

St Raphael's Hospice
Minutes of a Meeting of the Clinical Quality & Governance Committee
Held using Zoom Video Conferencing
At 10:00 on Friday 26th February 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)
 Norman McWhinney – Chair of Trustees (NM)
 Alex Rudkin – Quality Development Manager (AR)
 Dr Gaby Tamura-Rose – Consultant (JS)
 Rebecca Trower – Clinical Director (BT)
 Anna Machin (Clerk – AM)

Actions arising

Agenda item	Action	Responsible	Timeline	Ref.
4. Actions list	Share Trustee training details & start training log	Anna Machin	March 2021	26.02/01
6. Evidence of Excellent Practice register	Explore opportunities to share good practice in Hospice communications	Gail Linehan, Comms team	Spring 2021	26.02/02
7. Clinical Risk Register	Add risk on vaccine hesitancy	Gail Linehan, Rebecca Trower	May meeting	26.02/03
9. Clinical Quality & Governance Report	Publish Community and IPU services Data Dashboards on Trustee portal	Alex Rudkin	March 2021	26.02/04
10. Minutes of internal meetings	Share VOICES 2020 survey report	Alex Rudkin	May meeting	26.02/05
12. AOB & date of next meeting	Take forward outreach process for new Committee members	Anna Machin	March 2021	26.02/06
	Confirm start time of May meeting	Anna Machin	March 2021	26.02/07

1. Apologies for absence

Committee members were welcomed to the meeting. Apologies were received and accepted from Dr Joy Tweed and Dr Jenny Strawson. The meeting was confirmed as quorate. Alan Cogbill took the Chair.

2. Terms of Reference review

Anna Machin confirmed that this document had been updated to reflect the Hospice Scheme of Delegation approved by Trustees in autumn 2020 and reflect the charity's newly independent status. The Committee Terms of Reference reviewed and approved, subject to one alteration.

3. Review of minutes and matters arising from last meeting

The minutes of the 30th October 2020 meeting were reviewed and approved as an accurate record of proceedings.

4. 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 – this was under review with the Head of HR and would be brought to an upcoming meeting.
- 08/05 E-learning system – Trustees would be provided with access in follow up to the meeting and Anna Machin would start a trustee training log.
- 11/10 Approach to pain scoring – the audit has been presented at an internal meeting, and an educational plan will be put in place to implement enhanced staff awareness. The Hospice is also exploring using the OACC measures to support this development. The ISR audit had not raised any concerns in this area, and the efficacy of pain management in In-Patient Unit (IPU) will be reviewed again in summer 2021.

5. Recruitment & staffing (verbal update)

Gail Linehan confirmed that the Community Service is now fully staffed. Within IPU there are three full time Registered Nurse vacancies and two Healthcare Assistant (HCA) vacancies. The roles are out to advertisement and there has been strong interest in the HCA roles. The pipeline of nurse applicants is more challenging and there may be an internal recruit. The interviews for the third Consultant post will be held in early March. There are 5 nurse prescribers within the Community team which is working well particularly at weekends.

Staff have been undertaking additional shifts in order to support gaps although the leadership team are conscious of managing the risk of staff burnout, particularly in context of Covid-19. Agency staff do not often have the relevant palliative care experience. Committee members noted that bank staff for local acute care services could be approached in future.

Committee members asked for an update on the Nursing Associate and Physician Associate roles. Gail Linehan confirmed that they have been very positive, especially with the Physician Associate (PA) role supporting medical team. The PA is able to admit and assess patients but not prescribe medication. These type of roles are now being used more commonly in the acute sector.

The decision has been made to enhance the maternity leave offer and include paternity leave. Compassionate Leave has also been increased from 5 to 10 days to reflect the ethos of the Hospice and holding compassion for colleagues suffering a bereavement. The Sickness Policy is due for review next. Committees were supportive of this approach which also improved the Hospice's overall employment offer.

6. Evidence of Excellent Practice register

The Committee recognised the range of good practice examples and positive feedback noted in this document. Rebecca Trower shared further examples of staff going above and beyond across the team, for example in a recent deep clean of the Hospice wards.

Staff have a high commitment and collaborative approach and there are daily occurrences which it is important to record and celebrate. Committee members suggested that relevant stories of good practice could be communicated through the Hospice's digital media.

7. Clinical Risk Register

Committee members reviewed the Clinical Risk Register, which had also been subject to detailed review at the recent Trustee Board meeting, and focused on particular on the areas of highest risk:

- **Workforce: Registered General Nurses recruitment** – the team have reviewed the Hospice's recruitment adverts to ensure they communicate the strong ethos, and encourage promotion through word of mouth. Many nurses are taking early retirement due to the current pandemic which reduces the pool of applicants.
- **Allergy: Risk of anaphylaxis for staff member** – this had now been resolved through Medical Dismissal which had been managed sensitively as this was a longstanding member of staff and the team were sad to see this colleague leave.
- **Staff resilience: Impact of pandemic** – staff had early access to vaccine and are given weekly PCR testing, twice-weekly LFD testing. The Employee Assistance Programme (EAP) is open to all colleagues and there has been some uptake. The leadership hold regular meetings with staff give regular reminders and support for wellbeing. There have been no positive cases of Covid-19 amongst staff identified through testing in w/c 22nd February which has not happened since December 2020. Wider news on stages of lifting lockdown has helped with staff morale along with moving from winter into spring.
- **IT PAS System Failure** – Gail Linehan updated on a recent incident which had highlighted the challenge of out of hours cover from the IT team, who are not formally on call. At times of the IT managers' annual leave, the Hospice uses a Consultant who works in office hours to provide required support. The incident had been resolved thanks to staff acting swiftly but the Senior Management Team have undertaken a detailed review of systems. For example, the PAS and next of kin contact details downloaded every day to safeguard against loss of access and Medication Charts also provide assurance. A daily back-up is made of all clinical data. The Committee asked if 24-hour support could be produced. The challenge is to ensure that an external company would understand the Hospice's systems and be responsive, and cost may be prohibitively high considering IT systems failure does not occur often. Committee members received assurance that the reason for this failure had been identified and was not likely to re-occur. The Committee noted that FRC had a broader role in considering business continuity and should be alerted to this incident.

Committee members suggested that a risk be added on vaccine hesitancy and the level of immunisation amongst staff and volunteers. Gail Linehan confirmed that 166 staff had been offered the vaccine, of whom 119 had received the first dose and 46 have had a second dose. Uptake has been strong overall although some staff have chosen not to take vaccine which could have longer-term implications for staff health and safety. All Reception volunteers have been vaccinated and this will be a part of the risk assessment for others due to return, for example to the Orangery. Committee members noted the emerging debates in the Care Home and health sectors regarding whether the vaccine should be mandatory.

Committee members asked about staff morale in the Hospice relating to the recent Covid-19 outbreak which was experienced from 28th January to 11th February. Rebecca Trower confirmed that there had been some initial frustration however staff understood that 60-70% of Hospices had experienced an outbreak during this period of Covid-19. The break in patient admissions was used to provide IPU staff with mandatory training and take some annual leave. It was more challenging for the Community team, but they were able to admit

patients to other local Hospices. Reporting protocols were followed and regular updates given to staff and relevant stakeholders. Feedback showed that the Hospice's response had been handled well.

8. Corporate risk register

Committee members noted this paper and the clear link to the Clinical Risk Register.

9. Clinical Quality & Governance Report

Rebecca Trower confirmed that regular Head of Department meetings continued and the Education practice team members have provided in-depth training in Infection Control. The Capacity Tracker is completed on a daily basis by Gail Linehan supported by Alex Rudkin. The Hospice is adapting bed capacity based on staffing levels and is currently at six beds.

Alex Rudkin updated that audit reports were near to finalisation and being communicated as a developmental tool. The Consultants in the Medical team have been engaged in this process. The Data Dashboards have been published for Community and IPU services and would be published on the Trustee Portal.

Committee asked about the Complaints which had been upheld and asked whether this was a sign of the stretch on staff capacity experienced during this period. Dr Gaby Tamura-Rose confirmed that the challenges were primarily around communication and discharge planning. The Discharge Policy is under review and an updated leaflet is being produced to support patients' expectations. There have also been specific reflections on complaints, for example the patient who was discharged and returned the next day. Family dynamics and multi-agency working are also in play as part of understanding and addressing complaints.

10. CAP 2020/21 & plans for 2021/22

Gail Linehan confirmed that the plan runs to the end of March 2021, with many projects completed and some due to extend into 2021/22. This document is embedded into discussions with Clinical Heads of Department and has been a useful tool to keep the teams focused. The Committee received assurance that the MDT is in place, with decisions recorded on patients' notes. OACC will further support the development of this practice. Committee members encouraged this approach to be included in the 2021/22 action plan including consideration of extending this practice to other Primary Care and Care Home networks. It was acknowledged that this would be beneficial but is also dependent on staff availability and workload pressures.

11. Minutes of meetings and other documents

Committee members noted the minutes from internal Committees, and asked for colleagues' perspectives on the VOICES report and key themes. The data is from 2019 and had included some feedback on patients' expectations on the timeliness of the service not being met. It was felt that this would be addressed through the teams now being at establishment. The Medical Revalidation Policy has also been recently updated and is a robust document. The 2020 report would be reviewed at the next meeting. Alex Rudkin confirmed that the CQC Temporary Monitoring Arrangement Self-Assessment has been undertaken. Dr Gaby Tamura-Rose had recently been on a Caldicott Guardian training course and would be taking on this role.

12. Any Other Business and Dates of future meetings

The Committee expressed interest in recruiting new members with Clinical expertise, for example in Primary Care and nursing. Anna Machin would take forward next steps. There were no further items raised under Any Other Business. Committee members noted the date of the next meeting of 14th May and the start time of this meeting would be confirmed.

The meeting ended at 12.15pm.

Approved..... Date.....

ITEM 03 ACTION LIST

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

Reference	Lead	Description	Target Date for Completion	Comments
04/01;11/01	GL	Performance Management	May 2021	HR27 People Performance Management Policy was published in December 2019. GL reviewing with KC to adjust to distinguish policy from procedure. Revised draft alongside Disciplinary and Grievance Procedures to be brought back to the CQ&G Sub.
08/05; 11/03	GL	Explore feasibility of facilitating access to the new e-learning system via the Hospice's web site.	May 2021	Complete. Trustees have been provided with access in follow up to the meeting and Anna Machin will start a trustee training log
11/10	RT	Approach to pain scoring	Feb 2021	Complete : Efficacy of pain management incorporated into 2020/21 quality improvement/audit program
21/02/26-01	AM	Share Trustee training details & start training log	May 2021	
21/02/26-02	GL	Explore opportunities to share good practice (from Excellent Practice Register) in Hospice communications	Spring 2021	Ongoing Complete
21/02/26-03	GL/RT	Add risk on vaccine hesitancy to clinical risk register	May 2021	To discuss at May CQ&G
21/02/26-04	AR	Publish Community and IPU services Data Dashboards on Trustee portal	May 2021	Complete
21/02/26-05	AR	Share VOICES 2020 survey report	May 2021	Complete

ITEM 03 ACTION LIST

Reference	Lead	Description	Target Date for Completion	Comments
21/02/26-06	AM	Take forward outreach process for new Committee members	May-2021	

Ref No.	Recorded By	Date	EXAMPLES OF EXCELLENT PRACTICE - Description	Link to evidence	PT Id	KLOE	Key Staff	Related System
2021/23	TY	12/02/2021	Over the last few weeks and months ALL the housekeeping and clinical staff have shown how adaptable they are and how they are pulling together as a team. TY feels they all deserve a mention but on this occasion she would like to mention a few individuals who work on the IPU for the outstanding commitment and gigantic hearts over the last few weeks. <ul style="list-style-type: none"> •JF – JF has stepped up to run the IPU while TY off with Covid 19 recently and has been the glue that has held it together. JF has been pulled in every direction possible but she has remained professional and passionate about what we do here at the Hospice and has the patients best interest at heart and endeavours to be the voice of the patient, family and staff alike. •DM – DM is a whirlwind when it comes to practical tasks on the ward , her enthusiasm carries people and she ALWAYS has a cheery voice and a phenomenal “can do” attitude. DM has taken on the mammoth task of assisting with the deep clean of the ward area and TY cannot thank her enough for her attitude towards embracing the team work spirit. •PDP – PDP has the task of coordinating the housekeeping team and a variety of issues have been raised in the changing COVID environment over the last few weeks. PDP has kept her smile and cheery manner the whole time despite some trying situations brought to her attention. Nothing sees to be too much bother for her when asked. 	TY E-mail		C,R,E,S,W	JF, DM, PDP	Clinical
2021/24	TY	19/02/2021	Excellent care demonstrated by SD on Thursday. The patient in bed 9 was very frightened and SOB she did not want to be left alone. SD stayed with her for almost 3 hours until her family arrived. During this time SD was a great comfort to the patient relaxing her with gentle massage and making her feel safe and cared for. This is true palliative care.	TY E-mail		C,R,E	SD	Clinical
2021/25	TY	23/02/2021	JL in IT is so responsive to the IPU – no query is too small or too much of a bother – well at least that is how he makes it seem. He is always responsive when he is on duty in the Hospice to help with our IT queries and issues. We have had an issue with the wi fi for a patient on the ward today who could not access it but he has gone away and done what he needs to do and has sorted it for her and come back and made sure she is happy with the solution (wearing the full PPE of course!) . He has even stayed longer in his day than he should to sort this out for her.	TY E-mail		C,R	JL	IT
2021/26	TC	24/02/2021	Linda has visited every day this week and was present yesterday when she died. She stayed on in the house and together with the District Nurse helped lay her out and dress her in her wedding dress at the request of the husband.		14907	C	LM	Clinical
2021/27	AR	23/03/2021	Gold awarded to Pete Morris, Facilities, in the National Health Hero's Awards. Outstanding.	Evidence of excellence c	n/a	R, E, C	PM	Facilities
2021/28	JG	08/04/2021	Excellent response and review of causation caused by IT system downtime between 25-30 March 2021	N:\Care Quality Commission\Excellence in Practice\Evidence of excellence copy\SystemDowntime Line 25-30 March 2021.pdf	n/a	W,R	JG & IT	IT
2021/28	JS	19/04/2021	We looked after a patient who was admitted from a local prison. Our community consultant arranged a timely admission to the IPU for end of life care. The staff demonstrated compassionate and excellent care. Mediation was ordered from a local pharmacy that had been left behind on a Bank holiday Friday, the doctor on call went herself to pick up medication from the local pharmacy. The ward manager communicated with the prison team and considered information governance and Caldicott principles with regards to 'need to know' sensitive information. The nursing team and specialist social worker spent a lot of time ensuring his family were aware of the situation and organising complexities around his affairs. One of the doctors on the ward recognised how important his spirituality was to him and read to him from the bible where he had book marked important passage to him. He died shortly after this. I think this demonstrates how compassionate and caring the IPU team are, treating all patients with respect and dignity and ensuring all holistic needs are addressed to ensure a 'good' death.	Evidence of excellence copy\2021-04-19 JS Excellence recording.msg		R, C, E, W	IPU MDT	Clinical
2021/29	RT	20/04/2021	A neighbouring hospice ran out of a needed injectable drug and we 'loaned' some of our stock medication to them so that their patients didn't go without and they also didn't incur a large fee for emergency ordering. This was endorsed by our clinical Pharmacist and the practice supported within policy/procedure.			R,C,E,W	IPU MDT	Clinical
2021/30	GL	06/05/2021	Investors in Volunteers Accreditation Achieved - May 2021			E,W	G Toubal	Volunteers Organisational

Serial	Cause of Risk	Description of Principle Risk to Charity	Current Controls to prevent occurrence	Current Impact	Current Probability	Raw Score	Additional Controls	Residual Impact	Residual Probability	Residual Score
1	Sustainable and relevant service provision	Reluctance of some staff to embrace change to working practice as outlined in Clinical Action Plan (CAP).	Proactive leadership 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 communicated 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 Comparable 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 sufficient, the number of patients that can be safely supported will be affected as safe staffing is across 24hours. Increasing difficulty in recruiting Band 5 nurses for day duty - staff undertaking extra shifts to cover requirement risk burnout. Managing unexpected sick/compassionate leave can put pressure on the staff cover.	Current qualified nursing staff levels are adequate to support 8/10 IPU beds on day duty with full current complement of staff. Current deficit on night duty is approx 88hrs per week. This is equating to approximately 14 night shifts per week of RN cover to be provided. COVIDis impacting staffing levels due to requirement to self isolate and furlough of clinically vulnerable staff. Active recruitment of Band 5 nurses to fill permanent and Bank to support core team at times of AL/SL or increased high dependency. Requirement for continued review of night RGN cover for safety assurance. Staff flexibility from day duty to night duty- Consultation is complete and rotation has commenced.. On the job training,, mentoring and educational support to obtain required qualifications e.g. Support of the TNA programme for HCAs	4	4	20	In situations where staffing levels are adversely affected there would be a managed reduction of available beds.Caveat is that even with one bed open there is a requirement to have 2 RNs on duty. Engaging with local and national training schemes to demonstrate the attractiveness of the hospice as an employer. Review sickness policy and maternity leave	4	4	20
4.	Remove - Lack of medical team capacity	1.Patient safety at risk. 2. Impact on on-call across 7 days. 3. Delays impact of EVE. 4. Increase staff anxiety. 5. Reputational damage	1. Agency cover in place until 3rd consultant in post. 2. 2x new consultant in post and 3rd consultant to commence in July 2021. 3. Collaboration with other Hospices for shared cover.	3	1	6	1. Two-weekly meetings to review medical cover in place. 2. Responsive to need - providing equity of medical team coverage across IPU and Community. 3. Develop existing expertise. 4. Take every opportunity to become increasingly innovative and collaborative. 5. Re-instatement of StR from April 2021.	3	1	6
5.	Staff Resilience negatively impacted during long pandemic	1. Inability to continue delivering service to the desired standard. 2. Consequential impact on EVE	1. Peer Support implemented for managers- aim to equip staff effectively. 2. HR proactive and available to hear and escalate issues 3. HR Mental Health Helpline. 4. Regular and open communication from Senior Team. 5. Weekly testing for staff. 6. Vaccine roll out to most staff	3	2	9	1. SRH standing by staff for one month beyond government recommendations. 2. Provide some other welfare benefits to acknowledge difficulties i.e. small treats. Supportive communication across teams, Access to vaccinations improved. Increase in use of LFDs.	3	1	6
6.	Clinical Incidents	Patient Safety (Falls/Pressure Ulcers/Medication Errors). Risk of complaints from patients/families Requirement to report outside the organisation to CQC Preempt a CQC Inspection Reputational damage	Reporting of all incidents related to clinical care Hierarchy of investigation Outputs- Learning informs improved procedures and processes Regular review of incidents Report to EXEC, Clinical Governance Committee & Advisory Committee, Dissemination to all hospice teams to inform learning	4	2	12	Continued staff training and awareness of new techniques and products. Report at Clinical HoDs. Report by managers at team meetings. Opportunity to participate in reflection and sharing learning and outcomes. Feedback to complainants regarding change in practice. Encourage an environment of comprehensive reporting to support learning and quality improvement. Introduction of Datix in Q2 2021 will support reporting and monitoring.	4	1	8
7.	Lone working	Staff/volunteers work singularly in the community within referred patients homes. Risk of accident/incident in a patient's home and individual risk to staff member. Risk in travel to and from home visits	Policy and procedure in place to support community working (SOP). Supplied with a mobile phone for contact with the hospice or other healthcare professionals. ACC informed of access and egress. Lone worker alert devices in place.	3	1	6	Lone Worker Policy informing steps to follow if a colleague does not return to base at expected time. Clarification and supported training on use of safety devices. EXEC OOH on call in place for contact and advice on further action.	3	1	6

Serial	Cause of Risk	Description of Principle Risk to Charity	Current Controls to prevent occurrence	Current Impact	Current Probability	Raw Score	Additional Controls	Residual Impact	Residual Probability	Residual Score
8.	Complaints	Rumours Local press coverage Potential for public concern Elements of public expectation not being met Loss of confidence in the service Reputational damage	All complaints both verbal and written treated with the same level of scrutiny Complaints procedure in policy for staff to follow- escalation process Complaints documented and reported via Quality Manager Reported at Clinical Quality Improvement and Clinical Quality and Governance meetings Complainants (both verbal and written) are offered the opportunity to meet and discuss concerns with Director of Care All complaints discussed at hospice team meetings for awareness and learning across the organisation Bi-annual review by EXEC Required action taken to address concerns with staff members where individuals have been identified by the complainant File notes kept of discussions by HR	3	2	9	Use of root cause analysis for significant incidents. Feedback to complainants regarding change/improvement in practice. Scoping to establish all clinical staffs access to communication skills training Training on care delivery Information shared re: Duty of Candour and scope of the policy Reporting of any concerns- no blame but responsibility	3	1	6
9.	Breaches of confidentiality involving person identifiable data (PID), including data loss	If low risk breach- dealt with locally as per policy- CUI reporting More serious breach - RCA may be required- may have wider implications if data not encrypted If serious IG breach may be media coverage Potential loss of public confidence to keep PID safe	All staff paid and unpaid trained on IG on induction and annual mandatory training. Policy communicated to whole organisation Clinical staff have nhs emails (encrypted) Regular organisational sweeps in all departments	3	2	9	IT monitoring and oversight of PID in received and sent emails. Monitoring includes audit and test phishing emails via IT Dept. Intermittent checking in areas such as photocopier/clear desks.	3	1	6
10.	Brexit - Risk of medication shortages via suppliers	Required medication (opioids, neuropathic agents, anti seizure etc.) not available in specified dose ranges to support symptom management. Impact on patients.	Liaison with clinical pharmacy Ashtons - Reassurance that adequate supplies in stock.	2	2	6	Regular updates from clinical pharmacist. Communication with wider CCG pharmacy colleagues.	2	2	6
11.	Corona Virus	Infection spread within hospice	All staff emails alert. Signage directing all staff & visitors to hand-washing on entering and leaving the ward / rooms and use of hand sanitiser. Staff adherence to control of infection policy. As per government guidance clinical staff that can work from home have been facilitated 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 identified case within the Hospice - as per government 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 training and advice and support from PHE. Weekly PCR & LFD testing for all staff.	3	2	9
12.	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 facilitate essential community visits as well as all PPE	2	2	6
13.	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 possible.	3	2	9	Monthly HoDS to include any COVID issues and regular EXEC emails providing update and reassurance.	3	1	6
14.	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 office.	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
15.	IT PAS System Failure	Inability to access contemporaneous clinical records.	Contactable team OOH (not formal contract). Back up resource - outsourced at times of AL. Back up to PAS system facilitating access to the PAS. Risk is that recent recording may not be captured.	5	2	15	Daily back up of PAS. Risk Assessment undertaken related to IT risk to PAS. Highlighting gaps. Resolutions being considered. Access to OOH IT Consultant response in place.	4	2	12

ITEM 07

Clinical Quality and Governance Report

Contents

Aim	1
Recommendation	1
Report.....	2
Update on Organisational Response to the Covid 19 Pandemic	2
Clinical Services	2
Recruitment	3
Medical Team	3
Education/Training.....	3
Capacity Tracker	3
IPU Refresh	3
Governance meetings.....	4
Clinical Audit, Monitoring and Research	6
Data Dashboards.....	6
Quality Account	7
CQC and Organisational Assurance.....	8
Audit/Research 2021/22	9
Clinical Risk Management	11
Records – Access Requests.....	15
Clinical Complaints	16
Complaints Overview.....	20
Notifications	21
Clinical Commissioning Group (CCG) Data.....	21
Activity Dataset provided to the Hospice’s Commissioners 2020/21	23

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

As lockdown has lifted and restrictions are easing, we are gradually returning some of our staff to the hospice. This is being done in a careful and measured way to ensure that staff continue to feel safe, particularly as we are aware that some may feel anxious. Our staff have remained consistent in their provision of advice and support, despite recent surges in referrals and occasional depletion in staffing.

A large number of our staff have now been vaccinated, increasing their and our confidence in managing patients and their families during Covid, and we have seen a clear reduction in the number of positive cases locally and internally.

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.

Visiting restrictions for the IPU have eased a little in line with government guidance but we remain mindful of footfall and are managing to balance the importance of patient contact with visitors, with reducing risk through essential visiting only.

Our infection control practice remains rigorous in order to mitigate as much as possible against the spread of Covid 19. The gradual return of some of our volunteer receptionists has been monitored closely to ensure their safety and the safety of others, whilst ensuring moral support and infection control update training.

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. Our Clinical Directorate administrator and one of our volunteers now take the lead on testing and we are encouraging as many staff as possible to undertake the postal testing for the sake of ease.

We have had no positive tests for approximately 2 months now and uptake of vaccinations amongst staff has been good.

The Managing Covid 19 policy (Clin52) continues to be reviewed monthly and adapted as changes to service provision occur.

HoDs has now been reduced to monthly from two weekly as Covid management becomes steadier and more predictable.

Clinical Services

Our Psychological Support Team remain extremely busy and also reduced in number due to sickness. The degree students who have been supporting the service under Steve Molyneux' mentorship have been invaluable during this time and we are looking to increase the number of students from six to twelve later in the year.

Our Wellbeing team is now complete – we had a number of strong candidates and appointed Simon Oliver (one of our volunteers) and Katie McKenna (from our HK team) – to the posts. Both have a variety of skills and qualifications suitable for the roles and their enthusiasm is encouraging.. The

Wellbeing centre reopened its doors on 12 March and a number of sessions are now being run face to face and on zoom.

Our new Living Well programme will be launched on 19 May and we are looking forward to a good attendance, within Covid guidelines.

The IPU have been flexing bed capacity in line with our staffing levels and over recent weeks have opened two more beds – meaning we now have 8 beds open for admission.

The Community team have recently held workshops to look at remodelling the way in which they work. The new approach will involve working in three locality teams, therefore allowing closer working relationships and improved continuity for patient and their families. The model will be trialled and reviewed after six months to evaluate the impact before finalising the model.

Recruitment

We have recently appointed a band 6 nurse to the IPU – and she will be joining us over the next few weeks. We have also appointed a number of bank RNs and once their induction is completed, they will help to shore up the regular staff.. We are holding HCA interviews over the next few weeks and are delighted to have received so many high calibre applications.

Our night nursing team on the IPU remains depleted but the day staff have embraced internal rotation which has helped to fill some of the gaps.

We are interviewing for a band 6 training post/band 7 CNS for the Community Team over the next couple of weeks and have shortlisted 3 candidates.

Medical Team

We successfully appointed to our third consultant post back in March and Dr Naomi Collins will be joining us from 5 July 2021. Naomi has been a Palliative Medicine consultant at East Surrey hospital for the past 12 years and will be working with us as 0.8WTE. The rest of the team include our specialty doctors and locum consultant as well as a GPVTS and our Physician Associate. We have also recently been joined by Sabrina Vitello, a Specialist training Registrar.

