ITEM 03 ACTION LIST

SAINT RAPHAEL'S HOSPICE
CLINICAL QUALITY & GOVERNANCE SUB-COMMITTEE ACTION LIST
FOR JULY 2021 MEETING

Reference	Lead	Description	Target Date for Completion	Comments
04/01;11/01	GL	Performance Management	May 2021	Complete. HR26 People Performance Management Policy and HR 27 Capability Policy have been reviewed and revised by GL and KC (Human Resources).
21/02/26-01	AM	Share Trustee training details & start training log	May 2021	
21/02/26-06	AM	Take forward outreach process for new Committee members	May-2021	
21/05/14-01	AM	Share Excellent Practice Register extract with Board	June 2021	
21/05/14-02	GL/AM	Ensure HR Committee consider position on staff contracts and vaccination	Next HR Cttee	

ITEM 06

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 with our gradual return of staff to the Hospice whilst keeping a close eye on what is happening both locally and nationally in terms of Covid-19.
Our visiting restrictions have now eased further and we are pleased to be able to welcome more family and friends to visit patients on the IPU. However, we remain vigilant in terms of infection prevention and control procedures to keep everyone as safe as possible.

We are aware of numbers rising again locally, specifically people needing to isolate which is often due to children being exposed to the virus at schools and clubs. Remote working is now part of the norm and it is good that staff are able to flex and work from home if needed.

Staffing levels fluctuate but the demand on our service remains high with Q1 2021-2022 being our busiest to date. Our staff have remained consistent in their provision of advice and support, but we are aware that they are tired and often feeling the pressure. We are doing all we can to support them and are extremely proud of the way in which they have worked both in individual teams and as a wider group.

We continue to work closely with SWL CCG and our local hospices and palliative care providers to ensure that we are reaching as many people as possible who need our support and expertise.

Our Practice Educators have continued as a valuable resource in terms of ensuring staff and volunteers are up to date with infection control protocols, providing refresher and training updates. Testing continues on a regular basis and the majority of our staff now undertake the postal testing, reducing the pressure on our volunteer and admin team, who were taking the lead on testing as an additional responsibility.

The Managing Covid 19 policy (Clin52) continues to be reviewed monthly and adapted as changes to service provision occur.
HoDs continues on a monthly basis to ensure that information is shared and communication is effective.

Clinical Services

Our Psychological Support Team remains extremely busy and Steve Molyneux (Psychological Support Lead) is in the process of recruiting 8 more students and 2 more bereavement volunteers. Letters have been sent to bereaved families/loved ones explaining that the service is in high demand and therefore encouraging people to be proactive in requesting support should they need it. Sr Anne is commencing a bereavement group on a Friday in the Wellbeing Centre.

Our Wellbeing team is now established and numbers of attendees are starting to increase despite the pandemic and public hesitancy to actively engage in new initiatives. The new Living Well programme has commenced and received very positive feedback, despite it being early days. The medical team have assisted in providing education sessions for those attending and the sessions have been well received.

The IPU have been flexing bed capacity in line with our staffing and we now have 8 beds open for admission. Staff have been busy and on occasion there have been a high number of deaths on the unit in a short space of time. This is both emotionally and physically demanding for staff, allowing little or no time for recuperation but the care has remained of a high standard, and the staff have been extremely supportive of one another. There was also a wedding held in the orangery for a patient recently – she was too unwell to remain at home so the wedding date was brought forward and the patient was admitted for end of life care. She married here at SRH with her family present. Staff and volunteers from various services ensured that the day went smoothly for all involved. The patient died a few days later.

The Community team have begun their new model of working in three locality teams, therefore allowing closer working relationships and improved continuity for patient and their families. There have been a number of absences due to bereavements and illness within the team and the first few weeks of the new model have been challenging but once again, the standard of service has remained high and appropriately responsive.

Recruitment

Penny James, our new IPU band 6 nurse has now started on the IPU and we have a number of new bank nurses who have been completing their supernumerary shifts and inductions so that they can help to shore up the regular staff. We were unsuccessful in appointing during our first recruitment round of HCAs but have more than 20 new applications so will be shortlisting and interviewing as soon as possible.
We have recruited to a band 6 training post and band 7 CNS for the Community Team. Both are coming to us with previous hospice experience and begin in August.

Medical Team

Dr Naomi Collins has now joined us as of 5 July 2021. Naomi has been a Palliative Medicine consultant at East Surrey hospital for the past 12 years and is working with us as 0.8WTE. Dr Andrew Hoy and Dr Annelise Matthews have now left us, but Andrew will remain on our bank and will also be providing Advanced Communications training later in the year. We continue to support medical students and also have an elective student Becky who is with us for 5 weeks.

Education/Training

Our Practice Educators presented a very informative and well attended International Nurses Day in May as well as producing their quarterly newsletter 'Team Coach'. Simulation study days have commenced, utilising the training mannequin recently purchased. Much of their time has been spent overseeing the Infection Control Needs of the organisation and we are in the process of considering how we support this going forward. The girls have also planned a training schedule for the upcoming refurb when staff will have time to undertake training, as well as prep for the Equality and Diversity Study Days.

Three of our registered nurses have completed the European Certificate In Essential Palliative care at Princess Alice Hospice and are currently awaiting their results.

Capacity Tracker

We continue to contribute our inputs into the NHS capacity Tracker which is aligned to the HUK grant from Treasury.

IPU Refresh

The IPU Refresh Project team continue to meet fortnightly and are on schedule for works to commence on 19th July. The IPU is winding down admissions, with 'dual-planning' required for those patients still on our IPU. Trinity hospice in particular, has supported us by admitting patients from our catchment area when they have capacity.
The refresh of the unit will transform the environment by improving lighting, flooring and decoration to create a more contemporary and comfortable space for the benefit of our patients, families, staff and volunteers. We will also be upgrading the audio-visual and digital technology to enable patients and their families to access services they may familiar with at home, such as Netflix or Spotify.
IPU Staff will use the closure time for educational opportunities as well as supporting other services such as the community team and retail. There will also be the opportunity for staff to take annual leave.

Governance meetings

The Hospice's 'Governance' meetings feed into the work of all the Hospice Sub-committees.
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 and the Education, Training & Development Committee feed 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	Jun'21	Jan'20	Aug'21
Clinical HoDs	Jun'21	Jun'21	July'21
Medical Business	Mar'21	Mar'21	May'21
Drugs & Therapeutics	Apr'21	Apr'21	Jul'21
Falls	Apr'21	Jun'20	Dec'21
Incidents	Nov'20	Mar'19	Mar'21
Infection Control	Feb'21	Feb'21	Sep'21
Prescribers	Mar'21	Mar'21	May'21
Quality Improvement	Dec'20	Jun'20	Aug'21

Incidents / Accidents / Near Misses

- All incidents are reviewed by the respective Head of Department and in turn the Clinical Director and Head of Quality and Improvement. Review is complemented by the Hospice's Incident Review Meeting that aims to meet every two months. Those that are non-clinical are further reviewed at H&S Committee as required. Representatives are expected to cascade review information back to their teams.

- Quarterly submission to Hospice UK's Quality Metrics project began in July 2017 and are on-going with the latest submission provided in April 2021. The submission categories cover pressure sores, patient medication incidents and incidents of patient falls.

- Hospice UK collects a mini-MDS dataset from participating Hospices annually; to which we made submission for 2018/19 data in October 2019 following their request. Request has not been made in 2020 but the provision of activity data is provided on a daily basis via the capacity tracker.

- All falls are reviewed at bespoke meetings of the Falls Group; its last meeting took place in April 2021 and its next meeting is scheduled for December 2021. The Falls Policy was last reviewed and re-published in October 2020.

- Datix is the market leader for Patient Safety and Risk Management software with over 80% of the NHS as customers. It is recognised as a gold standard amongst commissioners and providers alike. It is highly flexible and configurable and general operational efficiencies will include more accurate information capture, improved information sharing and more rapid corrective actions. The system has been purchased to primarily support the incident reporting, management and review process. A second module covering the capture of complaints will be utilised to facilitate capture of all 'feedback' including suggestions, concerns and compliments. The third and final module that provides for the capture of organisational risk registers has been explored to determine its practical potential for being a one stop resource for all risk assessments but it is not designed to service that function. An alternative in-house electronic RA form remains the Hospice's data collection mode for risk assessments, eventually updating previously hard copy risk assessments. Risk assessment refresher training was delivered to key staff by Hettle Andrews (our insurers and health & safety advisers) on 30-31 July 2019 and is kept under review at our Health & Safety Committee. Further refresher training will be considered at Health & Safety Committee.

- Administrator training for Datix will be refreshed before implementation in 2021. User Testing was delayed owing initially to technical issues with Datix then competing demands on IT and project lead resources and then the pandemic. Our testing has now completed and system roll out aims for September 2021 following the IPU re-opening. A further user training video and policy changes to support the software use remain work in progress. Whilst implementation of the new system has been delayed, the established manual reporting system has remained in place.

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. Our Ashton's Clinical Pharmacist is Margaret Gibbs.

A Clinical Audit and Activity Data forum (CAAD), established in October 2019, supports the construct and review of the Hospice's Clinical Audit program and provides opportunity to review Activity Data that feeds into data dashboards. The meeting alternates between review of clinical audit and activity data respectively. It was well-received by the MDT and, pre-COVID, began to make in-roads into understanding how supportive a process the audit process can be and how by improving data ownership there is better connectivity between data input and output. A clinical audit training day was externally facilitated in February 2020 and received very positive feedback. During the pandemic the meeting has been pended. The meeting re-commenced in June 2021.

The Audit/Research Programme with timeline is set out on page 9.
4 reports remain to be written up for 2020/21.
2021/22 program itemises 25 projects spanning, clinical audit, quality improvement and data monitoring. Ownership is delegated across the clinical teams.

Data Dashboards

Work continues on the progression of clinical data dashboards that inform the service areas of the IPU, Well-being Centre, Community and Psycho-Social teams. 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?**	**Presentation Tool / Depository**
20/001	CMC Monitoring	BG	Jan-20	To improve CMC data capture	CPCT	Yes	Weekly	AR	Yes	N:\CrossCare\Data Analysis\Community Team\CMC.xlsx
20/002	NoK Details	SM	Jan-20	To improve NoK data capture	Psy / Qual / Donor Support	No	Monthly	AR	Yes	N:\CrossCare\Data Analysis\Next of Kin\NoK Details Monitoring.xlsx
20/003	Community Team Visit Responsiveness	LB	Jan-20	To support responsiveness evidence	CPCT	Yes	Quarterly	AR	Yes	N:\CrossCare\Data Analysis\Community Team\Community Team - Type of Review Data (AR) December 2019 +.xlsx
20/004	Sharing Information Consent	TC	2018	To monitor and improve Sharing Information Consent data capture	CPCT	No	Monthly	AR	Yes	N:\CrossCare\Data Analysis\Community Team\Information Sharing.xlsx
20/005	Safeguarding Monitoring	RW	Feb-20	To highlight patients with safeguarding concerns and track follow up	CPCT	No	Monthly	JL	No	N:\Clinical\Weekly Crosscare Reports
20/006	Referrals Monitoring	JO'G	Mar-20	To monitor and improve Referrals data capture	CPCT	No	Monthly	AR	Yes	N:\CrossCare\Data Analysis\Community Team\Referrals.xlsx

Report Reference	Title	Lead	Created	Function	Primary Aud.	Exec / CCG Interest	Freq.	Resp.	Is Data Presented?	Presentation Tool / Depository
20/007	Referral to RIP Monitoring	JO'G	Mar-20	To monitor time between referral and death	CPCT	No	Monthly	AR	Yes	N:\CrossCare\Data Analysis\Community Team\Referral and RIP.xlsx
20/008	Active Caseloads	NS/GL	May-20	To monitor active caseload levels	Exec	Yes	Weekly	AR	Yes	N:\CrossCare\Data Analysis\Active Caseloads\Active Caseloads as at 22-10-2020.xlsx
20/009	Daily Activity Data - capacity tracker support	NS/GL	May-20	To monitor activity recorded on Crosscare	Exec	Yes	Daily	AR	Yes	N:\CrossCare\Data Analysis\Hospice UK COVID-19 Data Submission\Activity Data for Hospice UK COVID 19 Daily Report.xlsx
20/010	Referrals by Postcode	DN	Jun-20	To monitor referrals by postcode	Fundraising & Exec	Yes	Monthly	AR	Yes	N:\CrossCare\Data Analysis\Postcodes\Referrals 2019-20 by Postcode wip (AR).xlsx
21/013	PPoD vs Actual PoD Monitoring	RT	April 2021	To monitor PPoD achievement rates	Exec	Yes	Quarterly	AR	Yes	N:\CrossCare\Data Analysis\PPoD & RIPs\Deaths & PPD.xlsx
21/002	Community Risk Assessment Monitoring	TC	To create	To monitor completion of the community RA	CPCT	Yes	Monthly	AR	It will be	TBA
21/003	DoLs Monitoring	TBA	To create	To monitor DoLs applications and follow up	Exec	Yes	Weekly	AR	No	TBA
21/004	Wandsworth Activity Profiling	TBA	To create		Exec	Yes	Quarterly	AR	It will be	TBA

Quality Account

The Hospice last submitted its **Quality Account** for 2020/2021 to the NHS Choices web site in June 2021 and is available on the Hospice's website at https://www.straphaels.org.uk/Handlers/Download.ashx?IDMF=a1a6bf91-8067-44e8-b3e1-aaeca9a274b6lt.-

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 was established to periodically populate and keep 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. Most recent 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 certain information elements required by the Provider Information Return (PIR) that we submit prior to an announced inspection as well as evidentially determining our own assessment and actions required against the criteria that are utilised by the inspection team on a site visit.
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 will aim to incorporate sign-posting within our KLOE self-assessment as it is populated. We hope that this will support our evidence base to achieve an 'Outstanding' rating at our next inspection and maintain it in the future.

