SAINT RAPHAEL'S HOSPICE

MINUTES OF THE
INFECTION CONTROL COMMITTEE

Held on 9th February 2020
at St Bede's Conference Centre and via Zoom

Attendance		
	(Dr JS) Dr J Stephenson, Consultant Microbiologist -SHH, SSAH - Chair	(NS) N Stevens – Joint CEO
	(RT) R Trower – Clinical Director	(GL) G Linehan – Joint CEO
	(LB) L Briant – Practice Educator	(TY) T Young – IPU Manager
	(JF) J Ford – IPU Senior Nurse	
	(TC) T Christmas – Community Team Manager	(JS) – CNS - Community Link Nurse for IC
	(AR) A Rudkin – Quality (Minutes)	(DC) D Calver – SWL CCG Infection Control Lead Nurse

Apologies	(SC) S Cresswell – Facilities	(SD-E) S Davies-Evans – Housekeeping
	(KM) K Mackie – Nursing Associate – IPU IC Link Nurse	(PD-P) P Di-Palma - Housekeeping
	(MF) M Flint – Practice Educator	

Action

ITEM 1: Welcome

JS extended welcome to all present and everyone introduced themselves. DC advised that she was not in attendance in an official capacity but had been invited following her close liaison with the Hospice during the pandemic and particularly during the most recent ‘Outbreak’ status.

ITEM 2: Apologies for Absence

Apologies had been received from SC, S-DE, PD-P, KM. Carolyn Moore – Infection Prevention and Control Specialist – London Borough of Sutton - extended her apology as she too had been invited alongside DC.

ITEM 3: Minutes of the last meeting held on 08 December 2020

3.1 These were accepted.

ITEM 4: Matters Arising

4.1 FFP3 Masks – RT reported that fit mask training had been delivered to staff but use in the Community had yet to commence and further consideration needed to be afforded to such use relative to the patient’s AGP status. Presently, FFP3 masks are not in use on the IPU. LB advised that 2 members of IPU staff failed the FFP3 fit — **RT**

mask training.

4.2	Water Management Policy is under draft.	AR
4.3	Infection Control Policy review is nearly complete.	LB/RT

ITEM 5: COVID-19 Update

Status / Support : RT advised that there is one inpatient presently on the IPU and that patient is now out of the isolation period. The IPU remains closed to admissions until the 'Deep Clean' is complete. The last action will be the steam clean of the carpet which, hopefully, will be achieved by close on Thursday this week.

SWL CCG have had outbreak meetings with SRH and DC confirmed that it is reasonable given 14 days since the last COVID + and the deep clean to re-commence admissions.

RT expressed how helpful Debbie Calver and Carolyn Moore had been in providing practical support and relayed our thanks.

Incident : RT has completed a timeline incident review of the outbreak and provided short report covering the 5 patients and 8 staff members included. It is difficult to be certain if staff acquired the infection at SRH or from elsewhere. JS confirmed that this formal outbreak had required incident reporting and investigation to identify points of learning.

Testing : Use of SSAH for swab testing will transfer to use of SHH after the outbreak once contract for service is in place and the practicalities have been worked through. Testing had increased during the outbreak with the introduction of more frequent LFD testing in addition to weekly PCR testing. LFD testing will reduce to twice weekly post outbreak status. JS advised that it made sense for staff to undertake LFD testing immediately prior to their shift. LB confirmed that all LFD positives are being confirmed through PCR test. RT

Vaccination : 117 staff have received vaccination – a high proportion of whom are frontline staff. Popular vaccination centres have been The Wilson and the Non-Such site.

TC advised that there had been a few positives for staff who've received the vaccination. JS advised that increased immunity kicks in 10-12 days post jab.

Accessibility to the vaccination program has included volunteers on Reception.

PPE : No supply issues. Use of visors implemented.

ITEM 6: Sharps Injuries & Body Fluids

6.1 Nil Sharps and nil incidents to report.

ITEM 7: Alert Organisms Surveillance

7.1 JS advised that unsurprisingly numbers of patients with other seasonal respiratory conditions are well down.

ITEM 8: Water Assessment and testing

8.1 SC had provided textual update. HSL Compliance attended site on 18th January. They carried out a service to both of the cold water dosing pumps, serving our mains cold water supply and the cold water storage tank. The chemical used for our cold water storage tank was changed from a powder to a liquid form to provide improved dosing system reliability. An engineer from HSL attended site on 28th January and confirmed that the pumps were operating correctly and that the chlorine dioxide values were correct at various parts of the water system. Regular flushing by the Housekeeping staff continues. Samples to be taken and tested during the latter part of February.

ITEM 9: Occupational Health Update

9.1 It was noted that the Occupational Health Service had moved to Maitland Medical, an Occupational Health Service provider, based in Chislehurst, Kent.

ITEM 10: Any Other Business

10.1 There was a good uptake in staff receiving the flu jab.

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

ITEM 11: Future Dates

11.1 Dates of future meetings:

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

SAINT RAPHAEL'S HOSPICE

MINUTES OF THE INFECTION CONTROL COMMITTEE

Held on 8th December 2020
at St Bede's Conference Centre and via Zoom

Members in Attendance		
	(RT) R Trower – Clinical Director	(GL) G Linehan – Joint CEO
	(LB) L Briant – Practice Educator	(SC) S Cresswell – Facilities
	(MF) M Flint – Practice Educator	(TY) T Young – IPU Manager
	(PD-P) P Di-Palma - Housekeeping	
	(AR) A Rudkin – Quality (Minutes & Chair Stand-In)	(LI) L Ibrahim – Occupational Health

Apologies	(Dr JS) Dr J Stephenson, Consultant Microbiologist -SHH, SSAH - Chair	(NS) N Stevens – Joint CEO
	(TC) T Christmas – Community Team	(PM) K Mackie – IPU – I C Link Nurse
	(SD-E) S Davies-Evans – Housekeeping	

Action

ITEM 1: Welcome

AR extended welcome to all present.