Education/Training

We are gradually beginning to plan our scheduled education and training, now that the restrictions are easing and the Practice Educators are busy planning simulation training in conjunction with our Medical Team, as well as study days, workshop Wednesdays and other initiatives in line with the strategy for the coming year.

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 are now meeting fortnightly to ensure planning and preparation are undertaken in good time. The IPU will start to wind down admissions during the first half of July, so that works can begin on 26 July. The refresh is scheduled for completion over a four week period

and we hope to reopen on Tuesday 31 August. Our fellow hospices have agreed to support admission of our patients as appropriate and if they have the capacity to do so.

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 be 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	Feb'21	Jan'20	May'21
Clinical HoDs	Apr'21	Apr'21	May'21
Medical Business	Mar'21	Mar'21	May'21
Drugs & Therapeutics	Apr'21	Nov'20	Jul'21
Falls	Apr'21	Jun'20	Oct'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	Jun'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 ongoing 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 June 2021. 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 will re-commence as it was originally designed to later in 2021. In the meantime, an audit review meeting has discussed and agreed program for 2021/22.

The Audit/Research Programme with timeline is set out on page 9. The Audit Program was effectively suspended in mid March 2020 with the onset of the outbreak and participation re-commenced in June 2020 but progress has been disrupted this year. Data collection has completed for all bar 5 of the 20 projects (3 of which are deferred to 2021/22. I have 5 reports to write up before the end of June 2021.

Data Dashboards

Work continues on the development of clinical data dashboards that will inform the service areas of the IPU, Well-being Centre, Community and Psycho-Social teams. The CAAD meeting reviews have been postponed during the Pandemic. Their re-introduction is planned for later in 2021. An index of tracked data that is presented and regularly 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

Report Reference	Title	Lead	Created	Function	Primary Aud.	Exec / CCG Interest	Freq.	Resp.	Is Data Presented?	Presentation Tool / Depository
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
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 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 2019/2020 to the NHS Choices web site in December 2020:- <https://www.straphaels.org.uk/Handlers/Download.ashx?IDMF=3c367392-0be2-4ec3-913f-f814e5e1b386>

It is also available on the Hospice's website at:- <https://www.straphaels.org.uk/quality-accounts>

Plan is for the Hospice's Quality Account for 2020/2021 to receive a 'face-lift' and be updated in support of the Hospice's vision.

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 convenes periodically to 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 May 2021

20 projects scheduled in 2020/2021 : as at 10-05-2021, 10 are reported/ongoing complete, 5 have data collection completed and AR is writing them up, and 5 are deferred to 2021/22.

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 (Deferred)	Survey suspended		
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 (Deferred)	Not yet started		
2021/22-07	Pain management Audit (Deferred)	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 - Audit of Medication recording on Discharge from IPU : EPR 'Medication Module' vs Discharge Letter (Deferred)	Not yet started		
2021/22-11	IPU - Re-Audit of Discharge Documentation (Deferred)	Not yet started		
2021/22-12	OACC measures (Step 1 - Phase of Illness + Karnofsky performance status; Phase 2 - iPOS)	Not yet started		
2021/22-13	IPU : Patient Handling / Pressure Areas / Mouthcare	Not yet started		
2021/22-14	Use of the After Death window	Not yet started		

Project Ref.	Title	Status	Report Link	Results
2021/22-15	Quality of 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	Advanced Care Planning -(timelines)	Not yet started		
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 & Psycho-social - 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		

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										36	195	212	211	214
Beds	6	6	6														
Bed Occupied Days	154	85	164														
Bed Available Days	186	168	186														
Bed Occupancy (variable beds)	82.80%	50.60%	88.17%														
Bed Occupancy (10 beds)	49.68%	29.31%	52.90%														
CD Medication Incident			3										3	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													0	4	12	22	27
Non-CD Medication Near Miss													0	0	1	5	12
Pressure Sore on Admission	2	1											3	19	16	20	23
Pressure Sore during Admission													0	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)													0	1	1	2	1
PE													0	0	0	3	4
Staffing													0	0	1	1	
IG													0	3	0	7	12
IG near miss													0	1	0	1	4
Manual Handling													0	1	5	10	2
Slips, trips, falls			2										2	20	21	29	18
Verbal Violence													0	1	0	0	1
Bump													0	0	0	0	2
Other - Admin/property/Documentation/Clinical		1	1										2	14	12	18	15
* Incidents reported to Community – non-SRH													0	8	12	25	24
Total 2021 *excluded	2	2	7	0	0	0	0	0	0	0	0	0	11				
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 March has decreased on last year. The IPU had a reduced capacity during February due to the COVID outbreak..

Incident Key

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

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

<i>Clinical Significance</i>	Jan	Feb	Mar	Jan-Mar	Apr	May	Jun	Apr-Jun	Jul	Aug	Sep	Jul-Sep	Oct	Nov	Dec	Oct-Dec	2021	2020	2019	2018	2017
Admissions to IPU	9	10	17	36				0				0				0	17	193	212	211	214
Bed Occupied Days	154	85	164																		
Bed Available Days	186	168	186																		
Bed Occupancy	82.80%	50.60%	88.17%																		
Fall No Harm			1	1				0				0				0	1	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				0				0				0	3	9	13	6	
Med Level 1			1	1				0				0				0	1	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				0				0				0	1	15	19	38	
Moderate		1		1				0				0				0	1	6	2	21	
Serious				0				0				0				0	0	1	1	3	
Pressure Sores	2	1		3				0				0				0	3	23	19	27	
Totals 2021	2	2	7	11													11				
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 2 access to health records request : 1 x wife (January), 1 x partner (April)
- In 2021, there have been 2 sharing requests : 2 x SWL LeDeR (January, February)

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

Clinical Complaints

- There have been 3 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
2021/03	ORAL	Partner	12/03/2021	Complaint raised by patient's partner during telephone call with CNS 3 days post patient's death. Apology extended by CNS. Complaint regarded the care provided by a member of the H@H team on the day before his death. Partner felt that the HCA was quite forceful in the way that she changed the patient's position in the bed - leading to the patient requiring a number of analgesic injections to resettle him. Partner said that the patient had spinal fractures and was very stiff so moving him caused pain. He didn't feel the HCA assessed the patient adequately and consequently moved him too quickly and forcefully. The 2 carers in attendance had apparently told the partner after the H@H HCA had left that they didn't know who she was and didn't feel she could be questioned.	H@H Care	Partner was telephoned by the Clinical Director on 18/03/2021, apology extended and explained that she would be speaking with the HCA and will follow up by either telephone or letter. Letter of apology sent 06-04-2021 Community Team Manager discussed complaint with HCA on 26/03 & 30/03. HCA reflected and acknowledged that given the DNs were present she could requested pain relief for the patient pre / post re-positioning. Use of the Abbey Pain Scale highlighted.	Upheld	Closed

ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASS	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE	STATUS
2021/04	ORAL	Sister	25/03/2021	Patient's sister advised IPU Manager that her brother had told her that he had been left on the toilet in his en-suite for over an hour on 23/03/2021 despite him calling out and ringing the bell	IPU Care	<p>IPU Manager investigated. Reflection held by Clinical Director on 12 April 2021 with staff on duty on day of incident. Practice educator also present.</p> <p>Evidence presented included:</p> <ul style="list-style-type: none"> • Pt was on the toilet for what is thought to be approximately an hour (not documented and some differing recollections by staff) • Pt was known to be a private man and therefore wouldn't want anyone in the bathroom with him • Pt had previously been able to use the call bell independently (earlier that morning) • During the past few hours, Pt had required the toilet more frequently and on reflection it is possible that he was harbouring a UTI • Pt was becoming mildly but increasingly confused • The call bell in the bathroom was a pull cord and different to the call bell near the bed – possibly being more difficult to identify when mildly confused • This was during a particularly busy time of the day when patient lunches are being distributed, patients are being fed, and staff are staggering their own breaks • The morning ward round can initiate drug changes, care plan changes and discharge plans which might need expediting around this time • The staff handover is at 12.30 and lasted approximately 20 minutes – at this time there would have been one or two staff on the IPU floor • Pt was assisted on to the toilet at approximately midday • The door to Pt's room was closed due to Covid precautions and therefore it would not be 	Upheld	Closed

ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASS	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE	STATUS
						<p>obvious from the corridor that Pt was not at his bedside</p> <ul style="list-style-type: none"> In order to enter a patient's room, staff have to don PPE which creates a minor delay, and discourages 'popping in' <p>The information listed above does not justify the incident but goes some way in helping to understand the context of the incident and how these factors may have contributed to the occurrence.</p> <p>Factors for future consideration and action:</p> <ul style="list-style-type: none"> Written apology to family – Action: RT completed 13/04/2021 In future, either stay in room until patient is ready for assistance (preferable option) or if staffing doesn't allow this, alert other staff that the patient is likely to require assistance shortly If a patient is confused, it is essential that a staff member is within reaching and hearing distance Consider placing room call bell in the bathroom within easy reach of the patient as easier than the pull cord to identify as a call bell PPE and infection control precautions cannot be reduced and therefore staffing numbers need to allow for these delays – other demands on staff time will need to be rationalised. : ensure MDT/ medical team are aware (RT already actioned)/ Consider altering time of staff breaks to ensure adequate staffing numbers on IPU at all times/ ? introduce coffee break so that there is not such a long wait from start of shift until lunch break Action: TY and band 6 nurses. 		

ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASS	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE	STATUS
2021/05	ORAL	Partner	15/04/2021	CNS visited as pt hadn't had a F2F assessment for some time. Partner felt that the conversation that ensued which related to planning for EOLC (PPC/PPD) was not well timed as pt could have another '5-10 years'. She also said that pt doesn't like to talk about the future and she felt that the CNS was persistent in her questioning even though pt had indicated that he didn't want to discuss it.	Community Comms	30/04/2021 Telephone call from Clinical Director to Pt partner explaining that it can be difficult at times to know when to have these conversations particularly when we don't know the patients as well as we would like due to the a number of constraints—some people are keen to plan ahead and find this reassuring whilst others find it difficult to discuss. I explained about the CMC record and how helpful it can be at a time when someone is less well/deteriorating (often unexpectedly). Partner said that she understood this but it wasn't a conversation for her and pt at the present time and that she will have that conversation with him privately when the time is right. Pt and partner remain happy for the CNS to visit. Partner was also critical of the 'Advice and Support before and after Bereavement' leaflet stating that there was very little in the way of 'before' and that there were too many adverts for funeral directors. She provided some constructive feedback on the leaflet and provided her e-mail address if we wished to utilise her in commenting on our leaflet content review.	Upheld	Closed

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									0			
June									0			
July									0			
August									0			
September									0			
October									0			
November									0			
December									0			
2021	1	2	1	0	1	0	0	0	5	2	3	5
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

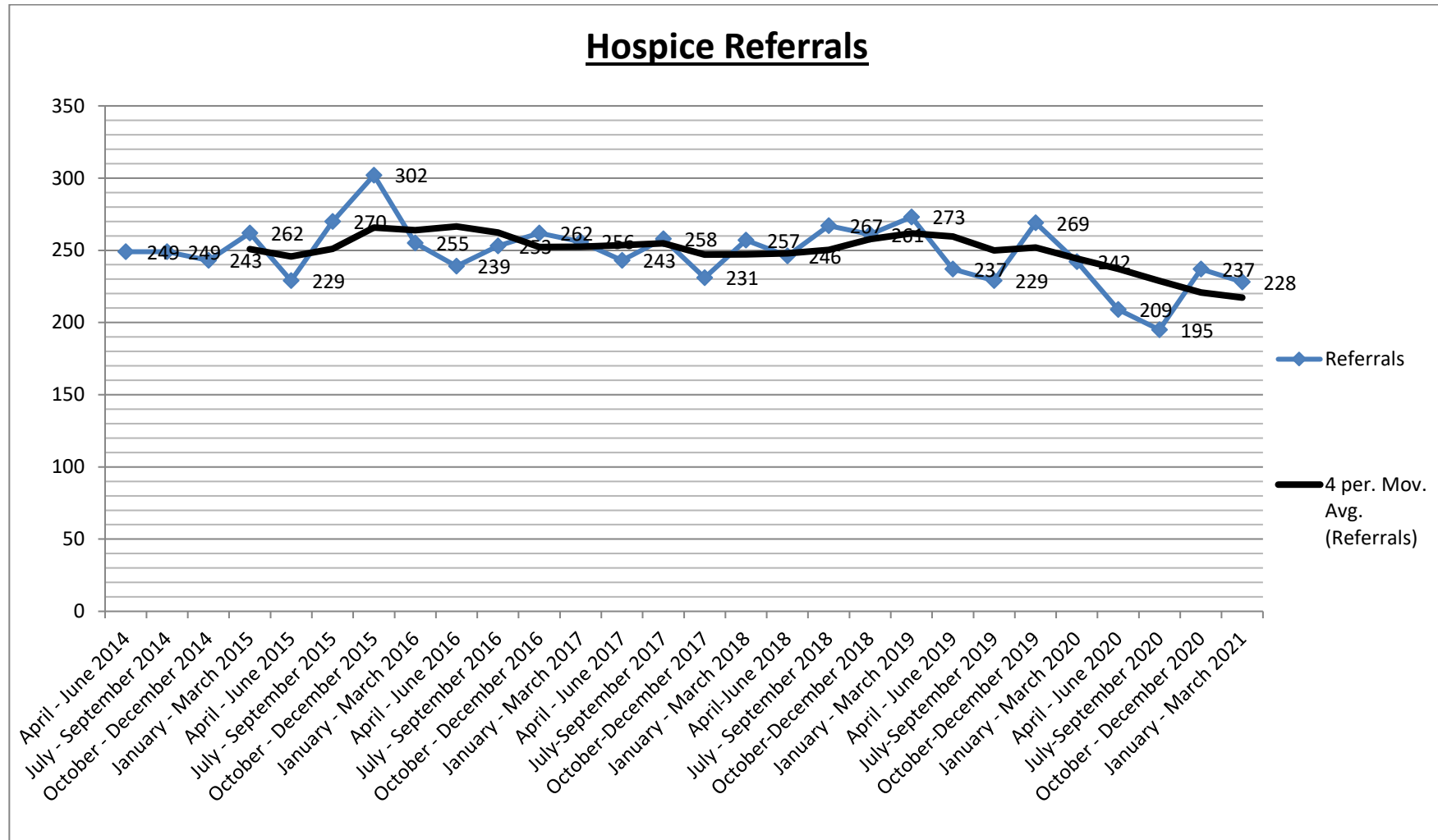
There were 2 serious injury notifications made to the CQC between January and April 2021 all concerning pressure sores grade 3 or above.

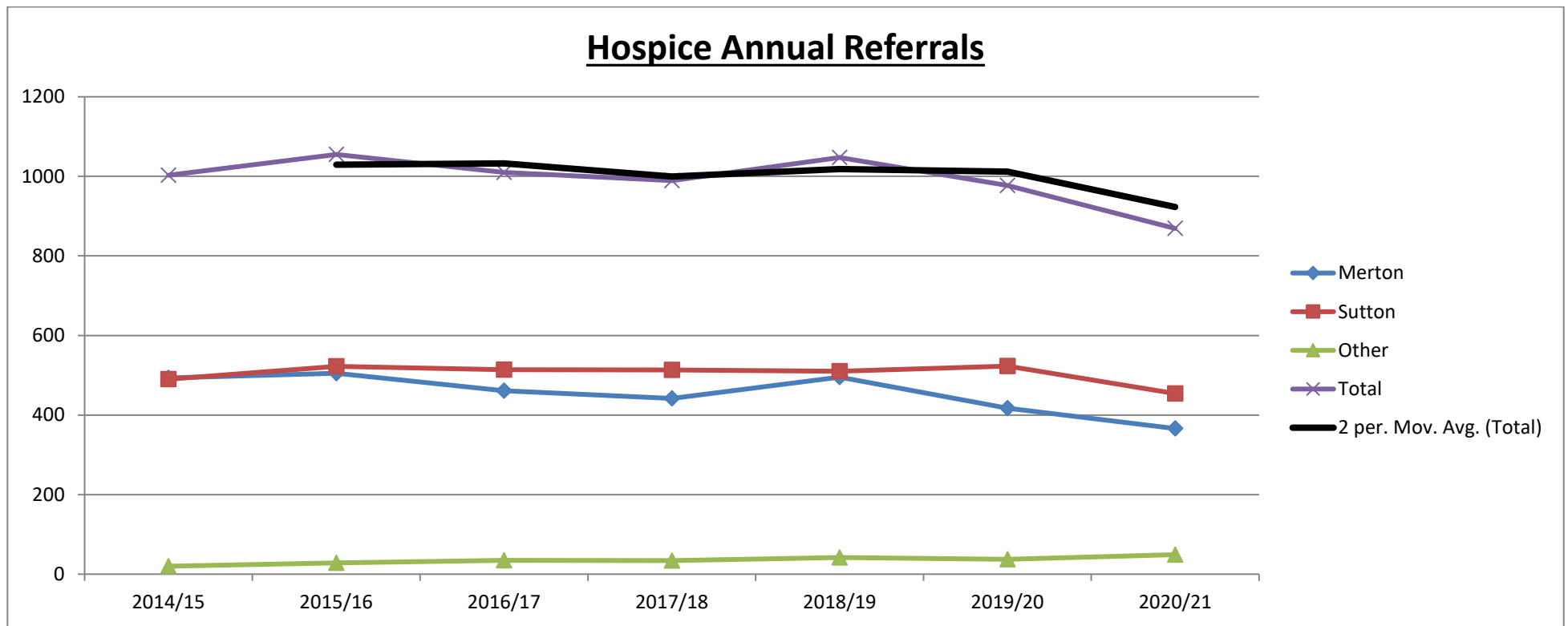
There were 7 safeguarding notifications made to the CQC between January and April 2021: 6 concerning individuals and 1 care home. All 7 were reported to the local safeguarding teams.

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. A selection of graphical representations for some of the data items have been produced for data up to end of 2020 and will be updated quarterly.

Hospice Referrals





[Activity Dataset provided to the Hospice's Commissioners 2020/21](#)

[Homecare Service Data Dashboard April 2017 - December 2020](#)

[IPU Service Data Dashboard April 2017 - December 2020](#)

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).

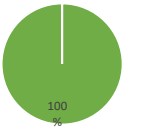
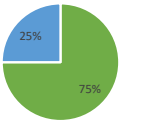
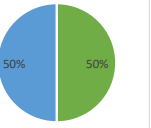
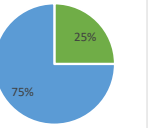

The Hospice deploys a Multidisciplinary Team (MDT) model to the delivery of its clinical services to achieve excellence. This necessitates all levels of clinical staff embracing an inclusive, proactive approach where responsibility and accountability are enabled and supported. Every voice and contribution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


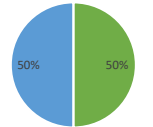
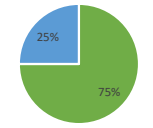
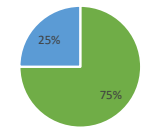
The Clinical Action Plan is operationally overseen and routinely reviewed by the Clinical Heads of Department Meeting.

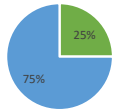


UPDATE OVERVIEW					
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23-Apr-21	0	4	4	2	10


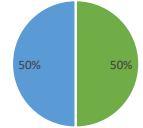

Clinical Action Plan



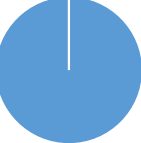
Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status						
CAP01	Review suitability of staff support / clinical supervision/reflection mechanisms : consideration of Schwartz rounds	<p>To facilitate and enable clinical discussion relative to the care of dying patients and their families.</p> <p>To provide a safe forum to support emotions and stresses.</p> <p>To enhance understanding of the professional environment in order to support practice development.</p> <p>To develop the IPU's skill set in undertaking level 1 psycho-social support for patients and families.</p> <p>To reduce silo-working and facilitate inclusivity of all staff in shared learning</p> <p>Provide opportunity to rotate to Community Team for further</p>	<p>Staff protected time</p> <p>External facilitation</p> <p>Psychological Services lead training time</p> <p>Employment contract updates</p>	<p>Engagement isn't compulsory</p> <p>Staff will leave</p> <p>Potential for variability in skills and abilities across days and nights.</p>	<p>Staff and facilitator time</p> <p>Schwartz training and set up.</p>	<p>Caring</p> <p>Effective</p> <p>Well-led</p> <p>Responsive</p> <p>Safe</p>	<p>Clinical supervision for all staff remains ongoing.</p> <p>100% compliance against plans affected by COVID</p> <p>SLT Peer Support being delivered regularly</p> <p>Psycho-social training to up-skill IPU team to deliver level 1 psycho-social support. Pended post COVID.</p> <p>Educational Updates</p> <p>Schwartz rounds to be prepped for</p>	<table border="1"> <tr> <th>Category</th> <th>Percentage</th> </tr> <tr> <td>Complete</td> <td>75%</td> </tr> <tr> <td>Incomplete</td> <td>25%</td> </tr> </table>	Category	Percentage	Complete	75%	Incomplete	25%
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CAP02	Rotation of IPU staff across 24 hours Provide adequate competent staffing across days and nights	<p>To ensure consistency of approach and delivery to service provision across 24 hours.</p> <p>Assurance of clinical competence via night staff coming on to days for 1 week every 4 months and accessing education, development and competency assessment.</p> <p>To break down cultural barriers between day and night teams.</p> <p>All newly recruited staff will have internal rotation across days and nights built into contract.</p> <p>To support the one team approach.</p> <p>To ensure that staff across all shifts are accessing education and associated competencies.</p> <p>To ensure that staff across all shifts are accessing education and associated competencies.</p> <p>To ensure all staff are being developed and feel part of the wider team.</p> <p>New community team member induction includes IPU working for up to 1 month</p>	<p>Consultation time for existing staff across day and nights with HR and Clinical Director</p>	<p>Staff will not engage with the process.</p> <p>Staff retention / recruitment</p>	<p>Current Staff Costs</p> <p>Possible requirement for identified external training</p>	<p>Caring</p> <p>Effective</p> <p>Well-led</p> <p>Responsive</p> <p>Safe</p>	<p>Consultation complete</p> <p>Implementation commenced January 2021</p> <p>Rotation days to nights in place. Nights to days on hold impacted by staffing shortages</p> <p>Aim to rotate nursing staff from the IPU into community 'for experience' from date tbc (on hold due to staffing shortages)</p> <p>Incorporated into new recruitment contracts</p> <p>Implementation happening for both days and nights.</p> <p>Affected by COVID re staff sickness / furlough</p> <p>New community team induction that includes IPU working implemented.</p>	<table border="1"> <tr> <th>Category</th> <th>Percentage</th> </tr> <tr> <td>Complete</td> <td>75%</td> </tr> <tr> <td>Incomplete</td> <td>25%</td> </tr> </table>	Category	Percentage	Complete	75%	Incomplete	25%
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CAP03	Increase counselling support for post bereavement care from 6 student counsellors to 12	<p>To improve responsive access</p>	<p>Volunteer student counsellor recruitment and supervision</p>	<p>Reduced counselling provision by the Head of Psycho-social</p>	<p>N/A</p>	<p>Caring</p> <p>Effective</p> <p>Well-led</p> <p>Responsive</p>	<p>August – September 2021</p>	<table border="1"> <tr> <th>Category</th> <th>Percentage</th> </tr> <tr> <td>Complete</td> <td>100%</td> </tr> <tr> <td>Incomplete</td> <td>0%</td> </tr> </table>	Category	Percentage	Complete	100%	Incomplete	0%
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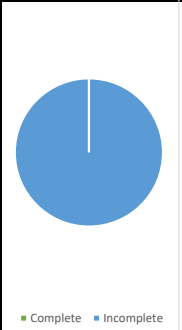
Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP04	Increase establishment of Band 5 nurses on the IPU to facilitate secondment to other clinical departments to support staff development and a 'One Team' approach.	<p>To develop team of nurses with assurance of palliative care clinical skills.</p> <p>Increasing the establishment to allow flexibility to open more beds routinely in the longer term.</p> <p>Opportunity of secondment to other clinical services to enhance understanding of the wider palliative care practice</p>	<p>HR</p> <p>Recruitment</p> <p>Training</p> <p>Development</p>	<p>Difficulty in recruiting.</p> <p>Loss of momentum subject to recruitment</p>	Cost of Band 5 nurse recruitment	<p>Caring</p> <p>Effective</p> <p>Well-led</p> <p>Responsive</p>	Advert for Band 5s and Band 6s in place for current vacancies.	<p>75% Complete, 25% Incomplete</p>
CAP05	To maintain CNS Development posts	<p>For succession planning.</p> <p>To ensure we have replacements for future retirees or those leaving through natural attrition.</p> <p>To ensure the service can operate in the future.</p> <p>To ensure competencies and training allows for development nurses to progress to CNS level and work within all departments</p>	<p>HR</p> <p>Recruitment</p>	<p>Cost to organisation in terms of care delivery if not planned. This could be mitigated by Trust application funding.</p>	Salary costs	<p>Safe</p> <p>Effective</p> <p>Responsive</p>	3 positions : band 7 & 2 band 6s filled for 2021	<p>75% Complete, 25% Incomplete</p>
CAP06	To include the audit of clinical risk assessment that supports individualised care planning in the clinical audit program	<p>To ensure our planning is individualised and documentation is supportive.</p> <p>Individualised care planning and risk assessment that is comprehensive</p>	<p>Time to train</p> <p>Staff engagement</p>	<p>Sub-standard communication and documentation that supports care delivered / planned.</p> <p>Lack of engagement</p>	None	<p>Caring</p> <p>Effective</p> <p>Well-led</p> <p>Responsive</p> <p>Safe</p>	Audit of risk assessment planned for 2021/22 audit program.	<p>50% Complete, 50% Incomplete</p>

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,TV&JF). Project implementation task and finish group first met in December 2020 Draft Pol / Karnofsky March / April 2021 Phase and Karnofsky for 2021/22 audit program 2021/22 : Phase & Karnofsky 2022/23 : iPOS - IPU 2022/23 : iPOS - Community	 ■ Complete ■ Incomplete
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 & Time may be accessed / implemented in 2021	 ■ 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 Policy amendments : April 2021 Full implementation for incidents – May 2021 Implementation for Complaints / Complements - July 2021	 ■ 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	 ■ 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	October 2021 for all Band 6 & 7 staff to be assessed as competent.	 <p>■ Complete ■ Incomplete</p>
CAP12	Review of the CPCT service model	To ensure optimum use of resources in relation to demand	Time for consultation Engagement by 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 Sep - Nov 21 Initial review	 <p>■ Complete ■ Incomplete</p>
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 launch - May 2021	 <p>■ Complete ■ Incomplete</p>

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 appropriate 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	Jan-23	 ■ Complete ■ Incomplete
CAP15	Identification and allocation of clinical lead for the Medical Team Designated areas of responsibility 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.	 ■ Complete ■ 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	Dec-21	 ■ Complete ■ Incomplete

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP17	To review the palliative intervention offer (Parcentesis) - 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	 ■ 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	 ■ 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	

SAINT RAPHAEL'S HOSPICE

**MINUTES OF THE MEDICAL BUSINESS MEETING
Held on 31.3.2021**

In attendance: Ambreen Akhtar Specialty Doctor
Andrew Hoy Consultant (Chair)
Jenny Strawson Consultant
Pascale Evans Secretary (minutes)

ITEM 1: Apologies for Absence

- 1.1 Gaby Tamura-Rose, Annelise Matthews, Busi Da Silva, Jovy Giles, Laura Yalley-Ogunro, Martine Meyer

ITEM 2: Minutes of the Last Meeting

- 2.1 Approved.