Audit/Research 2021/22

Overview in June 2021

25 projects scheduled in 2021/2022 :

2021/22 Listing

Project Ref.	Title	Status	Report Link	Results
2021/22-01	Community - Carer & relative questionnaires for the Hospice @ Home Service	Ongoing		
2021/22-02	IPU & Community - VOICES survey of bereaved next of kin 3-6months post bereavement	Ongoing		
2021/22-03	IPU - Patient Satisfaction	Re-start September 2021		
2021/22-04	IPU – Infection Control : Environment & Hand-washing Audit	Ongoing		
2021/22-05	IPU - Medicines Management Audit	Ongoing		
2021/22-06	Non-pharmacological intervention Audit (ISR Recs 2-5) - prevalence / effectiveness monitoring	Not yet started		
2021/22-08	IPU - Re- Audit against Audit NICE Guidance NG31 Care of Dying Adults at the End of Life	Not yet started		
2021/22-09	Controlled Drugs Annual Audit	Ongoing		
2021/22-10	IPU - Re-audit of Discharge letter to include medication recording on Discharge from IPU corroboration with the EPR 'Medication Module'	Not yet started		
2021/22-12	OACC measures (Step 1 - Phase of Illness + Karnofsky performance status; Phase 2 - iPOS)	Policy Published. Training to be delivered Aug 2021		
2021/22-13	IPU : Patient Handling / Pressure Areas / Mouthcare	Planning		
2021/22-14	IPU - Use of the After Death window	Not yet started		
2021/22-15	Quality of Admissions & Discharge Planning	Not yet started		
2021/22-16	Referral to PS triggers	Not yet started		
2021/22-17	Bereavement Questionnaire	Not yet started		
2021/22-18	Non-medical Prescribing Activity Comparative : FP10.	Not yet started		
2021/22-19	Advance Care Planning -(timelines)	Planning		

Project Ref.	Title	Status	Report Link	Results
2021/22-20	Activity Monitoring Data CMC NoK CPCT Responsiveness Sharing Information Safeguarding Referrals Referrals to RIP Active Caseloads Daily Activity Data - capacity tracker Referrals by Postcode Community RA DoLs PPoD Wandsworth Activity	Ongoing		
2021/22-21	IPU & Community & Psychological Support Services - Activity Data Dashboards Development	Ongoing		
2021/22-22	Incidents	Ongoing		
2021/22-23	Falls	Ongoing		
2021/22-24	Complaints	Ongoing		
2021/22-25	IV & Paracentesis	Project Planned		
2021/22-26	Safeguarding Documentation	Data Collection Phase		
2021/22-27	Admissions Clerking	Data Collection Phase		

Clinical Risk Management

Clinical Unexpected Incidents

Overview of incident data for January – December 2021 is shown below:-

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2021	2020	2019	2018	2017
Admissions to IPU	**9**	**10**	**17**	**21**	**12**	**12**							**36**	**195**	**212**	**211**	**214**
Beds	**6**	**6**	**6**	**8**	**8**	**8**											
Bed Occupied Days	**154**	**85**	**164**	**175**	**185**	**203**											
Bed Available Days	**186**	**168**	**186**	**240**	**248**	**240**											
Bed Occupancy (variable beds)	**82.80%**	**50.60%**	**88.17%**	**72.92%**	**74.60%**	**84.58%**											
Bed Occupancy (10 beds)	**49.68%**	**29.31%**	**52.90%**	**58.33%**	**59.68%**	**67.67%**											
CD Medication Incident			3	3	7	6							**19**	**15**	**23**	**27**	**18**
CD Medication Near Miss			1										**1**	**1**	**1**	**3**	**7**
Adverse Reaction (Opioid Toxicity)													**0**	**0**	**1**	**10**	**8**
Adverse Reaction													**0**	**0**	**0**	**1**	**2**
Non-CD Medication Incident				2									**2**	**4**	**12**	**22**	**27**
Non-CD Medication Near Miss													**0**	**0**	**1**	**5**	**12**
Pressure Sore on Admission	2	1			1	3							**7**	**19**	**16**	**20**	**23**
Pressure Sore during Admission					1	1							**2**	**4**	**3**	**8**	**4**
Sharps													**0**	**0**	**0**	**2**	**0**
Infection													**0**	**0**	**0**	**0**	**2**

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2021	2020	2019	2018	2017
Readm <7days													0	0	1	4	1
Unexpected Transfer													0	0	0	2	
Near Miss(non-medication & non-IG)					1								1	1	1	2	1
PE													0	0	0	3	4
Staffing													0	0	1	1	
IG													0	3	0	7	12
IG near miss				2	1	1							4	1	0	1	4
Manual Handling													0	1	5	10	2
Slips, trips, falls			2		1								3	20	21	29	18
Verbal Violence													0	1	0	0	1
Bump													0	0	0	0	2
Other - Admin/property/Documentation/Clinical		1	1		3								5	14	12	18	15
* Incidents reported to Community – non-SRH													0	8	12	25	24
Total 2021 *excluded	2	2	7	7	15	11	0	0	0	0	0	0	44				
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		
Total 2018 *excluded	21	14	11	10	18	24	15	8	13	16	17	9				176	
Total 2017	13	11	19	15	15	17	12	2	16	16	15	12					163

Reported clinical incidents in January to June is similar to last year. The IPU had a reduced capacity during February due to the COVID outbreak. Rise in low significance medication incidents.

Incident Key

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

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

Clinical Significance	Jan	Feb	Mar	Jan-Mar	Apr	May	Jun	Apr-Jun	Jul	Aug	Sep	Jul-Sep	Oct	Nov	Dec	Oct-Dec	2021	2020	2019	2018	2017
Admissions to IPU	**9**	**10**	**17**	36	**21**	**12**	**12**	0				0				0	**17**	**193**	**212**	**211**	**214**
Bed Occupied Days	**154**	**85**	**164**		**175**	**185**	**203**														
Bed Available Days	**186**	**168**	**186**		**240**	**248**	**240**														
Bed Occupancy	**82.80%**	**50.60%**	**88.17%**		**72.92%**	**74.60%**	**84.58%**														
Fall No Harm			1	1		1		1				0				0	**2**	**14**	**15**	**21**	
Fall Low Harm			1	1				0				0				0	**1**	**6**	**6**	**10**	
Fall Moderate Harm				0				0				0				0	**0**	**0**	**0**	**1**	
Med Level 0			3	3	3	3	1	7				0				0	**10**	**9**	**13**	**6**	
Med Level 1			1	1	2	3	3	8				0				0	**9**	**10**	**21**	**37**	
Med Level 2				0				0				0				0	**0**	**0**	**3**	**10**	
Med Level 3				0				0				0				0	**0**	**0**	**0**	**3**	
Minor			1	1	1	5	3	9				0				0	**10**	**15**	**19**	**38**	
Moderate		1		1	1	1		2				0				0	**3**	**6**	**2**	**21**	
Serious				0				0				0				0	**0**	**1**	**1**	**3**	
Pressure Sores	2	1		3		2	4	6				0				0	**9**	**23**	**19**	**27**	
Totals 2021	**2**	**2**	**7**	**11**	**7**	**15**	**11**	**33**									**44**				
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**				**0**				**0**				**0**					**163**

Records – Access Requests

- In 2021, there have been 3 access to health records request : 1 x wife (January), 1 x partner (April), 1 x Solicitor (May)
- In 2021, there have been 2 sharing requests : 2 x SWL LeDeR (January, February)

	DSARs	Access To Health Records	Sharing
2021	0	3	2
2020	0	3	4
2019	1	4	0

Clinical Complaints

- There have been 2 clinical complaints received since last report. Details are below.

ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASS	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE	STATUS
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.	Upheld	Closed

ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASS	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE	STATUS
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 ie 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 –	Upheld	Closed

ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASS	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE	STATUS
						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.		

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Complaints Overview

2021 - Complaints	CPCT / H@H Care	CPCT / H@H Comms	IPU Care	IPU Comms	IPU Care & Comms	Bereavement Comms	Fundraising /Shop Comms	HR	Total	Merton	Sutton	UPHELD
January	0	1	0	0	0	0	0	**0**	**1**	**0**	**1**	**1**
February	0	0	0	0	1	0	0	0	**1**	**1**		**1**
March	1	0	1	0	0	0	0	**0**	**2**	**0**	**2**	**2**
April	0	1	0	0	0	0	0	**0**	**1**	**1**	**0**	**1**
May	1	0	0	0	0	0	0	**0**	**1**	**0**	**1**	**1**
June	0	1	0	0	0	0	0	**0**	**1**	**0**	**1**	**1**
July									**0**			
August									**0**			
September									**0**			
October									**0**			
November									**0**			
December									**0**			
2021	**2**	**3**	**1**	**0**	**1**	**0**	**0**	**0**	**7**	**2**	**5**	**7**
2020	4	1	2	3	1	1	1	2	15	6	6	14
2019	0	0	3	3	0	1	2	2	14			9
2018	2	5	10	4	1	0	1	0	27			19

Notifications

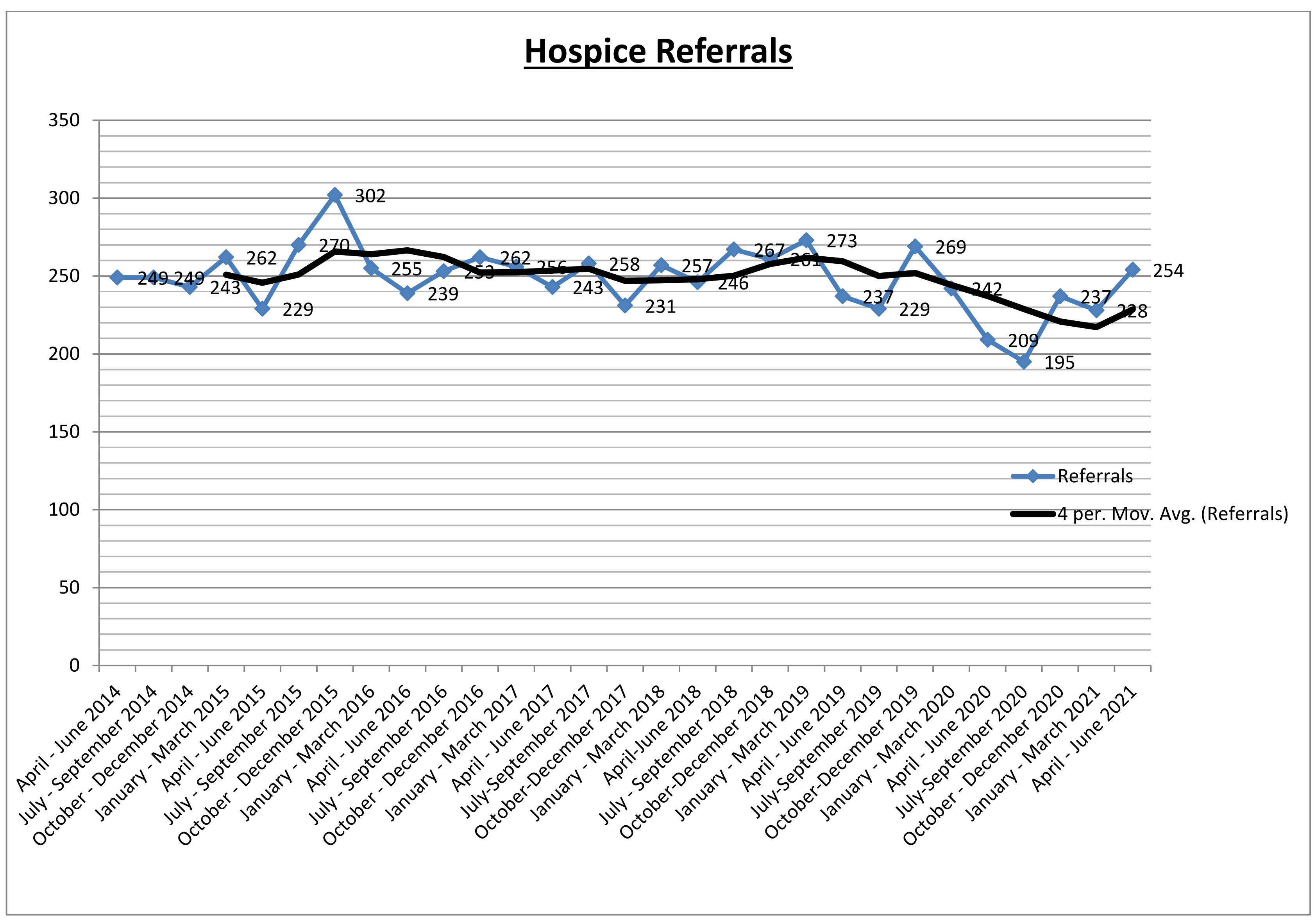
There were 3 serious injury notifications made to the CQC between January and June 2021 all concerning pressure sores grade 3 or above.

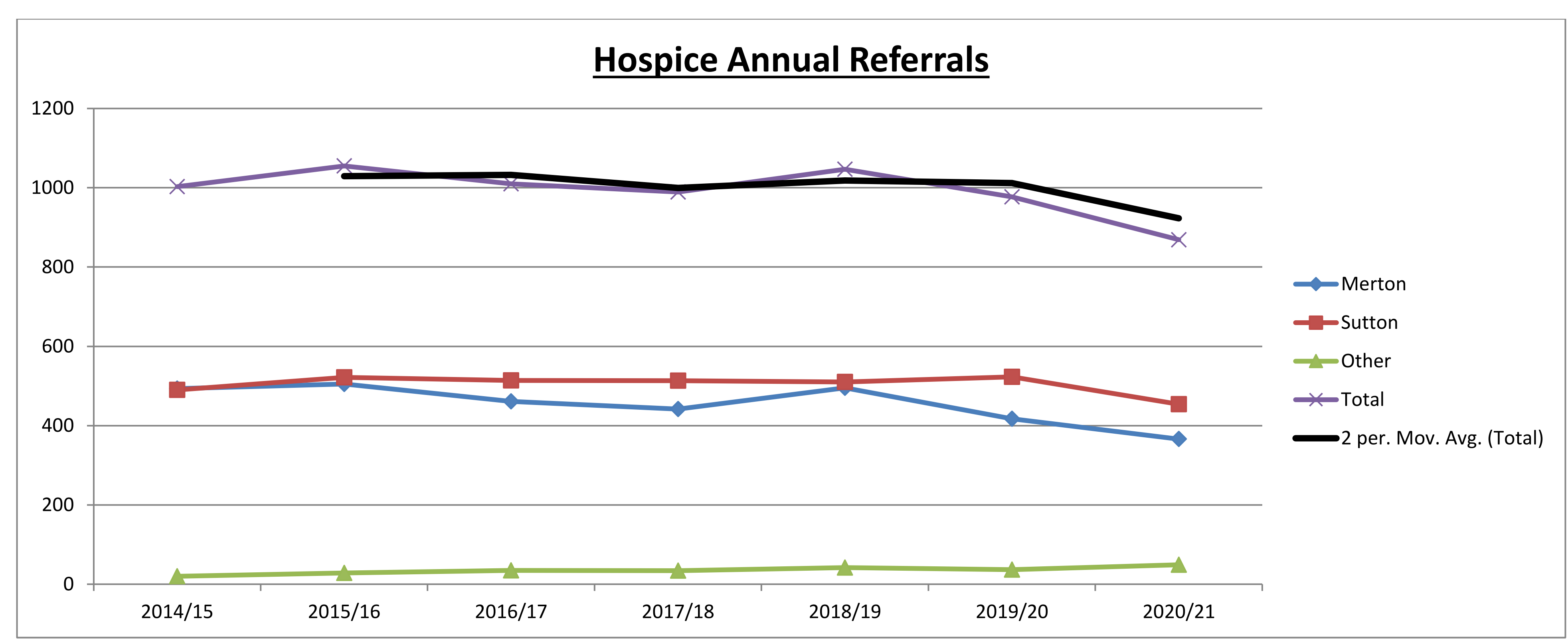
There were 13 safeguarding notifications made to the CQC between January and June 2021: 12 concerning individuals and 1 care home. All 13 were reported to the local safeguarding teams.

