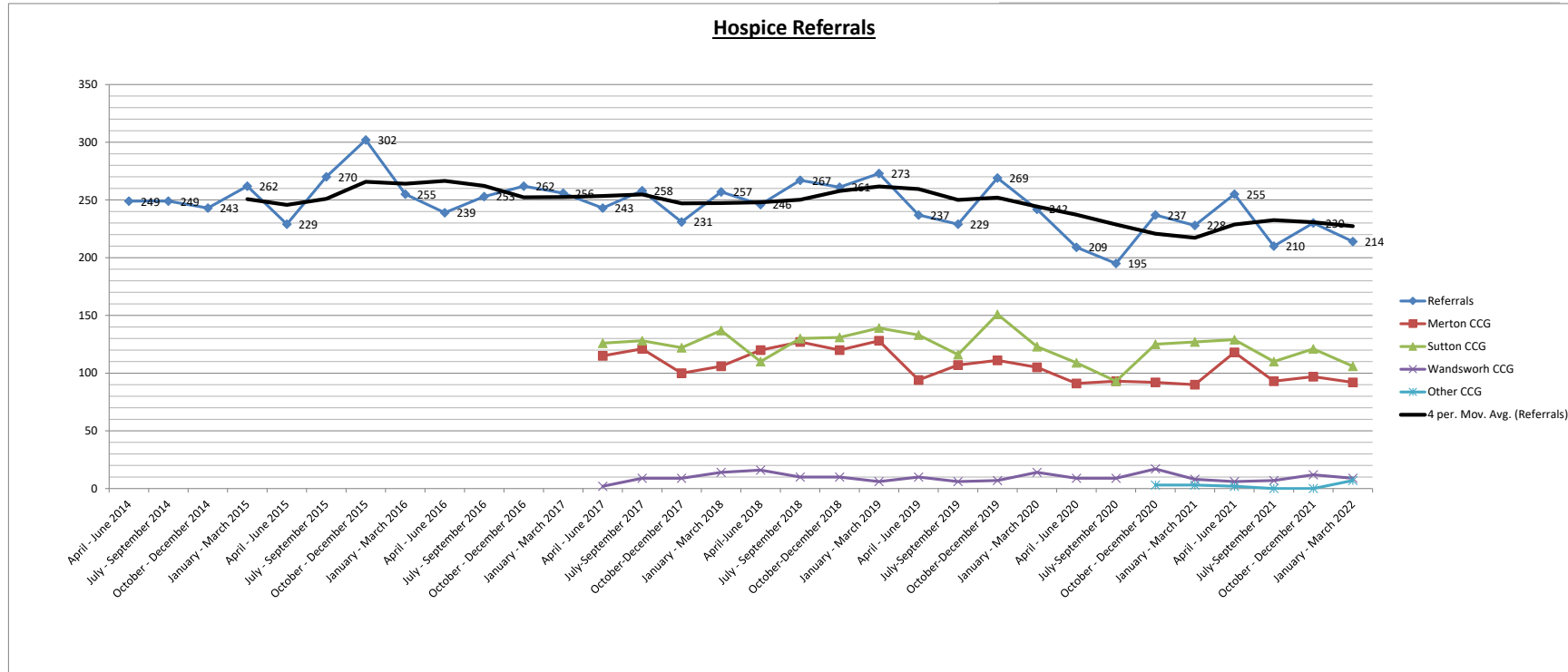
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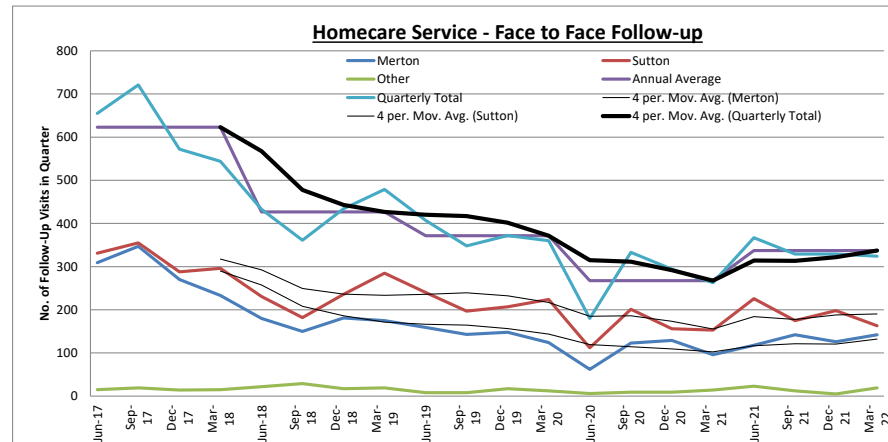
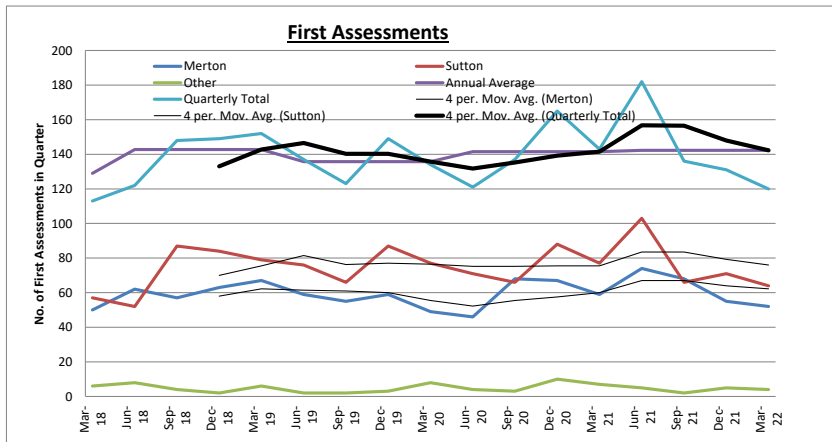
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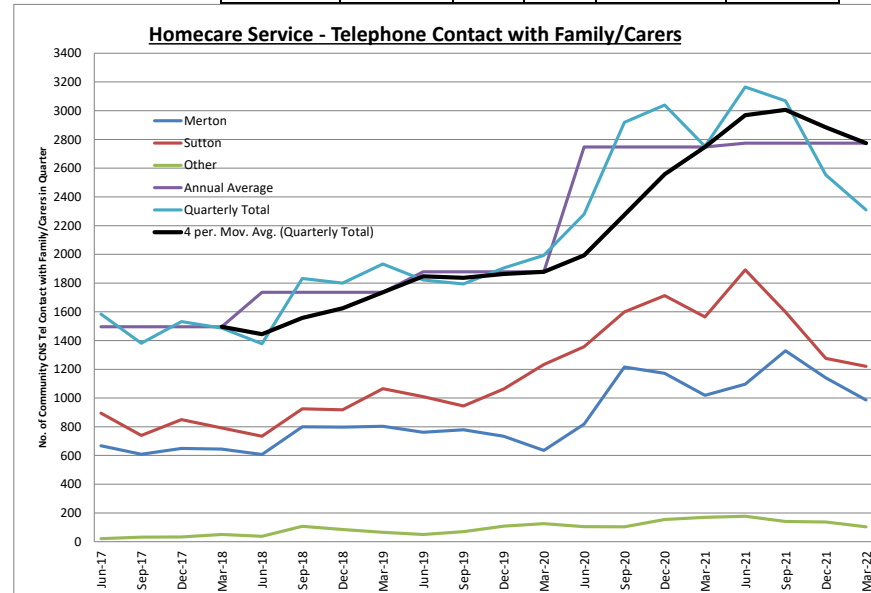
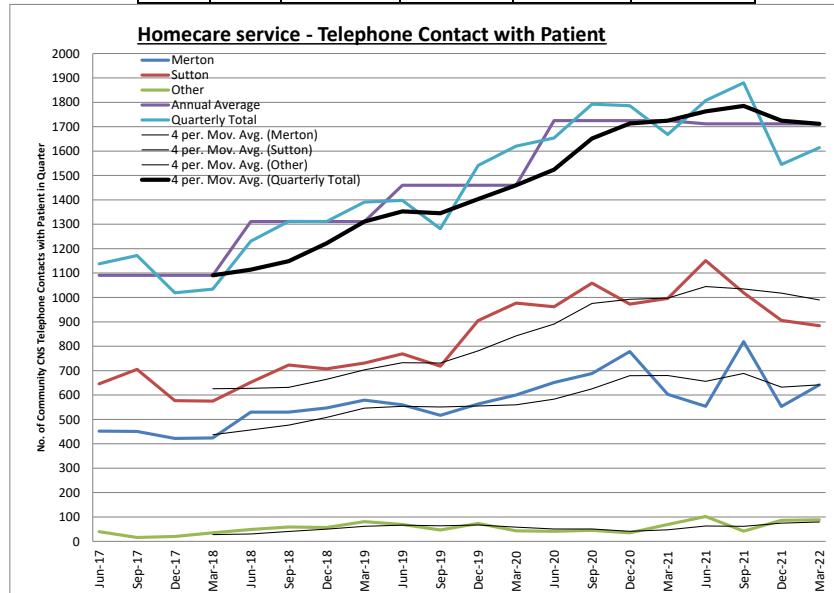
Community Team						
Homecare Service - First Assessments						
	Merton	Sutton	Other	Annual Average	Quarterly Total	
Jun-17	60	70	2	129	132	
Sep-17	67	75	5	129	147	
Dec-17	54	66	4	129	124	
Mar-18	50	57	6	129	113	
Jun-18	62	52	8	143	122	
Sep-18	57	87	4	143	148	
Dec-18	63	84	2	143	149	
Mar-19	67	79	6	143	152	
Jun-19	59	76	2	136	137	
Sep-19	55	66	2	136	123	
Dec-19	59	87	3	136	149	
Mar-20	49	77	8	136	134	
Jun-20	46	71	4	142	121	
Sep-20	68	66	3	142	137	
Dec-20	67	88	10	142	165	
Mar-21	59	77	7	142	143	
Jun-21	74	103	5	142	182	
Sep-21	68	66	2	142	136	
Dec-21	55	71	5	142	131	
Mar-22	52	64	4	142	120	

Community Team						
Homecare service - Face to Face Follow Up						
	Merton	Sutton	Other	Annual Average	Quarterly Total	
Jun-17	309	331	15	623	655	
Sep-17	347	355	19	623	721	
Dec-17	270	288	14	623	572	
Mar-18	233	296	15	623	544	
Jun-18	180	231	22	427	433	
Sep-18	150	182	29	427	361	
Dec-18	181	236	17	427	434	
Mar-19	175	285	19	427	479	
Jun-19	159	240	8	372	407	
Sep-19	143	197	8	372	348	
Dec-19	148	207	17	372	372	
Mar-20	124	224	12	372	360	
Jun-20	62	112	6	268	180	
Sep-20	123	201	9	268	333	
Dec-20	129	156	9	268	294	
Mar-21	96	153	14	268	263	
Jun-21	118	226	23	337	367	
Sep-21	142	175	12	337	329	
Dec-21	126	198	5	337	329	
Mar-22	142	163	19	337	324	

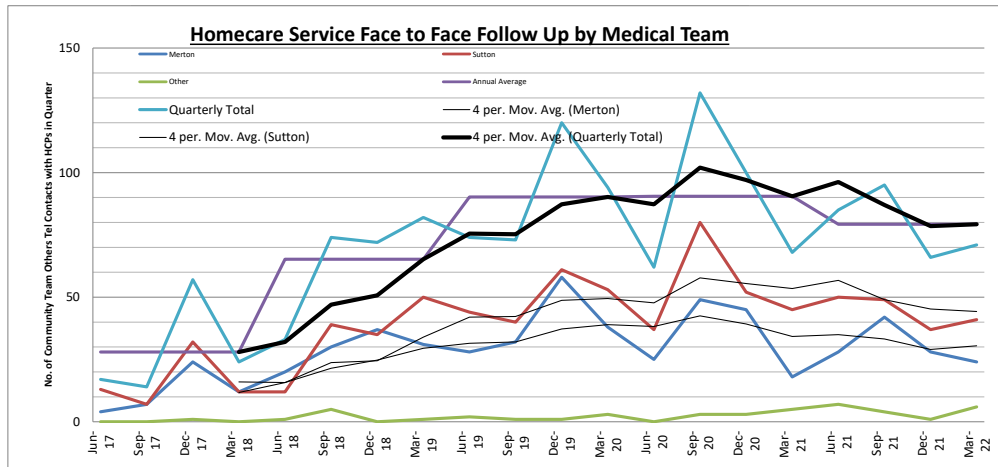
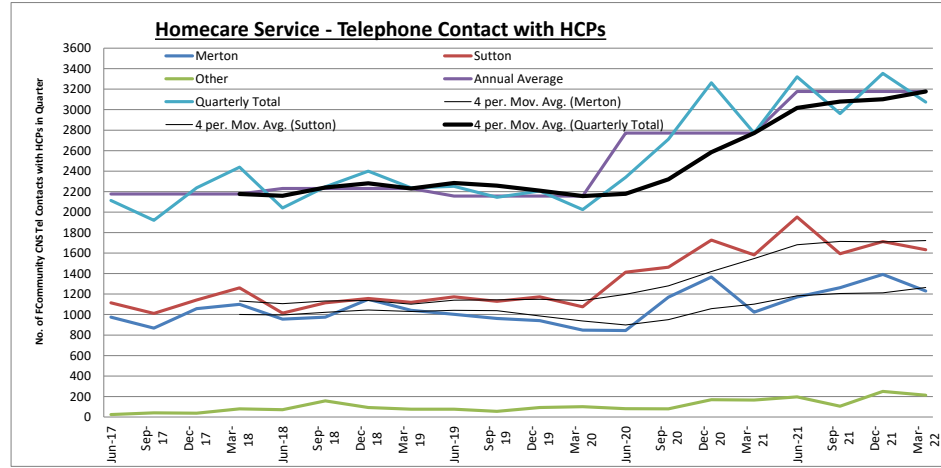


Community Team						
Homecare Service - Telephone Contact with Patient						
	Merton	Sutton	Other	Annual Average	Quarterly Total	
Jun-17	452	646	40	1091	1138	
Sep-17	451	705	16	1091	1172	
Dec-17	422	577	20	1091	1019	
Mar-18	424	575	35	1091	1034	
Jun-18	530	652	49	1311	1231	
Sep-18	530	723	59	1311	1312	
Dec-18	547	707	57	1311	1311	
Mar-19	579	731	81	1311	1391	
Jun-19	560	769	69	1460	1398	
Sep-19	517	718	47	1460	1282	
Dec-19	563	905	73	1460	1541	
Mar-20	600	977	43	1460	1620	
Jun-20	651	962	41	1725	1654	
Sep-20	688	1059	45	1725	1792	
Dec-20	778	973	35	1725	1786	
Mar-21	603	996	69	1725	1668	
Jun-21	554	1151	102	1712	1807	
Sep-21	819	1019	42	1712	1880	
Dec-21	553	906	86	1712	1545	
Mar-22	642	884	88	1712	1614	

Community Team						
Homecare Service - Telephone Contact with Family/Carers						
	Merton	Sutton	Other	Annual Average	Quarterly Total	
Jun-17	668	895	21	1496	1584	
Sep-17	609	740	32	1496	1381	
Dec-17	649	850	33	1496	1532	
Mar-18	645	792	50	1496	1487	
Jun-18	607	734	37	1736	1378	
Sep-18	800	925	107	1736	1832	
Dec-18	797	918	85	1736	1800	
Mar-19	803	1065	65	1736	1933	
Jun-19	762	1010	50	1879	1822	
Sep-19	779	945	70	1879	1794	
Dec-19	734	1063	108	1879	1905	
Mar-20	635	1233	125	1879	1993	
Jun-20	818	1357	105	2748	2280	
Sep-20	1216	1599	104	2748	2919	
Dec-20	1172	1713	154	2748	3039	
Mar-21	1019	1564	169	2748	2752	
Jun-21	1096	1892	177	2774	3165	
Sep-21	1329	1598	141	2774	3068	
Dec-21	1140	1276	137	2774	2553	
Mar-22	986	1220	104	2774	2310	