ITEM 3: Rota / staffing for the next three months

- 3.1 StR Sabrina Vitello is starting on 6th April and an induction timetable has been prepared.
- 3.2 3rd Consultant Naomi Collins will join the team on 5th July.
- 3.3 Ambreen's day in the community is going well.
- 3.4 Jenny will review Busi's hours increase. Jenny
- 3.5 Andrew might not be available from 4 till 26 July and the rota will have to be amended. TBC Andrew

ITEM 4: Clinical Challenges

- 4.1 Use of ultrasound is a working progress. The team need to compile a checklist of equipment required and also look at the practical side of things. The simulation dummy could be used for training purposes. Jenny will ask Princess Alice for their checklist. Jenny
- 4.2 A policy on multiple medication is needed. Ambreen and Sabrina will follow-up. Ambreen/
Sabrina

ITEM 5: Infection Control

- 5.1 Public Health England visited the Hospice to give advice. The hospice is doing well with infection control and vaccination status. It is important for HR to keep track of staff vaccinations.

ITEM 6: Education

- 6.1 Ambreen attended the Palliative Care Congress on 24th March. Overuse of pain score was addressed.
- 6.2 Next GP masterclass will focus on pain management and how we approach pain.

6.3 Mortality & Morbidity meetings usually take place once a month but some nurses find the meetings negative.

ITEM 7: Audit and Governance

7.1 Possible new audits will be discussed.

ITEM 8: Any other business

8.1 Dates of future meetings:

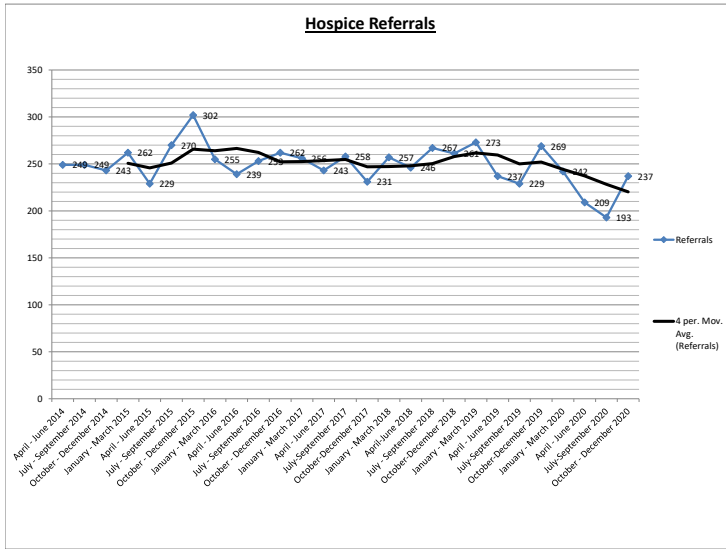
Date	Event	Venue/Time
5.5.2021	Medical Business Meeting	15.00

Meeting: Clinical HODs Meeting			
Date: 13.04.21		Time: 14:00	
Chair : Rebecca T RT		Minutes: Lynn Jackson	
Present: Tracy Y TY Tracy C TC Maura F MF Laura B LB Alex R AR Dr Gaby TR GTR			
Apologies: Steve M SM Dr Jenny S JS			
Agenda item	Discussion	Actions & by whom	Anticipated date for completion
Review of previous minutes	Agreed		
Matters Arising	Clinical action plan – 20 actions some of which will not be achievable in this year & will be ongoing due to being large projects or Covid restraints	RT to email to CHODS & response comments to be emailed to RT	Ongoing
Topic			
Infection Prevention	Covid 19 up date meeting to be held	MF/LB to arrange	
Medical Devices			
Medicine Management	medication to be audited due to increase in prescriptions over past year	AR & Kevin H	On going
Incidents & Accidents/RCA's	None to report		
Complaints	None to report		
Health & Safety			

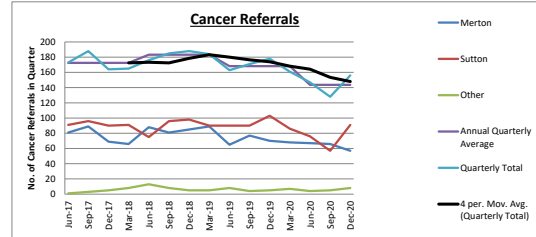
New Policies/ Guidelines			
Documentation/ Crosscare	Advanced Care planning has been completed by TC & requires verification Verification of Expected Death. Training to be given in Wednesday workshops – video to be shown.	TC to send to AR MF/LB, TC & GTR	September 2021 October 2021
Audit/Research	Clinical audit – routine audits to be completed & risk assessments Clinical staff Audit training to be undertaken via Wednesday workshops OAK – to be embedded in working practices	AR MF/LB ClinicalStaff	 ongoing Dec 2021
Education/Training Reflective Forums	Clinical supervision Advanced communication skills training Datix training/video/policy to be implemented Bladder Scanner training Associate Physician position to be evaluated to demonstrate the impact within SRH	LB to email RT MF/LB to research AR & staff MF/LB JS to survey & report back	May 2021 Autumn 2021 Quarter 2 To be arranged Ongoing
Recruitment/ Staffing	IPU staff to rotate in respect of competencies Staff recruitment – HR are advertising in different sectors. GTR suggested looking at the wording of adverts in respect of our location – SW London/Sutton There's to be an increase in councillor support students to 12 Band 5 nurses – retention & recruitment Band 6 CNS CPCT development posts – increased funding to Band 7	TY, MF/LB, TC RT & HR SM RT, TY, HR TC, HR	Ongoing Ongoing Ongoing Ongoing Ongoing
CQC/PIR			

AOB			
CPCT	The service has been remodelled & will now consist of 3 locality teams. A review & evaluation of the new model will take place after approx.. 6 months	TC, CPCT staff	To be active in June
Well Being Centre	The service has been remodelled & after a delay the service will be officially launched in May. The service has now also recruited 2 new facilitators – Simon Oliver & Katie McKenna.	RT & Shelia P	May – launch & ongoing
SRH collaboration	SRH is working in collaboration with other SWL hospice's with regards information & best practice. Also to discuss AGP patients, advanced communication & possible on call programme	RT & CEO's	Ongoing

Date next meeting:

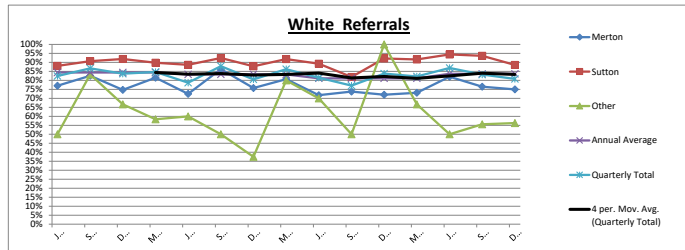
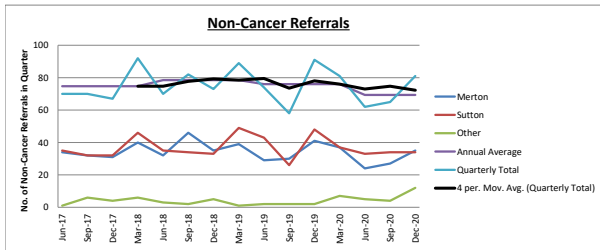


Community Team						
Cancer Referrals						
	Merton	Sutton	Other	Annual Average	Quarterly Total	Quarterly Total
Jun-17	81	91	1	172.5	172.5	173
Sep-17	89	96	3	172.5	172.5	188
Dec-17	69	90	5	172.5	172.5	164
Mar-18	69	91	8	172.5	172.5	165
Jun-18	88	75	13	183.25	183.25	176
Sep-18	81	96	8	183.25	183.25	185
Dec-18	85	98	5	183.25	183.25	188
Mar-19	89	90	5	183.25	183.25	184
Jun-19	65	90	8	168.25	168.25	163
Sep-19	77	90	4	168.25	168.25	171
Dec-19	70	103	5	168.25	168.25	178
Mar-20	68	86	7	168.25	168.25	161
Jun-20	67	76	4	143.67	143.67	147
Sep-20	66	57	5	143.67	143.67	128
Dec-20	57	91	8	143.67	143.67	156
Mar-21						



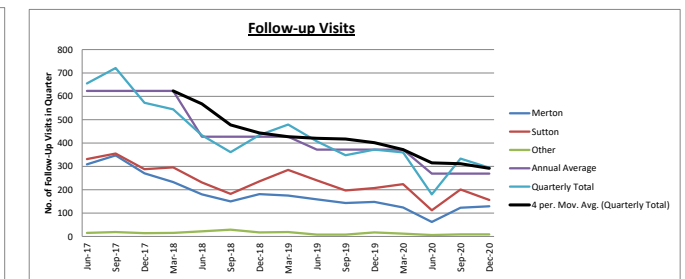
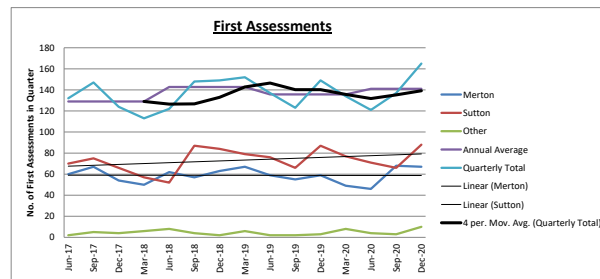
Community Team						
Non-Cancer Referrals						
	Merton	Sutton	Other	Annual Average	Quarterly Total	Quarterly Total
Jun-17	34	35	1	74.75	74.75	70
Sep-17	32	32	6	74.75	74.75	70
Dec-17	31	32	4	74.75	74.75	67
Mar-18	40	46	6	74.75	74.75	92
Jun-18	32	35	3	78.5	78.5	70
Sep-18	46	34	2	78.5	78.5	82
Dec-18	35	33	5	78.5	78.5	73
Mar-19	39	49	1	78.5	78.5	89
Jun-19	29	43	2	76.00	76.00	74
Sep-19	30	26	2	76.00	76.00	58
Dec-19	41	48	2	76.00	76.00	91
Mar-20	37	37	7	76.00	76.00	81
Jun-20	24	33	5	69.33	69.33	62
Sep-20	27	34	4	69.33	69.33	65
Dec-20	35	34	12	69.33	69.33	81
Mar-21						

Community Team						
White Referrals (British / Irish / Other) excluding Ethnicity Not Stated						
	Merton	Sutton	Other	Annual Average	Quarterly Total	Quarterly Total
Jun-17	77%	88%	50%	84%	84%	82%
Sep-17	83%	91%	83%	84%	84%	87%
Dec-17	75%	92%	67%	84%	84%	84%
Mar-18	82%	90%	58%	84%	84%	85%
Jun-18	72%	89%	60%	83%	83%	79%
Sep-18	86%	92%	50%	83%	83%	88%
Dec-18	76%	88%	38%	83%	83%	81%
Mar-19	81%	92%	80%	83%	83%	86%
Jun-19	72%	89%	70%	81%	81%	81%
Sep-19	74%	82%	50%	81%	81%	77%
Dec-19	72%	92%	100%	81%	81%	84%
Mar-20	73%	92%	67%	81%	81%	82%
Jun-20	82%	94%	50%	84%	84%	87%
Sep-20	76%	94%	86%	84%	84%	83%
Dec-20	75%	89%	56%	84%	84%	81%
Mar-21						



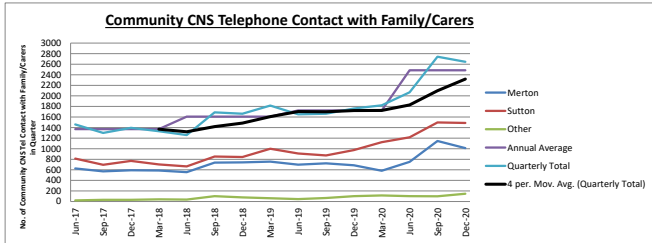
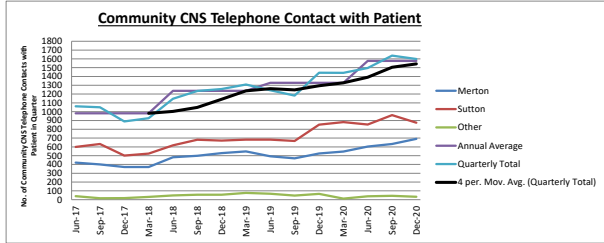
Community Team						
First Assessments						
	Merton	Sutton	Other	Annual Average	Quarterly Total	Quarterly Total
Jun-17	60	70	2	129	129	132
Sep-17	67	75	5	129	129	147
Dec-17	54	66	4	129	129	124
Mar-18	50	57	6	129	129	113
Jun-18	62	52	8	143	143	122
Sep-18	57	87	4	143	143	148
Dec-18	63	84	2	143	143	149
Mar-19	67	79	6	143	143	152
Jun-19	59	76	2	136	136	137
Sep-19	55	66	2	136	136	123
Dec-19	59	87	3	136	136	149
Mar-20	49	77	8	136	136	134
Jun-20	46	71	4	141	141	121
Sep-20	68	66	3	141	141	137
Dec-20	67	88	10	141	141	165
Mar-21						

Community Team						
Follow Up Visits						
	Merton	Sutton	Other	Annual Average	Quarterly Total	Quarterly Total
Jun-17	309	331	15	623	623	655
Sep-17	347	355	19	623	623	721
Dec-17	270	288	14	623	623	572
Mar-18	233	296	15	623	623	544
Jun-18	180	231	22	426.75	426.75	433
Sep-18	150	182	29	426.75	426.75	361
Dec-18	181	236	17	426.75	426.75	434
Mar-19	175	285	19	426.75	426.75	479
Jun-19	159	240	8	372	372	407
Sep-19	143	197	8	372	372	348
Dec-19	148	207	17	372	372	372
Mar-20	124	224	12	372	372	360
Jun-20	62	112	6	269	269	180
Sep-20	123	201	9	269	269	333
Dec-20	129	156	9	269	269	294
Mar-21						



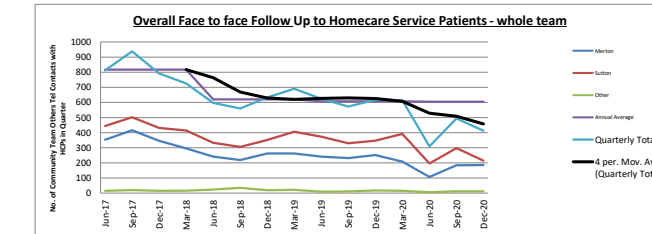
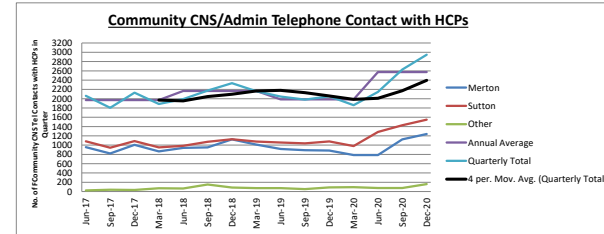
Community Team						
Community CNS Telephone Contact with Patient						
	Merton	Sutton	Other	Annual Average	Quarterly Total	
Jun-17	421	600	40	982	1061	
Sep-17	401	633	16	982	1050	
Dec-17	371	501	17	982	889	
Mar-18	371	523	32	982	926	
Jun-18	482	617	48	1237	1147	
Sep-18	498	681	56	1237	1235	
Dec-18	529	672	56	1237	1257	
Mar-19	549	683	77	1237	1309	
Jun-19	493	682	68	1328	1243	
Sep-19	469	667	47	1328	1183	
Dec-19	525	852	66	1328	1443	
Mar-20	547	882	12	1328	1441	
Jun-20	604	854	38	1577	1496	
Sep-20	632	961	44	1577	1637	
Dec-20	691	874	33	1577	1598	

Community Team						
Community CNS Telephone Contact with Family/Carers						
	Merton	Sutton	Other	Annual Average	Quarterly Total	
Jun-17	626	813	21	1460	1460	
Sep-17	572	695	31	1371	1298	
Dec-17	592	770	33	1371	1395	
Mar-18	588	702	41	1371	1331	
Jun-18	556	665	37	1606	1258	
Sep-18	736	852	100	1606	1688	
Dec-18	741	843	79	1606	1663	
Mar-19	756	999	61	1606	1816	
Jun-19	698	909	45	1725	1652	
Sep-19	724	872	67	1725	1663	
Dec-19	686	974	102	1725	1762	
Mar-20	583	1123	115	1725	1821	
Jun-20	751	1216	100	2485	2067	
Sep-20	1146	1497	99	2485	2742	
Dec-20	1010	1488	147	2485	2645	

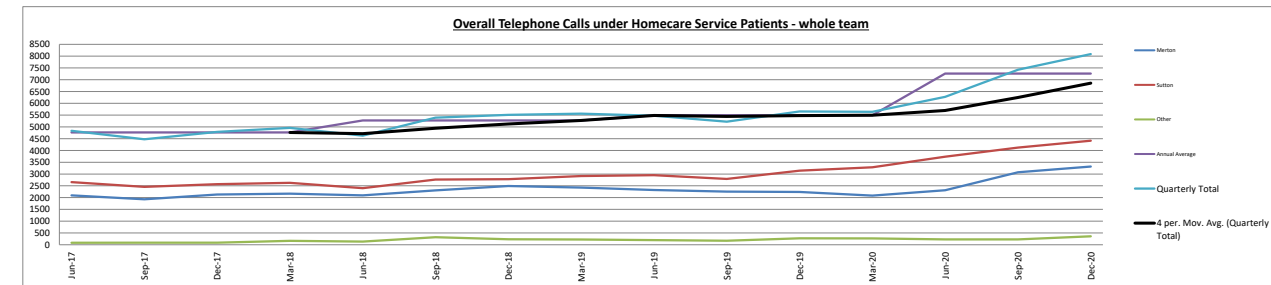


Community Team						
Community CNS/Admin Telephone Contact with HCPs						
	Merton	Sutton	Other	Annual Average	Quarterly Total	
Jun-17	957	1081	24	1970.5	2062	
Sep-17	821	946	39	1970.5	1804	
Dec-17	1007	1087	35	1970.5	2129	
Mar-18	864	952	71	1970.5	1887	
Jun-18	940	985	66	2165.5	1991	
Sep-18	951	1072	152	2165.5	2175	
Dec-18	1123	1127	85	2165.5	2335	
Mar-19	1011	1076	74	2165.5	2161	
Jun-19	917	1055	73	1985	2045	
Sep-19	891	1038	51	1985	1980	
Dec-19	883	1080	89	1985	2052	
Mar-20	787	979	95	1985	1861	
Jun-20	786	1284	76	2574	2146	
Sep-20	1124	1427	77	2574	2628	
Dec-20	1239	1548	160	2574	2947	

Homecare Service						
Overall Face to Face Follow Up to Homecare Patients - whole team						
	Merton	Sutton	Other	Annual Average	Quarterly Total	
Jun-17	353	444	15	817	817	
Sep-17	416	502	20	817	938	
Dec-17	346	431	15	817	792	
Mar-18	296	414	16	817	726	
Jun-18	241	333	23	620	597	
Sep-18	219	306	35	620	560	
Dec-18	262	352	19	620	633	
Mar-19	262	406	22	620	690	
Jun-19	241	373	10	607	624	
Sep-19	232	330	11	607	573	
Dec-19	252	347	18	607	617	
Mar-20	208	392	15	607	615	
Jun-20	107	196	6	605	309	
Sep-20	184	298	12	605	494	
Dec-20	186	213	12	605	413	

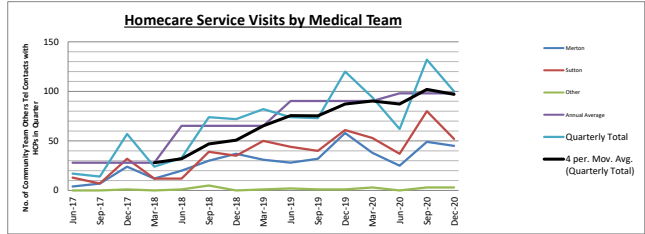
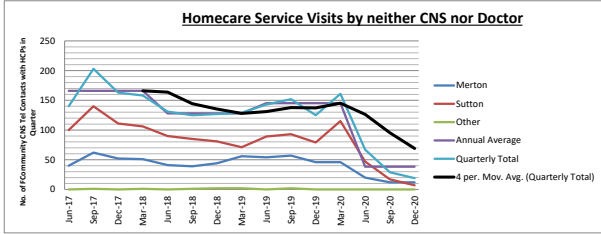


Homecare Service						
Overall Telephone Calls under Homecare Service - whole team						
	Merton	Sutton	Other	Annual Average	Quarterly Total	
Jun-17	2094	2956	85	4764	4835	
Sep-17	1928	2456	89	4764	4473	
Dec-17	2129	2569	90	4764	4788	
Mar-18	2169	2627	164	4764	4960	
Jun-18	2093	2400	133	5272	4626	
Sep-18	2305	2763	323	5272	5391	
Dec-18	2493	2782	235	5272	5510	
Mar-19	2423	2915	223	5272	5561	
Jun-19	2324	2952	195	5495	5471	
Sep-19	2257	2792	172	5495	5221	
Dec-19	2238	3141	273	5495	5652	
Mar-20	2083	3285	269	5495	5637	
Jun-20	2313	3733	227	7261	6273	
Sep-20	3074	4120	228	7261	7422	
Dec-20	3317	4413	358	7261	8088	



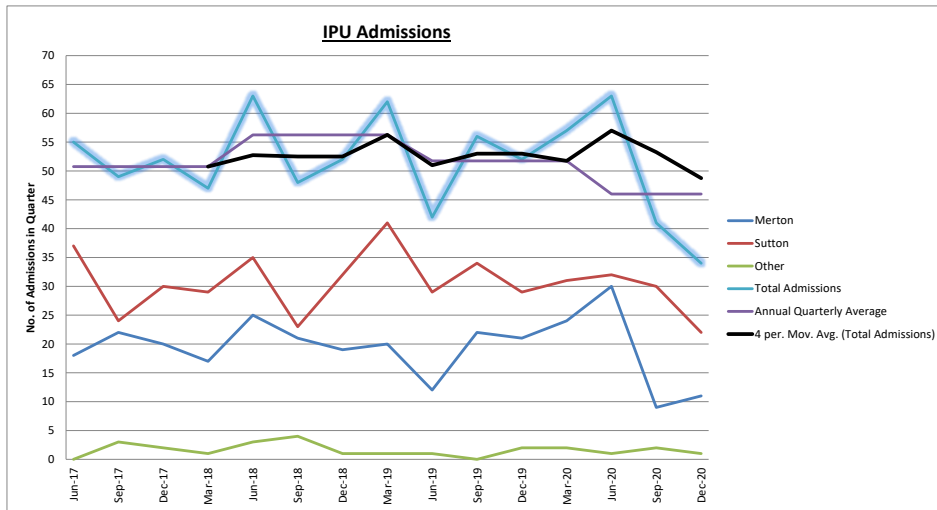
Homecare Service					
Visits by neither CNS nor Doctor					
	Merton	Sutton	Other	Annual Average	Quarterly Total
Jun-17	40	100	0	166	140
Sep-17	62	140	1	166	203
Dec-17	52	111	0	166	163
Mar-18	51	106	1	166	158
Jun-18	41	90	0	128	131
Sep-18	39	85	1	128	125
Dec-18	44	81	2	128	127
Mar-19	56	71	2	128	129
Jun-19	54	89	0	145	143
Sep-19	57	93	2	145	152
Dec-19	46	79	0	145	125
Mar-20	46	115	0	145	161
Jun-20	20	47	0	38	67
Sep-20	12	17	0	38	29
Dec-20	12	7	0	38	19

Homecare Service						
Medical Team Face to Face Follow Ups						
	Merton	Sutton	Other	Annual Average	Quarterly Total	
Jun-17	4	13	0	28	17	
Sep-17	7	7	0	28	14	
Dec-17	24	32	1	28	57	
Mar-18	12	12	0	28	24	
Jun-18	20	12	1	65	33	
Sep-18	30	39	5	65	74	
Dec-18	37	35	0	65	72	
Mar-19	31	50	1	65	82	
Jun-19	28	44	2	90	74	
Sep-19	32	40	1	90	73	
Dec-19	58	61	1	90	120	
Mar-20	38	53	3	90	94	
Jun-20	25	37	0	98	62	
Sep-20	49	80	3	98	132	
Dec-20	45	52	3	98	100	

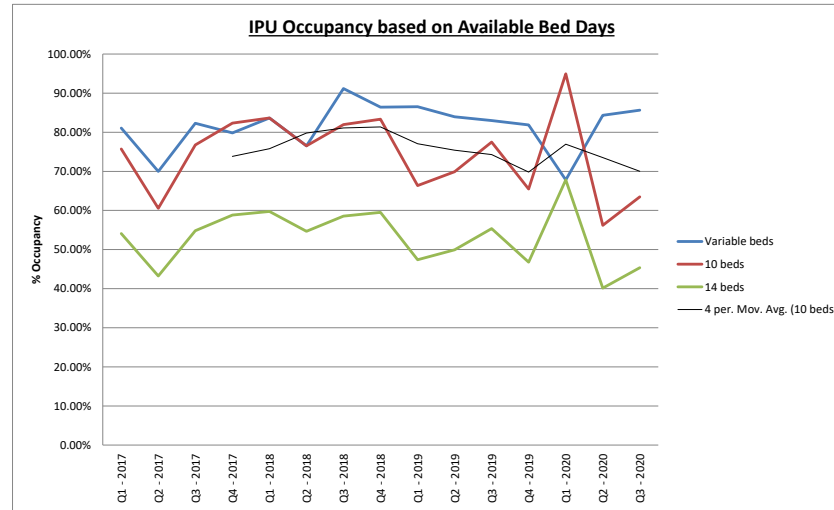


IPU						
No. of Admissions in Quarter						
	Merton	Sutton	Other	Total Admissions	Monthly Average	Annual Quarterly Average
Jun-17	18	37	0	55	18	50.75
Sep-17	22	24	3	49	16	50.75
Dec-17	20	30	2	52	17	50.75
Mar-18	17	29	1	47	16	50.75
Jun-18	25	35	3	63	21	56.25
Sep-18	21	23	4	48	16	56.25
Dec-18	19	32	1	52	17	56.25
Mar-19	20	41	1	62	21	56.25
Jun-19	12	29	1	42	14	51.75
Sep-19	22	34	0	56	19	51.75
Dec-19	21	29	2	52	17	51.75
Mar-20	24	31	2	57	19	51.75
Jun-20	30	32	1	63	21	46.00
Sep-20	9	30	2	41	14	46.00
Dec-20	11	22	1	34	11	46.00
Mar-21						