ITEM 2: Apologies for Absence

Apologies had been received from JS, TC, NS, SD-E, KM

ITEM 3: Minutes of the last meeting held on 30 June 2020

3.1 These were accepted.

ITEM 4: Matters Arising

4.1 FFP3 Masks – GL advised that given that Hospice was not taking patients requiring AGPs then acquisition of FFP3 masks is not required. RT expressed how this approach may need to be re-thought should demand for AGP support increase. A SHH contact has been provided. — RT

4.2 ToR07 Infection Control Committee Terms of Reference is revised and was re-published in November 2019.

4.3 Water Management Policy is under draft. — AR

ITEM 5: COVID-19 Update

GL advised that every member of staff and volunteer have been required to complete an individual COVID-19 risk assessment that includes a scoring system.

The majority of volunteers have been stepped down owing to achieving a score of 4+ on their RA. Occupational Health have followed up with the 4+ scorers and liaised with HR accordingly.

The COVID-19 (first 3 months) reflection report led by Practice Development has been reviewed by the Executive Team and the Hospice Board. Plan is for its publication to the Hospice network and a poster summary created in January 2021.

MF/LB

The consent for antibody testing information mirrored that which had been rolled out at SHH.

Infection Control refresher training has been rolled out. Every volunteer that returned to their Fundraising / Retail volunteer role received infection control and PPE training. Housekeeping have received a full IC update.

TY advised that currently the IPU has 4 patients – all negative for COVID. One staff member has tested positive and two are self-isolating.

Access to self-testing for staff has been agreed and sourced and RT will communicate requirements with expectation that PCR testing will be every Monday for staff working on the main site. It will not be mandated.

RT

Visiting on the IPU has been reduced inline with PHE advice to 1 visitor per patient for up to 1 hour per day unless the patient is in the last days of life in which case nursing discretion is advised.

Staff access to the vaccination program will hopefully be in line with SHH.

GL

LB advised how the Pfizzer vaccine was incredibly difficult to store and its access has been confined to Intensivists and the really elderly. SSAH is waiting for access to the Oxford vaccine next year.

JS queried the likely availability of clear masks. TY advised that she had had no further update but understood that they were not medical grade masks.

LB reiterated that if staff members received the vaccination then they must inform HR.

ALL

Cleaning is going well and staff are engaged in their understanding of why measures are being taken in the way they are. The need for consistent and constant reminding remains.

ALL

Signage has required updates owing to changes to visiting and changes in patient status.

PHE advice will be taken following any further positive swabbing results

RT

ITEM 6: Sharps Injuries & Body Fluids

6.1 Nil Sharps and nil incidents to report.

ITEM 7: IC Spot Checks

7.1 Infection control spot checking for the environment and hand-washing has been re-energised and is now more systematic.

ITEM 8: Water Assessment and testing

8.1 Water Assessment and testing is a routine agenda item at the Health & Safety Committee that last met on 13th November 2020. Both September and October sample results were all clear but following recommendation there is plan to update part of the treatment system. No contamination reported and an increased flushing regime is in place. — SC

ITEM 9: Occupational Health Update

9.1 LI reported that 'long COVID' is being recognised and may become a service issue alongside the stress and fatigue that has emerged.

9.2 LI reflected that whilst negative anti-body testing had provided individuals with some assurance it may have contributed to fuelling a degree of complacency for some.

9.3 LI commented that COVID vaccination will likely be an annual cycle like the flu.

9.4 She advised that Occupational Health communication with SRH and HR in particular is very good.

ITEM 10: Any Other Business

10.1 Monthly review of the CLIN52 COVID 19 Management Policy continues with review / revision often more frequent.

10.2 The review of the Infection Control Policy is nearly complete. — LB

10.3 A reminder that there is an Infection Control folder on the network drive at N:\Infection Control

ITEM 11: Future Dates

11.1 Dates of future meetings:

Date	Event	Venue/Time
Tues 9th February 2021	**ICC Meeting**	3pm - St Bedes / Zoom

SAINT RAPHAEL'S HOSPICE

MINUTES OF THE MEDICAL BUSINESS MEETING
Held on 3.2.2021

In attendance:	Abi Sutharsan	GPVTS
	Ambreen Akhtar	Specialty Doctor
	Andrew Hoy	Consultant (Chair)
	Annelise Matthews	Consultant
	Gaby Tamura-Rose	Consultant
	Jenny Strawson	Consultant
	Jovy Giles	Physician Associate
	Pascale Evans	Secretary (minutes)

ITEM 1: Apologies for Absence

1.1 Busi Da Silva; Laura Yalley-Ogunro; Martine Meyer; Rebecca Trower

ITEM 2: Minutes of the Last Meeting

2.1 Approved.

ITEM 3: Rota / staffing for the next three months

3.1 Abi is staying an extra month at the Hospice, as new GPVTS Zoe McQueen has been asked to stay in her current post in hospital due to the ongoing COVID situation. Abi's placement will end on 2nd March and Zoe will start on 3rd March.