Community Team					
Homecare Service Telephone Contact with HCPs					
	Merton	Sutton	Other	Annual Average	Quarterly Total
Jun-17	974	1115	24	2177	2113
Sep-17	868	1011	41	2177	1920
Dec-17	1058	1142	37	2177	2237
Mar-18	1100	1260	79	2177	2439
Jun-18	956	1014	71	2231	2041
Sep-18	975	1115	157	2231	2247
Dec-18	1149	1157	93	2231	2399
Mar-19	1041	1119	77	2231	2237
Jun-19	1002	1173	76	2157	2251
Sep-19	961	1129	55	2157	2145
Dec-19	941	1173	92	2157	2206
Mar-20	848	1075	101	2157	2024
Jun-20	844	1414	81	2771	2339
Sep-20	1170	1462	79	2771	2711
Dec-20	1367	1727	169	2771	3263
Mar-21	1023	1582	166	2771	2771
Jun-21	1172	1952	197	3178	3321
Sep-21	1262	1593	106	3178	2961
Dec-21	1392	1712	250	3178	3354
Mar-22	1230	1632	212	3178	3074



Homecare Service					
Medical Team Face to Face Follow Ups					
	Merton	Sutton	Other	Annual Average	Quarterly Total
Jun-17	4	13	0	28	17
Sep-17	7	7	0	28	14
Dec-17	24	32	1	28	57
Mar-18	12	12	0	28	24
Jun-18	20	12	1	65	33
Sep-18	30	39	5	65	74
Dec-18	37	35	0	65	72
Mar-19	31	50	1	65	82
Jun-19	28	44	2	90	74
Sep-19	32	40	1	90	73
Dec-19	58	61	1	90	120
Mar-20	38	53	3	90	94
Jun-20	25	37	0	91	62
Sep-20	49	80	3	91	132
Dec-20	45	52	3	91	100
Mar-21	18	45	5	91	68
Jun-21	28	50	7	79	85
Sep-21	42	49	4	79	95
Dec-21	28	37	1	79	66
Mar-22	24	41	6	79	71

St Raphael's Hospice Activity Dataset																			
	2020/2021 Annual			2021/2022 Q1 : April - June				2021/2022 Q2 : July - September				2021/2022 Q3 : October - December				2021/2022 Q4 : January - March			
	Merton	Sutton	Wandsworth et al	Merton	Sutton	Wandsworth	Other	Merton	Sutton	Wandsworth	Other	Merton	Sutton	Wandsworth	Other	Merton	Sutton	Wandsworth	Other
Homecare Service																			
Hospice Point of Contact																			
Number of Referrals Overall	366	454	49	118	129	6	2	93	110	7	0	97	121	12	0	92	106	9	7
Number of Referrals Accepted	321	402	37	102	113	6	2	79	90	5	0	76	90	11	0	74	91	7	2
Referral Doesn't Require SPC	27	33	3	14	11	0	0	8	16	1	0	18	24	0	0	15	13	1	2
Referral Information Outstanding / Patient RIP / Patient not consented / Cancelled by Referrer	4	3	2	1	2	0	0	3	3	0	0	2	6	1	0	2	1	0	0
Referred to another Hospice	4	6	6	1	3	0	0	3	1	1	0	1	1	0	0	1	1	1	3
Number of Referrals receiving either CNS or Med Team F1 1st Assessment or Assessment on Admission												62	73	6	0	54	77	7	0
Number of Referrals Cancer	245	320	24	82	96	3	2	71	77	5	0	64	89	9	0	77	88	5	5
Cancer Referrals %	67%	70%	49%	69%	74%	50%	100%	76%	70%	71%	0%	66%	74%	75%	0%	84%	83%	56%	71%
Number of Referrals Non-Cancer	121	134	25	36	33	3	0	22	33	2	0	33	32	3	0	15	18	4	2
Non-cancer Referrals %	33%	30%	51%	31%	26%	50%	0%	24%	30%	29%	0%	34%	26%	25%	0%	16%	17%	44%	29%
Gender Female n=	198	215	20	62	64	3	1	44	59	5	0	52	62	7	0	44	61	7	3
Gender Female %	54%	47%	41%	53%	50%	50%	50%	47%	54%	71%	0%	54%	51%	58%	0%	48%	58%	78%	43%
Gender Male n=	168	239	29	56	65	3	1	49	51	2	0	45	59	5	0	48	45	2	4
Gender Male %	46%	53%	59%	47%	50%	50%	0%	53%	46%	29%	0%	46%	49%	42%	0%	52%	42%	22%	57%
Ethnicity Split of Referrals																			
White British	206	328	17	59	90	3	2	54	77	3	0	62	90	3	0	47	69	1	4
White Irish	16	16	2	8	2	0	0	4	3	0	0	3	1	0	0	2	3	1	0
Any Other White	25	14	8	13	4	1	0	9	1	0	0	5	5	0	0	8	6	0	0
Black Caribbean	11	2	7	5	2	1	0	1	3	2	0	3	2	0	0	3	3	2	0
Other Asian	29	11	4	9	6	0	0	6	2	0	0	5	4	2	0	14	3	1	1
Black African	7	7	1	0	0	0	0	2	10	0	0	2	0	1	0	1	1	1	0
Not Stated	36	57	5	16	16	1	0	11	5	1	0	14	7	1	0	6	14	0	1
Far Eastern	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Chinese	0	2	0	1	0	0	0	1	3	0	0	0	4	0	0	0	1	0	1
Indian	4	6	1	0	3	0	0	0	2	1	0	0	1	1	0	4	1	0	0
Pakistani	9	4	1	0	2	0	0	1	0	0	0	1	1	1	0	1	1	0	0
White Asian	2	1	0	1	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0
Mixed White/Black African	2	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
Mixed White/Black Caribbean	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0
Bangladeshi	2	1	0	1	1	0	0	1	0	0	0	0	0	0	0	2	0	0	0
Black Other	9	1	1	3	0	0	0	1	0	0	0	1	3	0	0	1	0	1	0
Mixed Other	3	1	0	1	0	0	0	0	1	0	0	0	0	1	0	2	0	0	0
Other	4	2	0	1	3	0	0	2	3	0	0	1	1	0	0	1	0	2	0
Advanced Care Planning Offered																			
Based on patient deaths	93.31%	92.31%	87.50%	95.45%	96.74%	100.00%	100.00%	92.19%	91.78%	66.67%	n/a	96.67%	96.15%	100.00%	n/a	93.48%	90.48%	100.00%	n/a
Coordinate My Care (CMC)																			
Based on patient deaths	194	261	13	33	78	3	0	45	56	5	n/a	47	60	3	n/a	33	44	2	n/a
% Based on patient deaths	64.88%	71.51%	65.00%	61.11%	72.90%	60.00%	0.00%	61.64%	60.87%	83.33%	n/a	82.46%	83.33%	50.00%	n/a	63.46%	75.86%	100.00%	n/a
Community Palliative Care Team including HPoC																			
2020/2021 Annual																			
2021/2022 Q1 : April - June																			
2021/2022 Q2 : July - September																			
2021/2022 Q3 : October - December																			
2021/2022 Q4 : January - March																			
1st Assessments (Visits & Virtual)	229	283	23	73	102	5	0	65	66	2	0	52	68	5	0	49	63	4	0
1st Assessments by Phone	11	19	1	1	1	0	0	3	0	0	0	3	3	0	0	3	1	0	0
1st Assessments Cancer	193	243	12	52	87	3	0	59	52	1	0	44	59	3	0	50	54	4	0
1st Assessments Non-cancer	47	59	12	22	16	2	0	9	14	1	0	11	12	2	0	2	10	0	0
FU Visits by CPCT/HPoC CNS	410	622	38	118	226	23	0	142	175	12	0	126	198	20	0	142	163	19	0
Telephone Contacts Patients with CPCT/HPoC CNS/RGN	2492	3605	181	516	1081	92	0	721	876	33	0	518	842	80	0	607	821	61	0
Telephone Contacts Family / Carers with CPCT/HPoC CNS (includes Community Admin)	3826	5633	505	990	1724	151	2	1126	1408	128	1	1026	1147	128	0	888	1125	96	0
Telephone Contacts Healthcare Professionals with CPCT/HPoC CNS (includes Community Admin)	4089	5759	472	1116	1856	165	23	1106	1397	100	0	1309	1597	239	0	1179	1545	163	23
Homecare service : Telephone Contact Patients / Carers / HCPs Totals	10407	14997	1158	2622	4661	408	25	2953	3681	261	1	2853	3586	447	0	2674	3491	320	23

INPATIENT SERVICE	2020/2021			2021/2022				2021/2022				2021/2022				2021/2022			
	Annual			Q1 : April - June				Q2 : July - September				Q3 : October - December				Q4 : January - March			
	Merton	Sutton	Wandsworth et al	Merton	Sutton	Wandsworth	Other	Merton	Sutton	Wandsworth	Other	Merton	Sutton	Wandsworth	Other	Merton	Sutton	Wandsworth	Other
Total Admissions	67	102	5	15	41	1	2	7	9	0	0	14	26	1	0	12	28	4	0
Cancer Admissions	53	83	5	15	39	0	2	5	7	0	0	12	20	1	0	11	27	4	0
Non-cancer Admissions	14	19	0	0	2	1	0	2	2	0	0	2	6	0	0	1	1	0	0
Total No. of Distinct Patients Admitted	63	91	5	13	37	1	2	7	9	0	0	12	23	1	0	11	26	3	0
Total Deaths	49	66	4	9	24	0	2	4	7	0	0	7	16	0	0	10	15	1	0
Cancer Deaths	40	54	4	9	22	0	2	2	7	0	0	6	12	0	0	9	15	1	0
Non-Cancer Deaths	9	12	0	0	2	0	0	2	0	0	0	1	4	0	0	1	0	0	0
Total Discharges	22	31	0	7	13	2	0	2	6	0	0	7	9	1	0	4	10	2	0
Cancer Discharges	16	26	0	6	13	1	0	2	6	0	0	6	6	1	0	4	9	2	0
Non-Cancer Discharges	6	5	0	1	0	1	0	0	0	0	0	1	3	0	0	0	1	0	0
Cancer Death Total Length of Stay	500	734	48	79	121	0	30	20	69	0	0	85	69	0	0	77	165	28	0
Cancer Deaths Avg LoS	13	14	12	9	6	0	15	10	10	0	0	14	6	0	0	9	11	28	0
Non-Cancer Death Total Length of Stay	69	124	0	0	5	0	0	3	0	0	0	4	29	0	0	14	0	0	0
Non-Cancer Deaths Avg LoS	8	10	0	0	3	0	0	2	0	0	0	4	7	0	0	14	0	0	0
Cancer Discharges Total Length Of Stay	196	330	0	65	170	15	0	27	78	0	0	108	87	15	0	71	84	33	0
Cancer Discharges Avg LoS	12	13	0	11	13	15	0	14	13	0	0	18	15	15	0	18	9	17	0
Non-Cancer Discharges Total Length of Stay	170	86	0	10	0	7	0	0	0	0	0	26	101	0	0	0	28	0	0
Non-Cancer Discharges Avg LoS	28	17	0	10	0	7	0	0	0	0	0	26	34	0	0	0	28	0	0
Cancer Deaths/Discharges	56	80	4	15	35	1	2	4	13	0	0	12	18	1	0	13	24	3	0
Non-cancer Deaths/Discharges	15	17	0	1	2	1	0	2	0	0	0	2	7	0	0	1	1	0	0
Cancer Deaths/Discharges Avg LoS	12	13	12	10	8	15	15	12	11	0	0	16	9	15	0	11	10	20	0
Non-Cancer Deaths/Discharges Avg LoS	16	12	0	10	3	7	0	1.5	0	0	0	15	19	0	0	14	28	0	0
Deaths/Discharges Total Length of Stay	935	1274	48	154	296	22	30	50	147	0	0	223	286	15	0	162	277	61	0
	2020/2021			2021/2022				2021/2022				2021/2022				2021/2022			
	Annual			Q1 : April - June				Q2 : July - September				Q3 : October - December				Q4 : January - March			
	Merton	Sutton	Wandsworth et al	Merton	Sutton	Wandsworth	Other	Merton	Sutton	Wandsworth	Other	Merton	Sutton	Wandsworth	Other	Merton	Sutton	Wandsworth	Other
Hospice @ Home																			
Referrals	68	114	7	17	58	4	0	20	35	0	0	22	35	4	0	17	25	4	0
Cancer Referrals	50	81	3	12	43	1	0	20	24	0	0	16	28	3	0	15	21	3	0
Non-cancer Referrals	18	33	4	5	15	3	0	0	11	0	0	6	7	1	0	2	4	1	0
First Assessment Visits (Not an accurate fig as 1st assessments are also done by CPCT under Homecare Service)	7	18	3	1	6	0	0	2	3	0	0	6	7	1	0	0	5	2	0
Face to face encounters with Patients	270	604	18	132	254	8	0	62	271	5	0	126	212	16	0	119	191	18	2
Number of Individual Patients - Follow Up Visits Total	97	134	9	26	63	2	0	28	86	4	0	29	48	5	0	24	39	4	1
Follow Up Visits Total (Face to face encounters with patients minus First Assessment Visits)	263	586	15	131	248	8	0	60	268	5	0	120	205	15	0	119	186	16	2
Average Number of Follow Up Visits per patient	2.71	4.37	1.67	5.04	3.94	4.00	0.00	2.14	3.12	1.25	0.00	4.14	4.27	3.00	0.00	4.96	4.77	4.00	2.00
Number of Individual Patients - Telephone Contacts Patients Total	18	35	3	3	11	0	0	4	7	0	0	3	13	1	0	4	9	1	0
Telephone Contacts Patient Total	50	80	4	9	16	0	0	6	17	0	0	7	27	4	0	10	23	2	0
Number of Individual Patients - Telephone Contacts Family / Carers Total	79	133	9	23	56	3	0	21	50	2	0	21	42	5	0	20	34	5	1
Telephone Contacts Family / Carers Total	167	499	27	122	191	4	0	57	186	11	0	81	148	32	0	60	132	46	13
Number of Individual Patients - Telephone Contacts Healthcare Professionals (HCPs) Total	22	49	4	8	18	0	0	3	19	0	0	6	17	2	0	5	13	1	2
Telephone Contacts HCPs Total	37	90	5	9	40	0	0	3	40	0	0	12	32	2	0	13	45	1	2
DAYCARE SERVICE	2020/2021			2021/2022				2021/2022				2021/2022				2021/2022			
	Annual			Q1 : April - June				Q2 : July - September				Q3 : October - December				Q4 : January - March			
	Merton	Sutton	Wandsworth et al	Merton	Sutton	Wandsworth	Other	Merton	Sutton	Wandsworth	Other	Merton	Sutton	Wandsworth	Other	Merton	Sutton	Wandsworth	Other
No of distinct individuals attended	21	27	2	14	24	0	2	27	31	0	0	25	41	0	1	32	42	3	0
No of actual attendances	209	369	2	90	151	0	2	196	200	0	0	167	167	0	1	229	243	6	0
Number of Individuals - Telephone Contacts Attendees	30	47	3	21	42	3	0	29	35	0	0	29	43	0	0	23	38	0	0
Telephone Contacts Attendees	168	237	8	65	117	4	0	85	122	0	0	70	125	0	0	46	76	0	0
Number of Individuals - Telephone Contacts Family Carers	33	47	4	15	26	2	0	26	28	2	0	30	27	2	1	17	33	2	0
Telephone Contacts Family Carers	71	124	10	30	38	3	0	41	49	3	0	47	46	2	1	28	53	2	0
Number of Individuals - Telephone Contacts HCPs	8	10	0	0	0	0	0	2	1	0	0	2	0	0	0	0	4	1	0
Telephone Contacts HCPs	8	10	0	0	0	0	0	2	1	0	0	2	0	0	0	0	4	1	0