	IPU Variable Available	Based on 10 beds	Based on 14 beds
Q1 - 2017	81.06%	75.71%	54.08%
Q2 - 2017	69.97%	60.54%	43.25%
Q3 - 2017	82.28%	76.74%	54.81%
Q4 - 2017	79.85%	82.33%	58.81%
Q1 - 2018	83.63%	83.63%	59.73%
Q2 - 2018	76.52%	76.52%	54.66%
Q3 - 2018	91.17%	81.96%	58.54%
Q4 - 2018	86.41%	83.33%	59.52%
Q1 - 2019	86.53%	66.37%	47.41%
Q2 - 2019	83.94%	69.89%	49.92%
Q3 - 2019	83.00%	77.50%	55.36%
Q4 - 2019	81.87%	65.49%	46.78%
Q1 - 2020	67.82%	94.95%	67.82%
Q2 - 2020	84.34%	56.20%	40.14%
Q3 - 2020	85.63%	63.48%	45.34%
Q4 - 2020			

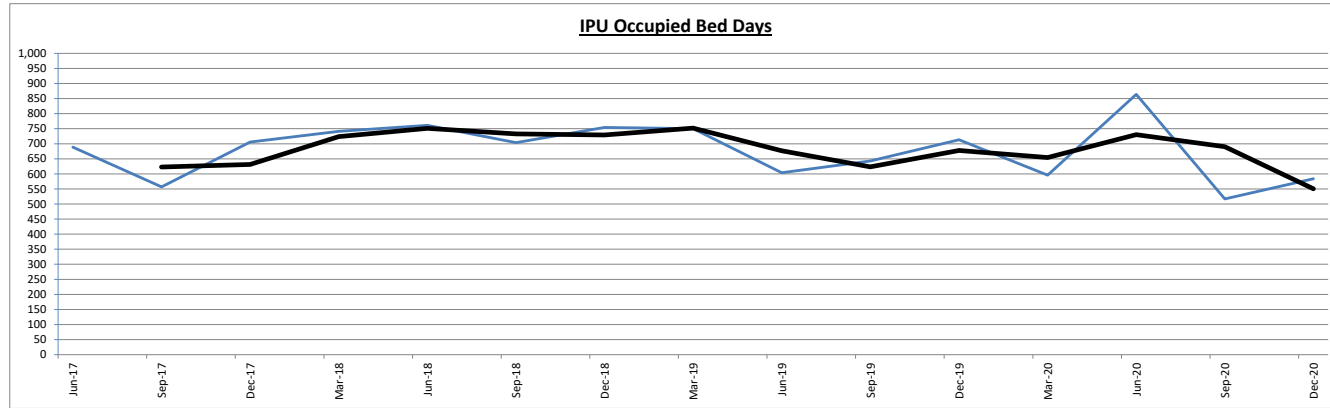


Comments to Dec 20: Admissions are declining across both CCGs ; decline accentuated from June 2020. Proportionately Merton admission are consistent at 38% c.f. Sutton admissions of 62% (c.f. Merton admissions of 38% and 39% in both 2018/19 & 2017/18



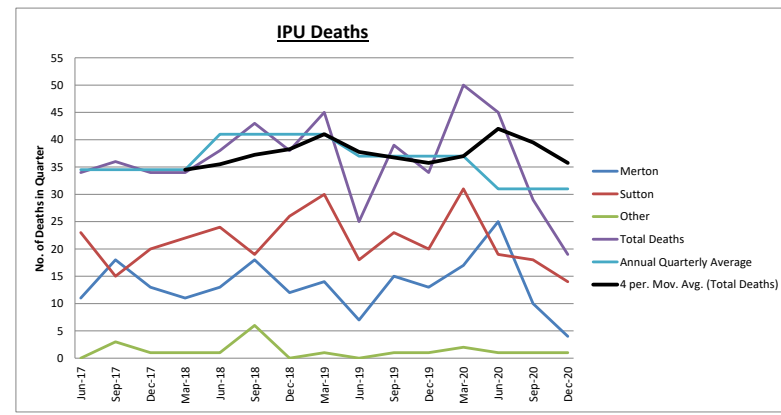
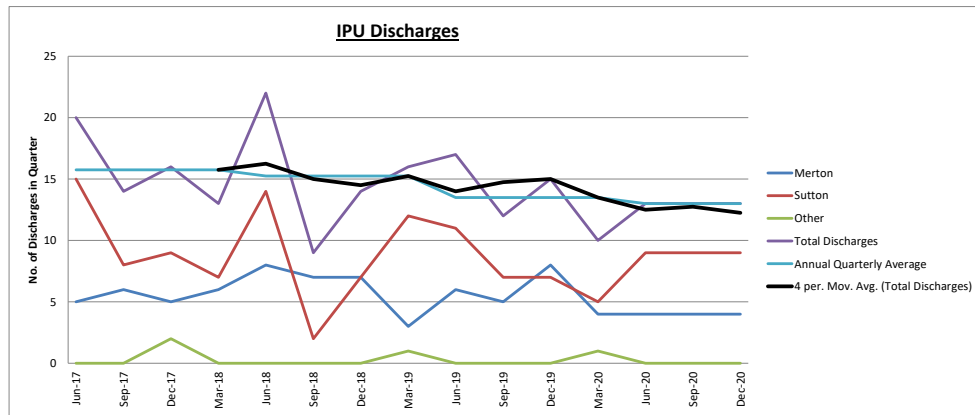
Comments to Dec 20: IPU Occupancy based on variable available bed data is distinct from static bed data. As such it represents the occupancy based on the staffing capacity to ensure safe provision of care. This is not the same as and is less than the occupancy figures that would be represented based upon on the routine availability of either 10 or 14 beds. Occupancy based on static bed availability figures is decreasing c.f the increasing trendline based on variable beds.

IPU Occupied Bed Days	Moving Average based on previous 12 months
Jun-17	689
Sep-17	557
Dec-17	706
Mar-18	741
Jun-18	761
Sep-18	704
Dec-18	754
Mar-19	750
Jun-19	604
Sep-19	643
Dec-19	713
Mar-20	596
Jun-20	864
Sep-20	517
Dec-20	584
Mar-21	

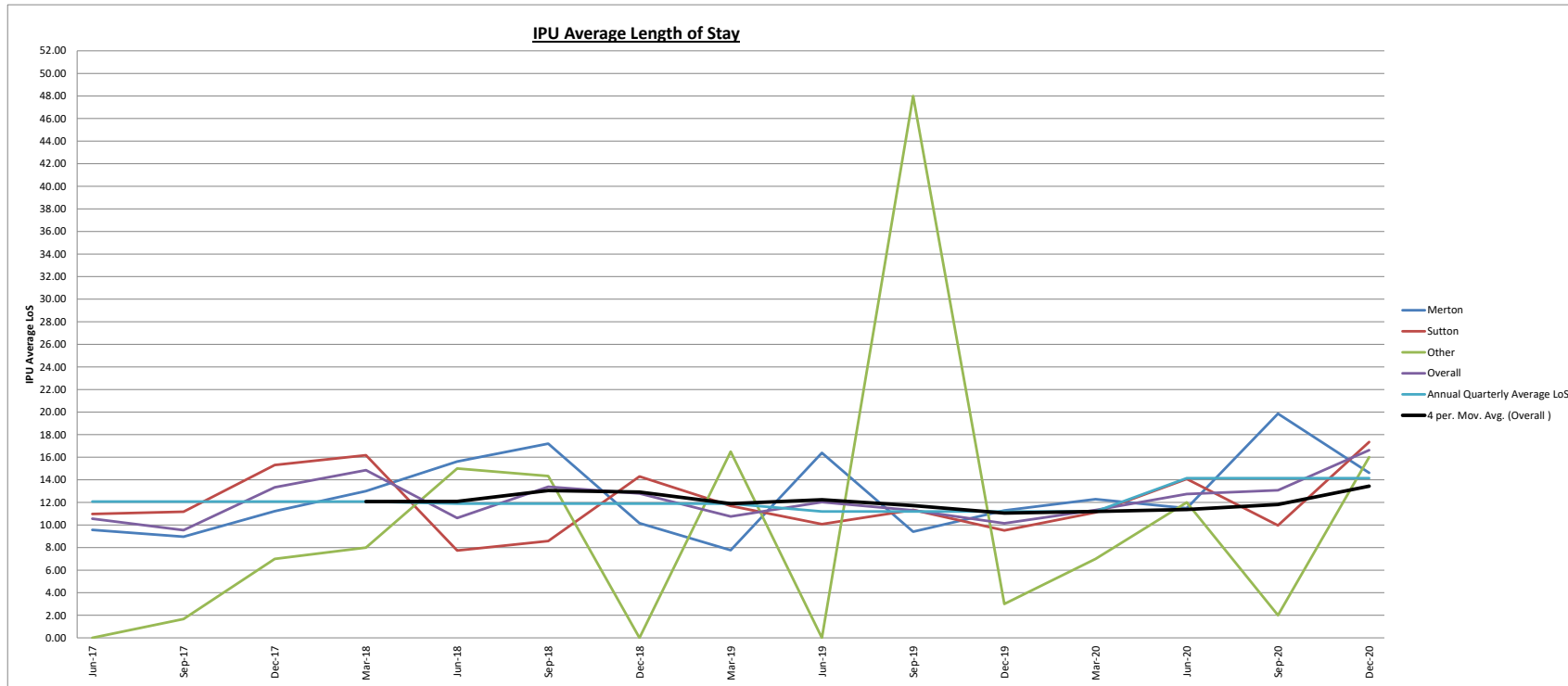


IPU						
No. of Discharges in Quarter						
	Merton	Sutton	Other	Total Discharges	Monthly Average	Annual Quarterly Average
Jun-17		5	15	0	20	16
Sep-17		6	8	0	14	16
Dec-17		5	9	2	16	16
Mar-18		6	7	0	13	16
Jun-18		8	14	0	22	15
Sep-18		7	2	0	9	15
Dec-18		7	7	0	14	15
Mar-19		3	12	1	16	15
Jun-19		6	11	0	17	14
Sep-19		5	7	0	12	14
Dec-19		8	7	0	15	14
Mar-20		4	5	1	10	14
Jun-20		4	9	0	13	13
Sep-20		4	9	0	13	13
Dec-20		4	9	0	13	13
Mar-21						

IPU						
No. of Deaths in Quarter						
	Merton	Sutton	Other	Total Deaths	Monthly Average	Annual Quarterly Average
Jun-17	11	23	0	34	11	35
Sep-17	18	15	3	36	12	35
Dec-17	13	20	1	34	11	35
Mar-18	11	22	1	34	11	35
Jun-18	13	24	1	38	13	41
Sep-18	18	19	6	43	14	41
Dec-18	12	26	0	38	13	41
Mar-19	14	30	1	45	15	41
Jun-19	7	18	0	25	8	37
Sep-19	15	23	1	39	13	37
Dec-19	13	20	1	34	11	37
Mar-20	17	31	2	50	17	37
Jun-20	25	19	1	45	15	31
Sep-20	10	18	1	29	10	31
Dec-20	4	14	1	19	6	31
Mar-21						



IPU						
Average Length of Stay (LoS)						
	Merton	Sutton	Other	Overall		Annual Quarterly Average LoS
Jun-17	9.56	10.97	0.00	10.56		12
Sep-17	8.96	11.17	1.67	9.54		12
Dec-17	11.22	15.31	7.00	13.34		12
Mar-18	13.00	16.17	8.00	14.85		12
Jun-18	15.62	7.74	15.00	10.62		12
Sep-18	17.20	8.57	14.33	13.38		12
Dec-18	10.16	14.30	0.00	12.79		12
Mar-19	7.76	11.69	16.50	10.75		12
Jun-19	16.38	10.07	0.00	12.02		11
Sep-19	9.40	11.33	48.00	11.29		11
Dec-19	11.29	9.52	3.00	10.14		11
Mar-20	12.29	11.11	7.00	11.32		11
Jun-20	11.48	14.07	12.00	12.74		14
Sep-20	19.86	9.96	2.00	13.07		14
Dec-20	14.63	17.35	16.00	16.63		14
Mar-21						



Prescriber's Meeting 4th March 2021

Present –

Kevin Hobson, Tracy Christmas, Jill Smith, Bernadette Griffin, Dr. Annelise Mathews

Previous minutes reviewed

Community Prescribing

Discussed recent prescribing practices / patterns

Challenges of weekend prescribing .

Kevin will try to look at auditing prescribing practices and capturing activities of last year / quarterly. Alex Rudkin should be able to help with this.

MARRS Charts

Tracy discussed new charts which should be in operation from 1st April this year.

Charts should be available on computer system (FORMS).

Power point presentation to be sent out for all to access / use forms (forms look easier and self-explanatory to use)

Prescribing Competencies

Mostly completed and awaiting signing off. Kevin will check!

Community s/c Guidelines

Recently reviewed and completed by Jenny and Gaby. Team agreed guidelines are easy to follow and very helpful.

Ongoing Education / Updates

Team still trying to attend sessions at St. Christopher's live but can access sessions after event!

D/N's Kim and Katrina currently doing Prescribing course. Have asked to spend time with prescribers. Kevin will get in touch. They can perhaps go out with whoever's available and also invite them to next Prescribers meeting.

Next meeting in May

St Raphael's Hospice Activity Dataset														
	2020			2020			2020				2020			
	Q1 : April - June			Q2 : July - September			Q3 : October - December				Q4 : January - March			
	Merton	Sutton	Wandsworth et al	Merton	Sutton	Wandsworth et al	Merton	Sutton	Wandsworth	Other	Merton	Sutton	Wandsworth	Other
HEMOCARE SERVICE														
Hospice Point of Contact														
Number of Referrals Overall	91	109	9	93	91	9	92	125	17	3	90	127	8	3
Number of Referrals Accepted	81	99	8	85	82	6	76	113	13	1	79	106	7	2
Referral Doesn't Require SPC				8	9	0	10	9	3	0	9	15	0	0
Referral Information Outstanding				0	0	1	3	1	1	0	1	2	0	0
Referred to another Hospice				0	0	2	3	2	0	2	1	4	1	1
Number of Referrals Cancer	67	76	4	66	57	5	57	91	6	2	55	94	6	1
Cancer Referrals %	74%	70%	44%	71%	63%	56%	62%	73%	35%	67%	61%	74%	75%	33%
Number of Referrals Non-Cancer	24	33	5	27	34	4	35	34	11	1	35	33	2	2
Non-cancer Referrals %	26%	30%	56%	29%	37%	44%	38%	27%	65%	33%	39%	26%	25%	67%
Gender Female n=	53	48	3	53	40	3	41	63	7	1	51	63	6	0
Gender Female %	58%	44%	33%	57%	44%	33%	45%	50%	41%	33%	57%	50%	75%	0%
Gender Male n=	38	61	6	40	51	6	51	62	10	2	39	64	2	3
Gender Male %	42%	56%	67%	43%	56%	67%	55%	50%	59%	67%	43%	50%	25%	0%
Ethnicity Split of Referrals														
White British	51	78	2	56	67	3	54	90	4	1	45	92	4	3
White Irish	5	4	1	5	5	1	3	5	0	0	3	2	0	0
Any Other White	8	3	1	4	2	1	6	6	3	1	7	3	2	0
Black Caribbean	2	0	1	3	1	2	0	0	4	0	6	1	0	0
Other Asian	6	1	0	7	1	1	10	4	2	0	6	5	1	0
Black African	1	1	1	4	1	0	0	2	0	0	2	2	0	0
Not Stated	13	18	1	8	12	0	8	11	4	0	7	16	0	0
Far Eastern	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Chinese	0	1	0	0	0	0	0	1	0	0	0	0	0	0
Indian	1	1	1	1	1	0	1	2	0	0	1	2	0	0
Pakistani	1	0	1	1	1	0	2	2	0	0	5	1	0	0
White Asian	0	0	0	0	0	0	1	0	0	0	1	1	0	0
Mixed White/Black African	0	0	0	1	0	0	1	0	0	0	0	0	0	0
Mixed White/Black Caribbean	0	0	0	0	0	0	0	0	0	0	1	0	1	0
Bangladeshi	0	0	0	0	0	0	2	0	0	0	0	1	0	0
Black Other	2	0	0	3	0	1	2	1	0	0	2	0	0	0
Mixed Other	0	0	0	0	0	0	2	0	0	0	1	1	0	0
Other	1	1	0	0	0	0	0	1	0	0	3	0	0	0
Advanced Care Planning Offered														
Based on patient deaths	93.33%	89.89%	100.00%	94.83%	93.90%	100.00%	94.37%	92.13%	80.00%	100.00%	90.00%	93.85%	75.00%	n/a
Coordinate My Care (CMC)														
Based on patient deaths	51	78	2	44	67	3	60	62	4	0	39	54	4	n/a
% Based on patient deaths	61.45%	78.79%	50.00%	65.67%	75.28%	75.00%	67.42%	63.92%	57.14%	0.00%	65.00%	67.50%	100.00%	n/a

Community Palliative Care Team including HPoC	2020 April - June			2020 Q2 : July - September			2020 Q3 : October - December				2020 Q4 : January - March			
	Merton	Sutton	Wandsworth et al	Merton	Sutton	Wandsworth et al	Merton	Sutton	Wandsworth	Other	Merton	Sutton	Wandsworth	Other
1st Assessments (Visits & Virtual))	46	71	4	68	66	3	67	88	10	0	48	58	4	2
1st Assessments by Phone											11	19	1	0
1st Assessments Cancer	41	58	2	58	52	1	52	68	5	0	42	65	4	0
1st Assessments Non-cancer	5	13	2	10	14	2	15	20	5	0	17	12	1	2
FU Visits by CPCT/HPoC CNS	62	112	6	123	201	9	129	156	9	0	96	153	14	0
Telephone Contacts Patients with CPCT/HPoC CNS/RGN	604	854	38	632	961	44	691	874	33	0	565	916	66	0
Telephone Contacts Family / Carers with CPCT/HPoC CNS (includes Community Admin from April 2018)	751	1216	100	1146	1497	99	1010	1488	142	5	919	1432	159	0
Telephone Contacts Healthcare Professionals with CPCT/HPoC CNS (includes Community Admin from April 2018)	786	1284	76	1124	1427	77	1239	1548	152	8	940	1500	145	14
Homecare service : Telephone Contact Patients / Carers / HCPs Totals	2141	3354	214	2902	3885	220	2940	3910	327	13	2424	3848	370	14
INPATIENT SERVICE	2020 April - June			2020 Q2 : July - September			2020 Q3 : October - December				2020 Q4 : January - March			
Inpatient Unit	Merton	Sutton	Wandsworth et al	Merton	Sutton	Wandsworth et al	Merton	Sutton	Wandsworth	Other	Merton	Sutton	Wandsworth	Other
Total Admissions	30	32	1	9	30	2	11	22	1	0	17	18	1	0
Cancer Admissions	24	25	1	6	24	2	10	16	1	0	13	18	1	0
Non-cancer Admissions	6	7	0	3	6	0	1	6	0	0	4	0	0	0
Total No. of Distinct Patients Admitted	30	31	1	9	30	2	11	22	1	0	16	17	1	0
Total Deaths	25	19	1	10	18	1	4	14	1	1	10	15	0	0
Cancer Deaths	20	14	1	8	16	1	3	9	1	1	9	15	0	0
Non-Cancer Deaths	5	5	0	2	2	0	1	5	0	0	1	0	0	0
Total Discharges	4	9	0	4	9	0	4	9	0	0	10	4	0	0
Cancer Discharges	3	9	0	2	6	0	4	7	0	0	7	4	0	0
Non-Cancer Discharges	1	0	0	2	3	0	0	2	0	0	3	0	0	0
Cancer Death Total Length of Stay	257	239	12	131	161	2	28	179	16	18	84	155	0	0
Cancer Deaths Avg LoS	13	17	12	16	10	2	9	20	16	18	9	10	0	0
Non-Cancer Death Total Length of Stay	21	36	0	25	13	0	19	75	0	0	4	0	0	0
Non-Cancer Deaths Avg LoS	4	7	0	13	7	0	19	15	0	0	4	0	0	0
Cancer Discharges Total Length Of Stay	38	119	0	15	65	0	70	89	0	0	73	57	0	0
Cancer Discharges Avg LoS	13	13	0	8	11	0	18	13	0	0	10	14	0	0
Non-Cancer Discharges Total Length of Stay	17	0	0	107	30	0	0	56	0	0	46	0	0	0
Non-Cancer Discharges Avg LoS	17	0	0	54	10	0	0	28	0	0	15	0	0	0
Cancer Deaths/Discharges	23	23	1	10	22	1	7	16	1	1	16	19	0	0
Non-cancer Deaths/Discharges	6	5	0	4	5	0	1	7	0	0	4	0	0	0
Cancer Deaths/Discharges Avg LoS	13	16	12	15	10	2	14	17	16	18	10	11	0	0
Non-Cancer Deaths/Discharges Avg LoS	6	7	0	33	9	0	19	19	0	0	12.5	0	0	0
Deaths/Discharges Total Length of Stay	333	394	12	278	269	2	117	399	16	18	207	212	0	0
Hospice @ Home	2020 April - June			2020 Q2 : July - September			2020 Q3 : October - December				2020 Q4 : January - March			
	Merton	Sutton	Wandsworth et al	Merton	Sutton	Wandsworth et al	Merton	Sutton	Wandsworth	Other	Merton	Sutton	Wandsworth	Other
Referrals	2	14	1	28	40	1	16	37	4	0	22	23	1	0
Cancer Referrals	2	9	0	19	27	0	10	24	3	0	19	21	0	0
Non-cancer Referrals	0	5	1	9	13	1	6	13	1	0	3	2	1	0
First Assessment Visits (Not an accurate fig as 1st assessments are also done by CPCT under Homecare Service)	0	3	0	6	10	2	1	5	1	0	0	0	0	0
Face to face encounters with Patients	23	59	1	92	136	8	91	250	6	0	64	159	3	0
Number of Individual Patients - Follow Up Visits Total	14	33	1	32	41	3	31	49	3	0	29	36	3	0
Follow Up Visits Total (Face to face encounters with patients minus First Assessment Visits)	23	56	1	86	126	6	90	245	5	0	64	159	3	0
Average Number of Follow Up Visits per patient	1.64	1.70	1.00	2.69	3.07	2.00	2.90	5.00	1.67	0.00	2.21	4.42	1.00	0.00
Number of Individual Patients - Telephone Contacts Patients Total	5	14	0	7	12	1	5	9	1	0	3	7	1	0
Telephone Contacts Patient Total	19	41	0	9	20	2	16	11	1	0	6	8	1	0
Number of Individual Patients -Telephone Contacts Family / Carers Total	14	39	2	29	48	4	20	39	3	0	26	34	2	0
Telephone Contacts Family / Carers Total	20	131	3	50	111	10	35	132	7	0	62	125	7	0
Number of Individual Patients - Telephone Contacts Healthcare Professionals (HCPs) Total	6	16	1	7	10	0	6	13	1	0	6	15	2	0
Telephone Contacts HCPs Total	6	22	1	10	13	0	9	29	2	0	12	26	2	0

DAYCARE SERVICE Wellbeing Centre	2020 April - June			2020 Q2 : July - September			2020 Q3 : October - December				2020 Q4 : January - March			
	Merton	Sutton	Wandsworth et al	Merton	Sutton	Wandsworth et al	Merton	Sutton	Wandsworth	Other	Merton	Sutton	Wandsworth	Other
	No of distinct patients (for attended)	9	12	0	6	15	0	7	9	1	0	6	17	1
No of actual attendances (for attended)	25	47	0	58	112	0	63	74	1	0	63	129	1	0
Number of Individual Patients - Telephone Contacts Patients	15	29	1	19	26	2	17	32	3	0	18	24	2	0
Telephone Contacts Patients	46	85	1	54	55	2	30	46	3	0	38	51	3	0
Number of Individual Patients - Telephone Contacts Family Carers	14	18	2	7	16	2	3	13	1	0	9	20	2	0
Telephone Contacts Family Carers	19	32	2	13	27	3	4	14	1	0	14	29	2	0
Number of Individual Patients - Telephone Contacts HCPs	5	7	0	3	2	0	0	1	0	0	0	0	0	0
Telephone Contacts HCPs	5	7	0	3	2	0	0	1	0	0	0	0	0	0
RISK	2020 April - June			2020 Q2 : July - September			2020 Q3 : October - December				2020 Q4 : January - March			
Risk Management	Merton	Sutton	Wandsworth et al	Merton	Sutton	Wandsworth et al	Merton	Sutton	Wandsworth	Other	Merton	Sutton	Wandsworth	Other
Inpatient Falls	2	7	0	2	3	0	0	2	0	0	2	0	0	0
Number of individual inpatients who fell	2	5	0	2	3	0	0	2	0	0	1	0	0	0
Wellbeing Centre Patient Falls	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of individual Jubilee Centre patients who fell	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CQC Reportable Events (SUIs)	0	2	0	0	1	0	0	1	0	0	1	1	0	0
Pressure Area Damage (Grade 2+) On Admission	1	4	0	1	1	0	0	3	0	0	2	1	0	0
Pressure Area Damage (Grade 2+) During Admission	0	0	0	0	2	0	0	3	0	0	0	0	0	0
MRSA Cases	0	0	0	0	0	0	0	0	0	0	0	0	0	0
C-Diff Cases	0	0	0	0	0	0	0	0	0	0	0	0	0	0

St Raphael's

Your Local Hospice



VOICES QUESTIONNAIRE

2019-2020

Compiled by: Audit Office

INDEX

.....	1
INTRODUCTION	3
AIMS.....	3
METHODOLOGY.....	3
Executive Summary.....	4
What can we learn?	8
What will we do or change?.....	8
Inpatient Care on Hospice Ward	10
Inpatient Stay	10
Care and Environment	11
Support	11
Communication and involvement	14
Food and Catering	17
St Raphael’s Community Services	20
Responsiveness	20
St Raphael’s Hospice Jubilee Centre.....	26
Circumstances surrounding his/her death.....	26
Bereavement Support.....	30
Bereavement Comments	32
2019/20 Community Team Manager Comments.....	37
2019/20 Palliative Care Consultant Comments	37
2019/20 Head of Psychological Services Team Comments	41
2019/20 Clinical Director Comments.....	43
2019/20 Joint CEO Comments.....	44

INTRODUCTION

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

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

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

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

AIMS

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

METHODOLOGY

The questionnaire used in this survey is taken from the National Survey of Bereaved People (VOICES) questionnaire. The next of kin / main carer of those Hospice patients that died during the period 1st October 2019 to 31st March 2020 were sent questionnaires 4-6 months post-bereavement. They were invited to complete the questionnaire under no obligation, and return completed surveys in pre-paid envelopes. This is a comparative audit report comparing the 2019/20 dataset with earlier audit from 2019.