3.2 The on-call rota is in place for the next 10 months but flexibility remains and the doctors can call each other if they need to swap shifts. They should notify the IPU, Community Team and Pascale of any such changes.

3.3 The medical team is providing as much support as possible to the Community Team although IPU doctors should not visit in the community.

3.4 Abi and Jovy will start making phone calls to patients in the community using the list provided on Crosscare. Annelise to help if needed. — **Abi/Jovy Annelise**

3.5 New StR will start in April till October.

ITEM 4: Clinical Challenges

4.1 Oxycontin modified release tablets for bowel cancer patient with an ileostomy – Margaret Gibbs is following up. — **Jenny**

4.2 Antipsychotic (Haloperidol) use for agitation/pain relief was discussed. A further discussion will be held at the next journal club.

ITEM 5: Infection Control

5.1 All necessary measures are in place and staff are reminded to be mindful of infection control at all times.

5.2 New Lateral Flow Tests are being handed to all hospice staff for daily testing.

5.3 Visors and goggles are to be disposed of after a single use.

ITEM 6: Education

6.1 It would be useful to collect feedback from hospice training post staff 1 month before the end of their placement. Abi and Jovy will compile a list of useful information and tips for the new trainees' welcome pack. — Abi/Jovy

6.2 Gaby and Jenny have booked a 2-day conference for the Palliative Car Congress. The conference will be virtual and material will be available online for 1 month after the event.

ITEM 7: Audit and Governance

7.1 Jenny attended an audit meeting with Alex Rudkin. Alex never received Ambreen and Busi's audit on pain assessment. Assessment of pain is not always defined by a number but also by character/descriptors. Ambreen to forward the results to Alex. — Ambreen

7.2 Margaret Gibbs collects data on pharmacy issues and errors as well as differences in prescribing habits. This would be a very useful audit – to be followed up.

7.3 Pascale will provide a matrix on appraisals details and dates for all the medical team. — Pascale

7.4 Gaby and Jenny have attended appraisal training provided by St Helier and will be appraisers for Busi Ambreen and Jovy.

ITEM 8: Any other business

8.1 Dates of future meetings:

Date	Event	Venue/Time
10.3.2021	**Medical Business Meeting**	15.00

ITEM 03 ACTION LIST

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

Reference	Lead	Description	Target Date for Completion	Comments
04/01;11/01	GL	Performance Management	Mar 2021	HR27 People Performance Management Policy was published in December 2019. GL to liaise 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.
04/08	JO'G/AR	Quantitative retrospective review be undertaken over May – July 2019 that shows the use of Hospice beds for symptom or terminal care on admission, identifies the referral source and shows the Hospice's facility to service requests for admission i.e. time from request to admission.	Nov 2020	Hospital to Hospice Audit led by J O'Grady (HPoC), supported by AR : audit extended to incorporate community admissions in January 2020. Data collection complete. Report expected in March 2021.
08/01; 11/02	GL	Medical Revalidation Policy and Chaperone Policy to construct	Nov 2020	Complete
08/05; 11/03	GL	Explore feasibility of facilitating access to the new e-learning system via the Hospice's web site.	Oct 2020	Complete
09/03	GL	Performance during COVID – a short paper to highlight the COVID experience.	Oct 2020	Complete. Comprehensive report drafted by Practice Educators in August 2020. Presented to Advisory Committee.

ITEM 03 ACTION LIST

Reference	Lead	Description	Target Date for Completion	Comments
09/07	GL	Discuss with TC – training for Care Home staff and collaborative working with EoLC Team – Sutton & Merton.	Oct 2021	On-going communication with both Merton and Sutton EoLC teams. No current plans re: education delivery in Care Homes due to current status. No further update.
10/03	GL/RT	Consideration of Care Home relationships / MDT participation	Oct 2021	No further update.
11/04	GL	Communication to staff re contract tracing	Oct 2020	Complete
11/05	GL	Risk register residual risk for PPE be lowered	Oct 2020	Complete
11/06	RT	Staffing update on Agenda	Feb 2021	Complete
11/07	AR	Publish Quality Account	Dec 2020	Complete
11/08	GL,RT,AR	Examples of Excellence Register included on Feb Agenda	Feb 2021	Complete
11/09	AR	VOICES survey report share with members	Dec 2020	Complete
11/10	RT	Approach to pain scoring	Feb 2021	iPOS re-implementation project planned for 2021/22 includes pain assessment
11/11	AR	Operational oversight of the Cap to be set out in introduction	Feb 2021	Complete