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3. Clinical Quality & Governance

	<i>Area of Development</i>	<i>What will we do?</i>	<i>How will we know?</i>	<i>Lead(s)</i>	<i>Target Date</i>	<i>KLOE</i>	<i>RAG</i>	<i>Notes</i>
3.1	Med Team : Training	<ul style="list-style-type: none"> All core medical team trained in advanced communication skills 	<ul style="list-style-type: none"> Team completion of Advanced Communications Course 	NC / Med Team	May 2022	R, W, C, E		<ul style="list-style-type: none"> Core team has Advanced Communication Skills
3.2	Clinical Audit	<ul style="list-style-type: none"> Produce and maintain an audit/monitoring/research project schedule 2022/23 	<ul style="list-style-type: none"> CQ & G Minutes Audit report library Audit progress/results summary report Clinical Audit Program & Timeline 	AR	May 2022	Well-led Effective Safe Caring Responsive		<ul style="list-style-type: none"> N:\Clinical\Clinical Governance\Clinical Audit
3.3	Psychological Support : Counselling for post - bereavement	<ul style="list-style-type: none"> To maintain student counselling cohort of 8 Appoint to an additional 0.6 Counsellor post 	<ul style="list-style-type: none"> Continuation of reduced need for counselling by the Head of PS Counselling by student numbers Shorter waiting list 	SM	Jun 2022	Well-led Effective Responsive		<ul style="list-style-type: none"> We now have 8 volunteer Bereavement Counsellors – 4 are qualified and 4 are in their final year of training. Appointed to an additional 0.6 Counsellor post. Added to this is the establishment of a rolling Bereavement Support Group.
3.4	Clinical : Diversify offer of Hospice service delivery to support patient choice	<ul style="list-style-type: none"> Re-establish Outpatient encounters Maintain diversified offer in Wellbeing/Living Well aligned to Social Prescribing 	<ul style="list-style-type: none"> Data extraction Cross Care CQ&G minutes User feedback 	Med Team /Clin Dir/T C	Jun 2022	Well-led Effective Safe Caring Responsive		<ul style="list-style-type: none"> Outpatient room operational
3.5	Community	Formalise Locality Team Lead Roles	<ul style="list-style-type: none"> Job Descriptions finalised 	TC	Jun 2022	Well-led Effective Responsive		<ul style="list-style-type: none"> JDs reviewed and updated to reflect role responsibilities

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	Area of Development	What will we do?	How will we know?	Lead(s)	Target Date	KLOE	RAG	Notes
3.6	Complementary Therapy Service	<ul style="list-style-type: none"> Re-establish the Service Ensure Crosscare / information collection sources are designed to support service Review Service Policy 	<ul style="list-style-type: none"> CHoDs 	LJ/RT/AR/JG	Jul 2022	Well-led Effective Safe		<ul style="list-style-type: none"> Service re-established Policy under review Crosscare changes being undertaken
3.7	Wellbeing – service users and attendances	<ul style="list-style-type: none"> Engage with external groups including social prescribers Collaborate with external groups to provide joint offers 	<ul style="list-style-type: none"> Crosscare Data 	SP	Jul 2022	Well-led Effective Caring Responsive		<ul style="list-style-type: none"> Collaboration with a number of external groups Increased social prescriber referrals Engaged with Age Uk and Merton and Sutton Uplift
3.8	Clinical Audit	<ul style="list-style-type: none"> All clinical services to feed into and support the clinical audit program 	<ul style="list-style-type: none"> Clinical Audit Program & Timeline 	CHoD S	Aug 2022	Well-led Effective		<ul style="list-style-type: none"> Psychological Support Services project tbc
3.9	Risk Management – DATIX	<ul style="list-style-type: none"> Incident Management <ul style="list-style-type: none"> Adjust input screens to service experience and data needs Establish reporting / output Feedback <ul style="list-style-type: none"> Adjust policy to support use of DATIX to capture complaints and feedback Effect design changes to Feedback Module Develop Complaints Feedback Training Video Implement Feedback Module 	<ul style="list-style-type: none"> CQ&G Report ChoDs Minutes 	AR	Sep 2022 Jul 2022	Well-led Effective		<ul style="list-style-type: none">

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	Area of Development	What will we do?	How will we know?	Lead(s)	Target Date	KLOE	RAG	Notes
3.10	Clinical : Access to/involvement with R&D	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> CQ & G Sub Minutes CHoDs 	GT-R/Me d Team	Sep 2022	Well-led Effective		<ul style="list-style-type: none"> Work collaboratively with other local hospices & acute Pall Care Teams
3.11	Wellbeing – Men’s Den	<ul style="list-style-type: none"> Launch a diversified offer to support male patients, carers, relatives and bereaved 	<ul style="list-style-type: none"> Crosscare Data 	SP	Oct 2022	Well-led Effective Caring Responsive		<ul style="list-style-type: none">
3.12	IPU : A more responsive and active IPU: Increase our admission capacity, providing more responsiveness and equity to our inpatient referral requests	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 10 beds open 90% of time as a minimum Increase in number of accepted referrals from acute sector Shorter LOS between discharge date set and actual discharge Datix data demonstrates no increase in incidents/accidents that can be related to inadequate staffing numbers 	TY/B W/M ed	Oct 2022	Well-led Effective Safe Responsive		<ul style="list-style-type: none"> 10 beds open as default Admissions meeting twice daily
3.13	Clinical : Reflection and Supervision	<ul style="list-style-type: none"> To support clinical reflection and supervision through introduction of Schwartz rounds 	<ul style="list-style-type: none"> Facilitator training Introduce 1st Schwartz round Introduce group HCA clinical supervision 	RT / Med Team	<ul style="list-style-type: none"> Oct 2022 Dec 2022 Feb 2023 	Well-led Effective Caring		<ul style="list-style-type: none"> Application made to Point of Care Foundation for the course

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	Area of Development	What will we do?	How will we know?	Lead(s)	Target Date	KLOE	RAG	Notes
3.14	Clinical : Digital Development	To support the transitioning of CMC to the Urgent Care Plan	UCP numbers are comparable to previous CMC records as a minimum	TC/ Med Team	Jan 2023	Well-led Effective Caring Responsive Safe		
3.15	IPU : Move IPU towards a model of Excellence and a role model for other hospices	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Clinical Standards and Project Lead role embedded at 6 months with demonstrable evidence of robust clinical standards, audit, streamlined processes, projects underway. IPU Sister role embedded at 6 months with demonstrable evidence of evolving staff culture of clinical enquiry Band 6 nurses leading on specific areas of development and utilizing management skills effectively in the absence of senior nursing staff 	TY/B W/RT	Jan 23	Well-led Effective Safe		<ul style="list-style-type: none"> IPU Sister and Clinical Standards and Project Lead in place
3.16	IPU : Staffing	<ul style="list-style-type: none"> To achieve full establishment of band 5 RGNs on the IPU that services rotation across days and nights 	<ul style="list-style-type: none"> Reduced agency usage Increased bed availability Secondment to other clinical areas 	RT	Mar 2023	Well-led Effective Safe Responsive		<ul style="list-style-type: none"> Increased bed availability
3.17	Verification of Expected Death (Community)	All Band 6 & band 7 community staff to be trained to complete VOED documentation	<ul style="list-style-type: none"> Assessed as competent 	TC	Mar 2023	Well-led Effective Caring Responsive		

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	Area of Development	What will we do?	How will we know?	Lead(s)	Target Date	KLOE	RAG	Notes
3.18	Referral Policy	Extend Referral Policy to capture self-referral for patients discharged from the Hospice clinical service	CLIN09 Referral Policy	TC / Med Team	Mar 2023	Well-led Effective Caring Responsive Safe		
3.19	Outcomes	Implement Step 3 /4 of OACC - CSNAT in H@H / Dependency in 2023/24	<ul style="list-style-type: none"> OMG Minutes 	OACC T&F Group Comm - TC	Mar 2023	Well-led Effective Responsive		<ul style="list-style-type: none"> Contact made with Gail Ewing re training and have 6 staff volunteering as trainers.
3.20	IPU : Increased Skillset of Registered Nurses	<ul style="list-style-type: none"> Education and training for RNs re Adv Phys Ass/IV /Nurse led assessment, ECEPC etc Sim training with PA and Ed Team 	<ul style="list-style-type: none"> Staff have passed competencies and can demonstrate Increased clinical input in patient assessment and procedures etc Medical time on specific clinical tasks decreases in line with specific clinical tasks undertaken by nursing team. Stable and satisfied workforce (HR evidence/staff survey) 	BW / LB/ MF	Mar 2023	Well-led Effective Safe		
3.21	IPU : Increased Skillset of Nursing Associates	<ul style="list-style-type: none"> Education and training for NAs Sim training with PA and Ed Team 	<ul style="list-style-type: none"> First Nursing Associate successfully completed ECEPC First Nursing Associates successfully completed NA competencies 	BW / LB/ MF	Mar 2023	Well-led Effective Safe		<ul style="list-style-type: none"> 1 NA undertaking ECEPC in June 2022

CQ& G Extract from Draft 2022-23 MANAGEMENT PLAN

	Area of Development	What will we do?	How will we know?	Lead(s)	Target Date	KLOE	RAG	Notes
3.22	IPU : Robust Infection Control practice across IPU	<ul style="list-style-type: none"> Service Level Agreement with STHH IPC team for 12 months from 1 April 2022 Clinical Standards and Project Lead to undertake formal IPC training with plan to lead on IPC in 12 months 	<ul style="list-style-type: none"> 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 	TY/SHH	Apr 2023	Safe		<ul style="list-style-type: none"> SLA in place with IP&C at SHH 'til March 2023
3.23	IPU : New EPR system and Staff competency in digital care planning	Introduce EMIS – collaborate with other users externally and refine to fit needs of SRH IPU	<ul style="list-style-type: none"> EPR is user friendly, information accessed and inputted is accurately reflective of patient care 	TY/Managed Team/JG	Jun 2023	Well-led Effective Safe Responsive		
3.24	Policy / working model	Develop Policy for servicing the transition of young adults (referral & working model)	<ul style="list-style-type: none"> Transition of Young Adults Policy 	TC / Med Team	Jun 2023	Well-led Effective Caring Responsive Safe		
3.25	IPU : Increased Skillset of HCAs	<ul style="list-style-type: none"> Education and training including Care Certificate, phlebotomy skills, second checker competencies, pharmacy assistant roles etc Train HCAs in audit and allocate specific areas 	<ul style="list-style-type: none"> HCAs have passed competencies and can demonstrate evidence of utilization of skills Increase in audits undertaken and actions to improve practice Stable and satisfied workforce (HR evidence/ staff survey) 	LB/Managed Team	Sep 2023	Well-led Effective Safe		<ul style="list-style-type: none"> Some HCAs have passed their second checker competency

CQ& G Extract from Draft 2022-23 MANAGEMENT PLAN

	Area of Development	What will we do?	How will we know?	Lead(s)	Target Date	KLOE	RAG	Notes
3.26	Outcomes	<ul style="list-style-type: none"> Implement Step 2 of OACC – iPOS on the IPU and in the Community <ul style="list-style-type: none"> Policy / Documentation System / Capture Education Implementation Audit 	<ul style="list-style-type: none"> OMG Minutes 	OACC T&F Group IPU-TY; Comm-TC	Mar 2024	Well-led Effective Responsive		<ul style="list-style-type: none"> Pended to 2023/24 unless feasible in 22/23
3.27	Community : Carer Admin of SC Meds	<ul style="list-style-type: none"> Develop Policy Include RA Establish training infrastructure 	<ul style="list-style-type: none"> CHoDS D&TC 	GT-R/TC	Mar 2024	Effective Safe Responsive		<ul style="list-style-type: none"> Pended to 2023/2024
3.28	Data Monitoring	<ul style="list-style-type: none"> To provide data updates on a quarterly basis across all clinical services. 	<ul style="list-style-type: none"> CQ & G Minutes 	AR	As per Index	Well-led Effective		<ul style="list-style-type: none"> Data Monitoring Index
3.29	Community : Staffing	<ul style="list-style-type: none"> To maintain CNS Development posts 	<ul style="list-style-type: none"> Staffing subject to vacancy 	TC/RT	Ongoing	Well-led Effective		<ul style="list-style-type: none"> In place for 2022/23
3.30	Clinical Activity: Daily data extraction to support data integrity	<ul style="list-style-type: none"> Review and revise training video to service data extraction for Xcare Produce data extract daily or as feasibly close to daily throughout the year 	<ul style="list-style-type: none"> Continued circulation of activity data / as close to daily as feasible 	AR	On going	Well-led Effective Responsive		<ul style="list-style-type: none"> Data extraction has supported allocation of government funding 2020-2022. Data extraction supports data integrity process

SAINT RAPHAEL'S HOSPICE

MINUTES OF THE INFECTION CONTROL COMMITTEE

Held on 9th November 2021
at St Bede's Conference Centre and via Zoom

Attendance		
	(Dr JS) Dr J Stephenson, Consultant Microbiologist -SHH, SSAH - Chair	(GL) G Linehan – Joint CEO
	(RT) R Trower – Clinical Director	(MF) M Flint – Practice Educator
	(LB) L Briant – Practice Educator	(SC) S Cresswell – Facilities
	(AR) A Rudkin – Quality (Minutes)	(JS) – CNS - Community Link Nurse for IC

Apologies		
	(TC) T Christmas – Community Team Manager	(PD-P) P Di-Palma - Housekeeping
	(KM) K Mackie – Nursing Associate – IPU IC Link Nurse	(TY) T Young – IPU Manager

ITEM 1: Welcome

JS extended welcome to all present and everyone introduced themselves.

ITEM 2: Apologies for Absence

Apologies as listed above.

ITEM 3: Minutes of the last meeting held on 09 February 2021

3.1 These were accepted.

ITEM 4: Matters Arising

- 4.1 FFP3 Masks – Two fit-testing sessions have been delivered. Coverage is very good with just a couple of staff to follow-up on.
- 4.2 Water Management Policy is published.
- 4.3 Revisions to the Infection Control Policy are complete.
- 4.4 Maitland Medical is the new Occupational Health Service provider for the Hospice. Reported that provision is satisfactory.

Action

RT

ITEM 5: COVID-19 Update

Vaccination : No access issues. Uptake has been very good across the staff. Out of 90 personnel, there are 3 not vaccinated owing to medical exemption.

Testing : PCR Testing remains in place for staff and LFD testing is in place for visitors.

COVID levels amongst staff at SHH isn't high.

Symptoms : Predominant COVID symptoms are now like the common cold. LB advised that these symptoms have been included on the screening questions.

PPE : No supply issues. Stock levels are good.

NEWS : Noted that there is a reported impetus growing nationally for mandating COVID vaccination across front line staff.

ITEM 6: Sharps Injuries & Body Fluids

6.1 Nil Sharps and nil incidents to report.

6.2 Refreshed infection control audit cycle has been introduced across the IPU and Community by the interim infection control team (Laura & Maura in Education). Thanks extended.

ITEM 7: IC Audit Report

7.1 PAH infection control nurse was invited to undertake a peer review audit. Results showed high levels of compliance (92%) and highlighted a few areas for improvement. Nothing was glaring and process allowed for the sharing of good practice.