Clinical Commissioning Group (CCG) Data

Submission of Activity data for the preceding quarterly period is routinely supplied to the CCGs prior to their review meetings. The latest data period Q4 (January – March 2021) was submitted in April 2021. Next submission is due in July 2021. A selection of graphical representations for some of the data items have been produced for data up to end of 2020 and aim to be updated quarterly.

Hospice Referrals





The authors of this paper are Mrs R Trower, Clinical Director and Mr A Rudkin, Head of Quality and Improvement/ISO

14th Meeting of the Clinical Quality and Governance Sub Committee

To be held remotely via Zoom

at 10.00am on 16th July 2021

Agenda

Chair : JT

Item	Description	Purpose[1]	Lead
1.	Apologies for absence	I	AM
2.	Minutes of the last meeting held on 14th May 2021	S	Chair
3.	Action List from previous meetings	I	Chair
4.	Evidence of Excellent Practice Register	I	GL/RT/AR
5.	Clinical Risk Register	S	RT
6.	Clinical Quality & Governance Report	I	RT/AR
7.	CAP 2021/22	I	GL/RT/AR
8.	Minutes of Meetings & Other Documents Uploaded (att) • Clinical HoDs – June 2021 • Drugs & Therapeutics Committee – April 2021 • NG31 - QS144 IPU & Community Arm Audit Dec 19 - Jan 20 • Quality Account 2020/21	I	GL/RT/ AR
9.	Any Other Business	I	Chair
10.	Dates of Future meetings • 29th October 2021	I	Chair

[1] Purpose: PIDS - Policy/ Information/ Decision/ Signoff

Meeting: **Clinical HODs Meeting**			
Date: 09.06.21		Time: 1400	
Chair : Rebecca Trower - RT		Minutes: Lynn Jackson	
Present: TC, LB, MF, GTR, AR, TY, PJ,JS			
Apologies: SM			
Agenda item	**Discussion**	**Actions & by whom**	**Anticipated date for completion**
Review of previous minutes	Bladder Scanner – probe had broke now fixed. JS & GTR are conducting an audit into use of USS for ascites. Merton using Micrel – DN's are very pleased with these devices that are being trialled in Merton. TC awaiting Trinity team for their policy on alfentanil use in community. Patient notes were stolen in previous incident. GTR informed no patient identifiable information in bag. Use of DNACPR icon - TC is met with JGr		
Matters Arising			
Topic			
Infection Prevention	TY to explore/audit the over use of gloves in line with new guidance. H/Keeping to possibly wear Marigold style of gloves	TY	By next meeting
Medical Devices	Medical team – unfortunately bladder scan probe not up to standard for assessing pts for ascites. Need to consider cost of equipment and training and keeping up to date versus infrequent need to perform on the ward. However it was discussed that until JS/GTR audit is complete- patients would be sent for ambulatory care if the need arose TENS – costings for machines to be sought	JS/GTR CT/LJ	Ongoing Next meeting

Medicine Management	Caroline Sterling has advised that SWL have been struggling to source certain injectable medications, she is aware of our issue with alfentanil +-cyclizine TC to look into SOP for possible use of Keppra use in community	TC/AR	Ongoing
Incidents & Accidents/RCA's	Nil		
Complaints	Group agreed that specific individuals should not be named on cross care when recording a complaint, oral complaints form should be used for this. Recent complaint has come in to community team, for response, reflection – see AOB.	TC RT/TC	
Health & Safety	nil		
New Policies/ Guidelines	TC explained new FP10 policy which ensures regular counting of FP10s to ensure no discrepancy. The Group reflected on a situation that arose over the bank holiday with regards IPU access to FP10. It was agreed that the code for the CPCT FP10 safe would be kept in IPU CD cupboard along with 1 pad of each Merton & Sutton FP10's in sealed envelope. These would need checking monthly. *since meeting decision to think further about this and safest option-? For consultant on call team to have access to code as alternative.	TC/GTR TY/TC	By next meeting
Documentation/ Crosscare	JGr is working on adding an IPU discharge window to crosscare	JGr/TY	
Audit/Research	AR thanked everyone for their reports CAP & Voices survey next	AR	Ongoing
Education/Training Reflective Forums	Induction videos continue to be worked on, will require short videos from team members. JS commented that mandatory training not pulling through to spreadsheet for PE. Spoke with PAH team, since resolved- but not sure if might recur.	LB LB/MF	

	Discussed Schwartz- Concern re funding expressed in previous meeting, however JS brought up with NS and GL and they have funding for this.		
Recruitment/ Staffing	Group welcomed Penny J HCA advert will be re advertised w/beg 14.06.21	TY/HR	
CQC/PIR	nil		
AOB			
IPU	**REFRESH** This remains on target. Internal emails are being circulated & external organisations have/are at present being informed verbally.	TY, Facilities, CEO's	31st August
	A poster is currently being devised for information.		
	It is important that the local community & health sector know that IPU is NOT closing but being REFRESHED.		
	Re-deployment of staff rota & A/L is being actioned with CPCT & outside agency shadowing	TY/TC	July
	Education have set up a program of training for IPU staff to participate in during the refresh.	LB/MF	End August
Doctors on call	From 01.10.21 the Drs will be working in collaboration with PAH in covering SRH/PAH & Kingston Hospital (telephone advice) Dr BDS will increase her hours – Days TBC Dr DK/Dr NA & Dr CK will not be working at SRH after the collaboration.	JS	
CPCT	HPOC JOG is currently on compassionate leave CC is to pause her working with SRH from July CPCT staff are covering HPOC		
	CPCT team are now split into 3 localities & this is currently working well. A review will take place in approx.. 6/7 months	TC	

Complaint	A written letter has been received from a patient's daughter, 3 areas were raised. RT has contacted the daughter & CPCT are holding a reflection meeting. Previous IPU complaint – an apology was given & reflection made by staff RT wanted to thank all staff for good reflection & learning practices with regards complaints	**RT/TC/CPCT** **TY/RT**	January 2022 – review Ongoing completed

Date next meeting: 13th July 2021

- **1st 45 minutes of meeting to be allocated to Clinical Action Plan**

Clinical Action Plan 2021-2022

Introduction

The Hospice aims to support innovation and excellence across all the clinical services delivered by its teams. This approach embodies the Hospice strategic plan, EVE (Excellence, Visibility and Engagement).

The Hospice deploys a Multidisciplinary Team (MDT) model to the delivery of its clinical services to achieve excellence. This necessities all levels of clinical staff embracing an inclusive, proactive approach where responsibility and accountability are enabled and supported. Every voice and contribution has value.

The Clinical Action Plan aims to provide a consistency of approach across teams, acknowledging the sharing of resource and advocating collaboration in its achievement. Robust processes and systems support and enable all the teams to work safely and effectively.

High importance is placed on the well-being of staff, recognising that staff are the Hospice's most valuable resource. The organisation actively supports education and training opportunities for people at all levels to learn and develop to achieve their full potential. This further supports our aim to be a centre of excellence.

Over the next 12 months we aim to further embed the MDT approach as part of our one team vision, recognising that every member of staff has a unique skill set which contributes to and supports the expert services we provide.

The Clinical Action Plan is operationally overseen and routinely reviewed by the Clinical Heads of Department Meeting.

UPDATE OVERVIEW

DATE	100% ■ Complete	25% 75% ■ Complete ■ Incomplete	50% 50% ■ Complete ■ Incomplete	25% 75% ■ Complete ■ Incomplete	■ Complete ■ Incomplete
23-Mar-21	0	4	3	2	11
23-Apr-21	0	4	4	2	10
09-Jul-21	0	6	3	7	4
13-Jul-21	0	6	5	7	2

Clinical Action Plan

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP01	**Review suitability of staff support / clinical supervision/reflection mechanisms : consideration of Schwartz rounds**	To facilitate and enable clinical discussion relative to the care of dying patients and their families. To provide a safe forum to support emotions and stresses. To enhance understanding of the professional environment in order to support practice development. To develop the IPU's skill set in undertaking level 1 psycho-social support for patients and families. To reduce silo-working and facilitate inclusivity of all staff in shared learning Provide opportunity to rotate to Community Team for further	Staff protected time External facilitation Psychological Services lead training time Employment contract updates	Engagement isn't compulsory Staff will leave Potential for variability in skills and abilities across days and nights.	Staff and facilitator time Schwartz training and set up.	Caring Effective Well-led Responsive Safe	Clinical supervision for all staff remains ongoing. 100% compliance against plans affected by COVID SLT Peer Support being delivered regularly Psycho-social training to up-skill IPU team to deliver level 1 psycho-social support. Pended post COVID. Educational Updates Schwartz rounds to be prepped for	25% 75%
CAP02	**Rotation of IPU staff across 24 hours** **Provide adequate competent staffing across days and nights**	To ensure consistency of approach and delivery to service provision across 24 hours. Assurance of clinical competence via night staff coming on to days for 1 week every 4 months and accessing education, development and competency assessment. To break down cultural barriers between day and night teams. All newly recruited staff will have internal rotation across days and nights built into contract. To support the one team approach. To ensure that staff across all shifts are accessing education and associated competencies. To ensure that staff across all shifts are accessing education and associated competencies. To ensure all staff are being developed and feel part of the wider team. New community team member induction includes IPU working for up to 1 month	Consultation time for existing staff across day and nights with HR and Clinical Director	Staff will not engage with the process. Staff retention / recruitment	Current Staff Costs Possible requirement for identified external training	Caring Effective Well-led Responsive Safe	Consultation complete Implementation commenced January 2021 Rotation days to nights in place. Nights to days on hold impacted by staffing shortages Aim to rotate nursing staff from the IPU into community 'for experience' from date tbc (on hold due to staffing shortages) Incorporated into new recruitment contracts Implementation happening for both days and nights. Affected by COVID re staff sickness / furlough New community team induction that includes IPU working implemented.	25% 75% Complete Incomplete
CAP03	**Increase counselling support for post bereavement care from 6 student counsellors to 12**	To improve responsive access	Volunteer student counsellor recruitment and supervision	Reduced counselling provision by the Head of Psycho-social	N/A	Caring Effective Well-led Responsive	August – September 2021 July 2021 - recruiting for bereavement volunteers to provide telephoen support July 2021 - Sr Ann hosting a bereavement café in the Wellbeing Centre	25% 75% Complete

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP04	**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.**	To develop team of nurses with assurance of palliative care clinical skills. Increasing the establishment to allow flexibility to open more beds routinely in the longer term. Opportunity of secondment to other clinical services to enhance understanding of the wider palliative care practice	HR Recruitment Training Development	Difficulty in recruiting. Loss of momentum subject to recruitment	Cost of Band 5 nurse recruitment	Caring Effective Well-led Responsive	Advert for Band 5s and Band 6s in place for current vacancies. May 2021 - advert updated July 2021 - social media advertising in place	25% 75% Complete
CAP05	**To maintain CNS Development posts**	For succession planning. To ensure we have replacements for future retirees or those leaving through natural attrition. To ensure the service can operate in the future. To ensure competencies and training allows for development nurses to progress to CNS level and work within all departments	HR Recruitment	Cost to organisation in terms of care delivery if not planned. This could be mitigated by Trust application funding.	Salary costs	Safe Effective Responsive	3 positions : band 7 & 2 band 6s filled for 2021 Introduced European Certificate in Essential Palliative Care for all RGNs for professional development	25% 75%
CAP06	**To include the audit of clinical risk assessment that supports individualised care planning in the clinical audit program**	To ensure our planning is individualised and documentation is supportive. Individualised care planning and risk assessment that is comprehensive	Time to train Staff engagement	Sub-standard communication and documentation that supports care delivered / planned. Lack of engagement	None	Caring Effective Well-led Responsive Safe	Audit of risk assessment planned for 2021/22 audit program.	50% 50% Complete Incomplete

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP07	**Implementation, training and embedding of Outcome Assessment and Complexity Collaborative (OACC)**	To measure outcomes and gain feedback and consider KPIs through its use. All departments using the Australian-modified Karnofsky Performance Status scale & Phase of Illness. To integrate aspects of the suite of measures into practice, documentation, training and audit.	Time Audit Multi-disciplinary education Collaboration with clinical teams to embed and integrate into daily practice	Becoming target driven in our care delivery – must remain mindful of patients and interrogate outcomes accordingly.	OACC education courses – facilitating key staff comprehension and practical application. Project management – team time	Caring Effective Well-led Responsive Safe	Key staff attendance at OACC training in February 2020 (TC,TY&JF). Project implementation task and finish group first met in December 2020 Draft PoI / Karnofsky March / April 2021 Phase and Karnofsky for 2021/22 audit program 2021/22 : Phase & Karnofsky 2022/23 : iPOS - IPU 2022/23 : iPOS - Community	25% 75% Complete
CAP08	**Incorporation of basic and advanced communication skills training for clinical staff into the mandatory training programme and delivering it**	To support expert communication with patients, families and colleagues. To develop less experienced staff in having difficult conversations To refresh and support clinicians on the topic.	Time Planning Facilitation	Increased complaints Staff burn out	Training Facilitation	Caring Effective Well-led Responsive Safe	2021/22 program to include basic and advanced communication skills training in September / October 2021 Training delivered to IPU and CPCT colleagues to enhance communication skills. Practice educators liaising with Steve M re IPU / H@H study day in March 2021 Consideration of how / if Sage & Thyme may be accessed / implemented in 2021	50% 50% Complete Incomplete
CAP09	**Implementation of Datix to manage Incident/complaint/complements**	To facilitate ongoing review of Incident/complaint/complement	Time – (project leads for Datix implementation) HoDs – Testing and Training Time – Training on new system	None – adequate manual reporting system in place. Time/resource	Cost of implementation of Datix	Safe Effective Responsive	Testing: September - December 2020 Training Videos: April 2021 / August 2021 Policy amendments : April 2021 / August 2021 Full implementation for incidents – September 2021 Implementation for Complaints / Complements - November 2021	25% 75% Complete Incomplete
CAP10	**To ensure there is participation in the planning and auditing of clinical practice across all clinical teams (IPU / Medical / Community / Psychological Support) in line with the Hospice's Clinical Audit program.**	To support the assessment of practice against standards	Time Staff Training	Deficient assurance evidence	Resource	Caring Effective Well-led Responsive Safe	As per clinical audit program for 2021/22	25% 75% Complete Incomplete