Serial	Cause of Risk	Description of Principle Risk to Charity	Current Controls to prevent occurance	Current Impact	Current Probability	Raw Score	Additional Controls	Residual Impact	Residual Probability	Residual Score
1	Sustainable and relevent service provisoin	Reticience of some staff to embrace change to working practice as outlined in Clinical Action Plan (CAP).	Proactive leadeship to communicate and support change in working practice in line with CAP with Managers and key staff.	3	2	9	CAP to be communicated to all staff to clarify the vision and direction of hospice clinical service provision. Concerns will be listened to and addressed. Monitoring of change and recognition of the improvements will be comunicated to all staff on an ongoing basis through team meetings and education sessions.	3	1	6
2.	Workforce: Community Clinical Nurse Specialist Ability to recruit suitably qualified Clinical Nurse Specialists to support the demands of referral for community support	Decrease in service delivery to support the demand in the community. Requirement to review service provision - modify the current offer	Succession Planning- Supporting CNS Development posts Comparible Salaries to NHS AfC Good working Environment Flexible Working Hours Introducing a skill mix of staff into the community service	2	2	6	Currently full CNS team establishment achieved. Keep under review the number of development posts which can be supported should vacancies occur.	2	1	4
3.	Workforce: Registered General Nurses Recruitment of appropriately qualified nurses to support the delivery of care on the In-Patient unit.	Night duty cover remains problematic . If RGN cover on night duty not suffcient, the number of patients that can be safely supported will be affected as safe staffing is across 24hours. Increasing difficulty in recruiting Band 5 nurses for day duty - staff undertaking extra shifts to cover requirement risk burnout. Managing unexpectd sick/compassionate leave can put pressure on the staff cover.	Current qualified nursing staff levels are adequate to support 8/10 IPU beds on day duty with full current complement of staff. Current deficit on night duty is aprox 88hrs per week. This is equating to approximately 14 night shifts per weeek 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 permenant and Bank to support core team at times of AL/SL or increased high dependency. Requirement for continued review of night RGN cover for safety assurance. Staff flexibility from day duty to night duty- Consultation is complete and rotation has commenced.. On the job training,, mentoring and educatuional support to obtain required qualifications e.g. Support of the TNA programme for HCAs	4	4	20	In situations where staffing levels are adversely affected there would be a managed reduction of avialable beds.Caveat is that even with one bed open there is a requirement to have 2 RNs on duty. Engaging with local and national training schemes to demonstrte the attractiveness of the hospice as an employer. Review sickness policy and maternity leave	4	4	20
4.	Allergy	Risk of anaphylaxis to an at risk staff member and related impact on staff and patients.	Staff member transfered to day duty . Mitigation- all staff made aware of the allergens- requested not to bring in food containing nuts. Staff member to have Epipen on their person at all times and take personal responsibility for their own health as well as reliance on staff support. Occupational Health review. Anaphalxis kit in the Clean Supply room on IPU. Notices informing where the kit is stored are displayed around hospice as an aid de memoir for staff. Staff member has been referred and seen by OH related to the risks and unpredicability of the allergic response.	4	3	16	Await any further mitigations advised by OH - currently all mitigations possible have been put in place	4	3	16
5.	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. 2. 2x new consultant in post and CD appointed	4	2	12	Seek 3rd new consultant to complete team. 2. Develop existing expertise. 3. Take every opportunity to become increasingly innovative and collaborative. 4. Re-instatemet of StR from April 2021	3	2	9
6.	Staff Resilience negatively impacted during long pandemic	1. Inability to continue delivering service to the desired standard. 2. Consequential impact on EVE	1. Peer Support implemented for managers- aim to equip staff effectively. 2. HR proactive and avaialbale to hear and escalate issues 3. HR Mental Health Helpline. 4. Regular and open communication from Senior Team. 5. Weekly testing fro staff. 6. Vaccine roll out to most staff	4	3	16	1. SRH standing by staff for one month beyond governemnt recommendations. 2. Provide some other welfare benefits to acknowldege difficulties i.e. small treats. Supportive communication across teams, Access to vaccinations improved. Increase in use of LFDs.	3	2	9
7.	Clinical Incidents	Patient Safety (Falls/Pressure Ulcers/Medication Errors). Risk of complaints from patients/families Requirement to report outside the organsiation to CQC Prempt a CQC Inspection Reputational damage	Reporting of all incidents related to clinial care Heirarchy of investigation Outputs- Learning informs improved proceedures and processes Regular review of incidents Report to EXEC, Clinical Governance Committee &Advisory Committee, Dissemination to all hospice teams to inform learning	4	2	12	Continued staff training and awareness of new techniques and products. Report at Clinical HoDs. Report by manages at team meetings. Opportunity to participate in refection and sharing learning and outcomes. Feedback to complainants regarding change in practice. Encourage an environment of comprehensive reporting to support learning and quality improvement. Introduction of Datix in Q1 2021 will support reporting and monitoring.	4	1	8