Executive Summary

- a) The number of returned questionnaires has marginally increased to 28% in 2019/20 (c.f. 25% in 2019, 29% in 2018/19 ;34% in 2018; 32% in 2017/18; 28% in 2017).
- b) Responses to the questions on the care and environment provided in the inpatient ward (IPU) are overwhelmingly positive, with all respondents agreeing that help with personal care and nursing care met their requirements and all but one agreeing that the environment respected the patients' privacy (see page 11).
- c) Definite assertion of the adequacy of emotional support increased to 96% in 2019/20 from 2019's 68% (page 12), whilst definitive assertion of the adequacy of religious/spiritual support increased marginally to 56% from 2019's 55%.
- d) Support regarding financial concerns or other practical problems was considered to be of lower need – 4 respondents (13%) in 2019/20 (c.f. 14% in 2019). That need was considered to have been definitely met by 3 (75% in 2019/20 c.f. 33% in 2019).
- e) Definite assertion that symptoms other than pain in the IPU had been relieved has increased to 83% (c.f. 67% in 2019) and 100% recorded either definitely or to some extent in 2019/20 (c.f. 95% in 2019).
- f) Support regarding family concerns was considered to be of lesser need – 42% in 2019/20 (c.f. 48% in 2019). That need was considered to have been definitely met by 92% in 2019/20 (c.f. 90% in 2019).
- g) Pain relief in the IPU has moved significantly from being completely relieved 'all of the time' to being relieved 'some of the time' or 'partially' in 2019/20. Pain relieved completely, 'all of the time' has reduced to 54% in 2019/20 (c.f. 79% 2019), marginally increased to 'most of the time' at 4% in 2019/20 (c.f. 0% in 2019), increased to 'some of the time' at 29% in 2019/20 (c.f. 11% in 2019) and increased 'partially' by 14% in 2019/20 (c.f. 5% in 2019) (Page 13). Having pain relieved 'all of the time' may trigger more concern and possibly raises the question over the sedative effects of the medication used.
- h) 90% in 2019/20 (c.f. 80% in 2019) of family members of IPU patients were always kept informed of the patients' condition. 10% considered family members were usually kept informed (c.f. 15% in 2019). The percentage of respondents who considered the language used by doctors and nurses to explain the condition to be 'very easy' to understand has increased to 90% in 2019/20 (c.f. 55% in 2019). (Page 14) with a decrease in 'fairly easy to understand' responses to 6% in 2019/20 (c.f.

40% in 2019). Their language comprehensibility was rated as ‘fairly difficult’ by 3% (c.f. 0% in 2019).

- i) The number of respondents that felt that decisions were made about the patients’ care/treatment that they wouldn’t have wanted has decreased to 13% in 2019/20 (c.f. 24% in 2019).
- j) Doctors and nurses ‘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 2019)
- k) Definite assertion that the Hospice worked well with patient GPs and other external services has marginally decreased to 45% in 2019/20 (c.f. 47% in 2019). However, this should be understood in context that there were no respondents that felt that they didn’t work well together and 31% in 2019/20 that didn’t know (c.f. 6% in 2019)
- l) A similar proportion of respondents regarded that being able to stay overnight in the Hospice was important – 54% (c.f. 55% in 2019) (page 16. Question 11).
- m) There has been a significant increase in respondents considering that they had ‘definitely received sufficient emotional support’ – 90% in 2019/20 (c.f. 62% in 2019) (page 16), with the shift away from ‘Yes to some extent’ – 7% in 2019/20 (c.f. 33% in 2019). Taken together, there is a positive marginal increase in 2019/20 – 97% being reflective upon the adequacy of emotional support as either definite or to some extent (c.f. 95% in 2019).
- n) Respondents were asked to rate care given to the patients by doctors and nurses on admission to the IPU and the responses in 2019/20 show a shift from ‘Excellent’ to ‘Exceptional.’ 65% considered doctor care on admission to be ‘Exceptional’ (c.f. 40% in 2019), 32% considered it to be ‘Excellent’ (c.f. 50% in 2019) and 3% considered it to be ‘Good’ (c.f. 10% in 2019) and 0% considered it ‘Fair’ (c.f. 0% in 2019). Taking ‘exceptional’ and ‘excellent’ together there is a marginal positive increase in 2019/20 – 97% (c.f. 95% in 2019). Responses relating to nursing care again show shift from ‘excellent’ to ‘exceptional’: 81% rating nursing care as ‘Exceptional’ (c.f. 57% in 2019) and 19% as ‘Excellent’ (c.f. 38% in 2019) and 0% as ‘Good’ (c.f. 5% in 2019) and 0% as ‘Fair’ (c.f. 0% in 2019) (Page 17). Again, taking ‘exceptional’ and ‘excellent’ together, there is a positive increase in 2019/20 – 100% (c.f. 95% in 2019).

- o) Regarding the food provided on the IPU in 2019/20, 38% rated the food as ‘Exceptional’ in 2019/20 (c.f. 12% in 2019), 19% ‘Excellent’ (c.f. 65% in 2019), 29% ‘Good’ (c.f. 24% in 2019), 5% ‘Fair’ (c.f. 0% in 2019). (Page 17) and 10% recorded ‘Don’t know’ (c.f. 0% in 2019). Combining ‘exceptional’ and ‘excellent’ ratings there has been a decrease in 2019/20 – 57% (c.f. 77% in 2019).
- p) 74% of respondents rated the patient bedroom as ‘Excellent’ which is an increase from 57% in 2019. The en-suite bathrooms were rated ‘Excellent’ by 68% in 2019/20 (c.f. 60% in 2019) (Page 18) which is a smaller increase.
- q) Satisfaction with the Community Services should be regarded with a degree of caution as it is difficult to isolate St Raphael’s impact amongst what may be a multitude of care providers. Responsiveness of visit is slightly decreased – 84% (c.f. 87% in 2019); ‘Yes definitely’ answers for emotional support have decreased slightly – 68% (c.f. 73% in 2019); Religious or spiritual support decreased slightly– 45% (c.f. 50% in 2019), but that question has a smaller data cohort, since fewer respondents consider religious/spiritual support to be necessary.
- r) A lower proportion felt that the patient required help with urgent problems during the evenings, between 5pm and 11pm, – 58% (c.f. 64% in 2019) and of those, an increased proportion – 64% (c.f. 61% in 2019) felt definitely that enough support had been received. (page 22)
- s) A slightly lower proportion felt that the patient required help with urgent problems during the night (7pm – 9am) – 54% (c.f. 55% in 2019) and of those, a slightly higher proportion – 65% (c.f. 63% in 2019) felt definitely that enough support had been received.
- t) A higher proportion of respondents considered that the patient’s pain had been completely relieved all of the time by the CPCT – 42% (c.f. 27% in 2019) (page 23). [Note – complete pain relief on the IPU decreased during this audit period – it was 54% (c.f. 79% in 2019)]
- u) A higher proportion in 2019/20 – 89% (c.f. 82% in 2019) stated that they and their family received enough help and support from the Hospice CPCT.
- v) The way in which the CPCT team explained the patient’s condition, treatment or tests shifted from ‘Very easy’ to understand - 61% (c.f. 69% in 2019) to ‘fairly easy’ in 2019/20 - 31% (c.f. 21% in 2019).

- w) Care received from the CPCT altogether saw increase to 50% rating it as 'Exceptional' (c.f. 41% in 2019), 3% rated it as 'Poor' (c.f. 3% in 2019) (Page 24). Overall care as a whole provided by the CPCT was maintained in 2019/20 as either 'Exceptional', 'Excellent' or 'Good' - 97% (c.f. 97% in 2019).
- x) CPCT involving family/carers in decisions about the patients; treatment has maintained at 88% in 2019/20 (c.f. 88% in 2019).
- y) Patient's explicit statement on their preferred place of death once again indicates that it is usually their home or the Hospice: Home – 53% (c.f. 62% in 2019) Hospice – 42% (c.f. 30% in 2019).
- z) 89% of respondents believed the patient died in the right place (c.f. 90% in 2019) (page 30).
- aa) 65% felt the patient achieved their preferred place of death (c.f. 63% in 2019) (page 27).
- bb) Bereavement support for those who died in the Hospice was considered definitely enough by 96% - a significant increase on 2019's 82% .
- cc) 77% felt able to talk to someone from the Hospice as soon as they wanted about their bereavement (c.f. 71% in 2019) and 8% wanted it sooner (c.f. 5% in 2019).
- dd) Following receipt of the bereavement leaflet – a greater proportion - 81% found it either definitely helpful or helpful to some degree (c.f. 59% in 2019). 18% did not receive the leaflet (c.f. 32% in 2019).
- ee) 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). 0% felt the contact was unhelpful (c.f. 5% in 2019). However, responses stating that contact wasn't received increased to 40% (c.f. 21% in 2019).
- ff) Responding to the Friends & Family question that was changed in the September 2019 – March 2020 survey, 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.

Audit Periods Overview

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

[VOICES Report Results Tracker 2015 - 2020.xlsx](#)

What can we learn?

- a) To continue the routine and monthly mailing of VOICES questionnaires in A3 format and ensure mailing is in 4th month post bereavement instead of either months 5 or 6 in an attempt to improve return rates.
- b) To improve the reconciliation of 'any actions' or 'comment' provided by respective Heads to critical comments raised in questionnaires. To use Datix for the September 2020-March 2021 (onward) cohort to effect such reconciliation.

What will we do or change?

- a) To audit the efficacy of pain management on the IPU in 2021/22 (Medical Team)
- b) To consider an information gathering exercise to demonstrate the IPU nurses perceptions and confidence in addressing/identifying religious /spiritual needs?
(Clinical Director/Head of Quality)
- c) To effect the routine survey of feedback from patients on the IPU prior to discharge. (IPU Nursing Team)
- d) To develop the PPD data item to facilitate the exaction of data that clarifies the reason should PPD not be achieved. (Head of Quality)

Update on Last Report Actions : April – September 2019 (signed off 03/12/2020 CHoDs)

- a) Audit Program 2021/22 : to agree symptoms (other than pain) for assessment and treatment audit (RT) : *breathlessness management potentially : Audit Mtg Jan 2021*
- b) Education : to source and deliver communication skills training annually to clinical staff (GL) *2021/22 education program*
- c) Education : to deliver training to support IPU staff in delivering informal emotional and psychological support (MF/LB/SM): *Face to face delivery session for 2021/22*
- d) Information Material : prioritise review/revision/production of patient / family information material supporting the Community and Psychological Services (Bereavement) Teams (*Info Project Team*): *ongoing*

OVERVIEW

In October 2019 – March 2020, there were 206 questionnaires mailed and 58 questionnaires returned, providing a return rate of 28% (c.f. 25% in 2019 & 29% in 2018-2019 & 34% in 2018 & 32% in 2017/18 & 28% in 2017).

Demographics:

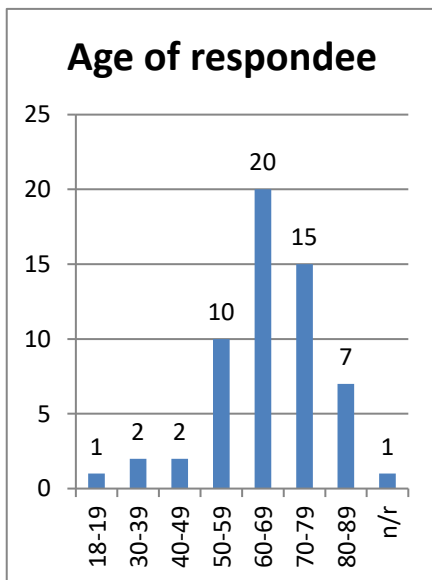
Gender of Respondent

Period	Male	Female	n/r
2019-20	19 (33%)	38 (67%)	1
2019	18 (36%)	32 (64%)	0
2018-19	19 (28%)	49 (72%)	1
2018	22 (31%)	50 (69%)	0
2017-18	16 (24%)	51 (76%)	0
2017	17 (35%)	31 (65%)	3

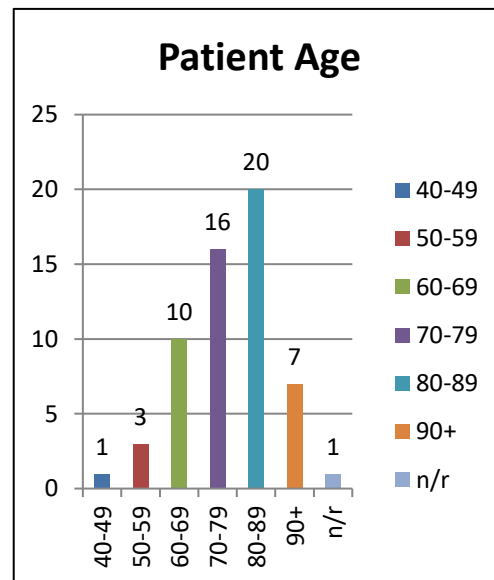
Gender of Patient

Period	Male	Female	n/r
2019-20	26 (46%)	31 (54%)	1
2019	23 (48%)	25 (52%)	2
2018-19	37 (54%)	31 (46%)	1
2018	38 (54%)	33 (46%)	1
2017-18	33 (49%)	34 (51%)	0
2017	23 (48%)	25 (52%)	3

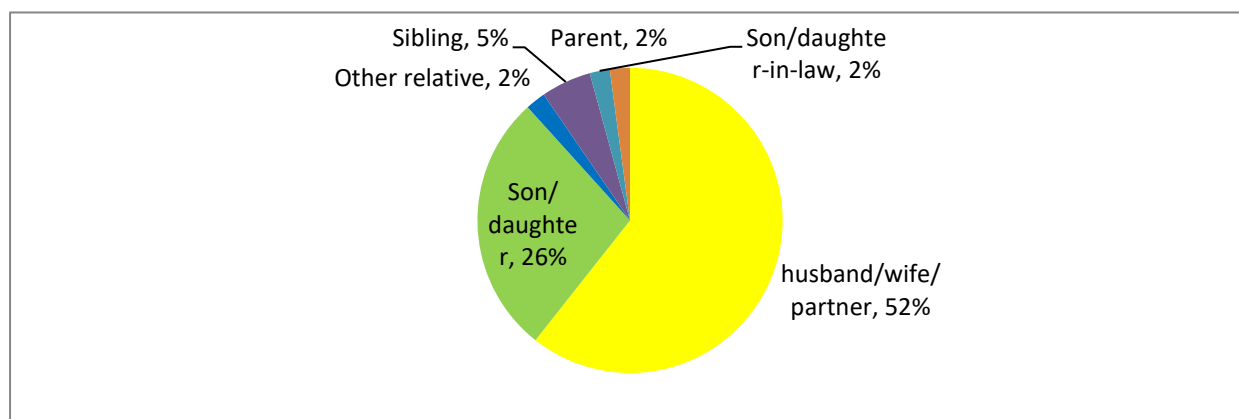
Age of respondent



Age of deceased



Respondent's relationship to patient

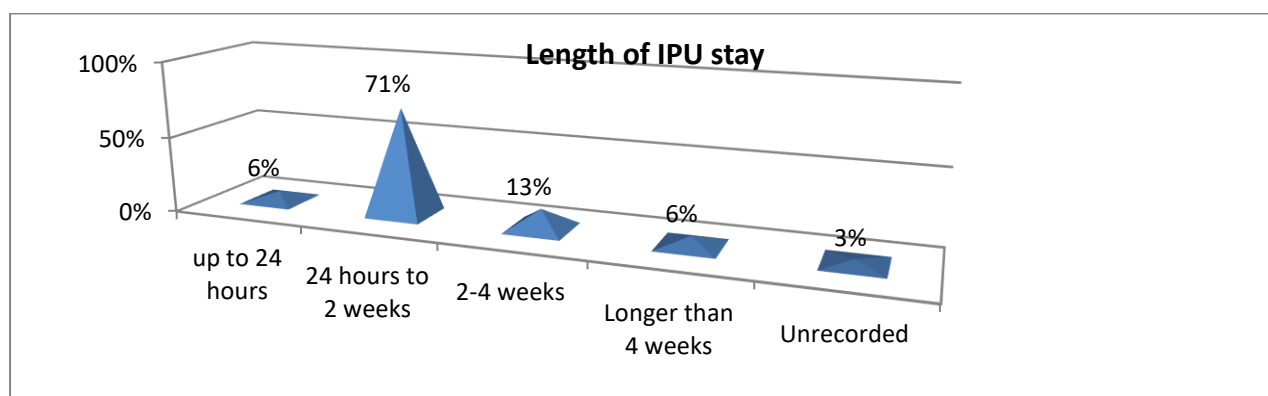


46 (82% c.f. 84% in 2019) of the 56 respondents who answered the question identified themselves as being 'White' (British/Irish/Other) with the remaining 10 (18%) identifying themselves as "Asian Indian," "Asian Other," and "Asian Pakistani." 44 (81% c.f. 89% in 2019) of the 54 patients who had the question answered on their behalf were identified as being white and the other 10 (19%) as 1 "Asian Pakistani," 2 "Asian Indian," "2 Asian Other," and 1 "Mixed White and Black African."

Inpatient Care on Hospice Ward

Inpatient Stay

Q2) 31 (53% c.f. 42% in 2019) of the 58 respondents stated that the patient had stayed in the IPU at some point. Of these, 22 (71% c.f. 67% in 2019) had stayed between 24 hours and two weeks, 4 (13% c.f. 10% in 2019) stayed between two and four weeks and 2 (6% c.f. 10% in 2019) stayed for longer than 4 weeks. Only 2 (6% c.f. 14% in 2019) stayed for less than 24 hours. One (3% c.f. 0% in 2019) did not record an answer.



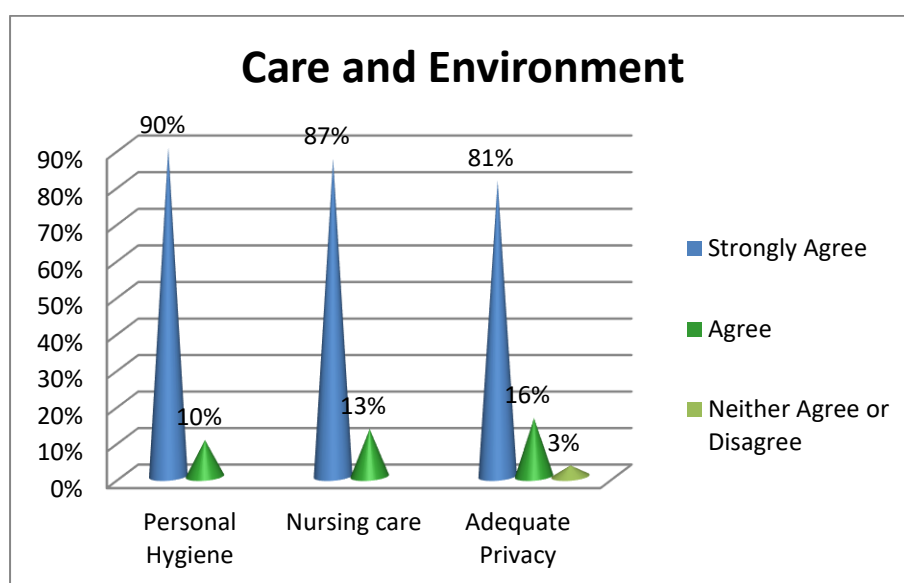
Care and Environment

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

Q3A) 90% ‘strongly agreed’ that there was enough help with personal care such as washing, personal hygiene and toileting needs (c.f. 76% in 2019), 10% ‘agreed’ (c.f. 24% in 2019) and none (0% c.f. 0% in 2019) neither agreed nor disagreed.).

Q3B) 87% ‘strongly agreed that there was enough help with nursing care such as giving medicine and helping the patient find a comfortable position in bed (c.f. 76% in 2019), a further 13% ‘agreed’ (c.f. 24% in 2019) and none (0%, 4% in 2018-2019) ‘Neither agreed nor disagreed.

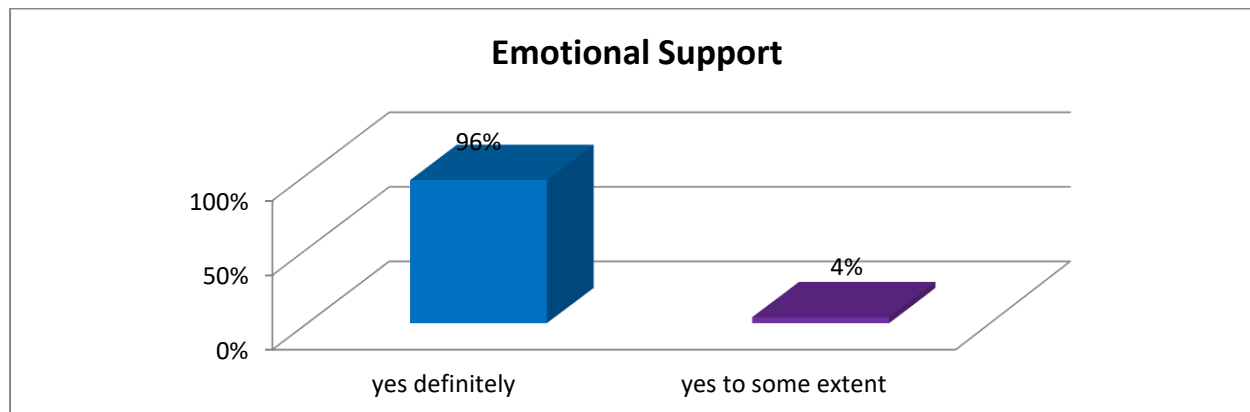
Q3C) With regards to the surrounding environment and bed area providing adequate privacy 81% ‘strongly agreed’ (c.f. 76% in 2019) and the other 16% ‘agreed’ (c.f. 19% in 2019) and 3% ‘disagreed’ (c.f. 5% in 2019).



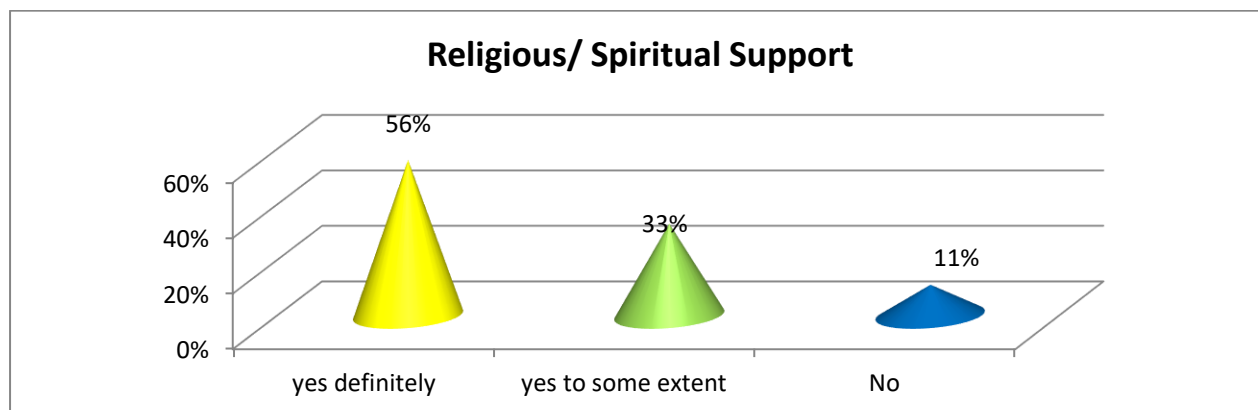
Support

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

Q4A) When asked if there was sufficient emotional support, 87% of respondents responded with a definite yes/no answer (c.f. 90% in 2019). Of these, 96% responded ‘Yes definitely’ (c.f. 68% in 2019) and 4% responded ‘Yes to some extent’ (c.f. 32% in 2019). None (0%, 0% in 2019) responded ‘No.’



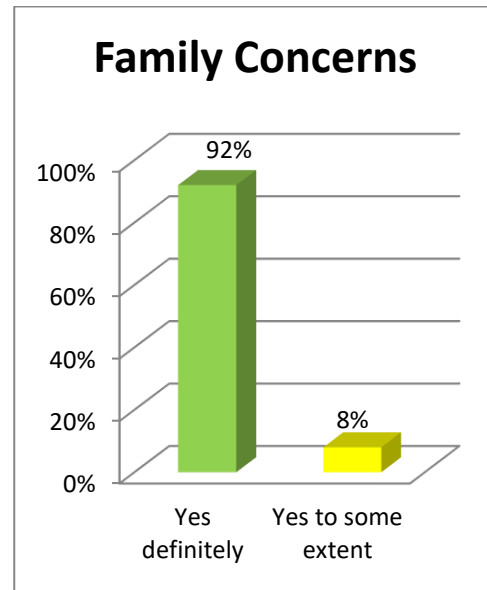
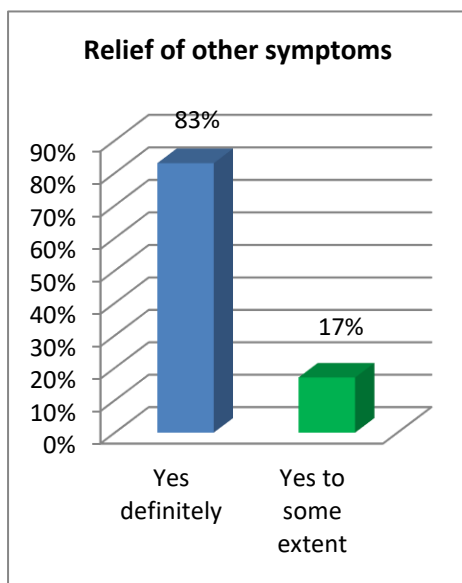
Q4B) Nine respondents felt the patients required religious/spiritual support. In answer to whether they received enough, 56% replied ‘Yes, definitely’ (c.f. 55% in 2019), 33% replied ‘Yes, to some extent’ (c.f. 45% in 2019), and 11% responded with ‘No, not when needed’ (c.f. 0% in 2019).