ITEM 8: Alert Organisms Surveillance

8.1 Nil to note.

ITEM 9: Water Assessment and testing

9.1 Service from HSL reduced between May and September 2021 (IPU Closure July/August 2021). The company acknowledged their deficiencies and have provided remedial assurances. Next visit is expected on 18th November 2021. Cold water tank was cleaned in August.

ITEM 10: Any Other Business

10.1 Flu vaccine uptake is encouraged. .

10.2 Standing reminder that there is an Infection Control folder on the network drive at <N:\Infection Control>

ITEM 11: Future Dates

11.1 Dates of future meetings:

Date	Event	Venue/Time
Tuesday 10 th May2022 1pm-2pm	ICC Meeting	St Bedes + Zoom / TBA

SAINT RAPHAEL'S HOSPICE

MINUTES OF THE MEDICAL BUSINESS MEETING

Held on 1 June 2022

In attendance:	Gaby Tamura-Rose	Consultant (Chair)
	Naomi Collins	Consultant
	Ambreen Akhtar	Specialty Doctor
	Jovy Giles	Physician Associate
	Luke Hollingsworth	GP Trainee
	Pascale Evans	Clinical Admin (minutes)

ITEM 1: Apologies for Absence

- 1.1 Busi Da Silva; Jenny Strawson; Rachel Clingan

ITEM 2: Minutes of the Last Meeting

- 2.1 Mandatory consent box on Crosscare is working.
- 2.2 Jenny is working on the Dying Patient screen on Crosscare which will include personalised care plans mainly hydration, nutrition, etc.
- 2.3 Discharge letters are being revised to make them more patient friendly however more clarity is needed on what is requested – Ambreen to potentially look at this in 2023.
- 2.4 Increase in the number of prescribers should address concerns about changes in medication dosage without doctors' advice.

ITEM 3: Rota / staffing for the next three months

- 3.1 No issues.
- 3.2 Gaby will be away on annual leave and off-site duties for most of June.

ITEM 4: Clinical Challenges

- 4.1 Any concerns regarding the young anorexia patient during out of hours should be referred to Gaby/the consultant team as it is an out of norm palliative care case.
- 4.2 OOH 1st on call support: recent case of provisional CSCI frusemide discussed – in agreement to handover verbally in these situations to provide more guidance to the 1st on call doctor and for the nursing team to not call back the 1st on call, or indeed escalate to consultant if appropriate, for support.
- 4.3 Patient details should be handwritten on DNAR forms rather than using stickers which can easily be removed or covered.

ITEM 5: Infection Control

- 5.1 The hand sanitizers have been removed from the IPU (on advice of infection control team) - concerns raised that this may discourage good hand hygiene - Jovy will audit.
- 5.2 Flowers are allowed again on the IPU if water is changed every 24 hours.

ITEM 6: Education

- 6.1 There will be an education update on 6th July.
- 6.2 1 GP has signed up for the GP masterclass on 14th September – cut off date/minimum attendance required TBC re whether or not this will go ahead.
- 6.3 Clinical supervision for the doctors will take place on 29th June, 27th July and 28 September. The team will then decide if monthly sessions are too frequent.
- 6.4 The journal club schedule will be revised to accommodate the clinical supervision dates and circulated – Ambreen to action.

ITEM 7: Audit

- 7.1 Latest Crosscare reports show that medical activity has decreased. The team often use 1 entry to record multiple consultations, or indeed there is uncertainty if true medical activity is captured from the free text box of writing who was in attendance for eg a ward round. Jenny to discuss with Crosscare team/Alex if there is another way of reporting.
- 7.2 More audits are available if members of the team are keen to undertake. See Gaby.

ITEM 8: Any other business:

- 8.1 Gaby participated in an interview to support a study at King's and was offered £75 for her time. The money could be used by the team to purchase small items or books, Pascale to follow up with the Finance department.
- 8.2 Dates of future meetings:

Date	Event	Venue/Time
06.07.2022	Medical Business Meeting	14.00 – 15.00 Training Room

Clinical Audit and Activity Data Committee
Minutes of the 5th meeting held at 13.30 on Wednesday 5th January 2022
(via Zoom & St Bedes Room B)

Present: (AR) A Rudkin (Chair, Head of Quality & Improvement)
 (RT) R Trower (Clinical Director)
 (MF) M Flint (Practice Development / Clinical Education)
 (LB) L Briant (Practice Development / Clinical Education)
 (GT-R) G Tamura-Rose (Palliative Care Consultant / Medical Team Audit & Research Lead)
 (TC) T Christmas (Community Team Manager)
 (RW) R Wallis (CNS / Safeguarding Lead Nurse)

Apologies

(SM) Steve Molyneux (Head of Psychological Support Services)
 (TY) T Young (IPU Manager)
 (JS) Dr Jenny Strawson (Lead Palliative Care Consultant)
 (AA) Dr Ambreen Akhtar (Hospice Doctor)

	Action
1. <u>Minutes of the last meeting held</u>	
Minutes of the meeting held on 23 rd June 2021 were accepted.	
2. <u>Matters Arising</u>	
Listed matters with Action Initials are to be carried over to the next meeting	AR
Clinical Audit Policy – remains an action	AR
Clinical Audit Education – Clinical Audit Information Leaflet and Project Proposal Form in place. Last externally facilitated clinical audit training was delivered and well-received on 4 th February 2020. Next session to be organised for 2022/23.	MF
ToR15 Clinical Audit & Activity Data Committee Terms of Reference reviewed.	
Waights Open University Hospice @ Home Research Study Outcome	GT-R
DNACPR Audit 2021 was undertaken by JS in December 2021.	
3. <u>Safeguarding Audit Presentation</u>	
<ul style="list-style-type: none"> • RW presented the results of the Safeguarding Audit that she undertook in 2021. <p><u>Conclusions</u></p> <ol style="list-style-type: none"> 1. All safeguarding events raised to the LA were raised with the CQC – 100% compliance. 2. 70% of patients had documentation as to whether consent was gained or not from them before the safeguarding concern was raised to the local authority. 3. 30% had no documentation on consent or capacity. 4. Of that 70%, half of the patients did not consent to the referral and 86% of those patients had a clear rationale for why not and why the safeguarding referral was still being raised. <p><u>Areas for Improvement</u></p> <ol style="list-style-type: none"> 1. Documenting the capacity of a patient when making a safeguarding referral to the local authority. 2. Documenting the rationale for making a best interest decision when the patient had not provided or been able to provide explicit consent. 3. Update current safeguarding flow chart and training to highlight importance of documenting consent and whether or not the safeguarding referral is being made in best interests. 	

<p><u>Comments</u></p> <ol style="list-style-type: none"> In the majority of patients, consent or the rationale for raising the concern without consent, was documented in the referral form sent to the local authority as there are clear prompts. This may reflect what is now needed within the hospice documentation system (Crosscare). Of 15% that were not followed up, 100% either died or were moved to a place of safety before safeguarding team acted. 	
<ul style="list-style-type: none"> TC reflected how the results showed the amount of work the clinical team puts into ensuring safeguarding cases are raised. 	
<ul style="list-style-type: none"> LB echoed TC's comments and praised the raised profile safeguarding has under the leadership of RW and Elisa Lunn. She remarked how very thorough the face to face safeguarding training was. 	
<ul style="list-style-type: none"> AR thanked RW for her presentation and the work she had put into the project. 	
<p>4. <u>Project Presentations</u></p>	
<ul style="list-style-type: none"> Owing to the unavoidable absences of two presenters, presentation was limited to the Safeguarding Audit led by Rebecca Wallis. 	
<ul style="list-style-type: none"> Future Audit project presentation will not occupy time for this meeting but rather be held at lunch-time sessions from 12.45-2pm in St Bedes Conference Centre. Project presentations will not cause project leads any additional administrative burden as they may use the project's written report for presentation. All members of the clinical teams will be welcome to attend. The presentation slots will be coordinated by AR and will provide opportunity to recognise the time and effort that has been put into the project, receive feedback from the audience and relay gratitude for engagement and participation across teams as appropriate. 	
<p>5. <u>Audit Program & Timetable</u></p>	
<p>Item deferred to next meeting</p>	
<p>6. <u>Audit Results Review</u></p>	
<p>Item deferred to next meeting</p>	
<p>7. <u>Education</u></p>	
<p>Item deferred to next meeting</p>	
<p>8. <u>Any Other Business</u></p>	
<p>It was agreed to expand the ToR15 for this Committee to provide coverage for Research and Quality Improvement Projects.</p>	AR
<p>9. <u>Dates of Future Meetings</u></p>	
<p>TBA</p>	



QUALITY ACCOUNT 2021-2022

“The service was very proactive. An assessment was made early on and a number of gadgets were lent to us to help my wife stay at home with myself as carer. We found the nurses very caring. They could not do enough to help us. The whole experience with the hospice was very positive. I will be forever grateful for the love and care we received.”

(2021 VOICES SURVEY)

~

Part 1

What is a Quality Account?

The Quality Account for St Raphael's Hospice covers the period from 1 April 2021 to 31 March 2022 and is a record of the cycle of continuous quality improvement as we strive to deliver excellent specialist palliative care. It provides an opportunity for us to share best practice and is driven by the experiences of both those providing and receiving our services. It allows us to demonstrate our commitment to engage with evidence-based quality improvement and to outline our progress to the public. We hope that our Quality Account will facilitate an opportunity for review, debate and reflection as well as provide the public, our regulator and commissioners, assurance that we are routinely evaluating our services and focusing on improvement that will enhance and support the delivery of expert specialist palliative and end of life care to the people who use our services.

St Raphael's Hospice

St Raphael's is an independent registered charity (charity number 1182636, company number 11732567) providing specialist palliative and end of life care services to our community.

Since 1987, St Raphael's has offered Hospice care to those facing life-limiting illness living in the boroughs of Merton and Sutton. The service is free of charge to all who use it and provides high quality, expert medical and nursing care delivered in our 14-bed unit or in patients' own homes. We also provide psychological support services including social work and bereavement support, wellbeing and related services, to patients and those who are important to them. St Raphael's welcomes, supports and cares for patients and families of all faiths, or none, respecting all cultural, ethnic and religious preferences.

Hospice care is holistic and tailored as far as is practicable to an individuals' needs. Our expert team are skilled in supporting patients to improve the quality of their life within the constraints of their condition. Our Services include:

- **Specialist clinical care provided by doctors and nurses in our in-patient unit or in the patients' own home.**
- **Hospice at Home service offering respite and support to carers.**
- **A Wellbeing Centre providing social and creative opportunities together with practical information and complementary therapies.**
- **Pastoral care and spiritual support.**
- **Psychological support for patients, counselling and bereavement support for those who are important to the patient (including children).**
- **Specialist education and information for patients, carers and other professionals.**

It costs around £6.5 million every year to run the hospice and support the services it provides. We receive a grant of around 25% of these costs from NHS sources, but we are reliant on the generosity of our local community through charity fundraising, donations and legacies, our lottery and charity shops to raise the remaining 75% to allow us to continue providing high quality care to the people referred to our service.



Statement from the Joint Chief Executive Officers

The philosophy and values of St Raphael's Hospice are based on the Christian Ethos of respect for all human life and recognition of the unique value of each person. We welcome, respect and support patients, families, staff and volunteers from a wide diversity of cultures and faiths which is reflective of the communities we serve. We believe that everyone has the right to expert palliative and end of life care with access to the services which enable people to have a dignified death in the place of their choosing.

We remain engaged with our five year Hospice Strategy, and have undertaken works to improve the hospice environment and recruitment to our teams to support excellence across all our services. By providing an inviting, quality environment with services delivered by expert staff, our aim is to give assurance to the people across Merton and Sutton that when they need hospice services we will be there to support their needs and those of the people that are important to them. We believe that by providing an accessible, quality service we will raise the visibility of St Raphael's within our community and enhance engagement across all sectors, where people will want to support the hospice both financially and with their time through volunteering.

We recognise and value the contribution made by all our dedicated staff and volunteers to the services the Hospice provides. To improve the delivery of palliative and end of life care, we work collaboratively across care sectors to support education in the principles of specialist palliative care both within the Hospice and the wider community.

Quality is integral to the services we provide. Its assurance is communicated every 2 months to the Board of Trustees through reports on aspects of clinical, corporate and financial governance. We are very grateful to those who compile and review these reports, acting as gate-keepers to the qualities we all aspire to.

To the best of our knowledge, the information reported in this Quality Account is accurate and represents the quality of the healthcare services provided by St Raphael's Hospice.

Gail Linehan and Nick Stevens
Joint Chief Executives

The image shows two handwritten signatures in black ink. The signature on the left is 'G Linehan' and the signature on the right is 'Nick Stevens'. Both are written in a cursive, flowing style.

Part 2

1. Priorities for improvement 2022 – 2023

St Raphael's Hospice is fully compliant with the Fundamental Standards of Quality and Safety that support the section 20 regulations of the Health and Social Care Act 2008 and its subsequent amendments. Consequently, there were no areas of shortfall to include in its priorities for improvement in 2021-2022.

Effective from 1st April 2015, has been our responsibility to meet two groups of regulations:

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)
- Care Quality Commission (Registration) Regulations 2009 (Part 4).

These regulations introduced the new fundamental standards which describe requirements that reflect the recommendations made by Sir Robert Francis following his inquiry into care at Mid-Staffordshire NHS Trust.

The Board of Trustees and/or its committees have endorsed the Management Plan for 2022/23 and considers that its top three quality improvement priorities are:

Future planning priority 1:

An improvement priority to replace the Hospice PAS system and increase functional accessibility to data sharing with Primary Care

Standard: To appraise the market for replacement of the Hospice Patient Administration System (PAS), initiate a PAS replacement project team and commence the purchase, and implementation of the replacement system that will facilitate the sharing of information across systems via the Health and Social Care Network (HSCN)

Measure: PAS replacement project team feedback

Review: Information Governance and Security Committee

Future planning priority 2:

- **An improvement project to implement CSNAT by commencement through the H@H service**

Standard: To introduce a short and simple evidence-based tool that facilitates tailored support for family members and friends (carers) of adults with long term life-limiting conditions.

The Carer Support Needs Assessment Tool comprises 14 domains (broad areas of need) in which carers commonly say they require support. Carers may use the tool to indicate further support they need both to enable them to care for their family member or friend and to preserve their own health and well-being within their care giving role.

Measure: Implementation of CSNAT : H@H service

Review: Outcome Measurement Group

Future planning priority 3:

- **An improvement project to implement Schwartz Rounds**

Standard: To introduce a recognised and structured forum for supporting staff handle the emotional impact of their work. Schwartz Rounds provide such a forum where all staff, clinical and non-clinical, can come together regularly to discuss the emotional and social aspects of working in healthcare.

The purpose of Rounds is to understand the challenges and rewards that are intrinsic to providing care, not to solve problems or to focus on the clinical aspects of patient care. Rounds can help staff feel more supported in their jobs, allowing them the time and space to reflect on their roles. Evidence shows that staff who attend Rounds feel less stressed and isolated, with increased insight and appreciation for each other's roles. They also help to reduce hierarchies between staff and to focus attention on relational aspects of care. The underlying premise for Rounds is that the compassion shown by staff can make all the difference to a patient's experience of care, but that in order to provide compassionate care staff must, in turn, feel supported in their work.

Measure: Staff survey pre-implementation and staff survey post-implementation.

Review: Clinical Heads of Department

2. Statements of Assurance from the Hospice Board of Trustees

The following are a series of statements that all providers are required to include in their Quality Account. Many of these statements are not directly applicable to specialist palliative care providers.