8.	Lone working	Staff/volunteers work singularly in the community within referred patients homes. Risk of accident/incident in a patients home and individual risk to staff member. Risk in travel to and from home visits	Policy and proceedure in place to support community working (SOP). Supplied with a mobile phone for conatct with the hospice or other healthcare professionals. ACC informed of access and egress. Lone worker alert devices in place.	4	1	8	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
9.	Complaints	Rumours Local press coverage Potential for public concern Elements of public expecation not being met Loss of confidence in the service Reputational damage	All complaints both verbal and written treated with the same level of scrutiny Complaints proceedure in policy for staff to follow- escalation process Complaints documented and reported via Quality Manager Reported at Clinical Quality Improvement and Clinical Quality and Governance meetings Complainants (both verbal and written)are offered the opportunity to meet and discuss concerns with Director of Care All complaints discussed at hospice team meetings for awareness and learning across the organisation Bi-annual review by EXEC	3	2	9	Use of root cause analysis for significant incidents. Feedback to complainants regarding change/improvemnt in practice. Scoping to establish all clinical staffs access to communication skills training Training on care delivery Information shared re: Duty of Candour and scope of the policy Reporting of any concerns- no blame but responsibility	3	1	6
10.	Breaches of confidentiality involving person identifiable data (PID), including data loss	If low risk breach- dealt with locally as per policy- CUI reporting More serious breach - RCA may be required- may have wider implications if data not encrypted If serious IG breach may be media coverage Potential loss of public confidence to keep PID safe	All staff paid and unpaid trained on IG on induction and annual mandatory training. Policy communicated to whole organsiation Clinical staff have nhs emials (encrypted) Regular organisational sweeps in all departments	3	2	9	nails. Monitoring includes audit and test Phisihing emails via IT Dept. Inte	3	1	6
11.	Brexit - Risk of medication shortages via suppliers	Required medication(opiods, neuropathic agents, anti seizure etc.) not available in specified dose ranges to support symptom management. Impact on patients.	Liaison with clinical pharmacy Ashtons - Reassurance that adequate supplies in stcck.	2	2	6	Regular updates from clinical pharmaist. Communication with wider CCG pharmacy colleagues.	2	2	6
12.	Corona Virus	Infection spread within hospice	All staff emails alert. Signage directing all staff & vistors to hand-washing on entering and leaving the ward / rooms and use of hand sanitiser. Staff adherence to control of infection policy. As per government guidance clinical staff that can work from home have been faciltated to do so. Community service provision has changed from face to face to telephone contact or virtual contact via skype.	5	2	15	Corona Virus Policy constructed to address all operational issues. PPE supplies checked. Contingency planning clarified for any identfied case within the Hospice - as per governemnt guidance. Single room nursing. Reduced face to face visiting dictated by urgency. Increased telephone contact. Introduction of virtual assessment. february.21, FFP3 mask testing. Deep clean of IPU. Refresher PPE trainng and advive and support from PHE. Daily LFD testing for all staff.	4	2	12
13.	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.	5	2	15	Wash bags provided to all staff in which to place uniform for transporting home. Advised wash uniform in bag at 60 degrees. CPCT supplied with uniforms to faciltate essentail community visits as well as all PPE	3	2	9
14.	Corona Virus	Staff Anxiety re: CV	Staff offered weekly PCR testing and vaccination. EAP accessible by all staff for wellbeing support. Clinically Vulnerable.staff furloughed. Working from home supported where possibe.	5	2	15	Two weekly HoDS to discuss any COVID issues and regular EXEC emails providing update and reassurrance.	3	2	9
15.	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 (Jubilee & old CPCT office). Admin Corridor : staff using available office space to meet social distancing. Psychosocial and other teams working from home where possible and service delivery can be maintained.. Face coverings worn in all public areas. Offices have signage stating masks to be worn when more than one person is in the offce.	3	2	9	ACC team moved into two offices(side by side) for space safety and assurrance.	3	1	6
16	IT PAS System Failure	Inability to access contemporaneous clinical records.	Contactable team OOH (not formaaal contract). Back up resource - outsourced at times of AL.Back up to PAS system faciltating access to the PAS. Risk is that recent recording may not be captured.	5	2	15	Daily back up of PAS. Risk Assessment undertaken related to IT risk to PAS. Highlightinhg gaps. Resolutions being considered.	5	2	15