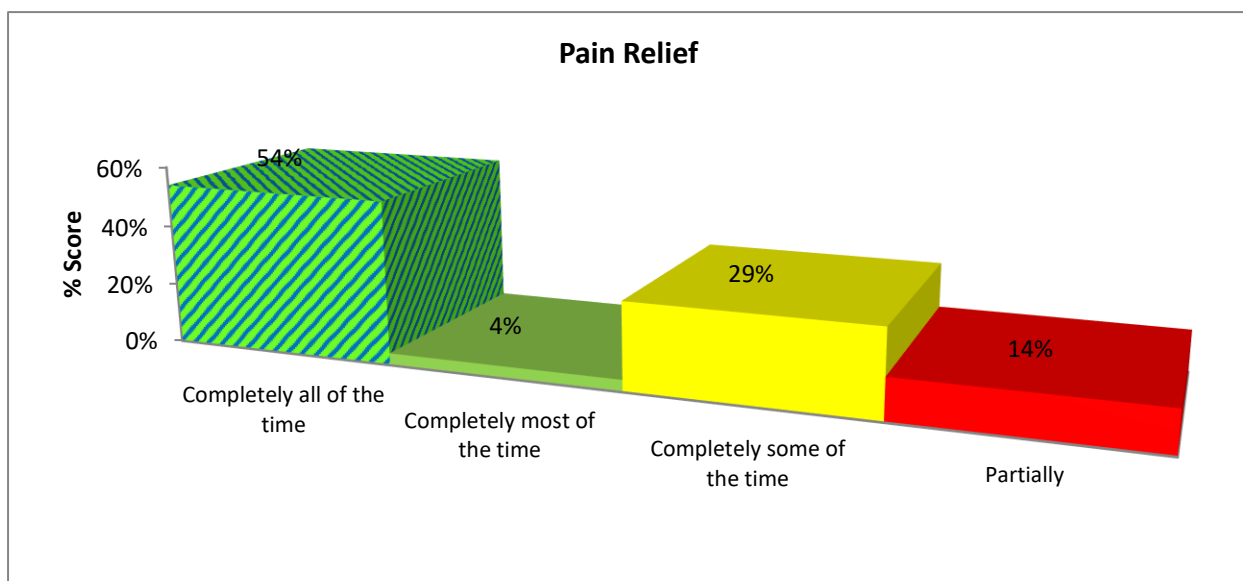
Q4C) 4 (13% c.f. 14% in 2019) respondents considered the patient to be in need of support regarding financial concerns or other practical problems. 3 (75% c.f. 33% in 2019) believed there was definitely enough support available and one (25% c.f. 67% in 2019) believed there was some support available. None (0% c.f. 0% in 2019) believed there was definitely not enough support available.

Q4D) With regard to enough support for relief of symptoms other than pain, 77% of respondents responded either ‘Yes’ or ‘No’ (c.f. 86% in 2019). Of these, 83% considered there to have definitely been enough support (c.f. 67% in 2019), 17% answered ‘Yes, to some extent’ (c.f. 28% in 2019) and none answered ‘No, not when needed’ (0% c.f. 6% in 2019).

Q4E) 42% of respondents considered that there was a need for support in family concerns (c.f. 48% in 2019). Of these, 92% considered there was definitely enough support (c.f. 90% in 2019) and 8% replied ‘Yes, to some extent’ (c.f. 0% in 2019) and 0% replied ‘No, not when needed’ (c.f. 10% in 2019).



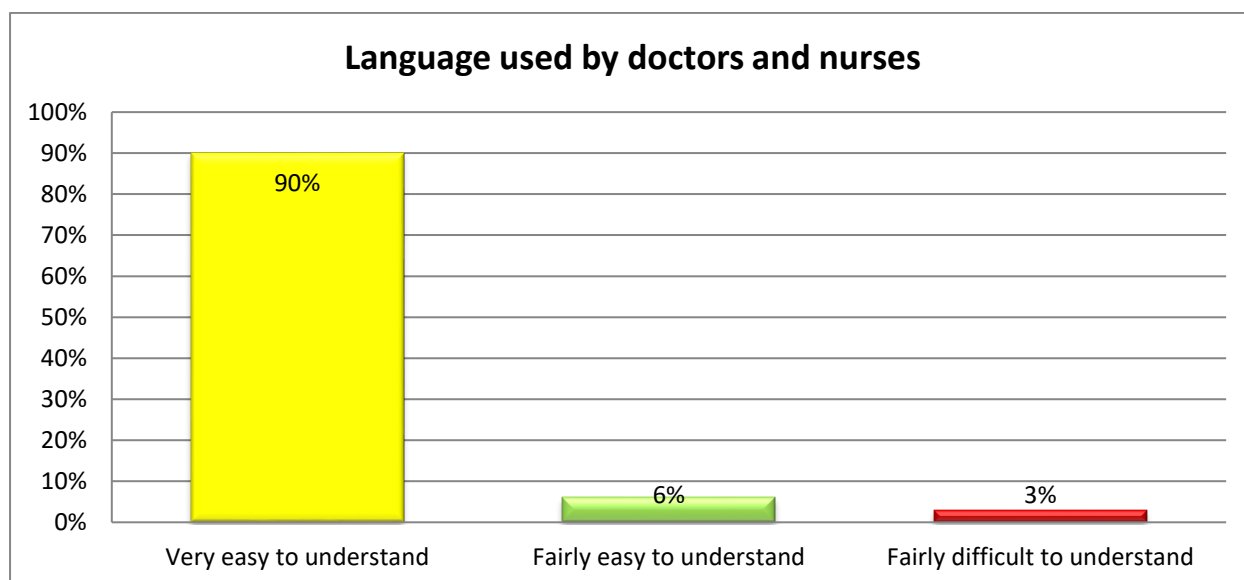
Q5) Respondents were asked how well the patient’s pain was relieved during their inpatient stay. 3 (10% c.f. 10% in 2019) said that the question did not apply because the patient had no pain. Of the 28 inpatient respondents who answered the question, 0% did not know the answer (c.f. 5% in 2019), 54% replied that the pain was relieved completely all of the time (c.f. 79% in 2019), one respondee (4%) added a new option to say that it was relieved completely most of the time, 29% that it was relieved completely some of the time (c.f. 11% in 2019) and 14% considered it to have only been partially relieved (c.f. 5% in 2019). None (0% c.f. 0% in 2019) recorded that the patient’s pain had not been relieved at all.



Communication and involvement

Q6) Relevant to 31 patients who stayed in the Hospice inpatient unit. 28 (90% c.f. 80% in 2019) reported that family members were always kept informed of the patient's condition, 3 (10% c.f. 15% in 2019) responded that this was usually the case and none (0% c.f. 5% in 2019) responded that this was sometimes the case. None (0% c.f. 0% in 2019) responded that this was occasionally the case and that the respondee had to ask specifically. None (0% c.f. 0% in 2019) responded that this was never the case. None (0% c.f. 0% in 2019) responded that they did not know the answer.

Q7) The language used by doctors and nurses when explaining the patient's condition, treatments or tests was thought to be either 'very easy' to understand by 90% of respondents (c.f. 55% in 2018-2019), fairly easy to understand by 6% (c.f. 40% in 2019). One (3% c.f. 0% in 2019) found them fairly difficult to understand. None (c.f. 0% in 2019) reported that the doctors and nurses were very difficult to understand. None (c.f. 5% in 2019) reported that the doctors and nurses did not explain to them.



Q8) When asked the question: “During this admission, were there any decisions made about his/her care or treatment that s/he would not have wanted?” 87% responded with a positive ‘No’ (c.f. 67% in 2019), 0% replied that they did not know (c.f. 10% in 2019) and 13% replied with a negative ‘Yes’ (c.f. 24% in 2019).

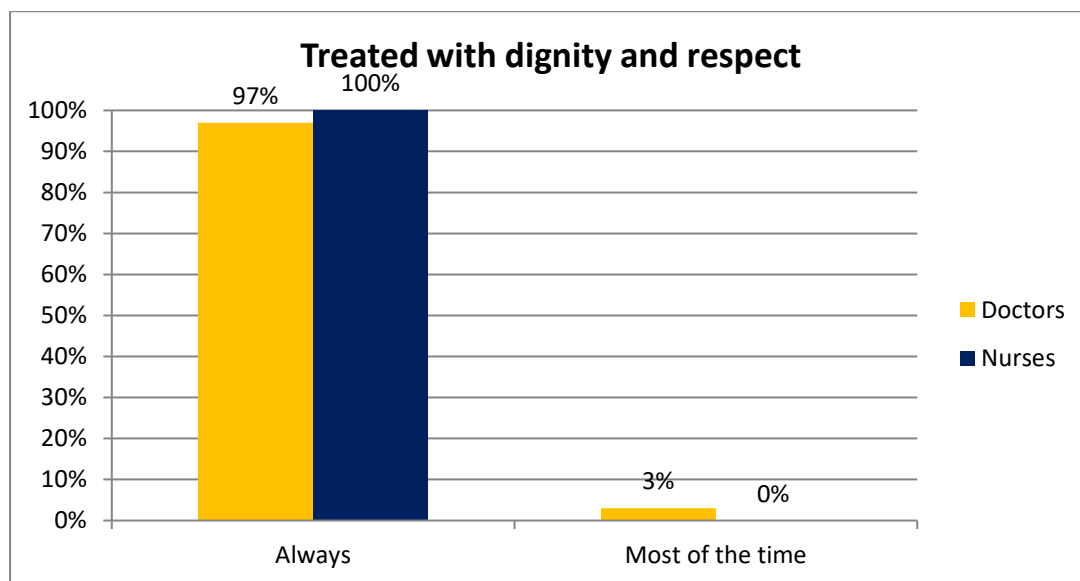
Three of the five respondents who replied with negative ‘Yes’ recorded comments:

‘Quite a difficult question - my mum didn't like having medication, but in the end, agreed due to the pain.’ – Daughter of patient

‘I feel patient would not have wanted to have been given treatment for his severe agitation as it made him drowsy and unresponsive. It was necessary though, as he was in distress and we were distressed watching him.’ – Wife of patient

Yes he was moved to a nursing home – Daughter of patient

Q9) The respondents were asked “How much of the time was s/he treated with respect and dignity by the Hospice doctors and nurses?” The questions were asked separately for both nurses and doctors. For doctors, 97% stated ‘Always’ and 3% stated ‘most of the time.’ (c.f. 89% stated Always and 11% stated most of the time in 2019). For the nurses, 100% stated Always and 0% stated ‘some of the time.’ (c.f. 90% stated ‘Always’ and 10% stated ‘some of the time in 2019.’)



Q10) Answering the question as to whether the respondent felt that the Hospice worked well with the patient’s GP and other external services : 45% stated ‘Yes definitely’ (c.f. 47% in 2019) and a further 21% agreeing ‘Yes to some extent’ (c.f. 35% in 2019). 31% answered ‘Don’t know’ (c.f. 6% in 2019), 0 recorded ‘No’ (c.f. 12% in 2019) and 3% recorded that they did not work together (c.f. 0% in 2019).

The respondee who replied that the hospice and GP did not work together had this comment to make:

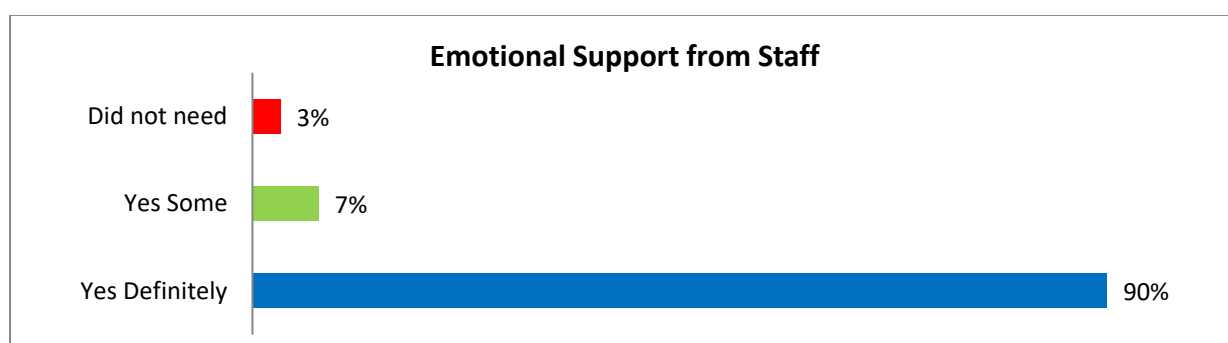
The GP was not very co-operative. They were initially unaware of my mother's condition and I had to keep calling them to keep them informed. – Daughter of Patient

Q11) Being able to stay in the Hospice overnight with their loved one was seen as important to 54% of respondents who recorded an answer (c.f. 55% in 2019). Of these, 80% were able to stay, and of these 80% who did get to stay, 92% found it helpful (c.f. 91% in 2019).

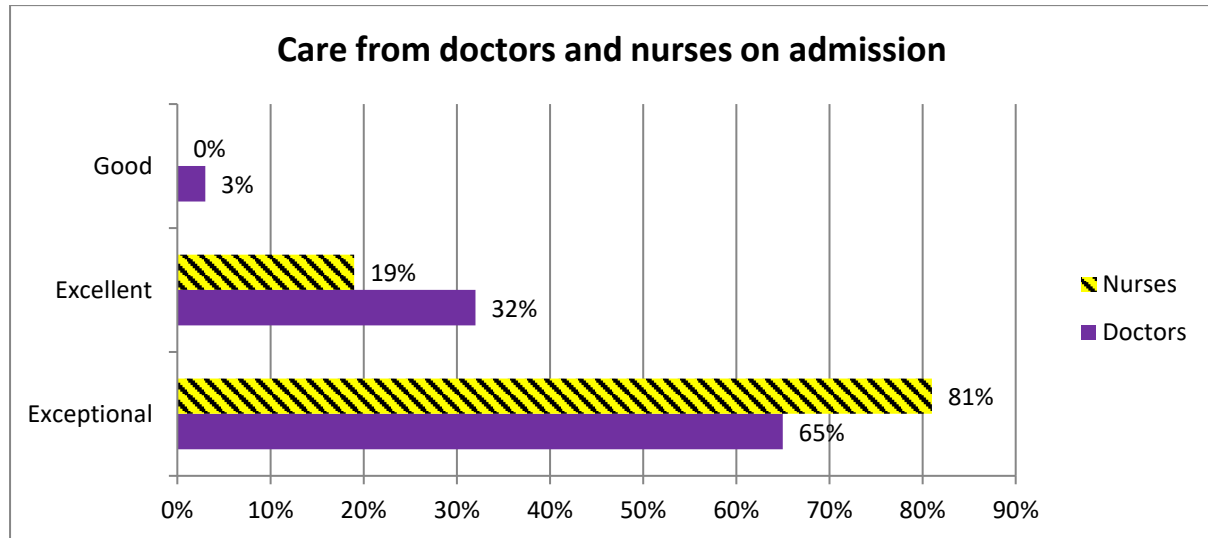
Comments on the subject of staying overnight:

'Did not need to stay as I live 20 minutes away' – Husband of patient
'My mother had the best care possible and I was able to visit anytime' – Daughter of patient
'My sister stayed for mum's last night. For seven nights we decided to get good sleep as mum was very comfortable and in good hands.' – Daughter of patient
'They were very very helpful' – Sister of patient
'She was in the hospice only 36 hours and death was very sudden' – Friend of patient
'Yes but declined.' – Son of patient
'My regret is I did not stay on the night she died. I wish now I had been encouraged to stay. Although it was a nice decision. I regret that I did not.' – Husband of patient
'It was not necessary. He did not survive until the night of the day he was admitted.' – Wife of patient
'I know I could have stayed if I wanted or needed to.' – Wife of patient
'My brother stayed with mum until she passed.' – Daughter of patient

Q12) Respondents were asked whether they felt that they had received sufficient emotional support from the Hospice staff. Responses showed 90% answering 'definitely yes' (c.f. 62% in 2019), 7% answering 'yes, to some extent' (c.f.33% in 2019), and 3% replying that they did not require this kind of help (c.f. 5% in 2019). None (0% c.f. 0% in 2019) recorded that she did not receive this kind of help, despite requiring it.



Q13) Respondents were asked to rate care given to the patients by doctors and nurses on admission and the responses were universally positive. 65% considered doctor care on admission to be ‘Exceptional’ (c.f. 40% in 2019), 32% considered it to be ‘Excellent’ (c.f. 50% in 2019) and 3% considered it to be ‘Good’ (c.f. 10% in 2019). Responses relating to nursing care were even higher, with 81% rating nursing care as ‘Exceptional’ (c.f. 57% in 2019), 19% as ‘Excellent’ (c.f. 38% in 2019) and 0% as ‘Good’ (c.f. 5% in 2019).



Food and Catering

Q14) It should be noted that 32% of respondents who answered the question about the quality of food provided for patients at the Hospice replied that their loved one did not have any food at the Hospice (c.f. 11% in 2019). Of those who replied that their loved one did partake of hospice food, 38% answered that the food was ‘Exceptional’ (c.f. 12% in 2019), 19% that it was ‘Excellent’ (c.f. 65% in 2019), 29% that it was good (c.f. 24% in 2019), 5% that it was ‘Fair’ (c.f. 0% in 2019) and 10% of the respondents (c.f. 0% in 2019) did not know what rating to give it.



Six of the general written comments about the Hospice IPU were altogether positive:

‘Mum was always clean, tidy and well kept. Mum always said everyone was lovely. Volunteers who came in. Mum was deaf, so she used a white board to read from which the nurses would write on so she could still communicate. Nurses were absolutely brilliant. Nothing was too much trouble.’ – Daughter of patient

‘The care received was amazing. All the nurses were so polite and generous, they made the whole experience so much easier.’ – Granddaughter of patient

‘Outstanding care and support for carers (me). Under difficult circumstances, the staff were a lifeline for me - the only point was I had to plead my mother's case with evidence of photos showing how quick the tumour was growing - I understand you have very few beds, but from my father's experience (he was refused admission to hospice and passed away two days later) I had to insist for my mother's admission as I knew she was deteriorating quickly.’ – Daughter of patient

‘Nurses gave enough emotional support, except for one nurse who informed me that my dying husband might be discharged after we had been there for 2-3 days! I found this very worrying.’ – Wife of patient

‘I was made to feel welcome to stay with my friend - nurses were always popping in to chat and keep an eye on me and my friend and keeping me updated. We knew she would die shortly!’ – Friend of patient

‘Myself and my family received exceptional emotional support. Thank you again, to all staff.’ – Husband of patient

There were two comments that was neither praise nor criticism:-

‘Could be noisy at night.’ – Wife of patient

‘Could not eat solids.’ – Son of patient

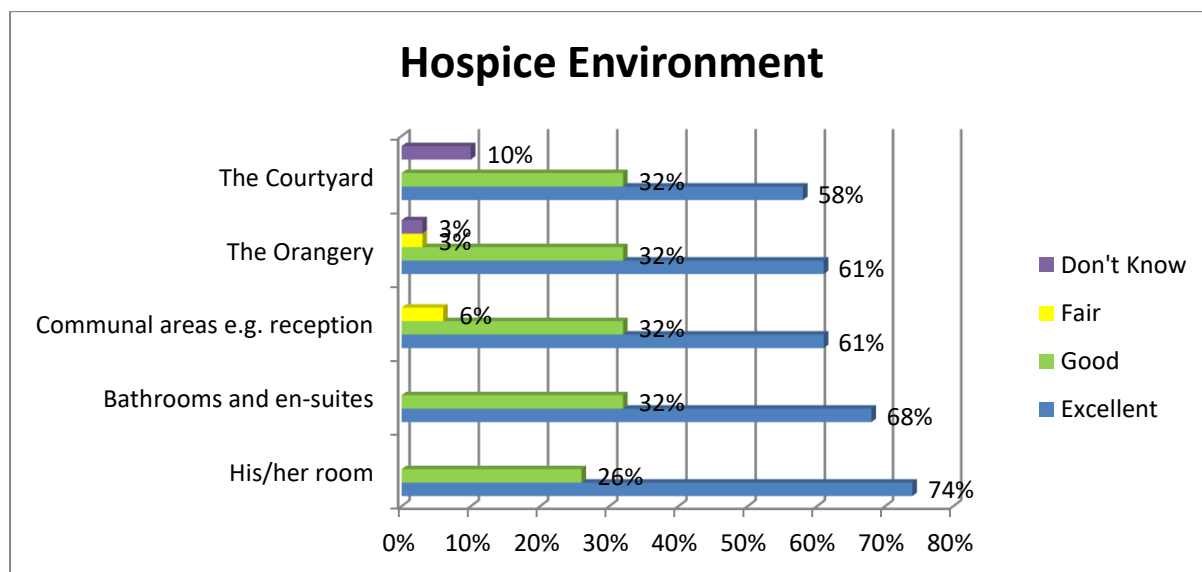
Q15 A-E) Respondents were asked to comment on different aspects of the Hospice.

The patient’s room was considered to be ‘Excellent’ by 74% (c.f. 57% in 2019) and the remaining 26% rated the room as ‘Good’ (c.f. 43% in 2019). 0% considered it to be fair (c.f. 0% in 2019). 68% of respondents considered the en-suite bathrooms on the IPU to be ‘Excellent’ (c.f. 60% in 2019), 32% rated them as ‘Good’ (c.f. 35% in 2019), 0% rated them as ‘Fair,’ (c.f. 0% in 2019) and 0% recorded that they did not know the answer to this question (c.f. 5% in 2019).

When asked to rate the communal areas of the Hospice, such as the Reception, 61% of respondents rated them as ‘Excellent’ (c.f. 55% in 2019), 32% rated them as good (c.f. 40% in 2019) and 6% rated them as fair (c.f. 5% in 2019).

When asked to rate the Orangery, 61% rated it as ‘Excellent’ (c.f. 63% in 2019), 32% rated it as ‘Good’ (c.f. 32% in 2019), 3% rated it as ‘Fair’ (c.f. 0% in 2019) and 3% answered that they did not know (c.f. 5% in 2019).

When asked to rate the courtyard, 58% rated it as ‘Excellent’ (c.f. 74% in 2019), 32% rated it as ‘Good’ (c.f. 16% in 2019), 0% rated it as ‘Fair’ (c.f. 5% in 2019) and 10% did not know how to rate the courtyard (c.f. 5% in 2019).



St Raphael's Community Services

Q16) 39 of the total 58 respondents, 67% (c.f. 70% in 2019) stated that the patient received care from the St Raphael's Hospice Community Palliative Care Team's (CPCT) Clinical Nurse Specialists, six were unsure whether they had or not, 12 answered 'no' they had not, and 1 simply left the entire section blank. The following data is extracted from responses relating to the 39 patients (67%) who were recorded as having definitely received care. The total number of respondents varies slightly per question, since not all respondents answered every question.

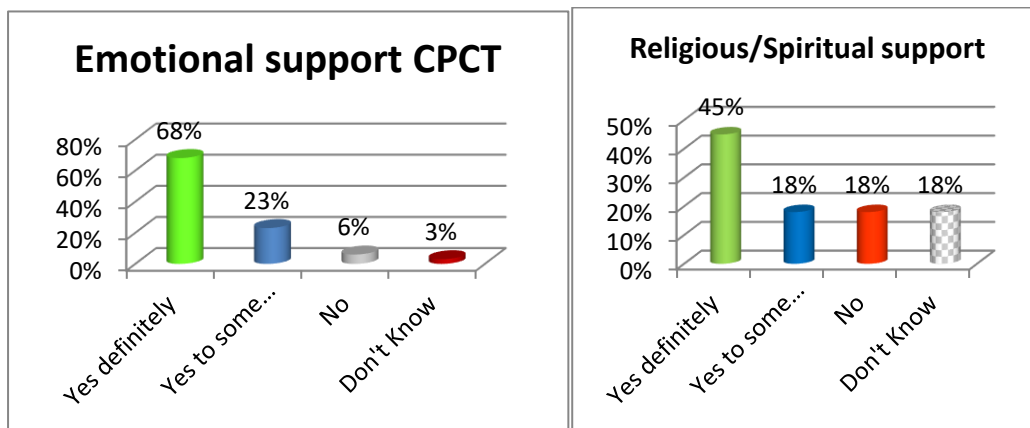
Responsiveness

Q17) Most respondents felt that the team visited as often as needed - 84% (c.f. 87% in 2019) and 8% felt that the team 'only sometimes' visited as often as needed (c.f. 13% in 2019), 5% replied 'no' (c.f. 0% in 2019) and 3% replied "don't know" (c.f. 0% in 2019).

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

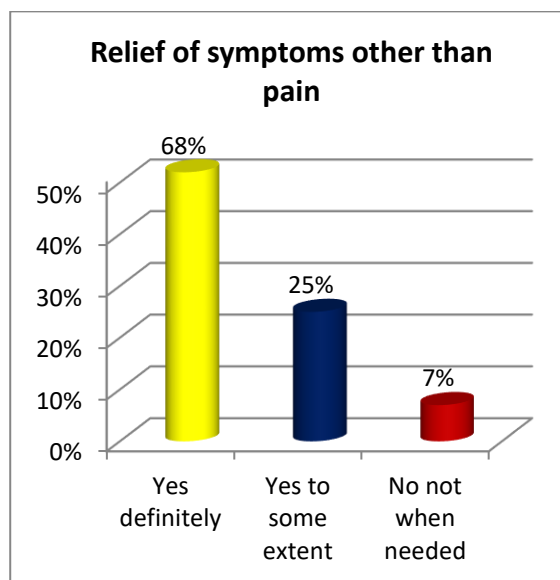
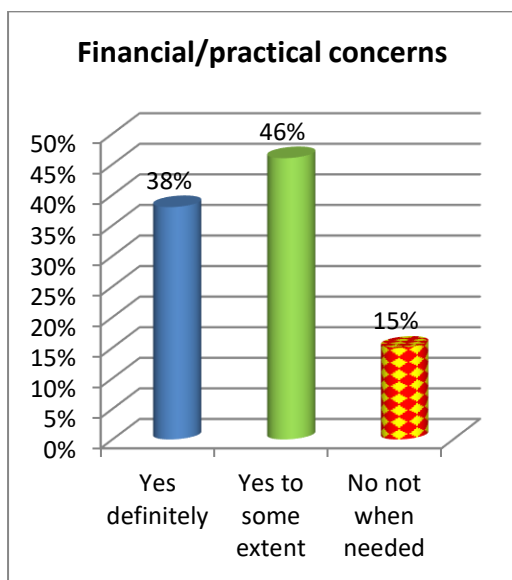
Q18A) When asked whether patient's received enough emotional support from the CPCT team, 31 (84% c.f. 74% in 2019) of the 37 respondents acknowledged that the patient had a need for emotional support and of these, 68% replied 'Yes definitely' (c.f. 73% in 2019), 23% 'Yes to some extent' (c.f. 19% in 2019), 6% recorded 'No, not when needed' (c.f. 0% in 2019) and 3% recorded 'Don't know' (c.f. 8% in 2019).