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP11	**To complete VOED** (Verification of Expected Death) **documentation in the Community**	To ensure clinical staff are competent to undertake conversation and completion of documentation to support VOED in the community.	Education Competency Assessment	Provision of a less than optimal end of life care service.	Resource Cost Time	Caring Effective Well-led Responsive Safe	December 2021 for all Band 6 & 7 staff to be assessed as competent.	25% Complete 75% Incomplete
CAP12	Review of the CPCT service model	To ensure optimum use of resources in relation to demand	Time for consultation Engagement bv medical and nursing teams	Disengagement by staff Negative impact on responsiveness Impact on external communications Staff retention / recruitment	Staff time	Well-led Responsive Effective	April 2021 initial discussion May/June Planning and Implementation Sep-21 Substantive Model in place Oct - Dec 21 Initial review	50% Complete 50% Incomplete
CAP13	Successful embedding of the new wellbeing model	Expand reach to different client group	Staff establishment increase to 1.6 WTE Ad hoc speciality support	Comprehension of the non-clinical offer Underwhelming or overwhelming take up	Staffing Travel	Responsive Well-led Effective	12 months + Service launched - May 2021	50% Complete 50% Incomplete

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP14	To increase community profile - GSFs - Nursing Home MDTs - GP Master Class - Foundation in Palliative Care for Community Nurses - Specialist OPD (Heart failure/ COPD/ Renal) To integrate Hospice into Acute Sector Site Specific Clinics to support fellow HCPs with approrpriate referral to Hospice Services	To support a holistic approach to service delivery To encourage earlier referral to the Hospice services	Consultant and CNS time Education input / time : Media production	Capacity to provide Raised expectations Increased pressure on clinical teams	Time	Responsive Well-led Effective	01/01/2023 July 2021 : Prison visits, GP masterclass, representation at PCN meetings, attendance at heart failure clinics (Doc and CNS), Consultants support hubs, collaborative work with Challenging behaviour team	25% Complete 75% Incomplete
CAP15	Identification and allocation of clinical lead for the Medical Team Designated areas of resposnibility clarified for Consultants	Strategic approach to consultant development To clarify delegated responsibilities	Consultant Time	Decreased satisfaction with roles	Nil	Well-led Effective Safe	Apr-21 : 18-24 month rotation (DR J Strawson initially) Jul-21 : Specific areas of responsibility to be clarified when 3rd Consultant has joined the Team.	75% Complete 25% Incomplete
CAP16	To demonstrate the impact of the Physician Associate position	To support future appointments and share experience with other Hospices	Medical time	Missed opportunity to service the rationale	Time	Responsive Well-led Effective	01/12/2021 july 2021 - Poster developed for Hospice Uk. Awaiting confirmation of acceptance	25% Complete 75% Incomplete

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP17	To review the palliative intervention offer (Paracentesis) - Bladder scanner use - Ultrasound course access	Reduce unnecessary Hospital admissions	Clinical time / training Manequin (Kevin / Kerry)	High / low demand	Time / Training	Safe Responsive	01/03/2022 May-21 : Bladder scanning training July -21 : Scoping other Hospices / costings / audit	50% 50% Complete Incomplete
CAP18	To increase SRH collaborations with other Hospices	Shared learning Enhance relationships Improved work/life balance	Planning / negotiation time Training	Intensity of workload at times Familiarity with other EPRs	Time	Well-led Effective Safe Responsive	01/09/2021 SWL Exec Hospice Mtg Sharing Practice Advanced Comms On-call medical collaboration with PAH & Kingston Hospital Clinical supervision collacoration initiative with PAH Research and ethics collaboration with PAH Exploring collaboration with RTH for Infection Control	25% 75% Complete Incomplete
CAP19	To review the reach and delivery of services provided by the Hospice @ Home service	To demonstrate effectiveness of service and ensure provision meets demand	Time	Staff sickness may undermine evaluation of full service provision	Time	Well-led Caring Effective Safe Responsive	Mar-22	Complete Incomplete

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP20	To increase identification of carers needs and provision of support	Tom meet the needs of carers	Staff time / training Knowledge of local resource sign-posting	Unfulfilled raised expectation Potential duplication of service offer	Time	Caring Responsive Well-led Effective	Mar-22	Complete / Incomplete

Serial	Cause of Risk	Description of Principle Risk to Charity	Current Controls to prevent occurance	Current Impact	Current Probability	Raw Score	Additional Controls	Residual Impact	Residual Probability	Residual Score
1	Sustainable and relevent service provision	Reticience of some staff to embrace change to working practice as outlined in Clinical Action Plan (CAP).	Proactive leadeship to communicate and support change in working practice in line with CAP with Managers and key staff.	3	2	9	CAP to be communicated to all staff to clarify the vision and direction of hospice clinical service provision. Concerns will be listened to and addressed. Monitoring of change and recognition of the improvements will be comunicated to all staff on an ongoing basis through team meetings and education sessions.	3	1	6
2.	Workforce: Community Clinical Nurse Specialist Ability to recruit suitably qualified Clinical Nurse Specialists to support the demands of referral for community support	Decrease in service delivery to support the demand in the community. Requirement to review service provision - modify the current offer	Succession Planning- Supporting CNS Development posts Comparible Salaries to NHS AfC Good working Environment Flexible Working Hours Introducing a skill mix of staff into the community service	2	2	6	Currently CNS team establishment is 1FTE short of establishment. Keep under review the number of development posts which can be supported should vacancies occur.	2	1	4
3.	Workforce: Registered General Nurses Recruitment of appropriately qualified nurses to support the delivery of care on the In-Patient unit.	Night duty cover remains problematic . If RGN cover on night duty not suffcient, the number of patients that can be safely supported will be affected as safe staffing is across 24hours. Increasing difficulty in recruiting Band 5 nurses for day duty - staff undertaking extra shifts to cover requirement risk burnout. Managing unexpectd sick/compassionate leave can put pressure on the staff cover.	Current qualified nursing staff levels are adequate to support 8/10 IPU beds on day duty with full current complement of staff. Signifiacnt current deficit on night duty. COVID is impacting staffing levels due to requirement to self isolate. Active recruitment of Band 5 nurses to fill permenant and Bank to support core team at times of AL/SL or increased high dependency. Requirement for continued review of night RGN cover for safety assurance. Staff flexibility from day duty to night duty- Consultation is complete and rotation has commenced.. On the job training, mentoring and educatuional support to obtain required qualifications e.g. Support of the TNA programme for HCAs	4	4	20	In situations where staffing levels are adversely affected there would be a managed reduction of avialable beds.Caveat is that even with one bed open there is a requirement to have 2 RNs on duty. Engaging with local and national training schemes to demonstrte the attractiveness of the hospice as an employer. Review sickness policy and maternity leave	4	4	20
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 avaialbale to hear and escalate issues 3. HR Mental Health Helpline. 4. Regular and open communication from Senior Team. 5. Weekly testing fro staff. 6. Vaccine roll out to most staff	3	2	9	1. SRH standing by staff for one month beyond governemnt recommendations. 2. Provide some other welfare benefits to acknowldege difficulties i.e. small treats. Supportive communication across teams, Access to vaccinations improved. Increase in use of LFDs.	3	1	6
5.	Clinical Incidents	Patient Safety (Falls/Pressure Ulcers/Medication Errors). Risk of complaints from patients/families Requirement to report outside the organsiation to CQC Prempt a CQC Inspection Reputational damage	Reporting of all incidents related to clinial care Heirarchy of investigation Outputs- Learning informs improved proceedures and processes Regular review of incidents Report to EXEC, Clinical Governance Committee &Advisory Committee, Dissemination to all hospice teams to inform learning	4	2	12	Continued staff training and awareness of new techniques and products. Report at Clinical HoDs. Report by manages at team meetings. Opportunity to participate in refection and sharing learning and outcomes. Feedback to complainants regarding change in practice. Encourage an environment of comprehensive reporting to support learning and quality improvement. Introduction of Datix in Q2 2021 will support reporting and monitoring.	4	1	8
6.	Lone working	Staff/volunteers work singularly in the community within referred patients homes. Risk of accident/incident in a patients home and individual risk to staff member. Risk in travel to and from home visits	Policy and proceedure in place to support community working (SOP). Supplied with a mobile phone for conatct with the hospice or other healthcare professionals. ACC informed of access and egress. Lone worker alert devices in place.	3	1	6	Lone Worker Policy informing steps to follow if a colleague does not return to base at expected time. Clarification and supported training on use of safety devices. EXEC OOH on call in place for contact and advice on further action.	3	1	6
7.	Complaints	Rumours Local press coverage Potential for public concern Elements of public expecation not being met Loss of confidence in the service Reputational damage	All complaints both verbal and written treated with the same level of scrutiny Complaints proceedure in policy for staff to follow- escalation process Complaints documented and reported via Quality Manager Reported at Clinical Quality Improvement and Clinical Quality and Governance meetings Complainants (both verbal and written)are offered the opportunity to meet and discuss concerns with Director of Care All complaints discussed at hospice team meetings for awareness and learning across the organisation Bi-annual review by EXEC Required action taken to address concerns with staff members where individuals have been identified by the complainant File notes kept of discussions by HR	3	2	9	Use of root cause analysis for significant incidents. Feedback to complainants regarding change/improvemnt in practice. Scoping to establish all clinical staffs access to communication skills training Training on care delivery Information shared re: Duty of Candour and scope of the policy Reporting of any concerns- no blame but responsibility	3	1	6

Serial	Cause of Risk	Description of Principle Risk to Charity	Current Controls to prevent occurance	Current Impact	Current Probability	Raw Score	Additional Controls	Residual Impact	Residual Probability	Residual Score
8.	Breaches of confidentiality involving person identifiable data (PID), including data loss	If low risk breach- dealt with locally as per policy- CUI reporting More serious breach - RCA may be required- may have wider implications if data not encrypted If serious IG breach may be media coverage Potential loss of public confidence to keep PID safe	All staff paid and unpaid trained on IG on induction and annual mandatory training. Policy communicated to whole organsiation Clinical staff have nhs emials (encrypted) Regular organisational sweeps in all departments	3	2	9	IT monitoring and oversight of PID in received and sent emails. Monitoring includes audit and test Phisihing emails via IT Dept. Intermittent checking in areas such as photocpier/clear desks.	3	1	6
9.	Brexit - Risk of medication shortages via suppliers	Required medication(opiods, 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 stcck.	2	2	6	Regular updates from clinical pharmaist. Communication with wider CCG pharmacy colleagues.	2	2	6
10.	Corona Virus	Infection spread within hospice	All staff emails alert. Signage directing all staff & vistors to hand-washing on entering and leaving the ward / rooms and use of hand sanitiser. Staff adherence to control of infection policy. As per government guidance clinical staff that can work from home have been faciltated to do so. Community service provision has changed from face to face to telephone contact or virtual contact via skype.	3	2	9	Corona Virus Policy constructed to address all operational issues. PPE supplies checked. Contingency planning clarified for any identfied case within the Hospice - as per governemnt guidance. Single room nursing. Reduced face to face visiting dictated by urgency. Increased telephone contact. Introduction of virtual assessment. february.21, FFP3 mask testing. Deep clean of IPU. Refresher PPE trainng and advive and support from PHE. Weekly PCR & LFD testing for all staff.	3	2	9
11.	Corona Virus	Infection brought in on clothing	Staff instructed not to wear uniform into work. Change in work , at beginning and end of shift. Scrubs and coveralls supplied.	2	2	6	Wash bags provided to all staff in which to place uniform for transporting home. Advised wash uniform in bag at 60 degrees. CPCT supplied with uniforms to faciltate essentail community visits as well as all PPE	2	2	6
12.	Corona Virus	Staff Anxiety re: CV	Staff offered weekly PCR testing and vaccination. EAP accessible by all staff for wellbeing support. Clinically Vulnerable.staff furloughed. Working from home supported where possibe.	3	2	9	Monthly HoDS to include any COVID issues and regular EXEC emails providing update and reassurrance.	3	1	6
13.	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. Psychosocial and other teams working from home where possible and service delivery can be maintained.. Face coverings worn in all public areas. Offices have signage stating masks to be worn when more than one person is in the offce.	3	2	9	Office reorganisation to make best use of space and required occupation. Regular infection control meetings and review of guidance. Staff confidence increased in social distancing regulations	3	1	6
14.	IT PAS System Failure	Inability to access contemporaneous clinical records.	Contactable team OOH (not formaaal contract). Back up resource - outsourced at times of AL.Back up to PAS system faciltating access to the PAS. Risk is that recent recording may not be captured.	5	2	15	Daily back up of PAS. Risk Assessment undertaken related to IT risk to PAS. Highlighting gaps. Resolutions being considered. Access to OOH IT Consultant response in place.	4	2	12

MINUTES OF THE
DRUGS & THERAPEUTICS COMMITTEE

Held on 7th April 2021
in St Bede's Conference Centre / Zoom

Attending

(RT) Rebecca Trower – Clinical Director / Chair (Dr JS) Dr Jenny Strawson, Hospice Palliative Care Consultant (Dr GT-R) Dr Gaby Tamura-Rose, Hospice Palliative Care Consultant (TC) Tracy Christmas – Community Services Manager NMP (AR) Alex Rudkin – Head of Quality and Improvement / Mins	(GL) Gail Linehan – Joint CEO (HT) Hai To - Sutton CCG Care Home Pharmacist (TY) Tracey Young - IPU Manager (HH) Heather Howell - Advisory Committee Member (LB) Laura Briant – Practice Educator

ITEM 1: Welcome

1.1 RT extended welcome

ITEM 2: Apologies for Absence

(BG) Bernadette Griffin -CNS, NMP, (KH) Kevin Hobson - CNS NMP, (AA) Dr Ambreen Akhtar – Doctor, (MG) M Gibbs - Ashton's Pharmacist, (AM) Dr Annelise Matthews - Hospice Palliative Care Consultant, (JS) Jill Smith -CNS, NMP

ITEM 3: Minutes of the Last Meeting

Minutes of the last meeting held on 11th November 2020 were agreed.