19/02/2021

St Raphael's Hospice
General Risk Register

Serial	Cause of Risk	Description of Principle Risk to Charity	Current Controls to prevent occurance	Current Impact	Current Probability	Raw Score	Additional Controls	Residual Impact	Residual Probability	Residual Score	Monitoring Process	Who is responsible for action	Date of last review	Date of next review	Clinical	Facilities &	Manageme	Finance
1.	**Coronavirus spreads within the Hospice**	• Patients, staff or volunteers suffer CV-19 • Reputational Damage	• All staff and volunteers Risk Assessed • Strong protocols in place for infection control • PPE in use - masks worn in all areas • Footfall minimised in all areas and social distancing observed • Government Guidance is observed weekly resting and vaccines in progress for all staff	5	2	15	• Elements of SRH activity reduced in order to focus resource on IPU and other critical work • Staff facilitated to work from home where possible	4	2	12	• Daily temperature checks • Staff anti-body count tested • Weekly patient and staff testing • Access to one-step rapid test for COVID	Exec	Feb-21	Mar-21	Y		Y	
2.	**Coronavirus negatively impacts Funding Streams**	• Financial Losses continue and cash drains	• Govt Grants supporting first four months • Strong cash position maintained • National level co-ordination to improve Hospice Funding model	4	3	16	• Losses in current FY are likely to be similar to budget and some EVE activity can continue • Govt and CCG considering further support	3	3	12	• Cash monitored monthly to actual and reforecast	Exec	Feb-21	Mar-21			Y	Y
3.	**Inability to Grow Longer Term Funding Streams**	• Financial Losses continue and cash drains • Reputational Damage	• Medium term plan includes provision for additional fundraising staff and resources • Staff restructure completed to maximise team effectiveness • Sufficient funds in place to ensure 3-5 years viability	4	3	16	• Mitigation funding has been agreed in principle to ensure time to react to unexpected changes to circumstance	3	3	12	• Budgets monitored monthly to actual and reforecast • KPIs to be introduced for non financial measures • Cash forecast to 24 months +	Exec	Feb-21	Mar-21			Y	Y
4.	**Staff resiliance negatively impacted during long pandemic**	• Inability to continue delivering service to the desired standards • Consequential impact on EVE	• Peer support implemented for Managers - aim to equip to support staff effectively • HR pro-active and available to hear and to escalate issues • HR mental health helpline • Regular and open communication from senior team • Weekly testing for staff to lower anxiety and lower risk of absences • Vaccines rolled out for most staff	4	2	12	• SRH standing by staff for one month beyond Govt recommendations • Provide some other welfare benefits, to acknowledge difficulties - ie small treats. Supportive communication across teams.Access to vaccinations. Increase in use of LFDs	3	2	9	• Manager feedback	Exec	Feb-21	Mar-21				
7.	**Aging staff profile against a backdrop of increasing NHS pay (AFC) and shortage of specialist practitioners**	• Hospice cannot keep pace with increasing staff costs • Staff leave to join NHS • Service Decline	• Work/Life balance is superior at SRH • Working environment is more pleasant • Staff/patient ratio is lower • All clinical staff receive supervision • Staff development and training encouraged to raise exterptise internally	4	3	16	• SRH can further enhance some elements of staff welfare and flexibility • EVE promotes our working environment and engagement with the vision • Enhanced support for education, informally and formally • Versitility of roles and continuous review of staff utilisation	4	2	12	• Monitor feedback through appraisal system • Monitor leavers and perform exit interviews	Exec	Feb-21	Mar-21			Y	
8.	**Loss of Medical Team capacity**	• Puts patient safety at risk • Delays the impact of EVE • Increased staff anxiety • Reputational Damage	• Agency cover is in place • First 2 x new Consultants in position, Clinical Director role appointed	4	2	12	• Seek third new consultant to complete the team • Develop existing expertise • Take every opportunity to become more innovative and collaborative • Re-instatement of STR from April 2021	3	2	9	• Regular review meetings • Seek external view on progress (ie RO from ESHHT team)	Exec	Feb-21	Mar-21	Y			
9.	**Less than "Good" CQC**	• Staff morale • Reputational Damage	• Staff engagement with EVE • Excellence is the primary objective of all activities • New training package and increased Education resource • Staff encouraged to "going the extra mile" to support patient care	4	2	12	• Pro-active review and action to improve patient experience and evidence of this • Drive to enhance Hospice environment commenced • Strong new recruits have added to capability and vacancies filled adds capacity	3	2	9	• Record of actions to enhance quality of delivery and record compliments to be promoted and completed • Introduce an action plan to include regular mock inspections, briefings, CQC steering group etc	Exec	Feb-21	Mar-21			Y	
10.	**Financial Fraud (significant sums)**	• Financial Loss • Reputational Damage	• Two signatures required for all transactions • Annual budget set as boundary for activity • Monthly review of accounts to budget and variances investigated	4	2	12	• Review of financial policies and accountability structures to be undertaken	4	1	8		Exec	Feb-21	Mar-21				Y
11.	**IT systems failure**	• Loss of access to patient data • Loss of service functionality • Loss of business processes	• Backup system in place, Critical data with 2-3 hours turnaround • Multiple servers to spread risk • Highly qualified and experienced team • failover power source	4	2	12	• Renewal of all systems completed • External support available if required	4	1	8		Exec	Feb-21	Mar-21		Y		