Q18B) 11 (28%) of the 39 respondents who answered the question stated that the patient did require some kind of religious or spiritual support. In response to whether they received enough religious or spiritual support from the CPCT, 5 of these (45% c.f. 50% in 2019) answered 'Yes definitely' and 2 (18%) replied 'Yes to some extent' (c.f. 38% in 2019), two (18%) replied 'No, not when needed' (c.f. 0% in 2019) and 2 (18%) replied 'Don't Know' (c.f. 13% in 2019). All IPU responses were either 'Yes definitely' or "Yes to some extent."

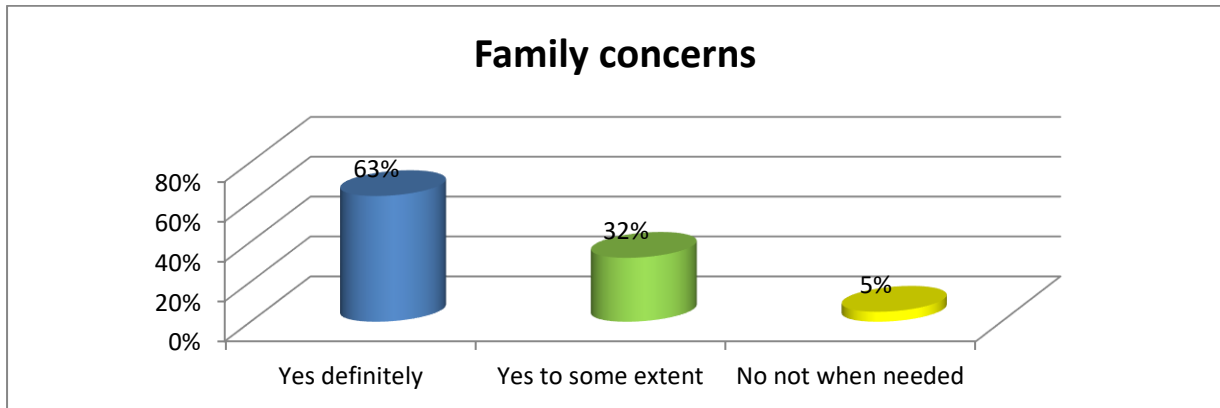


Q18C) 65% of respondents felt that the patient did not require help with financial concerns and other practical problems (c.f. 63% in 2019) and no respondents (0% c.f. 7% in 2019) did not know. Only 13 respondents felt that this support was needed and, of these, as to whether enough support was received, 38% replied ‘Yes definitely’ (c.f. 63% in 2019), 46% ‘Yes to some extent’ (c.f. 37% in 2019) and 15% ‘No not when needed’ (c.f. 0% in 2019).

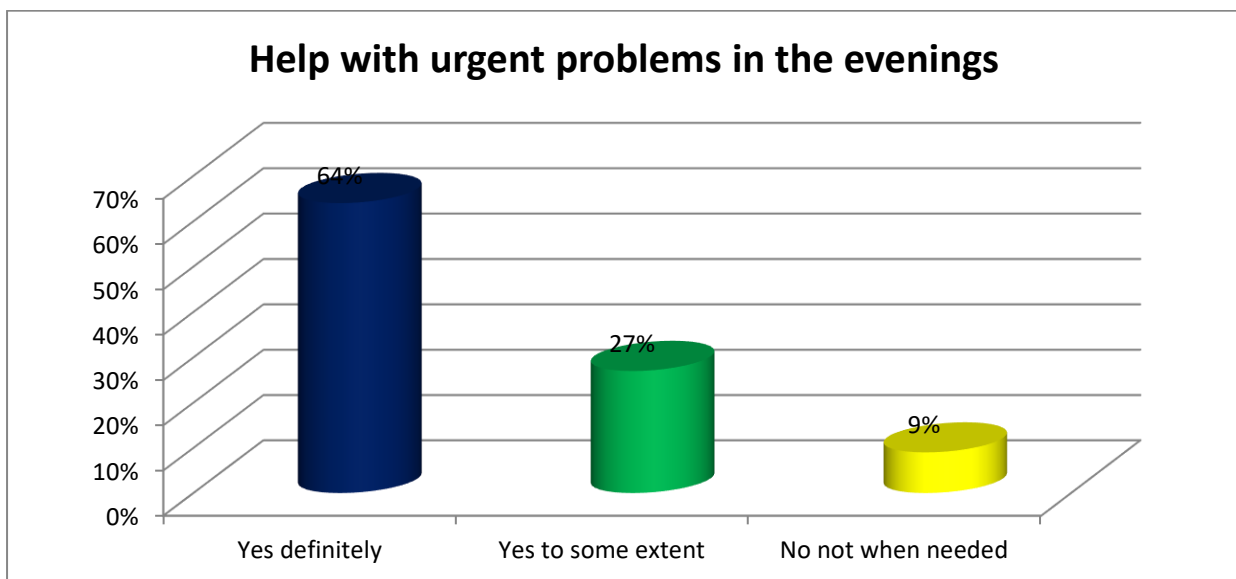
Q18D) 19% of respondents felt that the patient did not require help with relief of symptoms other than pain (c.f. 17% in 2019) and two respondents (5% c.f. 0% in 2019) did not know. 28 respondents felt that this support was needed and of these, as to whether enough support was received, 68% replied ‘Yes definitely’ (c.f. 59% in 2019), 25% ‘Yes to some extent’ (c.f. 37% in 2019) and 7% ‘No not when needed’ (c.f. 4% in 2019).



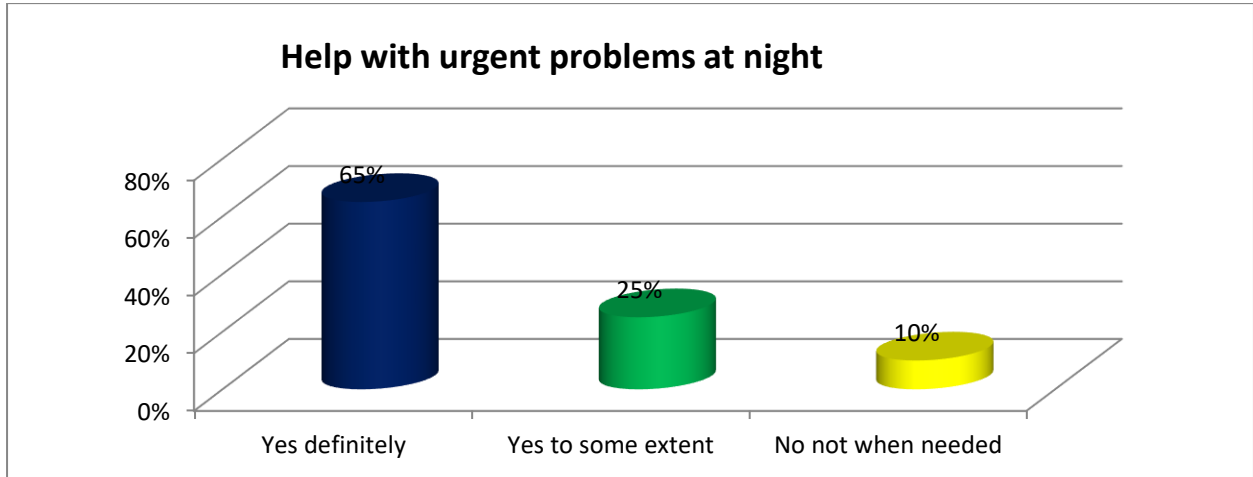
Q18E) 43% of respondents felt that the patient did not require help with family concerns (c.f. 50% in 2019) and two respondents (5% c.f. 3% in 2019) did not know. 19 respondents felt that this support was needed and of these, as to whether enough support was received, 63% replied ‘Yes definitely’ (c.f. 40% in 2019), 32% ‘Yes to some extent’ (c.f. 47% in 2019) and 5% ‘No not when needed’ (c.f. 13% in 2019).



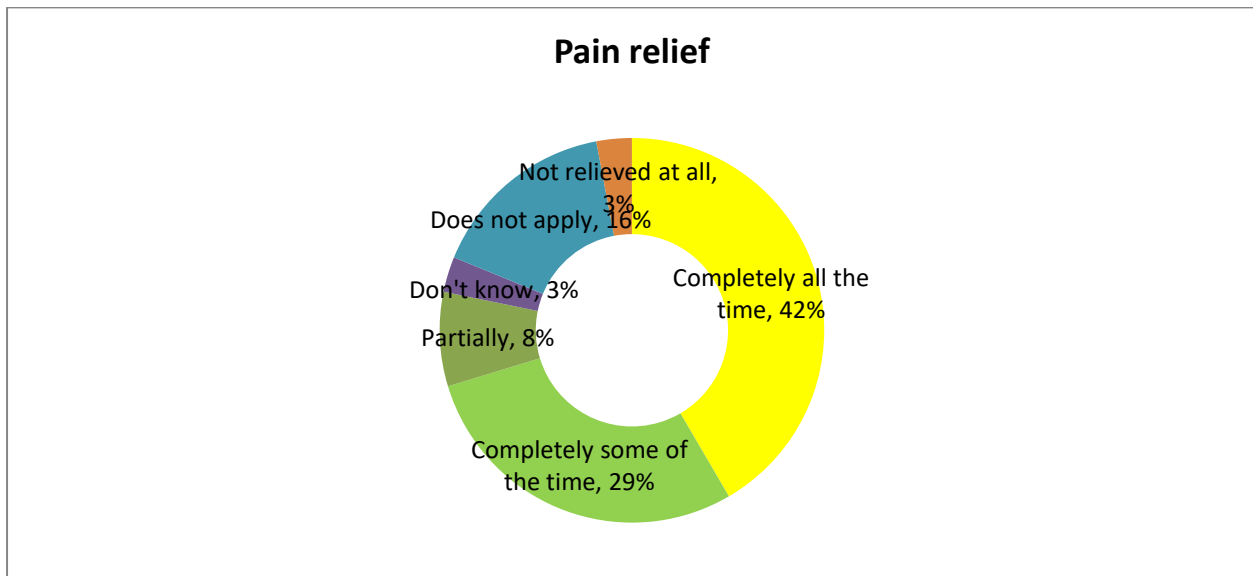
Q18F) 39% (c.f. 21% in 2019) of respondents felt that the patient did not require help with urgent problems during the evenings (between 5 PM and 11 PM) and another one respondent (3% c.f. 14% in 2019) did not know. 22 (58% c.f. 64% in 2019) respondents felt that this support was needed and of these, as to whether enough support was received, 64% replied ‘Yes definitely’ (c.f. 61% in 2019), 27% ‘Yes to some extent’ (c.f. 33% in 2019) and 9% ‘No not when needed’ (c.f. 6% in 2019).



Q18G) 43% of respondents felt that the patient did not require help with urgent problems during the nights (between 7 PM and 9 AM) (c.f. 28% in 2019) and 3% respondents (c.f. 17% in 2019) did not know. 20 respondents - 54% (c.f. 55% in 2019) felt that this support was needed and, of these, as to whether enough support was received, 65% replied ‘Yes definitely’ (c.f. 63% in 2019), 25% ‘Yes to some extent’ (c.f. 31% in 2019) and 10% ‘No not when needed’ (c.f. 6% in 2019).



Q19) 38 of the 39 respondents answered the question relating to their loved one’s pain relief provided by the CPCT. 42% reported that the pain was relieved ‘Completely all the time’ (c.f. 27% in 2019), 29% ‘Completely some of the time’ (c.f. 42% in 2019) and a further 8% considered that pain was only ever partially relieved (c.f. 9% in 2019). One (3% c.f. 3% in 2019) replied that the pain was not relieved at all. Furthermore, 3% did not know (c.f. 0% in 2019) and 16% responded that this did not apply because the patient had no pain (c.f. 18% in 2019).



Q20) 37 of the 39 respondents answered the question relating to whether they and their family got enough help and support from the Hospice CPCT. See table below.

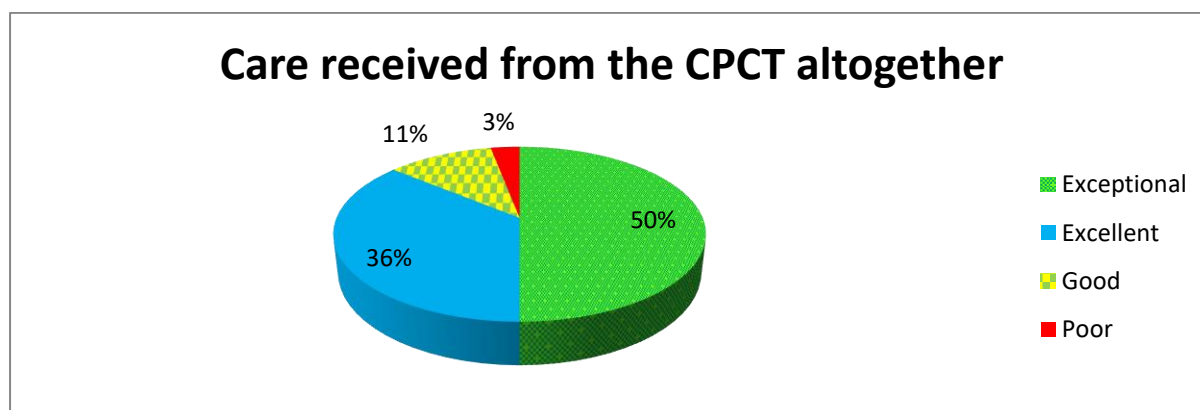
	2019-20	2019	2018-19	2018	2017- 18	2017
Yes as much as we wanted	89%	82%	85%	79%	78%	83%
Yes, some, but not as much as we wanted	8%	9%	8%	12%	7%	17%
No, tried to get more	3%	6%	2%	4%	6%	0%
No, did not ask for more	0%	3%	4%	5%	7%	0%
Did not need	0%	0%	2%	0%	2%	0%

Communication with the CPCT team was altogether positive.

Q21) The way in which the CPCT team explained the patient’s condition, treatment or tests was considered ‘Very easy’ to understand by 61% of respondents (c.f. 69% in 2019) and ‘fairly easy’ by 31% (c.f. 21% in 2019), ‘fairly difficult’ by 0% (c.f. 3% in 2019) and 3% recorded that they did not explain anything (c.f. 6% in 2019). Two (6% c.f. 0% in 2019) recorded that they never spoke with the team. 36 of the 39 respondents answered this question.

Q22) 36 of the 39 respondents answered the question relating to whether the CPCT team had time to listen to them and 83% responded ‘Yes, all the time’ (c.f. 84% in 2019) and 14% responded ‘Yes, some of the time’ (c.f. 9% in 2019), just none (0% c.f. 3% in 2019) recorded ‘No, not when needed,’ and one (3% c.f. 3% in 2019) responded that they did not know the answer to this question.

Q23) Overall impressions were mostly very positive. When asked their opinion on the care as a whole from the CPCT team, 36 of the 39 respondents recorded an answer and of these, 50% recorded ‘Exceptional’ (c.f. 41% in 2019), 36% ‘Excellent’ (41% in 2019), 11% ‘Good’ (15% in 2019), 0% ‘Fair’ (c.f. 0% in 2019), and 3% recorded ‘Poor’ (c.f. 3% in 2019).



Q24) 34 of the 39 respondents recorded an answer to the question as to whether the CPCT involved them in decisions about the patient's treatment and care as much as they wanted. Of these, 88% recorded that they had been involved as much as they wanted (c.f. 88% in 2019), 6% recorded that they would have liked to have been more involved (c.f. 9% in 2019), 6% (c.f. 3% in 2019) recorded 'Don't know.'

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

Id	CPCT Comment	Relation to patient
21	My mother found the first visit very helpful - she then kept telling them she was fine. By the time she really needed help - it was too late as she deteriorated so quickly that the nurses were shocked by how quickly she died.	Son of patient
22	They were so good that words are not enough. They are so marvellous.	Sister of patient
23	Cannot be faulted	Son of patient
28	Overall, the support was phenomenal. Her care was always uppermost and without comparison.	Friend of patient
31	The care from all the staff at St Raphael's was exceptional. I cannot praise them enough.	Husband of patient
37	Outstanding support second to none!	Son of patient

And then there were three equivocal comments:

Id	CPCT Comment	Relation to patient
39	I would have liked more information as to my wife's condition / progress of her cancer which would have given me some sort of timeline guidance.	Husband of patient
50	Because of Covid my mum received only one visit at home - none in the care home previously.	Daughter of patient
52	The nurses were amazing, especially in her last days. My mum did not accept help easily. There was the doctor I believe that upset mum, but I do not think they were part of CPCT. Doesn't matter now though. Carers were not helpful, but nurses were excellent.	Daughter of patient

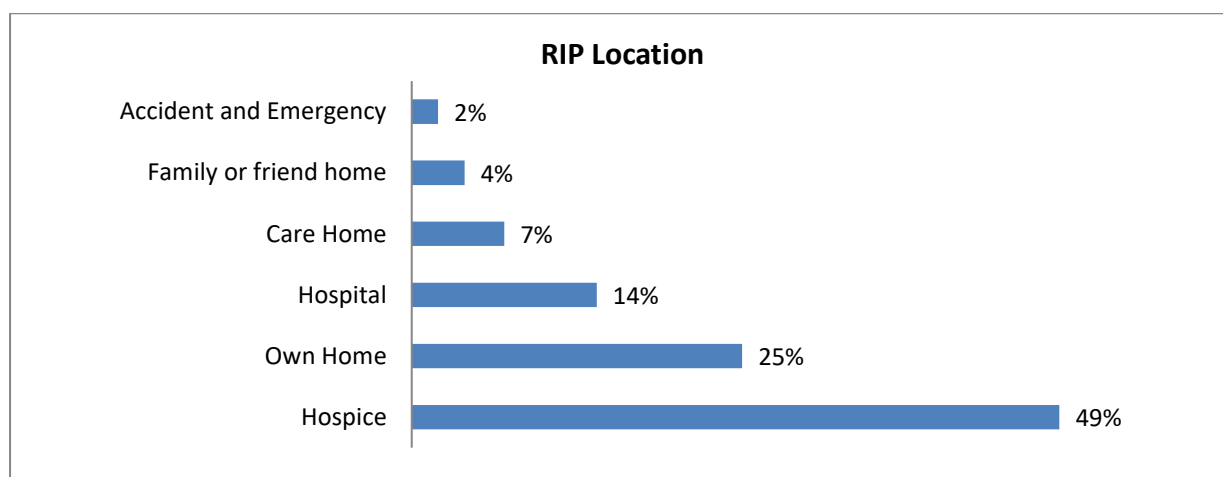
St Raphael's Hospice Jubilee Centre

Q25) & Q26) 1 of the 58 respondents said that the patient had visited the Jubilee Centre (c.f. 6 of the 50 in 2019). They recorded that they never benefited from it.

Circumstances surrounding his/her death

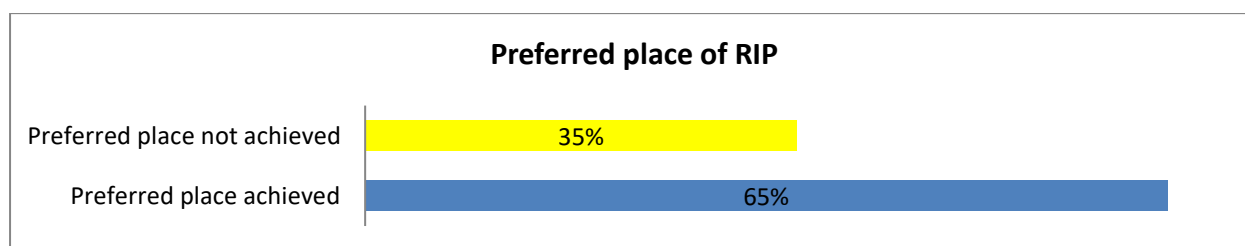
This section presents the views of the respondents regarding the circumstances of the patient's death and any expressed wishes. The questions were asked of all respondents.

Q27) Of the 58 respondents, 1 did not record an answer to this question. Of the remaining 57, 49% reported that their loved one died in the Hospice (c.f. 23% in 2019), 25% that they had died in their own home (47% in 2019), 14% that they had died in hospital (c.f. 11% in 2019), 7% that they had died in a care home (c.f. 15% in 2019), 4% (c.f. 0% in 2019) that they had died in a care home, and one patient (2% c.f. 4% in 2019) died in Accident and Emergency.



Q28) 39 respondents said that their loved ones explicitly stated where they wanted to die, 17 did not say, 1 was unsure and 1 recorded no answer. Of the 39 who recorded that the patient stated their preferred place of death, No one preferred a care home (c.f. 3% in 2019), 16 – 42% said they preferred a hospice (c.f. 30% in 2019) and 20 (53% c.f. 62% in 2019) their own home. One (3%) did not mind, and one (3%) recorded 'Somewhere Else.'

Q29) Of the 37 respondents who recorded that the patient had explicitly stated a specific preferred place of death (so not including the one who did not mind or the one who did not record a place), this was achieved in 24 (65%) of cases (c.f. 63% in 2019).



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

Preferred place	Achieved 2019-20	Not 2019-20	Achieved 2019	Not 2019	Achieved 2018-19	Not 2018-19	Achieved 2018	Not 2018
Hospice	13	3	4	7	9	3	12	3
Either Home or Hospice	0	0	0	0	0	0	1	0
Own Home	11	9	17	6	13	12	19	10
Somewhere Else	0	1	0	0	0	0	0	0
Friend/Family Member's Home	0	0	0	0	1	0	1	0
Son's Home	0	0	0	0	0	0	0	0
Daughter's Home	0	0	0	0	0	0	0	0
Hospital	0	0	0	0	0	0	0	1
Care Home	0	0	1	0	1	0	1	0
TOTAL	24	13	22	13	24	15	34	14

Q30) Respondents were asked whether their loved ones had enough choice about where they died. Of the 37 that did say where they wanted to die, 30 – 83% reflected their loved one had had enough choice about where they died (c.f. 83% in 2019), 3% were ‘Unsure’ (c.f. 0% in 2019) and 5 (14% c.f. 17% in 2019) said they did not have enough choice and one did not record an answer.

Actual place of death	Yes	Unsure	No	N/R
Care home	1	0	0	0
Hospice	17	1	2	1
Hospital	1	0	2	0
Family / Friend House	1	0	0	0
Own home	10	0	1	0
Total	30	1	5	1

The five respondents who believed the patient did not have enough choice recorded the following comments:

30 COMMENT ON ENOUGH CHOICE
‘There wasn't a bed available, but my husband's wish was to die at home so the lack of a bed didn't present a problem.’ – Wife of patient
‘No support whatsoever.’ - Wife of patient
‘Because of the sudden deterioration, she was taken into hospital with the thought she would come home if she died the next day.’ - Son of patient
‘He was only admitted 12 hours before he died. He was very uncomfortable for three weeks in hospital (bed too small for a start) and asked repeatedly to go to St Raphael's.’ – Wife of patient
‘The cancer dictated where my wife died, the speed of it meant she was unable to be cared for at home any longer so we agreed that hospice care was necessary.’ – Husband of patient

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

30 COMMENT ON ENOUGH CHOICE
‘He decided that whilst in St George's hospital.’ – Wife of patient
‘Hospital bed was ordered at home and did not arrive. This was one factor in admission to the hospice.’ – Wife of patient
‘She required the hospital treatment towards the end of her life.’ – Son of patient
‘We couldn't cope anymore with nan, she needed 24 hour care.’ – Granddaughter of patient
‘Too much support 24 hour needed, that we couldn't get at home.’ – Daughter of patient

Q31) On balance, when responding to the question of whether the patient died in the right place, 57 answered the question and of these, 51 replied that they did – 89% (c.f. 90% in 2019), none (0% c.f. 0% in 2019) were unsure, and 6 – 11% replied that they did not (c.f. 10% in 2019).

Actual place of death	Yes	No
Accident & Emergency	0	1
Care home	3	1
Family/ Friend Home	2	0
Hospice	28	0
Hospital	4	4
Own home	14	0
Total	51	6

Four of the six respondents who felt their loved ones died in the wrong place recorded comments.

31 COMMENT ON PLACE
'Patient was due to be admitted to St Raphael's hospice but died the night before.' – Wife of patient
'There were no wards available where we could all be there so only two people could stay with her - with just a curtain pulled round very little privacy.' – Son of patient
'Would have preferred being given 24 hour help at home or stayed at St Raphael's but mum wasn't ready to leave us for another four months.' – Daughter of patient
'She died before arrangements could be finalised to bring her home.' – Husband of patient

Three of the 51 respondents who believed the patient had died in the right place recorded comments:

31 COMMENT ON PLACE
'She died pain free and very comfortable and very peaceful.' – Friend of patient
'Definitely.' – Son of patient
'For her peace of mind (no) for her comfort and care (yes).'

Bereavement Support

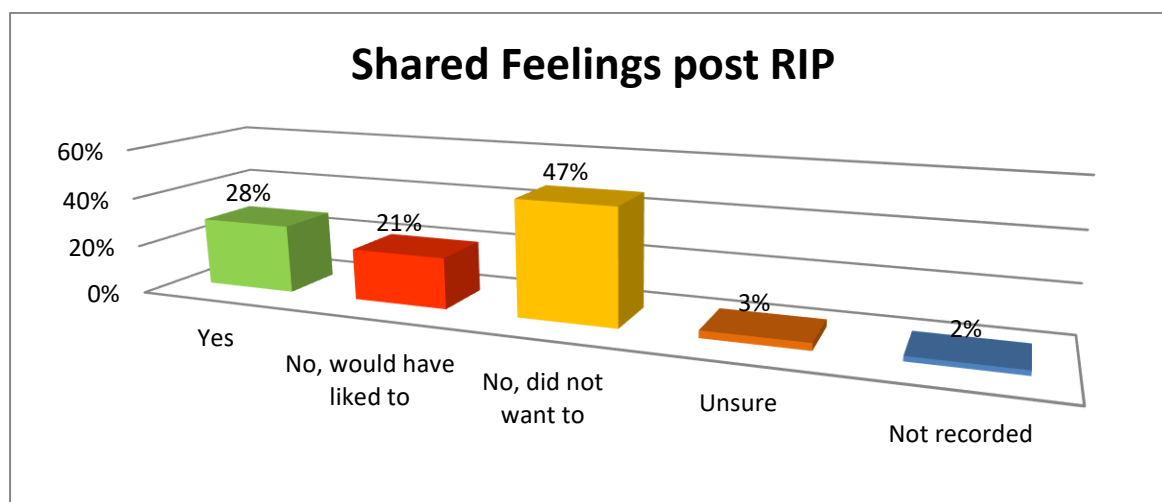
Q32) Of the 28 respondents who stated their loved ones died in the Hospice, 96% felt that they were definitely given enough support by staff (c.f. 82% in 2019), 4% replied ‘Yes, to some extent’ (c.f. 18% in 2019), and 0% responded ‘No, not at all’ (c.f. 0% in 2019).