ITEM 4: Matters Arising

a) The IPU medication stock list has been reviewed, revised and published. The stock list will be reviewed annually by the Med Team and Ward Manager.

b) PRN administration in the community by carers was a subject that TC had began considering pre-Covid and has been on hold. She has reflected previously that extending carers' involvement in medication administration in end of life care won't lessen the support that they will require and will likely be only useful to a minority. JS volunteered that this matter be taken up by the medical team. — JS

c) No further update on AM's review of the Hospice's Diabetic Guidelines last reviewed in November 2018 to reflect desired changes. JS to discuss with AM. — JS/AM

d) HT will send on the SWL Alliance Quick reference Guidelines for GPS and Primary Care Clinicians for 'The Identification, Treatment and Management of Malnutrition in Adults, Including the appropriate prescription of Oral Nutritional Supplements' for circulation to the clinical team. — HT

e) Nutritional supplement training was delivered to Hospice staff on 26 November 2020. HT advised that the CCG Dietician is available to advise on any specific dietary needs.

f) The need to regularly deliver IV therapies has not been realised and consequently IV Therapy provision has not been included in the CAP for 2021/22. Known difficulties regarding IV Therapy management are specifically related to ensuring competency of staff given the low demand and management at night. TC posed the question of how many patients are sign-posted to the acute sector rather than the Hospice due to hyperglycaemia. JS reflected that should a patient have sepsis then the Hospice isn't the correct environment. It was not known if other Hospices had audited their use of IV antibiotics. This item remains relevant and may be informed by more information on the demonstration of need. Removed from the Agenda for the time being.

g) Guidance for Prescribing and Administration of Continuous Subcutaneous Infusion Furosemide for Adults with End Stage Heart Failure in the Community has been issued. It was noted that the guidance hasn't been adopted by Sutton CCG due to different ways of working to Merton.

h) A Journal Club presentation has been delivered by AM with focus on UTIs and education before prescribing. Link to journal club topics and presentations will be circulated to the wider clinical team JS

i) Discussing the need for local guidance on ketamine and methadone use, it was acknowledged that the Hospice previously had guidance on ketamine use that was removed from its Manual owing to it replicating the PCF. It has its own CLIN28 Ketamine - Monitoring Guidelines for Palliative Care Patients. JS has accessed guidance on using Ketamine from PAH that is based on the PCF. The use of Methadone guidance is regarded as more useful at PAH and PAH kindly sent on copy of their audit tool to JS. Our use of methadone is very infrequent but the medical team will initiate draft of local guidance for methadone use and will explore a shared audit with PAH. The PCF provides primary reference. HT advised that methadone prescribing in primary care is via clinics and not GPs apart from the Cheam Family Practice. HT doesn't believe Methadone falls under shared care so recommends not prescribing it at all. JS

j) Further minor adjustments have been made to CLIN33 Non-medical Prescribers' Policy. TC queried from whose budget does oxygen prescribing come out of. She advised that a small prescribing budget had been allocated for the community team NMPs but that oxygen wasn't included on the medications list. In essence, its costs need to be re-directed to Primary Care given our budget doesn't cover it being prescribed. HT will email Sarah Taylor to ensure she's aware of the issue. HT

ITEM 5: Pharmacy Update

MG had sent apology for the meeting but provided an update in whish she advised that she has had no concerns to report over the past months. There have been no prescribing errors, only a very occasional tiny detail to clarify. The nurses manage medicines with great efficiency and attention to detail, expiry dates of medicines are checked, stock levels are being revised in the light of the updated stock list and disposal is done in a timely and thorough way. Controlled Drugs are managed extremely well and no discrepancies have been noted or reported.

She highlights that there has been a change to the service provided by Ashtons where the Hospice now receives a next day service now. Although it's always preferable for medicines to be dispensed in a pharmacy, she has talked about introducing an 'emergency dispensing' pack and procedure for use on rare occasions where a patient needs a medication which could be supplied from stock to cover the next 24 – 48 hours until a further supply can be provided. I know that alterations to TTOs can cause huge upheaval and using this approach could help to avoid a delayed discharge.

ITEM 6: End of Life Prescribing

6.1 Final amendments and proofing of CLIN57 Community Guidance on Injectable Medications for Symptom Control at the End of Life and CLIN57a Flow Chart for Community prescribing at the end of life are to made. Once completed and published the material will also be made available on the Hospice website. JS/GT-R AR

ITEM 7: Update on Medication Policy review

7.1 There have been 7 published updates to medication policy / guidance since the last meeting between December 2020 and March 2021:-

CLINSOP03 Inpatient Unit Medication Round N:\Policy Manual\CLINSOP\CLINSOP03 Inpatient Unit Medication Round.pdf v2 issued 24-02-2021 (amendments throughout)
CLIN25 Controlled Drug Policy N:\Policy Manual\CLIN\CLIN25 Controlled Drug Policy.pdf v2.0 issued 25/02/2021 (minor amendments throughout, CDAO changed to Clinical Director)
CLINSOP07 Inpatient Unit COVID swab testing and accessing results - Microbiology St Helier Hospital N:\Policy Manual\CLINSOP\CLINSOP07 Inpatient Unit COVID swab testing and accessing results - Microbiology - St Helier Hospital.pdf v1.0 issued 03/03/2021 (new)
CLIN21 Anaphylaxis Management Guidelines N:\Policy Manual\CLIN\CLIN21 Anaphylaxis Management Guidelines.pdf v2.5 issued 05/03/2021 (multiple amendments throughout)
CLIN58 Use of the MAAR Chart for subcutaneous and intramuscular medication in the community N:\Policy Manual\CLIN\CLIN58 Use of the MAAR Chart for subcutaneous and intramuscular medication in the community.pdf **v1.0 issued 19/03/2021** (NEW)
CLIN59 Prescribing Palliative Home Oxygen N:\Policy Manual\CLIN\CLIN59 Prescribing Palliative Home Oxygen.pdf v1.0 issued 19/03/2021 (NEW)
CLIN33 Non-medical Prescribers' Policy N:\Policy Manual\CLIN\CLIN33 Non-medical Prescribers' Policy.pdf v5.0 issued 31/03/2021 (minor adjustments throughout)

7.2 There have been 2 publications removed from the Manual:-

CLIN43 Urethral Catheterisation Policy

CLIN29 Preparing and Administering Injectable Medication Guidelines

7.3 Medication policy / guidance overdue for review are:-
CLIN27 IV Administration – Dr Akhtar lead AA
CLIN26 Generic Drugs – M Flint Lead MF

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 has been 1 alert relevant as listed.

Reference	Title	Date	Action
MDSB-20-02	Medical Devices Safety Bulletin 5-11-2020	05/11/2020	Duracell Plus battery – England NHS Supply Chain NPC code WPA244 recommended. Currently using Procell batteries. Continue with the Procell batteries but have a low threshold for completing an incident for any issue regarding our syringe drivers then review each incident.

ITEM 10: Any other business

10.1 HT will email AR the Management and Treatment of Infections in Primary Care Guidelines for circulation to clinical members HT/AR

10.2 GT-R has canvassed other Hospices for guidance on Using Keppra via syringe driver. GT-R

10.3 SWL MAAR Charts have been re-published.

10.4 AR has requested leaflet production for Anticipatory 'Just in Case' medications. He will chase. AR

10.5 Standard Operating Procedure for management of FP10s is a work in progress. TC

ITEM 11: Future Dates

11.1 Dates of future meetings in 2021

Date	Event	Venue/Time
Tues, 13th July 2021	Drugs and Therapeutic Committee	St Bede's 15.30
Wed, 17th November 2021	Drugs and Therapeutic Committee	St Bede's 13.30

Ref No.	Recorded By	Date	EXAMPLES OF EXCELLENT PRACTICE - Description	Link to evidence	PT Id	KLOE	Key Staff	Related System
2021/31	GL	12/05/2021	Award of 5 STARS following an unannounced inspection from the Kingston and Sutton Environment Regulatory Service on 12th May 2021. Congratulations and well done to Paula and all the Housekeeping Team.	Evidence of excellence copy\Congratulations on Achieving FIVE STARS for Environmental Health.msg	n/a	S,C,E,W	P Di Palma	Housekeeping
2021/32		13/05/2021	Bladder scanner probe broken on IPU a few months after purchase. Ward Clerk Carol Thompson has been liaising with the company re the bladder scanner probe and following a visit by them today she has managed to get a new probe for £700 instead of £1600 originally quoted ! Some EXCELLENT negotiations going on there!		n/a	E	C Thompson	IPU
2021/33	AR	14/05/2021	A short video made by Emma Burns alongside the funding application to help us to stand out from the crowd, emailed and shared directly with the potential funding organisation on Instagram. It shows innovation and ingenuity. Also, because the opportunity to apply was identified on application submission deadline day and instead of thinking 'it's too late to apply now' EB worked really hard all day to get it done as applications like this are a key part of our corporate strategy.	N:\Care Quality Commission\Excellence in Practice\Evidence of excellence copy\Octopus Charity of the Year Partnership.msg	n/a	R, E	E Burns	Corporate Fundraising
2021/34	JS	19/05/2021	An example of excellent team working in the community and IPU: A patient was identified for urgent admission to the hospice by Jane CNS. As he and his daughter are both deaf, Alison and Linda from the hospice at home team went to visit following the admissions meeting to tell him about there being a bed available. Alison was able to use her sign language skills to communicate this. He initially struggled to fully understand, so the team also thought to show him the video on our website about the hospice. Once he understood the reason for admission and more about what the hospice does, he accepted the bed. The community team then liaised with the IPU team so that a BSL interpreter known to the patient could be booked to have initial discussions with him at the hospice, they also alerted the team to a phone app which can transcribe speech into writing for communication. The IPU manager and ward administrator liaised with the CCG to request a carer with BSL skills to support his ongoing admission. One of the ward nurses Sara also had some signing experience and was able to use these to help settle the patient on admission. As the interpreter was late, the consultant stayed until after hours to review him with her. Alison from the hospice at home team offered to support the patient over the next few days on the IPU.		16373	R,C,E,W, S	Alison, Linda HCA,	H at H, Community team, IPU
2021/35	MF/AR	25/05/2021	Reflective Account from a senior RGN on the IPU : A young mother was admitted for terminal care. Over the weekend her condition rapidly deteriorated. Her husband and in-laws were very worried about what to tell her children who are a 7 year old girl and a 9 year old boy. The counsellor from Jigsaw was unavailable. Although an experienced nurse, our senior RGN felt she lacked knowledge about how to prepare the children as this situation fortunately has not arisen often at SRH. She learnt how important it is to build up a rapport with the children and the importance of listening to the husband for background information about how the children had been prepared. He had mentioned about the support the lady from Jigsaw had given the children. She had explained about what a hospice was and that "Mummy will not be coming home again. They had spoken about 'Mummy dying'. The lady from Jigsaw had also explained not to say "Mummy has a poorly tummy", to be honest and clear otherwise when the children get a bad tummy they might think they are going to die. All of this helped guide our RGN's care who also understood from reading the patient notes and speaking with her friends how important their Christian church was to them as a family. She knew therefore that the children would have a concept of a loving God and also heaven. Our social worker confirmed siblings should be told bad news together and not separately. Our RGN made sure both children were sitting comfortably in a private room with just Dad and grandparents present. She asked the children to tell her what the Jigsaw lady had said. They explained about Mummy coming to a hospice but both children went very quiet. After a silence which our RGN knew to allow she asked how they felt about that. The little boy said "very sad". Our RGN acknowledged how sad it is. She explained that Mummy is now very ill and her body is no longer working and is causing her pain. That we are giving her medicine to help her be comfortable and not in pain. She explained that Mummy will hear them and feel them touch her but is now so sick she cannot respond. Her breathing is noisy but the medicine is keeping her comfortable. On reflection, she states that she should have paused and asked them to recall what she had said so she could gauge their understanding and answer any questions. The children were listening intently but remained very quiet so our RGN continued. Knowing that their Christian faith was very important to them she explained that because Mummy's body isn't working now that God will call her and take her to heaven, a beautiful place, where she will be happy and not in pain. Our RGN explained that Mummy is struggling because when does not want to leave them but she has no choice because her body is so sick. She explained that we don't know when God will call her - it may be today but it could be in the next few days. The children understood because they started to cry and turned to their Daddy and grandparents who comforted them. Our RGN left them together. An hour or so later, she checked on the patient who had a close friend with her and realised her breathing was shallow and she imminently dying. Her rapid deterioration shocked our RGN because she bo nearly missed the moment. She quickly got the husband and use the words come she is dying and turned to the children and said God is calling Mummy now. I encouraged the children to climb onto the bed and cuddly Mummy and so did her husband. She left them in the room together taking down the bed sides so there were no barriers. The children and husband were crying in a heartfelt despairing way but I our RGn gave them space to spend this precious time with their Mummy/wife. The patient took occasional breaths and was dying very peacefully. Our RGN waited outside the room with the in-laws and family friends. After 10 minutes the rest of the family joined them including friends. Following her death we asked the children whether they wanted finger print of their mummy on a wooden heart. They did and finger prints were taken. We then went to the chapel and lit a candle and the family wrote prayers and her name in a book. Later, our RGN highlighted to our Practice Developer that our staff could do with more guidance in preparing children who may loose a parent. Our Practice Developer telephoned the lady from Jigsaw who confirmed the "children had told her in detail what had happened" and that she "could not fault our RGN's care".	Evidence of excellence copy\cf reflection.pdf		C, R, E, W	C Foster	IPU
2021/36	TY/JF	27/05/2021	Agency nurse Julie Otiena noticed a transdermal medication was not quite right on observation and checking on a drug round which is not normallly our practce and raised this with nurse in charge. Patient was not receiving medication prescribed but due to her timely intervention this was rectified within 4 hours of error. This has now made us more aware and has changed our practice with transdermal medication patches.			C, R, S		
2021/37	TC	25/05/2021	CNS Jill Smith and Nik Sanderson together responded promptly in a deteriorating complex home situation on the 25/ 05/21. NIK demonstrated flexibility and rearranged her working day so she could visit at home and spend a prolonged time with patient supporting her choices . .Not only did the team act responsively they recognised and respected her personal and cultural needs , validating her as an individual and supporting her personal choices . The situation was deteriorating and complex however there was evidence of good integrated working practices in the last days of Queens life with CPCT / DN's and LAS phoning the hospice OOH for advice and achieving her PPD	EPR	9892 QM	R, E ,S	Community JS / NS	
2021/38	SV	21/06/2021	An excellent example of practice across the community and inpatient setting as multiprofessional team from HCAs, day and night nurses, doctors, social worker, management, ward clerks to organise a marriage licence and ceremony at short notice under special circumstances for a lady to marry her partner in order to support their young son after her death. This was excellent on many levels: 1. Understanding of diversity: they were a same-sex couple with a child and so there was open communication about this between community and inpatient teams, and reception, in order to use the correct titles and no assume to ask about the 'dad' when the child was being brought up by two mums instead, and to aks about marriage to her wife rather than husband. 2. Finding the balance between physical symptom control and minimising side effects of medications: regular discussions between the patient, relatives, nurses and doctors to ensure that she had adequate pain relief but was not too drowsy to be able to participate in the wedding preparations, the ceremony itself, and time with her loved ones. 3. Timely compassionate and honest conversations with patient and family in the community and inpatient unit to explore and help prepare the patient and relatives for her reaching the end of her life and life after she would die especially regarding care of their child, assets etc. 5. Open and supportive about organising to the wedding to meet the patient and partner's wishes: open conversations with patient, partner, nurses,doctors, and social worker Elisa to organise the wedding they wanted 4. Care after death: legacy memory keepsakes organised by HCA Paula with family		15790	C, R, W	Community nurses/doctors, IPU nurses/ HCAs/ doctors/ PA/ ward clerks, reception, Eilsa,	
2021/39	sv	23/06/2021	Enabled patient to be discharged in time for important trip to Bournemouth in light of short prognosis by effective nursing and medical teamworking. This was followed by post-discharge support by Inpatient Unit Nursing and Medical Teams when patient called on day of discharge with queries related to medication changes and symptoms. IPU explored and addressed questions and new symptoms to provide a community plan so she could still go to Bournemouth. We liaised with GP about new prescriptions in time for her holiday, copied amended discharge summary to GP and patient to keep her informed. This was possible with MDT IPU teamworking - nurses, doctor (speciality doctors, registrar, consultant) and ward clerk - and with GP and we updated community follow up plan and discharge paperwork documentation to reflect changes and enable smoother continuity of care. IPU team addressed patient's concerns rather than ask patient to call community triage despite being discharged, in order to relieve pressure off community and perhaps make it more efficient to support patient as she had recently been discharged from IPU.		16303	C, R, W	IPU nurses (Helen, Julie, Carmen, Christina), doctors (Ambreen, Sabrina, Jenny), PA Jovie, Carol	