19/02/2021

St Raphael's Hospice
General Risk Register

Serial	Cause of Risk	Description of Principle Risk to Charity	Current Controls to prevent occurance	Current Impact	Current Probability	Raw Score	Additional Controls	Residual Impact	Residual Probability	Residual Score	Monitoring Process	Who is responsible for action	Date of last review	Date of next review	Clinical	Facilities &	Manageme	Finance
1.	**Coronavirus spreads within the Hospice**	• Patients, staff or volunteers suffer CV-19 • Reputational Damage	• All staff and volunteers Risk Assessed • Strong protocols in place for infection control • PPE in use - masks worn in all areas • Footfall minimised in all areas and social distancing observed • Government Guidance is observed weekly resting and vaccines in progress for all staff	5	2	15	• Elements of SRH activity reduced in order to focus resource on IPU and other critical work • Staff facilitated to work from home where possible	4	2	12	• Daily temperature checks • Staff anti-body count tested • Weekly patient and staff testing • Access to one-step rapid test for COVID	Exec	Feb-21	Mar-21	Y		Y	
2.	**Coronavirus negatively impacts Funding Streams**	• Financial Losses continue and cash drains	• Govt Grants supporting first four months • Strong cash position maintained • National level co-ordination to improve Hospice Funding model	4	3	16	• Losses in current FY are likely to be similar to budget and some EVE activity can continue • Govt and CCG considering further support	3	3	12	• Cash monitored monthly to actual and reforecast	Exec	Feb-21	Mar-21			Y	Y
3.	**Inability to Grow Longer Term Funding Streams**	• Financial Losses continue and cash drains • Reputational Damage	• Medium term plan includes provision for additional fundraising staff and resources • Staff restructure completed to maximise team effectiveness • Sufficient funds in place to ensure 3-5 years viability	4	3	16	• Mitigation funding has been agreed in principle to ensure time to react to unexpected changes to circumstance	3	3	12	• Budgets monitored monthly to actual and reforecast • KPIs to be introduced for non financial measures • Cash forecast to 24 months +	Exec	Feb-21	Mar-21			Y	Y
4.	**Staff resiliance negatively impacted during long pandemic**	• Inability to continue delivering service to the desired standards • Consequential impact on EVE	• Peer support implemented for Managers - aim to equip to support staff effectively • HR pro-active and available to hear and to escalate issues • HR mental health helpline • Regular and open communication from senior team • Weekly testing for staff to lower anxiety and lower risk of absences • Vaccines rolled out for most staff	4	2	12	• SRH standing by staff for one month beyond Govt recommendations • Provide some other welfare benefits, to acknowledge difficulties - ie small treats. Supportive communication across teams.Access to vaccinations. Increase in use of LFDs	3	2	9	• Manager feedback	Exec	Feb-21	Mar-21				
7.	**Aging staff profile against a backdrop of increasing NHS pay (AFC) and shortage of specialist practitioners**	• Hospice cannot keep pace with increasing staff costs • Staff leave to join NHS • Service Decline	• Work/Life balance is superior at SRH • Working environment is more pleasant • Staff/patient ratio is lower • All clinical staff receive supervision • Staff development and training encouraged to raise exterptise internally	4	3	16	• SRH can further enhance some elements of staff welfare and flexibility • EVE promotes our working environment and engagement with the vision • Enhanced support for education, informally and formally • Versitility of roles and continuous review of staff utilisation	4	2	12	• Monitor feedback through appraisal system • Monitor leavers and perform exit interviews	Exec	Feb-21	Mar-21			Y	
8.	**Loss of Medical Team capacity**	• Puts patient safety at risk • Delays the impact of EVE • Increased staff anxiety • Reputational Damage	• Agency cover is in place • First 2 x new Consultants in position, Clinical Director role appointed	4	2	12	• Seek third new consultant to complete the team • Develop existing expertise • Take every opportunity to become more innovative and collaborative • Re-instatement of STR from April 2021	3	2	9	• Regular review meetings • Seek external view on progress (ie RO from ESHHT team)	Exec	Feb-21	Mar-21	Y			
9.	**Less than "Good" CQC**	• Staff morale • Reputational Damage	• Staff engagement with EVE • Excellence is the primary objective of all activities • New training package and increased Education resource • Staff encouraged to "going the extra mile" to support patient care	4	2	12	• Pro-active review and action to improve patient experience and evidence of this • Drive to enhance Hospice environment commenced • Strong new recruits have added to capability and vacancies filled adds capacity	3	2	9	• Record of actions to enhance quality of delivery and record compliments to be promoted and completed • Introduce an action plan to include regular mock inspections, briefings, CQC steering group etc	Exec	Feb-21	Mar-21			Y	
10.	**Financial Fraud (significant sums)**	• Financial Loss • Reputational Damage	• Two signatures required for all transactions • Annual budget set as boundary for activity • Monthly review of accounts to budget and variances investigated	4	2	12	• Review of financial policies and accountability structures to be undertaken	4	1	8		Exec	Feb-21	Mar-21				Y
11.	**IT systems failure**	• Loss of access to patient data • Loss of service functionality • Loss of business processes	• Backup system in place, Critical data with 2-3 hours turnaround • Multiple servers to spread risk • Highly qualified and experienced team • failover power source	4	2	12	• Renewal of all systems completed • External support available if required	4	1	8		Exec	Feb-21	Mar-21		Y		

ITEM 09

Clinical Quality and Governance Report

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Aim

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

Recommendation

The report be noted.

Report

Update on Organisational Response to the Covid 19 Pandemic

Nationally we remain in lockdown and the Hospice is providing a safe and responsive service to our local communities of Sutton and Merton. Our staff are continuing to provide advice and support in a variety of ways to try and reduce the impact of the restrictions on those with palliative care needs during these difficult times.
Over the winter months, our staffing has been affected due to the need for people to isolate, care for family members or recover from Covid themselves.

On 28th Jan, we were advised to close the IPU to admissions due to a Covid-19 outbreak. During this time, our neighbouring hospices were able to support us by offering their IPU beds to our patients if needed, and our community palliative care team maintained their efforts to support people in their own homes as much as possible if that was their preferred setting, risk assessing prior to visiting and using remote assessment when they could.

We worked closely with SWL CCG, PHE and the Infection Prevention and Control Lead to manage the outbreak and were able to safely reopen on 12th Feb following a unit 'deep-clean. The feedback that we have received from those advisors was that we managed the outbreak extremely well. Visiting is more restrictive than previously because we need to be cautious in managing the footfall/contact, particularly since the variants seem to be more easily transmissible.

Our infection control practice remains rigorous in order to mitigate as much as possible against the spread of Covid 19. Our reduced cohort of front reception staff have continued to monitor those entering the building, remaining stringent with infection control guidance.
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 and leading on testing for staff and volunteers.

We are accessing PPE through the recommended channels more easily now and are no longer experiencing shortages in supply.

We have been offering weekly PCR testing for staff since the beginning of the year and following our outbreak, we have access to frequent Lateral Flow Device testing which means that staff and volunteers can undertake the tests in their own homes.
The availability of testing has meant that we have been able to identify a number of Covid positive asymptomatic staff and therefore reduce the spread further. The testing has been resource intensive, forcing us to flex and react, in line with regular changes in guidance and protocols – no week is the same but all part of the learning process and the outcomes have been worth the investment.

Staff have had access to the vaccination programme since December, albeit sporadic initially, and although not mandatory, we are pleased to see that the uptake is popular. There are a number of local vaccination centres that can be easily accessed and we can book our appointments via an email system.
Our Psychological Support Team is 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. Steve has also been approached by other organisations,

requesting formal support sessions and input but due to workload, this has had to be put on hold for the time being.