Two respondents recorded comments:

32 FAMILY HELP COMMENT
‘All the doctors and nurses were fantastic.’ – Granddaughter of patient
‘Covid 19 lockdown started’ – Brother of Patient

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

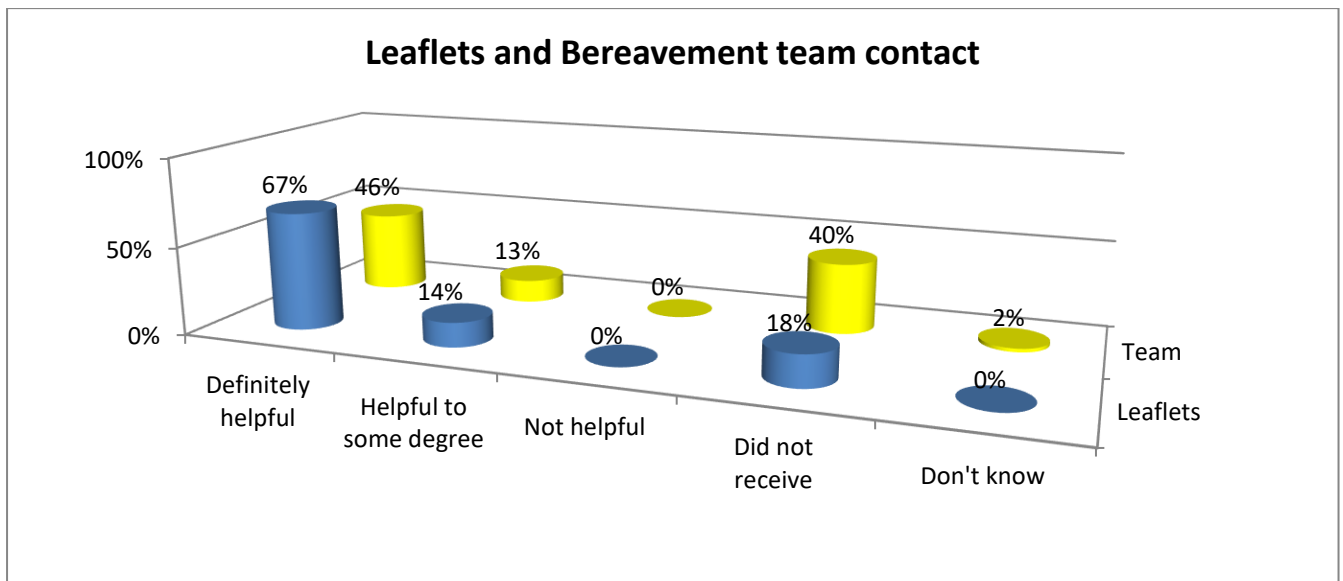
27 of the 58 respondents had not spoken to anyone, and said that it had been their choice. 12 replied that they would have liked to, 2 were unsure and one did not record an answer. 16 replied that they had (c.f. 29/50 respondents had in 2019). Of these 16, 2 (13%) spoke with a bereavement service volunteer, 5 (31%) spoke with a counsellor, 2 (13%) spoke with nurses, 2 (13%) spoke to both a counsellor and a complementary therapist, 1 (6%) spoke with a doctor, 1 (6%) spoke to both a bereavement service volunteer and a nurse, 1 (6%) spoke to both a counsellor and a bereavement service volunteer, 1 (6%) spoke to both a nurse and a doctor, and 1 (6%) did not share who precisely they spoke to.



Q35) Respondents were asked whether they felt able to talk to someone from the Hospice as soon as they wanted and of the 25 who had spoken to someone, 10 (77% c.f. 71% in 2019) responded that they had talked to them as quickly as they wanted to, 1 (8%) said they wanted it sooner (c.f. 5% in 19), 2 (15% c.f. 19% in 19) were unsure, and 3 did not record an answer (c.f. 4 in 2019).

Q36 A) When respondents were asked whether they had received a leaflet from the Hospice giving information about what to do after their bereavement, 9 did not record an answer, and of the 49 who did record an answer, 33 (67% c.f. 45% in 2019) found it ‘Definitely helpful,’ 7 (14% c.f. 14% in 2019) ‘Helpful to some degree,’ none (0% c.f. 9% in 2019) did not know, 0 (0% c.f. 0% in 2019) found it ‘Not helpful’ and 9 (18% c.f. 32% in 2019) did not receive it.

Q36 B) When respondents were asked whether they had received contact from the Hospice Bereavement Team, 10 did not record an answer and of the 48 who did record an answer, 22 - 46% found it ‘Definitely helpful (c.f. 40% in 2019),’ 6 - 13% ‘Helpful to some degree (c.f. 26% in 2019),’ 1 -2% did not know(c.f. 7% in 2019), none - 0% found it ‘Not Helpful’ (c.f. 5% in 2019)and 19 - 40% did not receive contact (c.f. 21% in 2019).



Bereavement Comments

The comments on this topic were all dissatisfied to some extent:

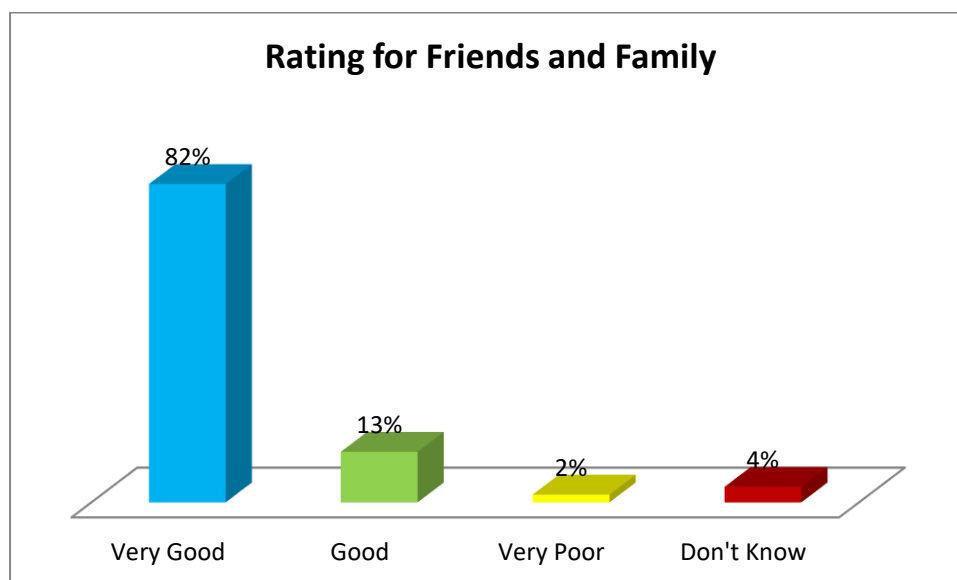
Bereavement Comment
'Covid was a problem gaining access to service.' – Daughter of patient
'What's the point, you were no help when he was dying.' Wife of patient
'I was not contacted. Would have liked to have been.' – Wife of patient
'The information we were given was from St Helier.' – Son of patient
'I would have loved to speak to someone from the team. I indicated but haven't been contacted. I understand though, with the pandemic, you must have been busy.' – Daughter of patient
'My wife died 4th feb this year. Shortly after came Covid 19. I would very much like to talk to the bereavement team at some point.' – Husband of patient

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

Q36 a)

Friends and Family section

When respondents were asked to rate their overall experiences of the hospice, 2 of the 58 respondents did not record an answer. Of the 56 who did record an answer, 46 (82% c.f. 77% in 2019) rated the hospice as 'Very Good', 7 (13% c.f. 16% in 2019) rated the hospice as 'Good', 1 (2% c.f. 0% in 2019) rated it as 'Very Poor,' and 2 (4% c.f. 7% in 2019) did not know the answer to this question.



Most comments were positive:

Id	36a friends and family comment	43 your relationship
1	Patient only had praise for her stay with you.	Husband of patient
2	They helped to get an attendance allowance for him.	Wife of patient
4	Receptive, empathic, knowledgeable and kindness offered at all times.	Wife of patient
5	Patient was contacted by phone whilst in hospital. Patient was visited once after initial diagnosis.	Wife of patient
6	If you can't die at home, what a wonderful place to end your journey. Beautiful gardens to look out on with birds outside your window, so peaceful. I wish everybody, especially the nurses a thank you.	Daughter of patient
7	Everyone who came into our home was professional, caring and so very kind - I could not have asked for anything more, they were superb.	Wife of patient
8	Firstly the hospice controlled my mother's pain. She was made comfortable and died as peacefully as she could.	Daughter of patient
9	Only thing I can think is that when help was needed it was received most of the time.	Son of patient
10	When I was struggling with care for my mum when she was at home, nurses would relieve me for two hours which helped me immensely.	Daughter of patient
14	The care for Mum was outstanding. It had become very difficult, nursing her in her own home, so it gave us quality time with her for the last week of her life.	Daughter of patient
15	All staff very helpful and very efficient in all care given.	Wife of patient
17	Everyone was very helpful.	Husband of patient
18	All the staff who visited Dad and whom I spoke to on the telephone were extremely friendly, understanding and very caring. Very approachable and helped with all my questions.	Mother of patient
19	There were occasions where we needed advice about the medication	Husband of patient
20	The caring was superb and that extended to the family members.	Wife of patient
23	Excellent all round	Son of patient
24	He was only there for twelve hours before he died. They cherished him. Thank you.	Wife of patient
26	They made the home feel calm. Always putting us at ease and explaining the stages my dad would go through. First class care.	Daughter of patient

Id	36a friends and family comment	43 your relationship
28	St Raphael's ensured constant interaction with all healthcare. They were kind, supportive and funny when needed. I don't have the words to express the incredible humanity of St Raphael's! - I will forever be in awe and humbled by their love and kindness!	Friend of patient
30	Although Mum would have preferred to have been at home, the care she got at the hospice was outstanding and helped get Mum's pain under control as best it could be.	Daughter of patient
31	All staff were extremely caring and empathetic.	Husband of patient
34	We received telephone calls from time to time, enquiring about her health. Not easy to rate that.	Husband of patient
35	Everybody who I spoke to at St Raphael's always listened and responded as appropriate. Everybody was exceptionally compassionate.	Husband of patient
36	Compassionate, caring environment where nothing is too much for the staff to do.	Husband of patient
37	The care and attention provided were outstanding, treated with dignity.	Son of patient
38	Extremely understanding and supportive but very professional gave practical advice.	Husband of patient
39	At an emotional time when I had to do the best for my wife, the hospice team, from nurse visits to home and everyone at hospice were always there for us.	Husband of patient
40	Named staff member and the rest of the team were very helpful and supportive. They signposted as to the right information at the right time and staff came as needed. We're very grateful for all received.	Daughter of patient
43	The whole team was very helpful and always available	Wife of patient
44	My mum passed at St Raphael's our family were so pleased that she passed there and not a casualty area, they gave the best care. I cannot thank them enough.	Daughter of patient
45	Very friendly, supportive and helpful.	Daughter in law
46	He felt confident in the treatment he was having. The staff were wonderful, always respectful and cheery. His dignity was always thought about. The environment of the whole hospice was very good.	Wife of patient
47	The nursing care was excellent but support after death was lacking.	Sister of patient
49	We felt we were able to ask for any additional help if we wanted to.	Husband of patient
50	I don't think in the circumstances you could've done anything. You were wonderful with my dad.	Daughter of patient
52	St Raphael's were great. The nurses were kind and professional. They knew what to do when mum was passing.	Daughter of patient

Id	36a friends and family comment	43 your relationship
53	My aunt spoke to a nurse on the phone who assisted her when she needed reassurance and I was not available. I think the assistance offered to her was very helpful.	Other relative
54	Because we felt warmly welcomed by everyone who worked there are they were so nice to talk to.	Granddaughter
55	Named staff member was very helpful in providing/organising Marie Curie night help and hospice homecare in the week before my husband passed. Nurse during day was excellent!	Wife of patient
58	In an era of mediocrity, St Raphael's is exceptional. It is not just the nursing, which is totally professional, it is the household staff as well. There is genuine love throughout the culture.	Husband of patient

These comments were critical:

Id	36a friends and family comment	43 your relationship
21	For lots of reasons including Mum saying she was fine and Christmas and new year holidays it was not easy to have people there as soon as we needed them.	Son of patient
47	The nursing care was excellent but support after death was lacking.	Sister of patient
50	My mum was rushed out of St George's to a care home due to Covid - I felt rushed.	Daughter of patient
51*	No help, no support left on my own, all as you kept saying was up his pain medication.	Wife of patient

*Follow up action taken

What could we have done better?

Id	36a done better	43 your relationship
4	Sometimes volunteer reception staff could have been gentler.	Wife of patient
9	At one stage when he fell in the middle of the night and injured himself badly. At this time he wanted to be admitted to the hospital. If he had been taken for a week or so in the hospice he may have felt a bit confident and it may have raised his morale.	Son of patient
10	Better communication with GP at initial stages of care.	Daughter of patient
14	I wrote in February and had a reply. We were told four times by four different staff that Mum would need to be moved to a nursing home. This caused the family and Mum a lot of stress. We understand the pressure on beds, but there needs to be a clear policy and one person telling the family.	Daughter of patient
30	Recommended care homes, the initial home Mum went to wasn't suitable, but no concerns were raised by staff at the hospice until Mum returned after the care home made mum worse! It was with the second care home where I was provided with a bit more advice around. The first time I felt rushed into making a decision.	Daughter of patient
39	I wish now that on the night she died, the hospice nurses could have given a guestimation that my wife was about to pass so I could have been there when she did. But I realise that this is probably not easy.	Husband of patient
51 *	Taken him in for pain management.	Wife of patient
52	I think the other agencies linked to St Raphael's in Mum's care were not as kind or professional. The doctors were clinical and carers generally not great.	Daughter of patient
58	After the death I would have liked the opportunity to talk with specific nurses and household staff who had become friends. Would have to be when they were not on duty and hence fully occupied.	Husband of patient

* Follow up action:

ID	Overall comment	What could Hospice have done better?	Relation to patient	Follow up action
51	What's the point, you were no help when he was dying.	Taken him in for pain management	Wife of patient	Survey return classified as Complaint. See Complaint reference 2020/07. Investigated by Community Services Team Manager and Head of Psycho-social Team. Call to wife and letter provided by Clinical Director. Apology extended for feeling of lack of support and bereavement service follow-up. Offer of bereavement support given.

2019/20 Community Team Manager Comments

“Enough financial support from CPCT” - we offer support by the application for grants and supporting applications of government benefits . Referrals are made to our SW for more complex financial concerns . Although only 13 respondents felt they required support there was a significant reduced percentage feeling the role was definitely fulfilled. This needs further discussion with the team including the medical staff / SW to explore how we address this need.

“Enough Religious / spirit support from CPCT”- the downward trend since 2015 /2016 cannot be ignored (apart 2018/19) . Reflecting on practice and what are we are now doing differently has led me to consider if the one team caseload approach may be a possible contributing factor . The therapeutic relationship can be lost with a lack of continuity. There was a significant increase that 42% felt their pain was relieved by CPCT . Although this is very positive it may raise the question of are we becoming symptom led as community visits are increasingly complex including the role of examining / prescribing . I would consider is are we losing focus on the holistic element of the role. With the recent implementation of the M+M meeting this should give opportunity to consider improvement in practice for this area

Overall response was positive with 50 % feeling they received exceptional care from CPCT , the highest response since 2017. This year will see us embedding IPOS and OACC in practice to improve patient outcomes .

2019/20 Palliative Care Consultant Comments

IPU

The feedback received demonstrates a team of nurses and doctors who treat patients with dignity and respect, who communicate effectively and deliver exceptional and excellent care.

The comments made around discharging patients from the IPU reflect one of the more challenging aspects of the service. The limited number of beds means that even when a patient would prefer to stay with us this is not always possible and may drive the need to discuss discharge proactively. This is also reflected in the figures with regards to not always meeting a person’s PPD. Going forward we have reviewed the discharge policy, to demonstrate the need to take an individualised patient approach and to move away from arbitrary time frames. Improving communication between members of the team to avoid

repeated conversations is key and the daily clinical team handover and re-established weekly MDT meeting every Wednesday, as well as joint ward rounds with the Nurse in charge will hopefully work to improve communication around discharges. The new Physician Associate role, will also contribute to better continuity within the medical team and should strengthen communication between the nursing and medical teams.

Embedding OACC and POI into the service may also help us to identify patients who may be ready for discharge. However, we need to understand that the use of the term 'stable' in terms of POI may be different to the patient and family's understanding of the term, which may suggest a disregard for how unwell someone is. i.e 'stable' might mean someone no longer requires the high level of specialist palliative care delivered on the IPU, whilst acknowledging that they remain terminally ill and may die within weeks/months. Prioritising communication skills training for the clinical team will help us work towards improving discussions around discharge planning and other complex and sensitive communication scenarios. Our new registrar (SV) who started in April has extensive experience in the use of simulation training and we should embrace these skills while she is with us over the next 6 months.

Symptom management: 54% replied that the pain was relieved completely all of the time (c.f. 79% in 2019) and control of other symptoms has improved. Striving to improve pain control for all our patients should continue to be a priority. While this figure dropped, achieving total pain control in more than 50% of patients may still be considered a good outcome, given that the patients admitted to the IPU are often those with the most complex pain which has failed to respond to initial treatment in hospital or in the community. Promising complete pain relief may be unachievable and setting realistic expectations is key. Using carers to report pain also has its limitations. Taking into account the psychological, emotional and spiritual aspects of pain also requires addressing through ongoing training and access to psychological and spiritual care services on the IPU. When COVID allows, reintroducing complementary and art therapies will be key to improving the patient pain experience. Integrating OACC into our practice to include IPOS, will ensure patient focused assessment of symptoms and will allow real time monitoring of symptoms, helping us to identify areas that require improvement more quickly.

With regards to the comment regarding privacy on the IPU, this should be taken into account during the refurbishment process. We have suggested we have small viewing windows in the door, as this will reduce the need to fully open the door to see if a patient is busy or should not be disturbed.

In terms of satisfaction with our catering provision on the IPU there has been a decrease from 77% to 57%. A change in food provider has been instigated recently which will hopefully improve these results. Considering the individual needs of patients in terms of diet with regards to religious, medical and lifestyle preferences remains key.

Community: This report highlights that the community service continues to deliver exceptional, excellent and good care and to be increasingly responsive to the needs of patients and families, in and out of hours, offering enough help and support at all times. Communication is rated highly, with high levels of shared decision making. The work we are doing on developing and updating the patient and family information leaflets may help to consolidate the excellence in communication further. Encouragingly, 83% felt CPCT had time to listen to them 'all the time', this reflects the accessibility and skill of the triage service.

Improvements are seen in pain and other symptom control compared to the previous year's figures. 89% believed their loved one died in the right place which suggests excellence in advance care planning around preferred place of death and the sharing of important information via CMC. An audit around ACP is planned this year which should identify areas for further improvement. Developing a regular education program for the CNS/CNP team will be essential to ensuring this standard is kept high.

Of those that felt financial support was needed, the feedback suggests more support with finances is an area for improvement. Considering a role for a SW or CNS with a special interest in financial support for palliative patients may be worth considering in the future. The same applies to family concerns, emotional and spiritual support. As commented on by the Community manager the one team caseload may be contributing to this as well as staff limitations within these core services. Embedding OACC and using it to guide safe discharges from the service and to triage better, may allow our team more time with those most in need

of specialist palliative care support, allowing us to focus on the holistic needs of our patients. Moving away from the current open access caseload will improve management of patient and should reduce the “periodic telephone call relationship” described in the comments.

Streamlining the EPR should also help to improve efficiency.

With regards to urgent advice overnight, overall the figures had slightly improved which is excellent to see and reflects that our service is available to support our patients and families 24/7. A small percentage felt they required more help. Driving forward the hospice education program (symptom control, SBAR) and the clinical plan to rotate staff between nights and days on the IPU, alongside improvements in the Crosscare EPR, should help to ensure nurses giving advice overnight have the information they need in an accessible form and are trained to offer up to date clinical advice.

The feedback suggests that joint working with GPs could be improved. This may reflect the one team case load model which may mean that making relationships with smaller groups of GPs and DNs is more difficult. Increasing visibility and engagement with our GPs is a core part of the hospice strategy and the consultant and education team are delivering a series of symptom control Masterclass sessions as part of this. Ways of engaging with the District Nursing team should be part of this. The local End of life care Hubs have access to consultant support during working hours which is improving engagement and communication between our teams. The Consultant team are also developing links with core secondary care MDTs, such as the heart failure team, with plans to connect with the MND and Respiratory care teams going forward. Working towards an EPR which shares more information between our service, GPs and DNS, should be prioritised. Working with South West London’s digital strategy group ‘connecting your care’ should be part of the hospice digital strategy going forward (<https://www.swlondon.nhs.uk/ourwork/connectingyourcare/>). We have also added important numbers for the District Nursing teams to the Crosscare record, to improve efficiency and early communication.

In terms of improving figures with regards to meeting PDD and empowering patients, the launch of myCMC will help with this. Of the 35% where PPD wasn’t achieved, a future audit to analyse if we could have done anything differently may improve this outcome in future.

The bed availability on the IPU may also be a contributory factor. Investing energy into recruitment of registered nurses is key. Working on improving diversity, equity and inclusion as an organisation may be key to this, as well as investing in time and education of student nurses and agency staff who come to the hospice.

2019/20 Practice Development Comments

Whilst the religions that are not adequately supported aren't specified, the Hospice does not have a dedicated prayer room for all faiths; the chapel is a Christian chapel and predominantly of the catholic denomination- this could be a reason. Provision of a prayer room is just one aspect of religious/spiritual support.

There was a change in medical leadership on the ward and the increase in regarding the language used by doctors and nurses being very easy to understand is likely due to this.

2019/20 Head of Psychological Services Team Comments

I own finding it difficult to comment objectively to the VOICES returns – primarily because there is no data that captures the psychological work we do with patients and their family members pre-bereavement. I would very much welcome conversations around how this can be captured as this is the bulk of the departments specialist work.

Secondly, the data captured regarding Bereavement is difficult to appraise as often family members are asked to respond when psychologically they are in turmoil and distress – post the death of their loved one. It would be commonplace for the bereft to display and project anger and blame for example; as well as to be forgetful and absent minded.

Nonetheless, bereavement support is recorded at 96% effective now and also considered to be appropriately responsive. Despite the comments submitted (but again in line with the natural responses to grief) – we do contact every NOK by letter and also follow up with a phone call. This has been the case throughout the pandemic. The

website pages for the department have now also gone live meaning that relatives can be more pro-active in accessing support and counselling should they see fit.

2019/20 Clinical Director Comments

This VOICES report is once again an overall positive read – the response rate is reasonably low but there have been a number of external factors that may have influenced this, including Q4 being consumed with the COVID pandemic.

Areas for focus over the coming year include communication with GPs and external agencies – the feeling from families that SRH communicate well with these providers is disappointingly low. It's difficult to ascertain whether this is something beyond our control and so further consideration is needed,

Provision of and access to pastoral/ religious care also remains low when trying to meet the need – as pointed out by others, this might be partially down to the building/organisation having a historically Catholic influence, but also recognition of or access to these services externally does not seem to meet the demand.

Conversely, the bereavement support and Psychological Support services have been increasingly utilised which is encouraging and probably pays dividends in terms of service user satisfaction and comfort. A new Head of Psycho-Social appointment was made during the 2019/20 period which has made a positive impact.

The access to the CPCT is positive and implies that the messaging about what the service is able to provide, is accurate and understood.

Staff have worked hard and been under increasing pressure during this survey period and I'm proud to read such positive results and affirmation from our service users that SRH is meeting the palliative needs of the public in the domain.

Having pain relieved 'all of the time ' may trigger more concern and possibly raises the question over the sedative effects of the medication used.

2019/20 Joint CEO Comments

The report reflects the overall satisfaction with all aspects of care and support delivered by the Hospice teams which is gratifying to read. The holistic approach is central to the delivery of palliative and end of life care and as a hospice our aim is to meet or exceed the expectations of the people who access and use our services.

It reflects positively across the teams that the majority of respondents reported overall satisfaction with the management of symptoms, psychological and emotional support, and communication; as well as feeling that their dignity and privacy were respected, that they were included in decisions about their care and the care delivered by the medical and nursing team on the IPU was viewed as exceptional.

Comments related to community support should be viewed with a degree of caution as people at home can be unclear as to the provenience of the care provider. However, lessons can be learned from small numbers of respondents and it is always beneficial to review data with an objective eye to see if lessons can be learned and positive change effected. In line with national data peoples preferred place of death remains home, followed by Hospice. This is the driver to ensure community support from the hospice is as good as it can be, utilising CMC to support this choice, which enables information sharing across healthcare settings.

The environment of the hospice was viewed positively. This could reflect the relief of the care burden which patients/families often feel when admitted to the unit. The hospice IPU is scheduled to be refreshed in the summer, which it is hoped will further enhance the quality of patient /family experience in the future.

There remains work to be done related to equality and diversity which is reflected in the adequacy of the religious and spiritual support provided by the hospice. Although it increased from 55% to 56% satisfaction, it highlights an area of development to improve the holistic approach.

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

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

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

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

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

13th Meeting of the Clinical Quality and Governance Sub Committee
To be held remotely via Zoom

at 10.00am on 14th May 2021

Agenda

Chair : CC

Item	Description	Purpose ¹	Lead
1.	Apologies for absence	I	AM
2.	Minutes of the last meeting held on 26th February 2021	S	Chair
3.	Action List from previous meetings	I	Chair
4.	IPU Refresh	I	RT
5.	Evidence of Excellent Practice Register	I	GL/RT/AR
6.	Clinical Risk Register	S	RT
7.	Clinical Quality & Governance Report	I	RT/AR
8.	CAP 2021/22	I	GL/RT/AR
9.	Minutes of Meetings & Other Documents Uploaded (att) <ul style="list-style-type: none"> • Medical Business Meeting : March 2021 • Prescribers – March 2021 • Clinical HoDs – April 2021 • VOICES Report to March 2020 • VOICES Report Results Tracker 2015 - 2020.pdf • SWL CCG SRH Quarterly Activity Data 2020/21 • Homecare Service Data Dashboard • IPU Service Data Dashboard 	I	GL/RT/ AR
10.	Any Other Business	I	Chair
11.	Dates of Future meetings <ul style="list-style-type: none"> • 25th June 2021 • 29th October 2021 	I	Chair

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