2.1 Review of Services

During 2021/2022, St Raphael's Hospice provided 5 NHS funded services:

- In-patient Unit
- Wellbeing Centre
- Outpatients
- Hospice @ Home
- Community Clinical Nurse Specialist Service

St Raphael's Hospice has reviewed all the data available to it on the 'quality of care' in all the above services.

The income generated by the NHS services reviewed in 2021/2022 represents 100% of the total income generated from the provision of the NHS funded services by St Raphael's Hospice for 2021/2022.

What this means

St Raphael's Hospice is funded via a standard NHS contract and fundraising activity. The income generated from the NHS represents approximately 25% of the overall running costs of the Hospice. The remaining income is generated through legacies, our hospice shops and lottery and support from our generous community.

2.2 Participation in national clinical audits and confidential enquiries

During 2021/2022, no national clinical audits and no confidential enquiries covered NHS services provided by St Raphael's Hospice.

What this means

There are no national clinical audits or confidential enquiries that cover the specialist palliative care services either commissioned or provided by St Raphael's Hospice.

However, St Raphael's Hospice carries out internal clinical audits throughout the year as part of its management planning process.

2.3 Participation in local clinical audits

The undertaking of clinical audits at a local level feeds into the management planning round for St Raphael's Hospice. Details of projects undertaken in 2021/2022 can be found at section 3.2.1.

2.4. Participation in clinical research

There has been no clinical research initiated in 2021/2022.

2.5 Goals agreed with commissioners

St Raphael's Hospice's income in 2021/2022 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework.

2.6 What others say about us

St Raphael's Hospice is required to register with the Care Quality Commission and has no conditions on its registration.

The Care Quality Commission's last undertook an announced inspection of St Raphael's Hospice on 11th & 12th November 2019. The Hospice was assessed as fully compliant with the required standards and achieved an overall rating of GOOD.

The Care Quality Commission has not taken enforcement action against St Raphael's Hospice during 2021/2022.

St Raphael's Hospice participates in Transitional Monitoring of Service calls with the Care Quality Commission as required. There were no areas of concern raised. The hospice has not participated in any special reviews or investigations by the CQC during the reporting period.

2.7 Data quality

St Raphael's Hospice constantly reviews the quality of its data to see if there are ways in which it can be improved. As a result, it undertakes the following action to further improve data quality:

- Data integrity checks to service production of activity data
- Programme of data completion assessments that facilitate user-defined data interrogation / report production
- System design enhancements to facilitate inputs and useful outputs

A high value is placed on the data and consequential information outputs that can be generated through the Hospice's information systems.

St Raphael's Hospice did not submit records to the Secondary Uses service for inclusion in the Hospital Episode Statistics as this is not applicable.

St Raphael's Hospice submitted its self assessment to service compliance with the NHS Digital Data Security and Protection Toolkit (DSPT) in June 2022.



Part 3

3. Quality Review

3.1 Review of quality performance in 2021/2022

This is the ninth year St Raphael's Hospice has published a 'Quality Account'.

Past planning priority 1 : An improvement priority to offer access to people with long term/chronic illness to the Living Well Programme

Standard: To widen access to palliative care advice and support to a non-specialist palliative care group of patients – Social Prescribing

Measure: Clinical Quality and Governance Report

Review: Wellbeing attendance numbers rose over the period and the Living Well programme has proven popular – with consistently positive feedback. Engaging with social prescribers has increased referrals and numbers are currently evenly divided between those already known to our service and those who have engaged with us from other referral sources. The team work in collaboration with a number of other local groups and services to promote a unified community service. Interest has been registered in accessing the service from people outside of the SRH catchment area and further work is planned to work with other hospices in order to increase efficiency and promote Wellbeing earlier on in disease trajectories.



Past planning priority 2: An improvement project to recognise and support the excellent practice demonstrated by staff and volunteers going over and above expectations

Standard: To provide an easy access/reference depository of excellent practice that facilitates contemporaneous capture of example

Measure: Evidence of Excellent Practice Register

Review: The introduction of the 'Excellent Practice' register has provided a reference point that facilitates the capture of examples of excellence that individuals produce in supporting patients, those important to them, their colleagues and services. Often staff and volunteers go 'over and above' their roles and the register provides a central archive of examples that all can contribute to. Establishing the register has supported the recognition that can often get missed to the many and has proven invaluable in re-enforcing the support and praise that staff and volunteers rarely ever seek yet thoroughly deserve.

Past planning priority 3: An improvement project to review, revise, re-brand and publish Hospice information material across a range of media to service the needs of the local population

Standard: To establish a forum for the steering of information material review, a prioritised program of material review and implement a standardised process for information material production, ownership and review.

Measure: Information Material Register

Review: Establishing an Information Material Task and Finish Group has provided a forum for members of the Communication Team alongside representation from the Executive, the Palliative Care Consultant Team, the IPU, Community Team and Quality to drive forward the review and revision of Hospice Information literature across the multi-media platforms to ensure appropriate branding, design and content.

3.2 Quality Management

Clinical Quality and Governance Committee

The Hospice's Quality Clinical Quality and Governance 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 ensures 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 contribute expertise, human resource capacity, and their professional perspectives to the development and successful operation of the Hospice's clinical governance activities. Chaired by a member of the Hospice Board of Trustees, it meets every 3 months. Its membership includes Trustee Members, Trustee Advisers, the Joint CEOs, the Clinical Director, the Lead Palliative Care Consultant and the Head of Quality and Improvement. Standing items for this Committee include Evidence of Excellent Practice, the Clinical Risk Register, Clinical Quality and Governance Objectives, the Clinical Quality and Governance Report (Clinical Developments, Clinical Risk Management, Clinical Audit, Clinical Effectiveness including Policy Development, Information Material, Practice Development, Patient/User Feedback, Organisational and Regulatory Assurance, Infection Control and Clinical Complaints).

Training & Development Committee

The Hospice's Training & Development Committee steers the Hospice's approach to education and all forms of training. Chaired by the Joint CEOs, it meets every 3 months. Its membership includes the Joint CEOs, the Clinical Director, the Head of HR, the Practice Development Team, the Inpatient Unit Sister, the Clinical Standards and Project Lead, the Community Services Team Manager and the Education Secretary. Standing items for this Committee include Funding Streams, Course Take Up, Course Applications, Induction Training, Mandatory Training and Course Provision.

Drugs & Therapeutics Committee

The Hospice's Drugs & Therapeutics Committee steers the Hospice's approach to drug and therapeutic governance. Chaired by a Hospice Palliative Care Consultant, it meets every 4 months. Its membership includes the Joint CEOs, Consultants in Palliative Medicine, medical prescribers, non-medical prescribers, the Inpatient Unit Sister, the Community Services Team Manager, the Practice Development Team, the Clinical Pharmacist, the Chief Pharmacists for both Sutton and Merton Clinical Commissioning Groups (or designated representative) and the Head of Quality and Improvement. Standing items for this Committee include Safe CD prescribing & administration, Guideline/Policy updates, Therapeutic Governance including cost trending, Medication Incident Review, Non-medical Prescribing and MHRA Drug & Device Alerts.

Health & Safety Committee

The Hospice's Health & Safety Committee steers the Hospice's approach to health and safety and supports the communications of 'Works' updates for the site. Chaired by the Head of Quality and Improvement, it meets every 2-3 months. Its membership includes the Facilities Manager, the joint CEOs, the Clinical Director, the Director of IT and Facilities, the Clinical Standards and Projects Lead, the Community Services Team link nurse, the Housekeeping Manager, the Head of Income Generation, Retail Area Management and both clinical and non-clinical link staff for Health & Safety. Standing items for this Committee include Health & Safety Management Update regarding H&S legislation/practice development, Compliance with Audit Recommendations, Policies & Risk Management, Water Quality and Management. Non-clinical Accident & Incident Review, Works Update, Health & Safety matters affecting staff, volunteers, systems and the environment.

Infection Control Committee

The Hospice's Infection Control Committee steers the Hospice's approach to infection control. Chaired by a Consultant Microbiologist from the local acute Trust, it meets between two and four times per year. Its membership includes the Joint CEOs, the Clinical Director, a Palliative Care Consultant, the Clinical Standards and Projects Lead Nurse, the IPU IC link nurse, the Practice Development Team, the Facilities Manager, the Head of Quality and Improvement, the Housekeeping Manager and representation from St Helier IP&C Team. Standing items for the Committee include Infection Control Issues, Sharps Injury & Body Fluid Exposure, Alert Organisms Surveillance, Water Management, Occupational Health Update and Regulatory/Best Practice Requirements.

3.2.1 Clinical Audit

During 2021/2022, the Hospice undertook a number of clinical audit projects, amongst which were:

Project	Results/Actions/Comments
Prescription Chart Documentation	Weekly audit by the Hospice's Clinical Pharmacist shows 193 charts assessed in 2021/22 (c.f. 276 in 2020/21) comprising 3171 prescription items (c.f. 4779 in 2020/21) and a respective evident prescription writing and error rate of 0.9% (c.f. 0.2% in 2020/21).
Hospice @ Home Carer/Relative Satisfaction	2021 results continue to show that 100% of respondents would recommend St Raphael's Hospice @ Home service with particular regard for how 'very' helpful the service had been across a range of criteria that includes comfort measures, emotional support, face to face advice, telephone advice during the day and night, respite sits, enabling the patient to stay at home and dealing with a crisis. Survey design will be reviewed and revised in 2022.
IPU -Discharge Letter Re-audit	<p>We are meeting all the standards set out by the SIGN discharge document template except for documenting whether a copy has been given to the patient.</p> <p>This is consistent with our performance back in 2019.</p> <p>We are, as a result of the recommendations from the last audit, now routinely including a section/heading for Action required by the GP. We have incorporated within the Medication Changes section, separate headings for started and stopped. And despite this not being a requirement from the SIGN guidelines, as per our previous recommendations, we now include a review of ACP discussions held whilst on the IPU (DNA CPR status, PPC/D, CMC).</p>
Admissions Clerking	<p>While only 64% of patients arrived before 3pm, 96% did arrive by 6pm with only one very late admission at 00.45 during the audit period. With a drive for 24/7 access to specialist palliative care as the gold standard, the hospice service may need to adapt ways of working to allow for this.</p> <p>The average time taken to admit a patient to the IPU averages at 1 hour 30 minutes, highlighting the complexities of this patient group and the time and care they and those important to them need. Having adequate staffing levels within both the medical and nursing team are essential for providing excellent and safe care. Given that the admission clerking is for many patients, and those important to them, their first impression of the hospice IPU, getting this part right and allowing the time needed, may make all the difference.</p>

Project	Results/Actions/Comments
DNACPR documentation	<p>This audit demonstrates evidence of good practice with regards to documentation of DNACPR decisions and discussions with patients and those important to them as part of wider conversations around advance care planning. 100% of case-note entries were compliant with case law relating to DNACPR with regards to documentation of involvement of patient, this is a significant improvement on previous hospice audits which showed only 71% compliance (2017) and 86% compliance (2018) with this standard. The clinical team show an understanding of the medicolegal requirements including when a patient with capacity is not involved in the decision-making process and clear documentation of why (i.e. high risk of psychological harm).</p>
Discharge Planning	<p>These results show that the standards for assessing for and initiating discharge conversations are currently being met. Most patients had discharge discussions less than 72 hours into their stay in line with standard 2.1.2.</p> <p>The tentative dates (of 7-10 days post admission) suggested in 2.1.2 were met in only half of the discharges. These dates were not recorded in the electronic record for any of the patients as the policy states, so this could be a contributing factor to why they were not met.</p> <p>Discharge planning is started in appropriate patients with only a small percentage having to be stopped due to deterioration, and the patients who were discharged also survived on average for a month afterwards, with no failed discharges. Most patients were stable at discharge, with suitable reasoning for discharging the unstable patients, which must contribute to the success of discharges.</p> <p>The commonest discharge destination was home, and commonest place of death was the hospice. PPD was successfully met in 89% of cases, showing the strength of advance care planning in the hospice.</p> <p>In half of the completed discharges, patients experienced delays to their leaving. The main cause of these were patient illness, then followed by administrative issues including medications not being ready, transport not being ordered in time, and care not being in place.</p> <p>In just over a third of patients where discharge was discussed there was patient or relative distress recorded. 3 of these concerned relatives not being properly informed about changes to discharge which is a failure to meet standard 2.1.13 on these occasions.</p> <p>Patients who experienced distress/ concerns were associated with longer hospice stays than the rest of the patients. This may be because patients get used to a certain level of care, which is suggested by the fact that 3 of the concerns were about the patient not wanting to leave the care of St Raphael's and worried about coping.</p> <p>Concerns were only raised on one occasion that was associated with early mention of discharge, despite the majority of patients having these discussions early. This indicates that early discussion of discharge is unlikely to be a major cause of additional patient/ relative distress.</p>

Project	Results/Actions/Comments
Safeguarding Documentation	<p>All safeguarding events raised to the LA were raised with the CQC – 100% compliance.</p> <p>70% of patients had documentation as to whether consent was gained or not from them before the safeguarding concern was raised to the local authority.</p> <p>30% had no documentation on consent or capacity.</p> <p>Of that 70%, half of the patients did not consent to the referral and 86% of those patients had a clear rationale for why not and why the safeguarding referral was still being raised.</p>
Clinical Records Documentation	<p>Consent for records to shared – specific, clear and easily visible 100%</p> <p>Report/record decisions made and rationale for those decisions 100%</p> <p>Demonstrate patient involvement in decision making where possible 100%</p> <p>All patients were able to actively participate in decision-making. 100%</p> <p>Two records gave specific detail about those who were to be included in the sharing of information, demonstrating individualised care.</p> <p>Are records objective? 100% Any opinions provided by the patient or family were surrounded by speech marks. All were to add value/context to the issue described.</p> <p>Do records contain jargon or meaningless phrases or irrelevant speculation? No – 100%</p> <p>Is third-party information relevant and appropriate? 100%</p> <p>Are they succinct? Some were wordier than others – tended to be down to the style of the inputter but 90% added value to the record. One record was unnecessarily wordy which could make identifying relevant detail more time-consuming.</p> <p>Comments: All records were informative and demonstrated compassion and sensitivity. Occasional spelling errors and one record described incorrect gender. There were some records whereby the surnames of HCPs were not included – this could make identification of those involved in the patient’s care more difficult to identify over time and therefore should be addressed.</p>
VOICES Survey	<p>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</p> <p>The information given in response to the survey supports us to improve people’s experiences of care at the end of life. Results in 2021:-</p> <p>Responses to the questions on the care and environment provided in the inpatient ward (IPU) remain overwhelmingly positive, with all respondents agreeing that help with personal care and nursing care met their requirements and all but one agreeing that the environment respected the patients’ privacy.</p> <p>Definite assertion of the adequacy of emotional support decreased to 69% from 96%.</p>

Project	Results/Actions/Comments
	<p>Definite assertion that symptoms other than pain in the IPU had been definitely or to some extent relieved has maintained at 100%.</p> <p>Pain relief in the IPU, reported to have been relieved completely, 'all of the time', has increased to 63% from 54%.</p> <p>Keeping family members always informed of the patient's condition was considered met for 81% from 90%.</p> <p>Always treating patients with respect and dignity was considered highly for both doctors and nurses at 90% from 100% for nurses and at 90% from 97% for doctors.</p> <p>A significant decrease in the numbers that considered they had definitely received enough emotional support – 45% from 90%.</p> <p>Respondents were asked to rate care given to the patients by doctors and nurses on admission to the IPU. Taking 'exceptional' and 'excellent' together there is a decrease to 91% from 97% for doctors and a maintained level of 100% for nurses.</p> <p>Regarding the food provided on the IPU in 2020, 'exceptional' and 'excellent' ratings combined decreased to 45% from 57%.</p> <p>Overall, care provided by the Community Palliative Care Team was considered as either 'Exceptional', 'Excellent' or 'Good' by 96% from 97% in the previous bi-annual report.</p> <p>The proportion of respondents that considered contact from the bereavement team was either definitely helpful or helpful to some degree has decreased to 51% from 59%.</p> <p>Responding to the Friends & Family question, 90% rated the hospice as either 'Very Good' or 'Good' (c.f.95%), 6% 'Neither Good Nor Poor' (c.f. 0%) and 2% rated it as either 'Poor' or 'Very Poor' (c.f. 2%). 2% did not know the answer to this question (c.f. 4%%).</p>

Risk Management

Project	Actions
Non-patient Accidents & Incidents	100% of reported non-patient accidents or incidents showed evidence of action taken consequential to occurrence. The number of reported non-patient accidents has increased in 2021 owing to the introduction of the electronic reporting system. There were no non-clinical incidents nor accidents that required report to the CQC in 2021/2022.
Clinical Incidents & Near Misses	An increase in reported incidents in 2021 across all incident areas reflected a recovery from the effects of the pandemic had on admissions to the IPU. In 2021, medication incidents constituted 40% of all clinical incidents (c.f. 24% in 2020 & 38% in 2019). The patient fall rate per 1000 bed days is 8.08 (c.f. 8.45 in 2020/21 & 5.48 recorded in 2019/20) and injurious falls in 2021 is 3.03 (c.f. 2.11 per 1000 occupied bed days in 2020/21 & 1.56 in 2019/20).
CQC notifications	In 2021 there were 10 pressure area and 19 safeguarding notifications made.
Continuous Improvement Log	In compliance with information governance requirements to log information incidents. 10 incidents were logged in 2021.
Subject Access Requests or Requests made under the Health Record Act 1990	There were 5 access requests made under the Health Record Act 1990.