St Raphael's Hospice

Minutes of a Meeting of the Clinical Quality & Governance Committee

Held using Zoom Video Conferencing

At 10:00 on Friday 14th May 2021

Members: Dr Carrie Chill – Board Advisor & Committee member (CC)
Alan Cogbill – Trustee & Committee member (AC)
Dr Joy Tweed – Trustee & Committee member (JT)

In attendance: Gail Linehan – Joint CEO (GL)
Nick Stevens – Joint CEO (NS)
Norman McWhinney – Chair of Trustees (NM)
John Groom – IT & Facilities Manager (JG – items 6-10)
Alex Rudkin – Quality Development Manager (AR)
Dr Jenny Strawson – Consultant (JS)
Dr Gaby Tamura-Rose – Consultant (GT-R)
Rebecca Trower – Clinical Director (BT)
Anna Machin (Clerk – AM – items 6-10)

Actions arising

Agenda item	Action	Responsible	Timeline	Ref.
5. Evidence of Excellent Practice register	Share document with Board	Anna Machin	2nd June meeting	21/05/14-01
6. Clinical risk register	Ensure HR Committee consider position on staff contracts and vaccination	Gail Linehan, Anna Machin	Next HR Committee meeting	21/05/14-02
10. AOB	Move date of next meeting	Anna Machin	Immediate	21/05/14-03

1. **Apologies for absence**

   Committee members were welcomed to the meeting. There were no apologies sent to the meeting.

2. **Review of minutes from last meeting**

   The minutes of the 26th February 2021 meeting were reviewed and approved as an accurate record of proceedings.

3. **Action list from previous meetings**

   Committee members reviewed the matters arising, noting that many actions had been completed since the prior meeting:

- 04/01; 11/01 Performance management policy – Gail Linehan and the Head of HR had a meeting planned to progress this policy.
- 21/02/26-06 – the outreach process for new Committee members is underway and an update will be provided at the next meeting.

4. IPU refresh

The IPU refresh project will start on 26th July and the ward will re-open 31st August 2021. The options appraisal considered re-locating the IPU service but due to the short term nature of the closure this has been decided against. Other local Hospices (StC & RTH) have agreed to accept admissions of our patients should their capacity allow. Admission wind-down of the IPU commences 26th June with plenty of communication planned with patients/ families. It is hoped that on the planned re-opening date of 31st August, a 12 bed service can be offered, subject to staffing safely.

The project will deliver a re-fresh, redecorated unit with design changes to accommodate a designated family area, a new IPU reception area and more effective use of storage space. The patient rooms will have SMART TVs installed, with the en-suite bathrooms refreshed and perhaps re-floored. The Mortuary will also be refreshed.

IPU and Housekeeping staff will be re-deployed/ take annual leave/ fulfil mandatory education needs. There will also be opportunity for IPU staff to enable the Community and Housekeeping staff to support Retail and Reception.

Recent email communication has diluted emerging anxiety amongst staff if they were to be re-deployed to areas they did not wish to work in or were forced to take annual leave and the staff outlook now is very positive for the 5 week period.

Infection control has been considered in the project's planning and there are plans for fewer soft furnishings in the refreshed unit than before and carpets will be replaced by an alternative flooring. The rooms will be more spacious.

Consideration of the required replacement of fire doors on the IPU and accommodation of viewing windows in such replacement doors will also be undertaken following the Fire RA visit planned for 27th May. Replacement of fire doors does have a significant funding implication and the requirement needs further consideration. The possibility of using technology to observe patients in their rooms was discussed and was not thought to be a currently viable solution due to issues around privacy and consent.

5. Evidence of Excellent Practice register

The following areas were highlighted from this document:

- The Gold Award to Pete Morris, Facilities Dept, at the Health Hero Awards
- The care delivered to a patient admitted from a local prison. Elisa Lunn has completed a reflection and MDT staff are all slightly wiser to the system.
- The willingness and commitment of staff on the IPU to step up to roles and that such behaviours are not taken for granted. A recent International Nurses' Day showed the unity amongst the team.

It was agreed that the Excellent Practice Register extracts would be useful documents for the Board to see, and this item would be added to the Board agenda.

6. Clinical Risk Register

The Committee discussed the organisational position regarding staff hesitancy to be vaccinated and supported the stance that there was no mandate for staff to be vaccinated. Staff are recommended to undertake weekly PCR and lateral flow testing.

It is understood that there is a consultation underway to consider the mandating of vaccination of healthcare staff but there is no official line at present.

The Hospice continues to follow government guidance on the use of PPE. The review of CLIN52 Managing COVID continues to be reviewed as required and each month. The organisational approach to staff who do not undertake testing may be a consideration that needs to be covered in the CLIN52 policy.

The Committee suggested further consideration for the Hospice's employment contracts to cover vaccination requirements. This item would be referred to the HR Committee to consider the matter of Staff Vaccination and Contractual Implications alongside any legal advice that can be obtained.

Registered nurse staffing on the IPU remains a risk despite recent appointment of a band 6 nurse and 4 RGNs to the bank. Consideration is being given to training up band 4 nurses but unsure if that would service acceptable cover for the 2nd RGN on nights. It was agreed that the rating should remain constant for this risk. The Hospice is upskilling Band 5 nurses and this is included in the Clinical Action Plan.

In relation to other risks notes on the risk register, the Sickness and Maternity leave policies have been reviewed. It is acknowledged that the IPU Manager has undertaken a lot of clinical shifts alongside her management role and Rebecca Trower is reviewing a number of issues aligned to the role. Supervision of the Nursing Associate hasn't added to the supervisory burden that is in place for all new clinical personnel, and the role is proving a real benefit. Nursing Associates have their own registration infrastructure. It was agreed that risk of incidents requires no change.

IT system failure out of hours is a risk that has recently seen a support contingency set up with an IT consultant but it remains a risk that is noted. John Groom, Head of IT, was invited to summarise recent IT issues and explained that the Hospice system had been recently upgraded to a hybrid system with servers in the cloud. A number of separate issues had regretfully happened in the space of 6 weeks including a cyber attack having had a sustained period of years with very little disruption. Disaster recovery testing is further planned for the IPU's down-time. It was agreed that the risk rating for IT would remain unchanged pending the DR testing review in August 2021.

7. Clinical Quality & Governance Report

Rebecca Trower updated on the Hospice's continued Covid-19 response. Head of Department meetings are held monthly and the Hospice will review visiting restrictions in line with government guidance. The updated Wellbeing Centre offer will be launched on Wednesday 19th May. The IPU is flexing bed capacity in line with staffing and recently moved from 6 to 8 beds. The Education team have produced a poster for Hospice UK on approaches to supporting non-clinical staff during Covid-19 which arose from the St Raphael's Reflections report. The Capacity Tracker continues to be completed on a daily basis.

In terms of staffing, the third Consultant has recently been appointed and commences in post on July 5th, the Phsyician Associate role is working well, and medical students from St Helier's Hospital spend time in the Hospice. Dr Andrew Hoy (Consultant) who is a longstanding team member has confirmed his resignation and will continue to deliver some training. Thanks are also due to Dr Annaliese Mathews who has been an agency Consultant for the Hospice for the past two years. The committee asked for their thanks to be passed on to both Andrew and Annaliese.

The Community Team will soon be moving from one to three teams based on geographical location. The Committee asked whether this would align with local primary care networks.

Rebecca Trower confirmed that this had been based on locations of GP surgeries to ensure support would be time-efficient and responsive. Once shift patterns have embedded, further opportunities to network with other agencies will also be explored.

The Committee noted the sensitive handling and learnings from Complaints. The Committee noted that referral numbers had decreased for the past year from around 1,000 to 870. It was confirmed that this had been experienced by other Hospices and was primarily due to the impact of Covid-19. There has been a recent rise in referrals, which may in part link to the increase in late presentation of cancer diagnoses.

8. CAP 2021/22

Alex Rudkin framed the Clinical Action Plan, noting that that some items that had been carried over from 2020/21 were at or nearing completion, such as increasing counselling support. The rotation of IPU staff across 24 hours (CAP2) continues to be a focus to ensure staffing at night. There has been progress in relation to including the audit of clinical risk assessment that supports individualised care planning (CAP6). The implementation of Outcome Assessment Complexity Collaborative (OACC) is a significant project (CAP7), the Policy has been written and a training session delivered to coincide with International Nurses' Day on May 12th.

Staff will engage further with the Datix system (CAP9) before the IPU refresh and new joiners to the organisation are engaging well with the data. Processes relating to the Verification of Expected Death (VoED) during daytime and out of hours are being reviewed (CAP11). There has been outreach to increase the Hospice's community profile (CAP14) through attendance at the Community Heart Failure MDT, a nursing home joint visit, and delivering GP masterclasses. The time when IPU is closed will be used to focus particularly on this area. The designation of Clinical Lead for the medical team (CAP15) will rotate every 18-24 months- the current Clinical Lead is Dr Jenny Strawson. Dr Gaby Tamura-Rose has taken on the Caldicott Guardian role.

The Committee commented on the extraordinary process of change within the Hospice as shown through this document during such a challenging year.

9. Minutes of meetings and other documents

The Committee noted that the VOICES report touched on linkages with other agencies, and equality and diversity, which had been considered at the March Board meeting. The Hospice is on a journey to increase the diversity of patient referrals, and providing information on patient equality data compared to the local area will help to contextualise progress towards this goal.

10. Any Other Business and Dates of future meetings

There were no further items raised under Any Other Business. It was agreed that the next meeting would be moved from 25th June to July to allow a greater interval between Committee meetings.

The meeting ended at 11.45pm.

Approved………………………………….. Date………………………………………..

Care of Dying Adults in the last days of life - IPU & Community Audit

1.0 Introduction

The ways in which people die and how long this takes varies widely, mostly because of the underlying diseases responsible but also the person's robustness or frailty, and their social setting. Some people remain mobile and largely self-caring, and can continue to take oral medication and eat and drink up until their death. Others may die suddenly and unexpectedly after a significant trauma or catastrophic medical event. Some people may never experience any symptoms. People with progressive cardiac, pulmonary or neurological disorders, dementia, some forms of cancer or who have had a stroke may spend several weeks or months in a gradual or intermittent decline. Although NICE guidance NG31 Care of Dying Adults at the End of Life guideline (NG31) focuses on the people who are thought to be in the last few days of life, for many people, especially those in a gradual decline, the principles of communication, shared decision-making and pharmacological care can be applied far earlier in their care. The guidance applies to all people at the end of life, whether they are conscious or unconscious.

For some people who are entering the last days of life, mental capacity to understand and engage in shared decision-making may be limited. This could be temporary or fluctuating, for example it may be caused by delirium associated with an infection or a biochemical imbalance such as dehydration or organ failure, or it could be a permanent loss of capacity from dementia or other similar irreversible conditions. NG31 makes clear the duties of the multi-professional team regarding communication and involving those people important to the dying person. The guideline provides recommendations to help healthcare professionals to recognise when a person is entering the last days of life or may have stabilised or be improving even temporarily; to communicate and share decisions respectfully with the dying person and people important to them; and to manage hydration and commonly experienced symptoms to maintain the person's comfort and dignity without causing unacceptable side effects.
This audit sets out to examine the Hospice’s compliance with QS144 – Care of dying adults in the last days of life which is based on NG31.

2.0 Aims

1. To assess compliance against the standards.
2. To inform discussion and required actions on the use of Phase of Illness and Karnofsky scoring.
3. To inform discussion and required actions on the suitability and use of the EPR.

3.0 Methodology

Retrospective audit of 32 inpatient unit and 41 community patient deaths in December 2019 and January 2020. Data collection criteria is based on NICE Quality Standard QS144. Excel data capture tool designed for data population via the EPR and clinical review of the EPR.

4.0 Standards

Standards are based on NICE Quality Standard 144 Hospice's care-of-dying-adults-in-the-last-days-of-life-pdf-quality standards March 2017.pdf :-

1. 100% dying adults in last days of life have DAILY monitoring of signs and symptoms
2. 100% dying adults in last days of life have individualised care plan
3. 100% dying adults in last days of life have care plan discussed with them and people important to them
4. 100% dying adults in last days of life have the care plan followed
5. 100% dying adults in last days of life have anticipatory prescribing needs assessed for symptoms likely to occur in last days of life
6. 100% dying adults in last days of life prescribed anticipatory medications with individualised indications for use, dosage and route of administration
7. 100% dying adults in last days of life have their hydration status assessed daily
8. 100% dying adults in last days of life have discussion about risks and benefits of hydration options

RESULTS

Introduction

Data reflects upon 32 inpatients and 41 community patients who died between December 2019 and January 2020.

Demographics

	IPU	IPU %	Community	Community %
Male	20	63%	13	32%
Female	12	37%	28	68%

Age

Age	IPU	Community
Range	33 - 94	62 - 100
Average Age at RIP	70	82
Median Age at RIP	72	84
Age Groups		
31-40	2	0
41-50	1	0
51-60	3	0
61-70	10	8
71-80	7	9
81-90	8	14
91-100	1	10

Diagnosis

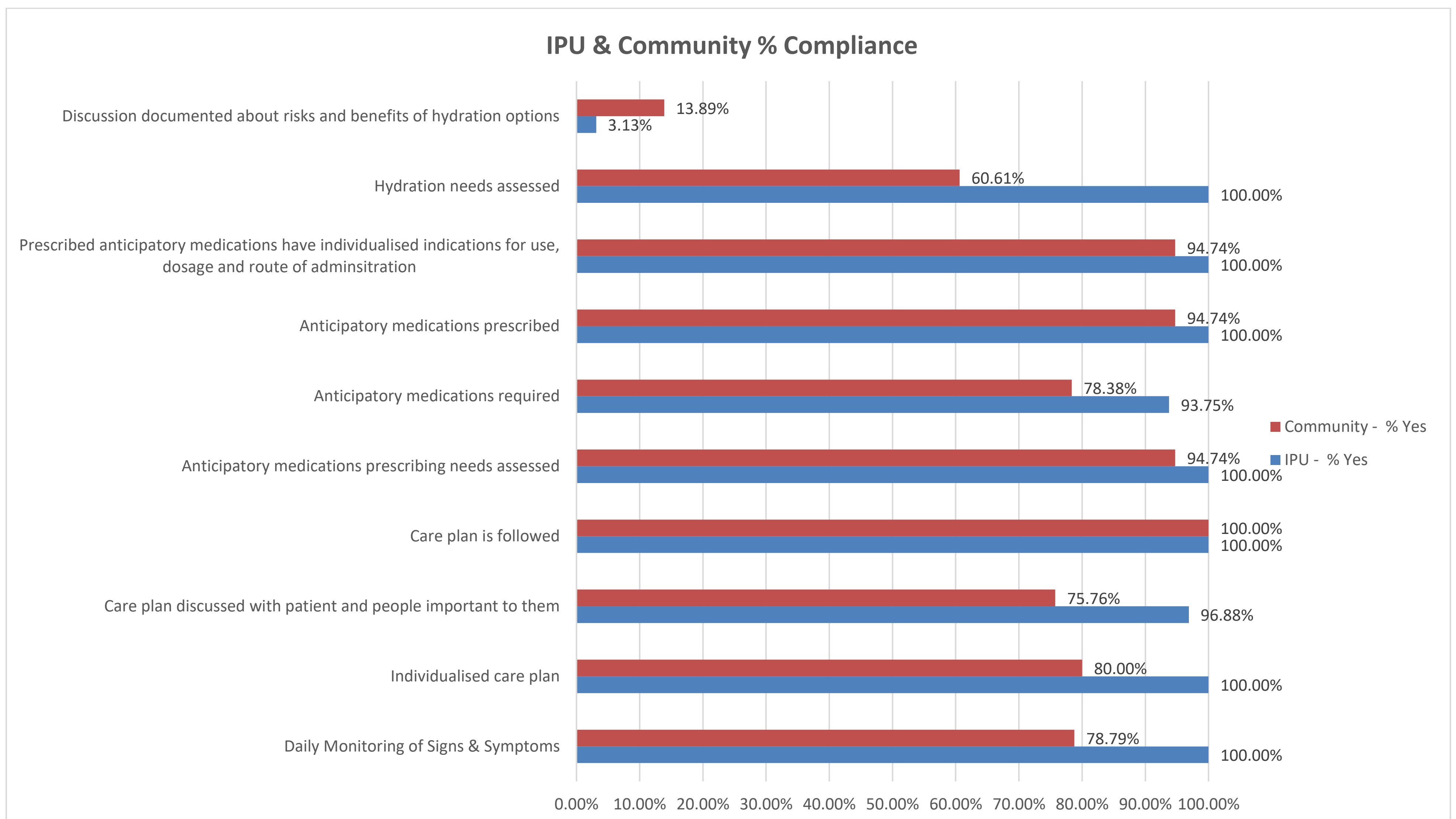
Diagnosis	IPU	IPU %	Community	Community %
Cancer	25	78%	24	59%
Non-cancer	7	22%	17	41%

LoS and Days Between Start of Referral and RIP

	IPU (LoS)	Community (Referral to RIP)
Range	0-86 days	0 – 617 days
Average No of Days	10.5	103 days
Median No of Days	5 days	33 days

Documentation

	IPU - Numbers			IPU - %			Community - Numbers			Community - %		
	Yes	No	N/A / Not Audited	Yes	No	N/A / Not Audited	Yes	No	N/A / Not Audited	Yes	No	N/A / Not Audited
Daily Monitoring of Signs & Symptoms	31	0	1	**100.00%**	0	1	26	7	8	**78.79%**	0	1
Individualised care plan	31	0	1	**100.00%**	0	1	28	7	6	**80.00%**	0	1
Care plan discussed with patient and people important to them	31	1	0	**96.88%**	3.12%	0	25	8	8	**75.76%**	1	0
Care plan is followed	32	0	0	**100.00%**	0	0	27	0	1	**100.00%**	0	0
Anticipatory medications prescribing needs assessed	32	0	0	**100.00%**	0	0	36	2	3	**94.74%**	0	0
Anticipatory medications required	30	2	0	**93.75%**	6.25%	0	29	8	4	**78.38%**	2	0
Anticipatory medications prescribed	32	0	0	**100.00%**	0	0	36	2	3	**94.74%**	0	0
Prescribed anticipatory medications have individualised indications for use, dosage and route of administration	32	0	0	**100.00%**	0	0	36	2	3	**94.74%**	0	0
Hydration needs assessed	327	0	0	**100.00%**	0	0	20	13	8	**60.61%**	0	0
Discussion documented about risks and benefits of hydration options	1	31	0	**3.13%**	96.87%	0	5	31	5	**13.89%**	36	0


IPU & Community % Compliance
Discussion documented about risks and benefits of hydration options
13.89%
3.13%
Hydration needs assessed
60.61%
100.00%
Prescribed anticipatory medications have individualised indications for use, dosage and route of adminsitration
94.74%
100.00%
Anticipatory medications prescribed
94.74%
100.00%
Anticipatory medications required
78.38%
93.75%
Anticipatory medications prescribing needs assessed
94.74%
100.00%
Care plan is followed
100.00%
100.00%
Care plan discussed with patient and people important to them
75.76%
96.88%
Individualised care plan
80.00%
100.00%
Daily Monitoring of Signs & Symptoms
78.79%
100.00%
0.00% 10.00% 20.00% 30.00% 40.00% 50.00% 60.00% 70.00% 80.00% 90.00% 100.00%
Community - % Yes
IPU - % Yes

Collateral Analysis

Phase of Illness Recording

	IPU			Community				
Latest Phase of Illness recording	Yes	Last recorded within 1 day of RIP	Last recorded within 3 days of RIP	Yes	Last recorded within 1 days of RIP	Last recorded within 3 days of RIP	Last recorded 4-7 days	Last recorded >7 days
Dying Stage	24			14				
Deteriorating	7	4	3	11	7		4	
Stable	0			5	1			4
Unstable	0			6		1	3	2
Phase Not Recorded	1			5				

Phase of Illness was recorded better on the IPU than in the Community

Was Dying Stage identified

	IPU			Community		
	Yes	No	Yes %	Yes	No	Yes %
Dying Stage Identified via PoI or Notes	30	2	94%	30	11	73%
POI 'Dying' recorded when identified	24	8	75%	10		33%

Karnofsky Scoring

The significance over the collateral analysis of Karnofsky scoring is sufficiently low not to warrant analysis. (see Conclusion Point 5).

Additional Review : Days between RIP and last Community Team Visit / last Community Team t/c

	Community					
Latest Phase of Illness recording	Yes	Last visited within 1 days of RIP	Last visited within 3 days of RIP	Last visited 4-7 days	Last visited >7 days	Not Visited before RIP
Dying Stage	14	10	2	2		
Deteriorating	11	6		2	2	1
Stable	5	2			3	
Unstable	6	1		2	3	
Phase Not Recorded	5	2				3

- 12 of the 14 patients (86%) with a POI 'Dying' were visited either by a CNS or a H@H HCA within 3 days of RIP
- 6 of the 11 patients (55%) with a POI 'Deteriorating' were visited either by a CNS or a H@H HCA within 3 days of RIP
- 2 of the 5 patients (40%) with a POI 'Stable' were visited either by a CNS or a H@H HCA within 3 days of RIP
- 1 of the 6 patients (17%) with a POI 'Unstable' were visited either by a CNS or a H@H HCA within 3 days of RIP
- 14 of the 14 patients (100%) with a POI 'Dying' were visited either by a CNS or a H@H HCA within 7 days of RIP
- 29 of the 41 patients (71%) who died were visited either by a CNS or a H@H HCA within 7 days of RIP

	Community					
Latest Phase of Illness recording	Yes	Last t/c within 1 day of RIP	Last t/c within 3 days of RIP	Last t/c within 4-7 days of RIP	Last t/c >7 days of RIP	No t/c before RIP
Dying Stage	14	11	3			
Deteriorating	11	6	2	3		
Stable	5	1	1		2	1
Unstable	6	1	2	1	1	1
Phase Not Recorded	5	3	1			1

- 14 of the 14 patients (100%) with a POI 'Dying' received a telephone call from a CNS or a H@H HCA within 3 days of RIP
- 8 of the 11 patients (73%) with a POI 'Deteriorating' received a telephone call from a CNS or a H@H HCA within 3 days of RIP
- 2 of the 5 patients (40%) with a POI 'Stable' received a telephone call from a CNS or a H@H HCA within 3 days of RIP
- 3 of the 6 patients (50%) with a POI 'Unstable' received a telephone call from a CNS or a H@H HCA within 3 days of RIP
- 14 of the 14 patients (100%) with a POI 'Dying' received a telephone call from a CNS or a H@H HCA within 7 days of RIP
- 35 of the 41 patients (85%) who died received a telephone call from a CNS or a H@H HCA within 7 days of RIP

5.0 Conclusions

1. Results show a higher percentage compliance across the standards on the IPU compared to the Community. Comparison is tenuous and should not be the focus.
2. Standards were met against 7 of the 9 standards on the IPU.
3. Standards were met against 1 of the 9 standards in the Community. However, despite nervousness about carrying out the audit in the community, compliance against the standards was high in all categories except assessing hydration needs, and documenting discussion about risks and benefits of hydration options.
4. Action required to improve the routine recording of discussion about risks and benefits of hydration options. Reviewers found documentation hard to find and scattered across domains of Crosscare. There was a perception that conversations were being had but not recorded.
5. A collateral finding of the audit was a reflection upon the use and recording of Karnofsky and Phase of Illness. The audit uncovered high variability between clinicians in assessing Phase of Illness and collection of this data highlighted the need for a re-implementation of Phase 1 of the OACC suite of measures that would support the use of Phase and Karnofsky through a documented procedure and planned education in 2021. The audit also identified the record prompted for Karnofsky definitions rather than the Australian modified Karnofsky definitions that is part of the OACC suite. The Crosscare record has since been updated with the Australian modified version of the Karnofsky performance score.
6. Re-audit in 2021/22

6.0 Areas for Improvement

6.1 To consider if changes to the Crosscare record or better worded prompts will resolve the recording of required information and facilitate the identification of where in the record's design should information servicing these standards be recorded.

6.2 Recording of discussion about risks and benefits of hydration options.

7.0 Auditor Comments

7.1 This audit arose out of interest in the IPU's compliance with NG31 and was originally designed to capture that data. Following the data collection period, interest also emerged into the compliance for our Community patients. The criteria were broadly transferred.

7.2 Audit data shows that there was high level of compliance in achieving the audit standards on the IPU. Whilst the 100% standard was not met across the majority of the Community standards, there were mitigations recorded in examination of the patient records

that made achieving 100% impossible, e.g. rapid and unexpected deterioration with unexpected death, patient not engaged with hospice services and therefore having received minimal support. The audit also uncovered factors which should be documented in future audit which are important in a patient's plan of care, for example:

- In the community some of the daily checks of signs and symptoms may be carried out by a patient's family members rather than health professionals
- Family members may not be available for the team to discuss the plan of care with them

7.3 Whilst the Crosscare record provides a prompt for the collection of specific data, it does not contain specific prompts aligned with the standards in this audit that would facilitate information recording. Consequently, only by examination of the whole record was the determination of compliance discerned. This extended the data collection period. Consideration should be given to an End of Life care template to facilitate care in accordance with NICE NG31 and demonstrating high quality care. It was the data collectors' shared impression that conversations and care were unrecorded due to there not being appropriate prompts for end of life related care such as hydration, or end of life symptom control, which made information difficult to find.

QUALITY ACCOUNT
2020-2021

"The care and attention was outstanding…Everyone who came into our home was professional, caring and so very kind. We could not have asked for anything more, they were superb"
(2020 VOICES SURVEY)

~

Part 1

What is a Quality Account?