3.2.3 Clinical Effectiveness

Clinical policy and guidelines are incorporated into the central system of policy document management. As with all policy, review lead ownership is attributed to individual members of the multi-disciplinary team.

There were 54 clinical policy/guideline reviews in 2021/22:-

CLINICAL	TITLE	ISSUE DATE
CLIN02	Care after Death	17/09/2021
CLIN03	Clinical Audit Policy	28/03/2022
CLIN06	Wellbeing Centre Operational Policy	18/01/2022
CLIN08	Infection Control	15/07/2021 23/09/2021 06/01/2022
CLIN09	Referral to Hospice Services	17/05/2021
CLIN11	Resuscitation Policy	06/12/2021
CLIN12	Safeguarding Children	24/09/2021
CLIN14	Safeguarding Adults	24/09/2021
CLIN17	Management of Patients with Enteral Catheters and Feeding Systems	27/09/2021
CLIN21	Anaphylaxis Management	04/10/2021
CLIN24	Diabetic Management	01/11/2021
CLIN25	Controlled Drugs	20/01/2022

CLINICAL	TITLE	ISSUE DATE
CLIN26	Generic Drugs	21/01/2022 15/03/2022
CLIN31	Mouth Care Guidelines	18/01/2022
CLIN33	Nutrition and Hydration Guidelines	01/04/2021
CLIN34	Non-medical Prescribers' Policy	01/04/2021
CLIN45	Wound Management Guidelines	25/05/2021
CLIN47	Being Open (Duty of Candour) Policy	20/01/2022
CLIN48	Community Services' Operational Policy	02/03/2022
CLIN51	Hospice Neighbour Scheme Operational Policy	17/06/2021
CLIN52	Managing Covid 19	11/05/2021 20/05/2021 06/07/2021 31/08/2021 29/09/2021 16/11/2021 07/12/2021 27/01/2022 21/02/2022 09/03/2022
CLIN57	Community Guidance on Injectable Medications for Symptom Control at the End of Life	04/05/2021
CLIN57a	Flow Chart for Community prescribing at the end of life	04/05/2021 18/10/2021
CLIN59	Prescribing Palliative Oxygen	12/10/2021
CLIN60	Subcutaneous Administration of Levetiracetam (Keppra)	08/10/2021
CLIN61	Prescribing Guidance for Methadone in Pain Management	11/10/2021
CLIN62	Clinical Supervision	22/03/2022
CLINSOP01	Inpatient Multidisciplinary Team Review	28/02/2022
CLINSOP02	Medical Team On-call	18/10/2021
CLINSOP04	Inpatient Unit Shift Coordinator	28/02/2022
CLINSOP05	Inpatient Unit Weekend or Bank Holiday Coordinator	28/02/2022
CLINSOP08	Using Phase of Illness and the Australian Karnofsky Performance Scale Index – integrating OACC step 1	05/05/2021 12/10/2021
CLINSOP09	Safe and Secure Management of NHS Prescription Stationery	25/05/2021 29/11/2021
CLINSOP10	Emergency transfer of medicines between Princess Alice Hospice and St Raphael's Hospice	14/06/2021
CLINSOP11	Aerosol Generated Procedures – Visiting Patients in the Community	23/06/2021
CLINSOP12	On-call Specialist Palliative Care Practitioner or CNS for CPCT	03/08/2021
CLINSOP13	Second On-call Specialist Palliative Care Practitioner or CNS for CPCT	03/08/2021
CLINSOP14	Admitting prisoners to the IPU	24/01/2022
CLINSOP15	Rapid Discharge Home from the Hospice for EOLC	28/03/2022
	Guidance for Prescribing and Administration of Continuous Subcutaneous Infusion Furosemide for Adults with End Stage Heart Failure in the Community	22/07/2021

Education is an on-going activity and is vitally significant to the care delivered at St Raphael's. There is a considerable amount of formal and informal clinical education usually delivered across all service areas. The pandemic affected the usual delivery of education as it required the re-direction of resources and an additional responsibility for infection control. Mandatory training remained a priority in 2021/2022. Whilst not an exhaustive list, the clinical training delivered in 2021/2022 included:

Clinical team training:

- Non-Medical Prescriber Update
- Manual Handling
- PPE training
- Fit testing
- Advanced Communications training
- Equality, diversity & inclusion
- OACC
- Psychology of Death & dying
- Infection Control updates

Nursing team training:

- Simulation training- anaphylaxis
- Heart failure
- Registered Nurse Verification of Adult Expected Death
- Tracheostomy care
- Safeguarding
- HCA second checker of controlled drugs
- Clinical skills for HCAs
- Difficult conversations in Palliative Care
- Placement of nasogastric tubes
- Stoma Care
- SBAR
- Clinical assessment and history taking
- Introduction to clinical audit
- Symptom control
- Palliative Care Emergencies
- Competencies

Medical team Journal club presentations:

- Patients' and carers' perspectives of palliative care in general practice: A systematic review with narrative synthesis
- Practice review: Evidence-based quality use of corticosteroids in the palliative care of patients with advanced cancer
- Incivility in the work place: A randomised control trial
- Severe and Enduring Anorexia Nervosa in the Court of Protection in England and Wales
- Racism in Palliative Care
- Antibiotic use towards the end of life: development of good practice recommendations
- Examining antidepressant use in palliative care patients by risk of antidepressant discontinuation syndrome
- Funding in palliative care
- Saint Raphael through the history of art
- Exploring communication difficulties with deaf patients
- Reflection on working in the community – BMA essay competition 2016 'Lessons from a good death' (at home)
- Loperamide: an emerging drug of abuse and cause of prolonged QTc
- Advanced decisions, directives and video advanced directives
- Including sustainability in QI projects
- Top 10 tips on psychosocial and family support
- Train the trainer simulation
- MDU cautionary tales 2021
- OACC
- Guildford Course feedback
- Transgender experiences with end of life care
- RMH study day - Palliative Care update video: Compassionate cultures for compassionate care
- Spiritual distress: symptoms, quality of life and hospital utilisation in home-based palliative care/ Ciptas et al BMJ Supp & Pall Care 2021; 11: 322-328
- Mortality Meeting Audit
- Whistle blower: Pfizer's vaccine trial
- Corneal donation
- MDU webinar: Conflict resolution
- NSAIDs and GI tract
- Diamorphine for pain and distress in young patient case examples and discussions on mechanisms
- Joint Audit presentation meeting: IPU Mortality meeting and Admissions to the IPU
- Conversations about assisted dying

Training for external healthcare professionals:

GP Masterclass- delivered by medical team

- Introduction to St Raphael's hospice and specialist palliative care
- Advance care planning
- Neuropathic pain
- Lesser known symptoms in palliative care

Virtual PACEs teaching for junior doctors in SW London fortnightly

“Talking about dying” afternoon seminar to GPVTSs in SW London

Foundations of Palliative Care- delivered by the education team

- What is palliative care
- Understanding prognosis
- Recognising dying
- Common symptoms at end of life
- Common medications at end of life
- Non-pharmacological interventions at end of life
- Syringe pumps- indications for use
- Syringe pumps and Saf T Intima devices – practical workshop

Education team attendance at the careers fair at a local secondary school and gave a presentation on nursing within the palliative care sector



3.2.4 Mandatory Training

Whilst the importance attached to clinical education is particularly high, all staff at St Raphael's and volunteers undertaking specific roles are required to undertake mandatory training. E-learning across the required mandatory training is complemented by 'hands-on' training as the topic requires. Training effected in 2020/2021 included the following topics:

- Allergy awareness
- Basic Life Support including anaphylaxis practical
- Basic Life Support theory
- Confidentiality & Information Governance
- Dementia Awareness
- Duty of Candour
- Equality & Diversity
- Falls Awareness
- Fire Safety
- Health, Safety and Welfare
- Infection prevention & control for clinical staff
- Infection prevention & control for non-clinical staff
- Introduction to safeguarding
- Lone Worker
- Manual Handling of objects
- Manual Handling practical for clinical staff
- Medical Gases
- Mental Capacity Act & DOLS
- Safeguarding level 2 & PREVENT for clinical and specified staff
- Safeguarding level 3 for specified staff only

3.2.5 Clinical Research

See 2.4.

3.2.6 Complaints Management

In 2021/22, there were 12 complaints received: 7 written and 5 oral complaints. All have been investigated by a member of the Executive and reviewed by the Hospice Board of Trustees. All complaints received in 2021/22 have been closed.

3.2.7 User Feedback

There are multiple feedback routes for patients, their carers and relatives. Routine surveys:-

- Inpatient Satisfaction
- Bereaved Carer/Relative Survey (VOICES)
- Hospice@Home Service Carer/Relative Survey

Feedback on the services provided and experienced is regarded highly at St Raphael's. User feedback is embraced as a spoke of the continuous quality improvement that the Hospice seeks to achieve. Actions arising from feedback either through survey or other route continue to inform plans amongst which are service re-design, development of literature, policy and stewardship arrangements alongside improved forms of communication and engagement.

3.2.8 Information Governance

Compliance with the NHS Digital Data Security and Protection Toolkit supports St Raphael's in its commitment to respect the confidentiality, integrity and availability of its information. There is an annual responsibility for the Hospice to ensure that evidence of compliance is accurate and up to date. Consequential to the Hospice's adequate demonstration of its compliance with the NHS Digital Data Security and Protection Toolkit is its facility to engage with the electronic Health and Social Care Network. With the patient's consent, engagement with the Urgent Care plan allows for the secure inputting of patient identifiable data on to the patient electronic care record at the end of life.

3.2.9 The National Minimum Dataset

Public Health England withdrew its support for the national minimum dataset (MDS) of anonymised and aggregated patient data that represents Hospice patient level activity in March 2017. The National Council for Specialist Palliative Care and Hospice UK merged in July 2017 and regard collection of the MDS as useful. Hospice UK continued to receive and share the MDS and the Hospice last received and serviced request for a mini-MDS dataset submission in October 2019.

3.2.10 Organisational Development

St Raphael's Hospice was established in 1987 and was operated by the Congregation of the Daughters of the Cross of Liege until 31 October 2020, at which point it became its own independent charity. The Hospice provides all support services which enable the delivery of its person-centred specialist palliative and end of life care to the boroughs of Merton and Sutton.

Organisational development is very much part of the management plan for the Hospice as it builds its independent identity and strives towards achieving its strategic vision. By delivering excellence across all our services we aim to raise the hospice profile and thus provide assurance to our community and external stakeholders upon whom we depend to raise funds, that the hospice will be there when needed to provide expert, compassionate specialist palliative and end of life care.

3.3 Who has been involved in the creation of this Quality Account?

The Quality Account was compiled by the Head of Quality and Improvement.

Extensive consultation with managers constitutes the annual management planning process that feeds into the Quality Account.

The Quality Account has been derived from the management planning process and the business of the Hospice's governance committees.



**MINUTES OF THE
INFECTION CONTROL COMMITTEE**

**Held on 10th May 2022
at St Bede's Conference Centre and via Zoom**

Attendance	
(Dr JS) Dr J Stephenson, Consultant Microbiologist -SHH, SSAH (Chair)	(TY) T Young – Clinical Standards and Projects Lead Nurse / IC Lead
(GL) G Linehan – Joint CEO	(NS) N Stevens – Joint CEO
(RT) R Trower – Clinical Director	(MF) M Flint – Practice Educator
(AR) A Rudkin – Quality (Minutes)	(SC) S Cresswell – Facilities
(SL) S Leech – IPU IC Link HCA	(PD-P) P Di-Palma – Housekeeping
(JS) J Smith – CNS - Community Link Nurse for IC	(CF) C Foster - IPU IC Link Nurse
(SN) S Njanike-Nyadzo - SHH IPC	(PK) P Kubalalika – SHH IPC

Apologies	None
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ITEM 1: Welcome

JS extended welcome to all present and everyone introduced themselves.

ITEM 2: Apologies for Absence

Apologies as listed above.

ITEM 3: Minutes of the last meeting held on 09 November 2021

3.1 These were accepted.

ITEM 4: Matters Arising

4.1 FFP3 Masks – two different models in use. Fit testing training cascaded. IPU can receive patients receiving AGPs.

ITEM 5: COVID-19 Update

Vaccination : Really good uptake on last round of vaccinations. Undecided on need for 4th dose.

Testing : Meeting held with PK and path forward agreed. Reduced testing to twice weekly LFD for patient facing roles. LFD testing for all admissions and if symptomatic.

Staffing : Fluctuating effect but very few staff are currently affected

PPE : No supply issues. Stock levels are good.

Action

ITEM 6: SHH SLA

- 6.1 JS expressed how pleased he was that a SLA with SHH had been put in place. The SLA is for one year (renewable) and commenced on 1st April 2022.
- 6.2 PK has visited SRH and undertook an unannounced inspection last week and baseline report is expected by mid May.
- 6.3 TY is the SRH IC lead and will be accessing additional training over the next few months.
- 6.4 There has been really good collaboration between SRH and SHH and there was shared expression of how excited we all are in working together.

ITEM 7: IC Incidents / Sharps Injuries / Body Fluid Exposures / Audit

- 7.1 Nil Sharps and nil incidents to report.
- 7.2 Regular infection control audit is undertaken by IC link staff across the IPU and Community and fed into the Quality Office.
- 7.3 Review of 6 patient incidents of diarrhoea on the IPU at the same time in March established one case of C-Diff. The incidents were coincidental rather than an outbreak. A review of pathology/microbiology service provision is required. RT/TY
- 7.4 No sharps injuries. Monthly auditing of Sharps bins in place.
- 7.5 No body exposure incidents. Vigilance continues.
- 7.6 Annual audit of IC to be incorporated into program. PK's baseline audit didn't show anything out of the ordinary. Some concern over dust build up on radiator grills in patient rooms that requires quick action and flowers in patient rooms. TY expressed how a good deal of what was verbally expressed at time of baseline audit has been addressed. Baseline Audit report awaited. TY/AR
PK/TY
- 7.7 JS reflected on flowers in patient rooms and urged a pragmatic approach given they have a positive effect on the environment and individual well-being. Feelings expressed urged pragmatism, risk assessment and comprehension of what is accepted practice regarding flowers and their management in other Hospices. PK advised that she was a little less comfortable in allowing flowers (in the same fashion as they are not permitted in Hospital) especially if flower water is disposed of using patient sinks. GL expressed her experience of never knowing of an incident of infection owing to flowers and also gave support for a holistic approach that is supportive of well-being. TY

ITEM 8: Alert Organisms Surveillance

- 8.1 Apart from the one case of C-Diff as already mentioned, nil to note.

ITEM 9: Water Assessment and testing

- 9.1 Water Quality is routine agenda item at the Hospice's Health & S Safety Committee.
- 9.2 Water Treatment and Testing company -HSL Compliance - have addressed the issues that reduced their visits in the mid part of last year and undertook monthly site testing in Jan, Feb and Mar of 2022 with all clear results. Chlorine dioxide levels recorded within our system are lower than the recommended range and this is due to the plant/equipment that requires upgrade. Upgrade is being sourced by Facilities.
- 9.3 Flushing regimes are undertaken by Facilities and Housekeeping staff and are set out in the Hospice Water Management Policy.
- 9.4 The Hospice's Water Risk Assessment was undertaken by HSL in January 2022 and report received in March 2022. Facilities are taking forward required actions.

ITEM 10: Any Other Business

- 10.1 Antimicrobial stewardship : JS is happy to help.
- 10.2 Standing reminder that there is an Infection Control folder on the network drive at [N:\Infection Control](#)
- 10.3 Everyone is encouraged to attend the next meeting in person if they can. Zoom will be available also.

ITEM 11: Future Dates

- 11.1 Dates of future meetings:

Date	Event	Venue/Time
TBA September 2022	ICC Meeting	St Bedes + Zoom / TBA

Meeting: Clinical HODs Meeting			
Date: 09.05.22		Time: 13.30	
Chair : Rebecca Trower - RT		Minutes: Lynn Jackson	
Present: Tracy C, Dr Jenny Strawson, Laura Briant, Maura Flint, Steve Molyneux , Dr Gaby Tamara-Rose, Alex Rudkin, Dr Naomi Collins, Rebecca Wallis			
Apologies: Tracey Young			
Agenda item	Discussion	Actions & by whom	Anticipated date for completion
Review of previous minutes	Accurate		
Matters Arising	Welcome to new Ward sister RW		
Topic			
Infection Prevention	<ul style="list-style-type: none"> ➤ SHH Infection control Support - Prodine carried out an unannounced visit – all went well. Prodine said no artificial flowers/plants to be in the IPU rooms due to dust risk & no flowers or plants to be in IPU rooms due to requirement of daily water changing AGP SOP to be reviewed CLIN 52 – Coronavirus policy – updated as appropriate to Government guidelines Yellow/black strippy bags to be used & large bin collection to be collected more regularly Training Course for TY to support her new role as Clinical Standards Lead TBA 	<p>Prodine, TC, TY, IPU</p> <p>Prodine, TC, TY</p> <p>RT, TY</p> <p>Housekeeping, JG, Facilities</p> <p>TY, Education, RT</p>	<p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>
Medical Devices	<ul style="list-style-type: none"> 5 syringe pumps have been sent for repair – no return yet? McKinley SP Policy to be written/amended when necessary Mercel SOP & training TBA CPCT – Purchase of equipment required e.g SAT machine, thermometers, stethoscopes etc 	<p>JG to follow up</p> <p>TY,AR</p> <p>Education</p> <p>TC, Education</p>	<p>June 22</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>

Medicine Management	<p>Yearly stocklist review – IPU</p> <p>Ashtons – Pharmasist has changed, contract updated & issues to be raised in planned June meeting</p> <p>Second checkers = 1 x IPU competencies to be completed</p>	<p>TY/Staff</p> <p>RT, RW,</p> <p>IPU, Education</p>	<p>June 22</p> <p>Ongoing</p> <p>June 22</p>
Incidents & Accidents/RCA's	<p>Datix March/April spike due to IPU Diarrhoea</p> <p>Less reported medication errors than last year</p> <p>“Make a Difference” (MAD) alerts – TC raised 2 with regards 1 x non collection of hospital bed from patient home 1 x length waited for a Verification of Expected Death</p>	<p>AR, IPU</p> <p>AR</p> <p>TC , CPCT</p>	<p>April 22</p> <p>April 22</p> <p>April 22</p>
Complaints & Compliments	<p>SRH have had lots of compliments, please feedback to AR for addition to excellence file</p> <p>Rt dealing with 1 x complaint</p>	<p>Staff, AR</p> <p>RT</p>	<p>Ongoing</p> <p>May 22</p>
Health & Safety	<p>Mandatory training – delays from PAH will relaunch in June</p> <p>Level 2 Safeguarding Children to be completed by clinical staff</p> <p>Risk assessment updates to be sent to AR</p> <p>IPU link is now Philomena</p> <p>Heather & Abi have been trialling new noise reduction head sets. Feedback from both them & patient/carers is extremely good. Cost £100 per set. 8 sets would be required for CPCT office. JG to look to purchase 2 for Triage & TC will request funding from fundraising to purchase other 6 sets</p>	<p>All staff /HR</p> <p>Clinical staff, Education, RW</p> <p>IPU, CPCT,RT</p> <p>TC, CPCT, JG, Fundraising</p>	<p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>
New Policies/ Guidelines	<p>Clinical supervision trainer for IPU HCA's is being sought</p> <p>Disaster Recovery Policy –completion of policy & SOP to be done</p>	<p>RT</p> <p>RT/TC/TY</p>	<p>Dec 22</p> <p>Ongoing</p>

Documentation/ Crosscare	<p>EPR systems - EMIS is to be introduced within 1 year . PAH gave a talk to SRH about usage of system. Prior planning is required with regard training & Contract agreements</p> <p>CMC is being replaced by Urgent Care Plan – UCP. Training will be needed by staff</p>	<p>JG/RT</p> <p>Clinical staff, JG</p>	<p>Ongoing</p> <p>July 22</p>
Audit/Research	<p>AR Thanked Medical team for their audit feedback</p> <p>Medical Team – Juniors have been allocated.</p> <p>Equality & diversity audit is being carried out by Dr Busi</p> <p>Dr Naomi informed CHODS that SRH has been accepted by Royal Surrey as one of 80 sites in the research of Clinically Assisted Hydration at End of Life Study.</p>	<p>JS,GTR</p> <p>Dr Busi, AR</p>	<p>Ongoing</p> <p>Ongoing</p>
Education/Training Reflective Forums	<p>HCA's training day to be arranged re completion of competencies</p> <p>Journal Club moved to Thursdays in the Orangery</p> <p>Learning Zone launch – 1st June TBC</p> <p>Clinical Induction meetings to be standardised?</p> <p>Foundations in Palliative care TBA</p> <p>Nurses day celebrations to be held</p> <p>LB, MF held presentation at Roehampton University for student nurses</p> <p>CYRO/ Caldicott training TBA</p> <p>Documentation/Narrative training is expensive – To be further investigated</p>	<p>LB/MF</p> <p>LB,MF, Staff</p> <p>LB/MF</p> <p>LB/MF/ RT</p> <p>LB, MF</p> <p>LB, MF, Nurses</p> <p>LB, MF</p> <p>RT</p> <p>RT, LB,MF</p>	<p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>12 May 22</p> <p>Ongoing</p> <p>Ongoing</p>
Recruitment/ Staffing	<p>IPU – Ward Sister RW started her secondment -1st May TY started her new role as Clinical Standards Lead 1st May</p> <p>CPCT Band 6 dev. Post Locality 3 - Katie starts on 23.05.22 Band 7 Locality 2 Beverley starts 30.05.22 Naomi Stammers takes over role of Locality 3 lead from RW H@H – Mansi STARTS 10.05.22</p>	<p>TC/HR</p>	<p>May 2022</p>

	<p>IPU – Sylvain RGN has started 2 days per week Vacancies = 5</p> <p>SM is due to interview 17.05.22 for P/T councillor</p>	<p>RW, RT, HR</p> <p>SM/HR</p>	<p>Ongoing</p> <p>May 22</p>
CQC/PIR	No known inspection date but likely to be over the coming months		
AOB			
	<p>AM & PM Admissions meetings are working & they are allowing for IPU admissions to take place in a timely manner planning.</p> <p>IPU are now open to 10 beds</p> <p>Organ Donation – CPCT Rebecca Lucas is Organ Donation Champion along with Education LB & MF</p> <p>Priorities of The Dying Person – TC liaise with SHH – 5 priorities - ? how they fit into CPCT</p> <p>MANAGEMENT PLAN was discussed with CHODS Priority items identified EMIS – development/transition/training & embed</p> <p>OACC – CsNAT – H@H/ WBC/ Compassionate neighbours</p> <p>Carer administration of sub cut medication training – meeting TBA</p> <p>Infection Control in Home</p> <p>Datix - Compliments & complaints set up</p> <p>Consultation room to be set up on outlook diary & crosscare</p>	<p>CPCT/IPU/ Medical team</p> <p>TC, SHH</p> <p>All Staff</p> <p>JS/GTR/ TC</p> <p>TC</p> <p>AR</p> <p>IT/JS</p>	<p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>March 23</p> <p>March 23</p> <p>September 22</p> <p>March 23</p> <p>March 23</p> <p>May 22</p>

Date next meeting: MONDAY 30th May 2022

**MINUTES OF THE
DRUGS & THERAPEUTICS COMMITTEE
Held on 9th March 2022
in St Bedes / Zoom**

Attending

(Dr JS) Dr Jenny Strawson, Hospice Palliative Care Consultant / Chair	(HT) Hai To - Sutton CCG Care Home Pharmacist
(NC) Dr Naomi Collins - Hospice Palliative Care Consultant	(TY) Tracey Young - IPU Manager
(JS) Jill Smith - CNS, NMP	(S-AB) Sally-Anne Bowen - Ashton's Pharmacist
(BD-S) Dr Busi Da Silva - Hospice Doctor	(PH) Philomena Hutchinson - IPU Senior Nurse
	(AR) Alex Rudkin - Head of Quality and Improvement / Mins

ITEM 1: Welcome

1.1 JS extended welcome.

ITEM 2: Apologies for Absence

(RT) Rebecca Trower – Clinical Director, (Dr GT-R) Dr Gaby Tamura-Rose, Hospice Palliative Care Consultant, (LB) Laura Briant – Practice Educator, (TC) Tracy Christmas – Community Services Manager NMP, (RC) Rachel Clingan – Registrar, (KH) Kevin Hobson - CNS NMP, (BG) Bernadette Griffin -CNS, NMP

ITEM 3: Minutes of the Last Meeting

Minutes of the last meeting held on 17th November 2021 were agreed.

ITEM 4: Matters Arising

- a) A review of the adequacy of the IPU medication chart design is being led by Dr BD-S medical team. It is understood that very few Hospices have moved to electronic medicine prescribing charts but it remains on our radar.
- b) HT confirmed receipt of Hospice copy re Guidance on Keppra via CSCI. Chief Pharmacist will feedback any comments if required.
- c) Leaflet on 'Just in Case' medications is with the Communications team for production. AR
- d) S-AB will send on a list of training topics that Ashton's provide. S-AB
- e) AR will send on copy to Ashton's of the Hospice's CLIN24 Diabetic Management Diabetes Policy. AR
- f) Lesley Spencer / Becca Trower meeting outcome update deferred. TY expressed how that, on occasion, TTOs order are sometimes incomplete. This is being monitored. S-AB advised that all packaging used by Ashton's is 100% recyclable and the amount used is to ensure safety of the product in transit. TY will send on to S-AB the Hospice medication stock list. S-AB advised that a permanent Pharmacist for RT
TY

SRH will commence in April 2022.

- g) Permissibility for the Hospice IPU to dispense medication for a community patient in an emergency will be followed up by HT with Sarah Taylor. HT

Addendum to Minute : 21st March 2022 : Advice received from HT: At DTC I was also asked to look into if IPU at St Raphs can dispense medications for patients to take home in emergency, I would like to confirm this is not possible as St Raphs IPU is not a licensed pharmacy/dispensing unit.

- h) RT to share the costs of medication information that Ashton's supplies with the medical team in order to increase awareness of any cost differentials across medications and their preparations. RT

- i) The capture of any medication prescribing nuances in SRH medication policy remains to be done. Medical Team to relay required updates to review leads. JS / RT & MF

Addendum to Minute : 21st March 2022 : Advice received from HT: Having had discussion with Sarah Taylor (chief pharmacist for Sutton), I would like to confirm that octreotide and Levvetiracetam injection are both hospital only drugs for SWL as they are specialist medications, hence the prescribing needs to be retained by specialists to ensure safe prescribing. Therefore, GPs should not be asked to prescribe. Should long term prescriptions required St Raphs team can use FP10 to prescribed for patients in community.

ITEM 5: Use of Oxycodone Concentrate

Discussion regarding oxycodone concentrate and possible increased risk of administrative overdosing in the Community if discharged on it. S-AB advised she was constructing an information leaflet for families on it.

S-AB

ITEM 6: Pharmacy Update

Errors remain really low. Documenting the max strength on PRN side can be improved.

ITEM 7: Update on medication policy review

7.1 There have been 3 published updates/revisions to medication policy / guidance since the last meeting between 17 November 2021 and 9th March 2022:-

- [CLINSOP09 Safe and Secure Management of NHS Prescription Stationery.pdf](#) issued 29-11-2021
- [CLIN25 Controlled Drug Policy.pdf](#) issued 20-01-2022
- [CLIN26 Generic Drugs Policy.pdf](#) issued 21-01-2022

7.2 Medication policy / guidance overdue for review are:-

CLIN18 Syringe Driver Policy (McKinley T34) IV Administration – T Young lead
CLIN27 IV Administration
CLIN 58 Use of MAAR Chart for s/c and i/m meds in the Community
CLIN57 Community Guidance on Injectable Meds for Sympton Control at EoL and Flow Chart

TY
MF
TY
JS &
GT-R

ITEM 8: Serious Medication Incidents

8.1 There have been no serious medication incidents for review.

ITEM 9: Update on CAS/MHRA Alerts

9.1 All CAS/MHRA alerts are logged on our register at <N:\Governance\Central Alerting System\Register of Alerts>.

9.2 There have been no alerts relevant.

ITEM 10: Any other business

JS posed question as to whether GPs can prescribe Ondansetron. HT advised that she believed it was Hospital-only and was not approved for primary care but she would check. She reflected that it was an old drug and there may well be more modern alternative available. Its not a first line medication. Some GPs would re-prescribe even though its not on the list.

HT

JS highlighted the shortage in levomepromazine (for injection) a few weeks ago. Supply is not a problem in the Community currently.

HT advised that SHH formulary is available on-line. She will forward her e-mail address to S-AB.

HT

The use of FP10s on the IPU is increasing but there was assurance that FP10s are not being used to duplicate orders that are missing medications.