The Quality Account for St Raphael's Hospice covers the period from 1 April 2020 to 31 March 2021 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 excellence 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, their families and friends. St Raphael's recognises and respects cultural, ethnic and religious preferences. We welcome, support and care for patients and families of all faiths, or none.

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 family members (including children) and other loved ones.**
- **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. 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 are actively engaging with our Hospice Strategy, EVE, which embraces **Excellence** in everything we deliver. We want the people of Merton and Sutton to have confidence that we will be there for them when they need us. We want to provide assurance that they will receive quality care in an environment which supports their wellbeing and that of those who are important to them, delivered by expert and skilled staff. We believe that by delivering on excellence we will raise the **Visibility** of St Raphael's within our community which will enhance **Engagement** across all sectors, creating a virtuous circle 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 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 excellent services that we aim to 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

St Raphael's Hospice

Part 2

1. Priorities for improvement 2021 – 2022

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 2020-2021. 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 Sub-committees have endorsed the Management Plan for 2021/22 and considers that its top three quality improvement priorities are:

Future planning priority 1:

An improvement priority to offer access to people with long term/chronic illness to the 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: Clinical Quality and Governance Sub-committee

Future 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: Clinical Quality and Governance Sub-committee and Board of Trustees

Future 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: Executive Team

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 2020/2021, 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 2020/2021 represents 100% of the total income generated from the provision of the NHS funded services by St Raphael's Hospice for 2020/2021.

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 2020/2021, 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 2020/2021 can be found at section 3.2.1.

2.4. Participation in clinical research

There has been no clinical research initiated in 2020/2021.

2.5 Goals agreed with commissioners

St Raphael's Hospice's income in 2020/2021 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 2020/2021.

St Raphael's Hospice participated in a Transitional Monitoring of Service call on February 23rd 2021 which is the new CQC model of ongoing inspection/review of services. 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 2021.

Part 3

3. Quality Review

3.1 Review of quality performance in 2020/2021

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

Past planning priority 1 : Datix Risk Management System

- **An improvement project to develop risk management**

Standard: To introduce a recognised gold standard amongst commissioners and providers alike in risk management software. To help measure and "move the needle" in improving quality.

Measure: Utilisation of Datix Risk Management software across incident reporting, feedback (complaints, compliments, concerns and suggestions) and risk assessment. General operational efficiencies will include more accurate information capture, improved information sharing and more rapid corrective actions.

Review: Plans for the implementation of the DATIX risk management system in 2020/21 were affected by the pandemic and consequential resource prioritisation of resources. Its implementation is now being progressed and implementation is expected to commence in September 2021.

Past planning priority 2:

An improvement priority to support counselling for post bereavement care

–

Standard: To target additional counselling support to the Hospice amongst psychological counselling students.

Measure: Psychological Update Report

Review: Additional counselling support provided by six student counsellors during 2020/21 has increased the service offered and alleviated pressures previously absorbed by the psychological support services team.

Past planning priority 3:

- An improvement project to demonstrate compliance with NICE guidance NG31 Care of Dying Adults in the last days of life

Standard: To demonstrate compliance across a range of criteria underpinned by NICE Quality Standard 144

Measure: Clinical audit report on NG31 Care of Dying Adults in the last days of life

Review: Results demonstrated a high level of compliance across the standards on the IPU and highlighted areas for improving documentation and aspects of outcome measurement.

3.2 Quality Management

Quality Improvement Committee

The Hospice's Quality Improvement Committee steers the Hospice's approach to quality assurance and improvement. Chaired by the Head of Quality & Improvement, it meets every 3 months. Its membership includes the Joint Chief Executive Officers, the Clinical Director, Palliative Care Consultant representation, the Community Services Team Manager, the Inpatient Unit Manager, a Practice Development Nurse and the Audit Support Officer. Standing items for this Committee include Clinical Risk Management, Clinical Audit, Clinical and Corporate Effectiveness including Policy Development, Information Material, Practice Development and NICE Quality Standards / CAS /MHRA clinical safety alerts, Patient/User Feedback, Organisational and Regulatory Assurance, Infection Control and 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, Clinical Director, the Head of HR, the Practice Development Team, the Inpatient Unit Manager, 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 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 Manager, 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 Inpatient Unit Manager, the Community Services Team link nurse, the Housekeeping Manager, the Head of Income Generation, Head of Retail 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, 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 twice per year. Its membership includes the Joint CEOs, the Clinical Director, the Inpatient Unit Manager, the IPU IC link nurse, the Practice Development Team, the Facilities Manager, the Head of Quality and Improvement and the Housekeeping Manager. Standing items for the Committee include Water Management, Infection Control Issues, Sharps Injury & Body Fluid Exposure, Alert Organisms Surveillance, Occupational Health Update and Regulatory/Best Practice Requirements.

Developments in 2020/21

Pursuit of both the Hospice's clinical audit and education program was compromised during 2020/21 by the pandemic. Resources targeted core requirements in delivering essential services whilst supporting patient and staff safety, infection control and the provision of activity data.

3.2.1 Clinical Audit

During 2020/2021, 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 276 charts assessed in 2020/21 (c.f. 300 in 2019/20) comprising 4779 prescription items (c.f. 5120 in 2019/20) and a respective evident prescription writing and error rate of 0.2% (c.f. 0.3% in 2019/20).
Hospice @ Home Carer/Relative Satisfaction	2020 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.
Care of Dying Adults in the last days of life	2020's audit supported and provided assurance regarding clinical practice on the IPU:- 100% dying adults in last days of life have DAILY monitoring of signs and symptoms 100% dying adults in last days of life have individualised care plan 97% dying adults in last days of life have care plan discussed with them and people important to them 100% dying adults in last days of life have the care plan followed 94 % dying adults in last days of life have anticipatory prescribing needs assessed for symptoms likely to occur in last days of life 100% dying adults in last days of life prescribed anticipatory medications with individualised indications for use, dosage and route of administration 100% dying adults in last days of life have their hydration status assessed daily 100% dying adults in last days of life have discussion about risks and benefits of hydration options
Hospice Admissions' Audit	2020's audit highlighted areas for improvement in the information captured on the Hospice Admission Score Sheet and the associated prioritisation of patients together with useful insight into the capture of Phase of Illness and Performance Status recording that has fed into a re-introduction of Step 1 of the OACC suite of measures in 2021.

Project	Results/Actions/Comments
VOICES Survey	The National Survey of Bereaved People (VOICES, Views of Informal Carers – Evaluation of Services) collects information on bereaved people's views on the quality of care provided to a friend or relative in the last 3 months of life. The survey was commissioned by the Department of Health in the NHS in 2011. Nationally, VOICES data provides information to inform policy requirements, including the End of Life Care Strategy, that promote high quality care for all adults at the end of life The information given in response to the survey supports us to improve people's experiences of care at the end of life. Results in 2020:- 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. Definite assertion of the adequacy of emotional support increased to 96% in from 2019's 68%. Definite assertion that symptoms other than pain in the IPU had been definitely or to some extent relieved has increased to 100% in 2020 (c.f. 95% in 2019). Pain relief in the IPU has moved significantly with it being reported to have been relieved completely, 'all of the time' by 54% in 2019 (c.f. 79% 2019). Keeping family members always informed of the patient's condition was met for 90% in 2020 (c.f. 80% in 2019). Always treating patients with respect and dignity was considered highly for both doctors and nurses – 100% for nurses and 97% for doctors (c.f. 90% for nurses and 89% for doctors in 19). A significant increase in the numbers that considered they had definitely received enough emotional support in 2020 – 90% (c.f. 62% in 2019). 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 marginal increase to 97% in 2020 (c.f. 95% in 2019). Responses relating to nursing care show regard at 'exceptional' or 'excellent' levels increase to 100% in 2020 (c.f. 95% in 2019). Regarding the food provided on the IPU in 2020, 'exceptional' and 'excellent' ratings combined decreased to 57% in 2020 (c.f. 77% in 2019) leading to a change in provision. Overall, care provided by the Community Palliative Care Team was considered as either 'Exceptional', 'Excellent' or 'Good' by 97% in 2020 (c.f. 97% in 2019). The proportion of respondents that considered contact from the bereavement team was either definitely helpful or helpful to some degree has decreased to 59% (c.f. 66% in 2019). Responding to the Friends & Family question, of the 56 who did record an answer, 46 (82%) rated the hospice as 'Very Good', 7 (13%) rated the hospice as 'Good', 1 (2%) rated it as 'Very Poor,' and 2 (4%) did not know the answer to this question.

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 decreased in 2020 as expected owing to the temporary closure of the Hospice Shops during the pandemic. There were no non-clinical incidents nor accidents that required report to the CQC in 2020/2021.
Clinical Unexpected Incidents & Near Misses	A reduction in reported incidents in 2020 across all incident areas reflected effects of the pandemic on admissions to the IPU. In 2020, medication incidents constituted 24% of all clinical incidents (c.f. 38% in 2019). The patient fall rate per 1000 bed days is 9.16 in 2020, higher than 5.48 recorded in 2019 and injurious falls in 2020 is at 2.04 per 1000 occupied bed days c.f. 1.56 in 2019.
CQC notifications	In 2020 there were 6 pressure area and 10 safeguarding notifications made.
Continuous Improvement Log	In compliance with information governance requirements to log information incidents. 9 incidents were logged in 2020 (c.f. 3 incidents in 2019).
Subject Access Requests or Requests made under the Health Record Act 1990	There were 5 data subject access requests serviced in 2020 (c.f. 5 in 2019)

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 53 clinical policy/guideline reviews in 2020/21:-

CLINICAL	TITLE	ISSUE DATE
CLIN01	Admissions	20/11/2020, 23/02/2021
CLIN02	Care after Death	16/02/2021
CLIN07	Discharge	21/09/2020
CLIN08	Infection Control	05/03/2021
CLIN09	Referral to Hospice Services	05/03/2021
CLIN11	Resuscitation Policy	09/04/2020
CLIN12	Safeguarding Children	24/12/2020
CLIN13	Suicide Policy	03/06/2020
CLIN14	Safeguarding Adults	06/07/2020, 20/11/2020
CLIN15	Deprivation of Liberty Guidelines	26/11/2020
CLIN16	Mental Capacity Act – Guidelines	20/11/2020
CLIN21	Anaphylaxis Management	05/03/2021

CLINICAL	TITLE	ISSUE DATE
CLIN25	Controlled Drugs	09/04/2020, 21/04/2020, 25/02/2021
CLIN26	Generic Drugs	09/04/2020, 21/04/2020
CLIN39	Pressure Ulcer Prevention and Management	24/02/2021
CLIN44	Venous Thromboembolism Prophylaxis Guidelines	22/06/2020
CLIN48	Community Services' Operational Policy	09-04-2020, 16/07/2020
CLIN51	Hospice Neighbour Scheme Operational Policy	19/01/2021
CLIN52	Managing Covid 19	09/04/2020, 29/05/2020, 12/06/2020, 18/08/2020, 25/09/2020, 14/10/2020 02/12/2020, 10/12/2020, 24/12/2020, 05/01/2021, 25/01/2021, 08/02/2021, 12/02/2021, 18/02/2021, 04/03/2021
CLIN53	Implantable Cardiac Defibrillator Guidance	02/06/2020
CLIN54	Medical Revalidation	19/01/2021
CLIN56	Chaperone Policy	10/12/2020
CLIN58	Use of the MAAR chart for subcutaneous and intramuscular medication in the community	19/03/2021
CLIN59	Prescribing Palliative Oxygen	19/03/2021
CLINSOP01	Inpatient Multidisciplinary Team Review	09/04/2020
CLINSOP02	First on-call Doctor	09/10/2020
CLINSOP03	Inpatient Unit Medication Round	24/02/2021
CLINSOP06	Second on-call (Consultant)	09/10/2020
CLINSOP07	Inpatient Unit COVID swab testing and accessing results	03/03/2021
OP01a	Managing and Supporting Staff following a Medication Error	18/09/2020
OP17	Lone Worker	14/10/2020
OP19	Medical Gas Policy	18/08/2020
OP37	Falls	20/10/2020

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 a heightened association with infection control. Mandatory training remained a priority in 2021/21. Whilst not an exhaustive list, the clinical training delivered in 2020/21 included:

Medical team training:

Medical Journal club presentations:

- Virtual consultations
- Outcome of pain assessment questionnaire survey
- RMH conference feedback
- Art on Behalf: Introducing an accessible art therapy approach used in palliative care
- Management of secretions at end of life
- Quality improvement initiative – improving written weekend handovers for PC teams in hospital setting
- Antibiotics stewardship
- Evidence-based dexamethasone dosing in malignant brain tumours: what do we really know?
- SGLT inhibitors in patients with heart failure with reduced ejection fraction: a meta-analysis of the EMPEROR-Reduced and DAPA-HF trials
- Covid 19 guidelines surrounding death certification
- Non-diabetic hypoglycaemia
- Psychiatric adverse effects of corticosteroids
- NAFLD - Non- Alcoholic fatty liver disease
- The use of crisis medication in the management of terminal haemorrhage due to incurable caner: a qualitative study
- Brain metastases; advances over the decade
- Symptom control flowcharts
- Prescribing oxygen
- Complementary and Alternative Medicine in Hospice and Palliative care: A systematic review

Clinical team training:

- Non Medical Prescriber Update
- Manual Handling
- PPE training

3.2.4 Mandatory Training

Whist 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 2020/21, there were 14 complaints received : 5 written and 9 oral complaints. All have been investigated by a member of the Executive and reviewed by the Hospice Board of Trustees. All complaints received in 2020/21 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 Coordinate My Care record (CMC) 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.

It shares a site with "Spire St Anthony's Hospital", part of Spire's private hospital network. "St Anthony's Hospital" was owned by the Daughters of the Cross until its sale to Spire Healthcare in April 2014. Prior to that date, a number of support services including Facilities Management, Catering, Portering, Purchasing, Payroll, Human Resources, Accounts and IT were provided by St Anthony's Hospital to St Raphael's. With the exception of a small number of time-limited service level agreements, these services have been entirely provided by St Raphael's as a stand-alone specialist palliative care facility since February 2014.

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 (EVE). The strategy promotes **Excellence** in all aspects of hospice service delivery, aims to increase **Visibility** across our community providing assurance that the hospice is there to provide quality services when needed and improves **Engagement** with users and external stakeholders who we depend upon to raise funds to support the works of the charity – a virtuous circle focussing first on excellence.

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

The Quality Account is an item for the Hospice's Quality Improvement Committee which includes representation from all clinical areas and the senior management team. The task of writing it was undertaken 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.