ITEM 11: Future Dates

11.1 Dates of future meetings in 2022

Date	Event	Venue/Time
Wed, 29 th June 2022	Drugs and Therapeutic Committee	St Bede's & Virtual 15.15

Meeting: Falls Meeting	
Date: 13/12/2021	Time: 11.15
Present: Alex Rudkin (AR- Chair, mins), Paula Julie Di Palma (PJD-P), Maura Flint(MF), Tracey Young (TY)	
Apologies: Gwynne Hawden (GH), Steve Cresswell(SC), Ginny Toubal(GT), Becca Trower (RT), Dr Naomi Collins (NC)	

Agenda item	Discussion	Actions & by whom
Review of previous minutes	Meeting held 13/04/2021- agreed.	
Matters Arising	<p>SC investigated falls incident at Carshalton Shop. Rear space now has storage shed. Walking surface is acceptable.</p> <p>A replacement program of fire doors on the IPU is in hand. Potential for trialling doors with viewing windows is a consideration.</p>	SC
Topic		
Patients Falls Statistics	<p>AR presented falls data up to October 2021. Non-clinical falls remain very low.</p> <p>The IPU fall rate per 1000 occupied bed days has risen greatly in Q2 2021/22 to 49.77 in context of an annual rate of 8.45 in 2020/21. This peak is due to the one patient in September 2021 who had 10 falls. Patient had full cognitive understanding that his mobility is compromised by his condition and he is at high risk of falling. Respecting patient wishes supported by access to required equipment and information.</p> <p>Patient incidents showed independence being dominant causative factor. Individual incidents were reviewed from April 2021 – September 2021.</p> <p>Patient Falls Chart Q3 2014 – Q2 2021 Falls Jan – Sep 2021 Patient Fall Rate Graph</p>	
Feedback from Teams	TY confirmed that sensor checks are part of the shift handover checking system that is in place but is a topic that requires constant reminder to ensure they are attached and documented.	
Training and staff development	<p>Train the Trainer MH training is expected to be complete by the end of September 2022 for Sam Dunstall, Maura Flint, Helen Agboola and Alison Fallows (Community). MF shared that training numbers are now looking better and FtF training is being worked through either individually or in small groups on the IPU: c60% clinical compliance and a higher % in eth community.</p> <p>Manual Handling Training remains part of the mandatory suite under the PAH Learning Zone.</p>	MF
AOB	None	

Date next meeting: Date TBA in July 2022 (Oct 2021-Jun 2022 review period)

Prescribers Meeting 29th March 2022

Minutes

Present – Kevin Hobson, Tracy Christmas, Jill Smith, Bernadette Griffin, Lorraine Jeffries, Kim Smith, Dr. Rachel Clingan, Dr. Busi De Silva, Angie Redpath

Previous meeting minutes reviewed and agreed

Community Prescribing

- All shared recent prescribing experiences. Tendency to be Friday / weekend prescribing.
- Some G.P. practices are still using templates for S/C charts. This is not good practice as all charts should be individualised to each pt.
- Anticipatory SD charts should only be written if expected to be needed – with clear rationale for commencing. Authorisation charts for prn s/c meds should be completed in first instance.
- D/N NMP's are not prescribing as much as expected and have a wider scope of practice. They may need support from hospice team when prescribing EOL meds. Invitation to join Prescribers meeting can be extended to D/N prescribers - Kevin will pursue.
- Dr. Clingan will complete examples of prescription writing for reference
- PACT data still showing wrong info re one of Jill's prescriptions – Jill will contact Sarah to try to clarify situation
- Kevin will try getting PACT data for Merton
- It is noted that some hospitals have been discharging pt's with anticipatory s/c meds without anti-emetics as it is felt these are less likely to be used. It currently remain hospice policy to include anti-emetics in anticipatory prescribing.

MAAR charts

- New revised charts going live from 1.4.22
- Tracy will check and let team know

Education

- Prescribers update day – virtual conference “Non Medical Prescribing in End of Life Care” was attended by the hospice NMP's (Kevin will attend conference in June). Team felt it was a very good day. Kevin will forward details to Angie and Kim.
- Royal Pharmaceutical Society competency framework has been revised and updated. NMP's will have to complete by Sept 2022 in line with hospice NMP policy. Kevin will print off competencies and distribute / discuss with hospice NMP's.

- Kevin will meet with Lorraine to discuss / sign off her competencies then we can order her prescription pads!

Prescription safety

- Personal and computer log of all prescriptions maintained – do not appear to be keeping record of SD / PRN charts we are completing.
- Angie mentioned that Prescription Log book checking has been reviewed at PAH – appears to be more frequent than our current practice (currently weekly). Kevin to look into this.
- Injectable Octreotide & Levetiracetam is held or can be ordered in by community pharmacies, however continues to be prescribed by Specialists only. Dr. Jenny & Dr. Gaby are to attend Formulary Prescribing Group to discuss. NMP's will continue NOT to prescribe these drugs until issue is clarified.
- We have not had chance to explore - Audit of Non Medical Prescribing / use of FP 10's - Kevin and Busi will meet to discuss ideas.

St Raphael's Hospice
Meeting of the Clinical Quality & Governance Committee
Held at St Raphael's Hospice with video dial-in option
At 10:00am on Friday 1st April 2022

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)
 Dr Joy Tweed – Trustee & Committee member (JT)

In attendance: Naomi Collins – (NC, items 5-9)
 Gail Linehan – Joint CEO (GL)
 Nick Stevens – Joint CEO (NS)
 Alex Rudkin – Head of Quality and Improvement (AR)
 Rebecca Trower – Clinical Director (BT)
 Anna Machin – Governance (AM)

Apologies: Dr Jenny Strawson – Consultant (JS)

Actions arising

Agenda item	Action	Responsible	Timeline	Ref.
1. Welcome and declarations	Update Declarations of Interest log with Eva Kalmus' appointment	Anna Machin, Eva Kalmus	Immediate	01.04.22/01
3. Evidence of Excellent Practice Register	Consider mechanisms to capture Community team feedback	Gail Linehan	July meeting	01.04.22/02
4. Clinical Quality & Governance Report	Collate examples to demonstrate impact of audit on clinical practice	Alex Rudkin	July meeting	01.04.22/03
	Update table in Clinical Action Plan page 8 to have most recent date first	Alex Rudkin	July meeting	01.04.22/04
	Itemise Management Plan on Committee agendas and include progress summary	Alex Rudkin, Anna Machin	July meeting	01.04.22/05
	Bring together Wellbeing programme case studies	Rebecca Trower	July meeting	01.04.22/06
5. Clinical Risk Register	Review pre-control score for Agenda for Change	Rebecca Trower	July meeting	01.04.22/07
6. Clinical Quality & Governance Objectives	Share timeline for completion of key goals	Rebecca Trower	July meeting	01.04.22/08

8. Annual Review of Committee Terms of Reference	Update point 11	Anna Machin	July meeting	01.04.22/09
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Agenda items arising

Agenda item arising	Details	Responsible	Timeline
Support for younger patients	Discuss Hospice paediatric care role and levels of support that can be provided	Invite colleague lead	July meeting
Benchmarking of Safeguarding referrals vs. other local Hospices	Share update from LA feedback	Alex Rudkin	July meeting
Twilight shift cover	Update on volunteer twilight shifts	Rebecca Trower	July meeting

The meeting began at 10.00am.

1. Welcome, apologies for absence and declarations of interest

Joy Tweed took the Chair and welcomed Committee members and attendees to the meeting. Apologies were received and accepted from Jenny Strawson. It was noted that Eva Kalmus has been appointed as a lead role on End of Life at Sutton Care which would be updated in the Register of Interests.

2. Review of minutes from 14th January 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 Committee reviewed the actions arising from the previous meeting:

- Share update on equality & diversity Working Group on patient behaviour towards staff - all members had engaged and were in the process of setting up the first meeting.
- Provide update on paediatric palliative trainee post and support for younger patients – this is proving a hugely beneficial role and is becoming a more pressing issue for Hospices. An update would be provided at the July meeting.
- Bring together document to frame progress outlined in CAP – This will be incorporated into the main Management Plan going forwards, which will mean it is visible to everyone across the Hospice.
- Benchmark level of Safeguarding referrals vs. other local Hospices – LAs have canvassed for feedback, this is to be shared at the next meeting.
- Take forward arranging Safeguarding Link Trustee visit – This has been completed.
- Provide update on conversations regarding staff vaccination – This has been completed. Conversations have been held with the few members of staff to make them aware of risks, there has now been a reversal of the government directive so no further action is required. There have been no questions from patients about vaccination rates.

3. Evidence of Excellent Practice Register

The Committee noted the examples of excellent practice, including attendance of colleagues at a patient's funeral and Medical Examiner Service feedback. Committee members

discussed the factors that explain the lower level of input into the Register from the Community team. They work across multiple sites and often work alone, whereas additions to the Register are often highlighted by others in the IPU setting. Gail Linehan and the team would consider how to capture Community team examples of feedback in more depth, for example from contemporaneous notes from colleagues taken during time with patients.

4. Clinical Quality & Governance Report

Alex Rudkin presented his section of the report:

- Datix software was introduced in November 2021, staff have adapted well and are demonstrating the Hospice's strong reporting culture, with relevant internal colleagues review and sign off incidents. The majority of incidents within the Community team are minor but they recognise the staff time involved in terms of resolving any incidents.
- 2021 was highly positive in terms of engagement from the Clinical team for audit which is helping to shape practice. The Hospice established an internal Clinical Engagement and Audit Project Improvement Forum for short presentations by project leads.
- Data extraction and monitoring work and plans are underway for key submissions.
- The Clinical Action Plan for 2021/22 has been reviewed and 18 out of 20 actions were fully completed by the end of the year – the two not completed hold awareness within the Committee –
 - Implementation of Datix to manage Incident/complaint/complements. Incident reporting was implemented in Nov'21. There are plans to implement the Feedback module in Q1 2022/23
 - Increase establishment of Band 5 nurses on the IPU to facilitate secondment to other clinical departments to support staff development and a 'One Team' approach. The recruitment of RGNs to the IPU remains a challenge
- Systems are in place to monitor the responsiveness of local health partners and report to the CCG on this. Preparation for the CQC inspection is continually updated.

The Committee reflected on the breadth of activity and how the audit report showed the reflection that the process had inspired with colleagues adapting and refining practice.

Committee members asked about how the audit process is designed. It was confirmed that the prioritisation of projects is primarily led by regulatory or statutory responsibilities or CQC engagement.

The Committee asked about the follow up process once an audit has taken place to see the impact on practice and outcome. It was confirmed that this is built into timelines for re-auditing to assess a snapshot at ongoing points in time. As an example of the impact of an audit, the Hospice's discharge letter is now addressed directly to the individual, and the GP subsequently receives this, which has demonstrated the personalised care offered.

The Committee asked for examples to be collated to show the impact of audits on clinical practice within the Clinical Audit Summary, and for this to be summarised in the Clinical Quality & Governance Report. Clinicians could be invited to present at a Committee meeting in future, and for Committee members to attend Forum meetings virtually, to observe the impact of the Hospice's audit programme.

The Committee asked how Action Plan items would be presented to the Committee given the change in plans to present as part of the Management Plan. It was confirmed that the Management Plan will be itemised on Committee agendas. The summary on progress that had been included in the Clinical Action Plan will be included.

The Committee reviewed the complaints log. They noted the actions taken to address complaints and the strong 'no blame' culture within the Hospice. Rebecca Trower echoed

that the team is timely and open when responding to complaints, analysing the Hospice's own records of care and using these to reflect on areas for improvement. The Committee asked if there are any grounds for refusing access to patient records if they are requested. The Hospice gains legal advice as needed as a safeguard for the Hospice to confirm that the relevant process is being followed, for example to ensure rights of access. Staff are always conscious that patient records need to be factual and not based on opinion.

Rebecca Trower updated on the report:

- It was noted that covid-related risks on the register are reducing slightly. Government guidance has relaxed now but providers are remaining responsive and safe. There has been a higher incidence of covid amongst staff in past weeks. Staff are still doing rigorous testing on a daily basis and staff are encouraged to stay at home if in any doubt. The Hospice has extended the covid-related sick leave allowance until the end of April.
- Rebecca Trower updated on admissions refused due to staff capacity. Many volunteers are returning including Ward Companions. The Psychological Support team approached SMT to bring on board a 0.6 FTE post to support bereaved families, showing more instances of PTSD from bereavement particularly linked to challenging experiences in covid.
- Wellbeing centre attendees now comprise around half Hospice patients and half referrals from external providers that the Hospice has put time into building relationships with. The Men's Den is fully installed in terms of external structure and the Hospice is now focusing on fit-out. Complementary therapies have recommenced with a strong new staff member and volunteers will also be recruited to work alongside.
- The Hospice is interviewing for vacancies for the Hospice at Home programme which is strong and well evaluated. The on-call collaboration service with other Hospices has been working well overall and covers evening admissions. A range of other roles such as one-day Volunteer Consultant Psychiatrist are working successfully. The Hospice is building links with local universities to support outreach and recruitment particularly Roehampton.

The Committee asked how the Hospice captures data and information on the Wellbeing programme. The Hospice is capturing attendance, with feedback summaries from sessions used to help feed into future funding applications. Rebecca Trower would put further work into developing case studies.

5. Clinical Risk Register

The Risk Register review focused on top-level risks. There is still a focus on ensuring there is cover on night shifts, some new colleagues are joining which will build out capacity. Agency cover requires nurses to have access to Electronic Patient Records Systems (EPR). The Hospice is exploring opportunities for volunteers who could be part of twilight shifts to help add capacity – an update on this will be shared at the next meeting. The Committee asked if the move to EMIS will help mitigate the risk of PAS system failure. It is web-based which could support back-ups and reduce the need for 24-hour IT cover. The Committee asked why the pre-control score is still high for the introduction of Agenda for Change, and it was agreed that the pre-control score will be reviewed.

6. Clinical Quality & Governance Objectives – Extract from Management Plan 2022/23

Rebecca Trower updated:

- The team have been thinking about how to foster CPD further on the IPU. The Hospice have made an internal appointment to a Ward Sister post for a 12-month secondment to focus on implementing areas such as nurse-led assessment. This enables Tracey

Young to focus on upcoming projects with a refocused role to bring in the EMIS system, infection control, embed OACC, embed audit, and streamline discharge processing. All relevant training will be put in place to support.

- The Hospice has implemented twice-daily Admissions meetings to ensure more priority for patients coming from the Acute sector. The Hospice is aiming to open up to 10 beds when appropriately staffed. Schwartz Rounds are also a priority to bring in into the longer term, which will require external training and registration.

The Committee reflected that these priorities align with the Hospice’s overall aims for cross-team working and requested to see timelines at the next meeting for the completion of key goals. Moving to the EMIS system will enable more streamlined work – it was noted that locally EMIS Community is still to link with EMIS GP. The Committee asked about preparation for change for CMC to the Urgent Care Plan. This has been integrated into plans and staff have received training recently on this area.

7. Minutes of internal meetings

The minutes of internal meetings were noted. The Committee asked about the relatively low uptake at GP masterclasses. The Hospice had consulted with some GPs to understand the drivers and also approached them to potentially slot into GP practices’ own sessions. The Committee recommend sharing dates well in advance and targeting Care Home Lead GPs.

St Helier’s will be providing support for Infection Control across a range of areas. This is in the budget for 12 months, capacity will be built in to take in-house if needed thereafter. A 0.6 FTE Psychological Support Services role is also in the budget.

8. Annual Review of Committee Terms of Reference

The Committee proposed updating point 11 to include not just a Trustee ‘or Board Advisor’. The Committee noted additions in relation to Safeguarding. The Board Chair confirmed the Committee is delivering well including the reporting link to the Board.

9. Any Other Business and Dates of future meetings

Gail Linehan updated on a new method of assessment from the regulator CQC for organisations with an existing Good rating - CQC will inspect organisations less frequently unless risk-related items are raised, and so the Hospice will be less likely to have a visit soon. The Committee asked how organisations can change their ratings – this is to be confirmed by CQC.

Committee members noted the dates for future meetings:

- Friday 1st July 2022, 10am-12pm – Alan Cogbill to Chair.
- Friday 7th October 2022, 10am-12pm.

The meeting ended at 12.00pm.

Approved.....

Date.....