We saw a slight dip in our Wellbeing remote attendance over the winter months for a variety of reasons (one of which was 'Zoom fatigue'). However, Sheila Payne held a fantastic Zoom Christmas party which was well attended and reviewed, culminating in an article accepted on the eHospice website back in January, detailing it's success.
Sheila has now been joined by a new recruit – Carla Scott. Carla has been appointed as a Wellbeing Facilitator, and has a background of Community Nursery Nursing, and more recently worked with the NHS Immunisations programme. Together Sheila and Carla are developing the Wellbeing programme and will be engaging with GPs and local community and charity groups, to invite referrals to our new programme. Contact with patients and carers is still regularly undertaken by Sheila and Carla as well as actively supporting and engaging patients via Zoom to deliver sessions.

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

The two weekly HoDs continue at 08.30 on a Thursday morning to update managers on the current status within the hospice and any changes in healthcare guidance.
Internal meetings have been held in St Bede's Conference Centre with appropriate social distancing for the small number of people coming into SRH to work but the majority of staff have attended remotely.

Recruitment

Our CPCT band 6 development posts are going well, with our new members of staff now settled well into the team. We have RN vacancies on the IPU and these posts are commonly difficult to recruit to, due to the national shortage in nurses. We have reviewed where we advertise as well as updating the wording to give a more welcoming feel and will monitor the response and feedback. Our night nursing team on the IPU is particularly depleted due to compassionate leave and a resignation. Despite the willingness of day staff to rotate on to nights, cover is challenging and requires continuous monitoring.

Medical Team

Our two medical consultants, Jenny Strawson and Gaby Tamura-Rose are now well established within the clinical team, working across the clinical services and providing supervision, mentorship and support. The rest of the team include our specialty doctors and locum consultant as well as a GPVTS and the new Physician Associate role. We are also expecting a Specialist training Registrar to be joining us in April. An interview for our third consultant post is being held on Tuesday 2 March.

Education/Training

Much of our scheduled education and training has had to be put on hold over recent months to allow us to respond to the Covid pandemic and relentless changes in practice. The Practice Educators have been tenacious in their provision of infection control training for staff and their adaptability during the speed of protocol changes has been truly commendable.

The infection control baton is now being passed to Tracey Young as the lead, and Julie Ford and Kayleigh Mackie (all IPU staff) , to ensure that the focus and ongoing maintenance continues. This means that the Practice Educators will now be able to focus on the educational initiatives for SRH as part of the strategy and 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.

Staff Wellbeing

Staff have continued to work incredibly hard, covering shifts or flexing their hours to meet the needs of the service. People have worked across roles to fill gaps and we are aware that they need time to rest and look after themselves. The CPCT have been undertaking short mindfulness sessions prior to starting their morning MDT and recognise the importance of prioritising this time for self-care. All clinical staff have access to clinical supervision and have been encouraged to access this during the pandemic.

We continue to work on improving the environment and the plans for brightening reception, updating the counselling rooms and planning for the IPU refresh are progressing.

Bed Capacity

Our bed capacity aligns with our staffing availability and we are ensuring that the acute trusts are aware of our bed status by communicating with them on a frequent basis. Visiting restrictions impact on the demand for beds and we endeavour to balance the need for reduced footfall with sensitivity to families wishing to visit their dying relative or friend.

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	Feb'21	Feb'21	Mar'21
Drugs & Therapeutics	Nov'20	Jun'20	Mar'21
Falls	Jun'20	Jun'20	Mar'21
Incidents	Nov'20	Mar'19	Mar'21
Infection Control	Feb'21	Jun'20	Sep'21
Prescribers	Jan'21	Jan'21	Mar'21
Quality Improvement	Dec'20	Jun'20	Apr'21

Incidents / Accidents / Near Misses

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

- Quarterly submission to Hospice UK's Quality Metrics project began in July 2017 and are on-going with the latest submission provided in January 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. Re quest 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 June 2020 and its next meeting is scheduled for March 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.

- 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 March 2021. A further user training video and policy changes to support the software use remain required and are being worked upon. 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 and 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 6 reports to write up before the end of March 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 the 2021 once we are out of lockdown. 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\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
20/011	Community Risk Assessment Monitoring	TC	To create Feb 2021	To monitor completion of the community RA	CPCT	Yes	Monthly	AR	It will be	TBA
20/012	DoLs Monitoring	TBA	To create Feb 2021	To monitor DoLs applications and follow up	Exec	Yes	Weekly	AR	No	TBA
20/013	PPoD vs Actual PoD Monitoring	RT	To create Feb 2021	To monitor PPoD achievement rates	Exec	Yes	Monthly	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 scheduled for 23rd February 2021 is included in the papers for the 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 2020/21

Overview in February 2021

20 projects scheduled in 2020/2021 : as at 18-02-2021, 8 are reported/ongoing complete, 6 have data collection completed and AR is finalising reports, 2 are in their data collection periods, 4 are deferred to 2021/22.

Engagement with the audit process was encouraging up to the COVID outbreak and there was a positivity in undertaking audit and it being taken further forward into 2020/21. Affording the time to input into projects remains the singularly largest challenge for clinical engagement but this is the most common issue with clinical audit and has been ever so. Mandating the completion of clinical audit project plans has been a development in 2019/20 and supports the project and staff involved. Our forum, CAAD, is a very positive forum that facilitates our reflection and overview of progress and results. Expanding the number of staff involved in audit projects is an ambition for 2021/22 and a revitalised medical team will support the process. A more realistic expectation of the support resource required to complete clinical audit work in 2021/22 will be effected with project leads taking responsibility for analysis and report writing.

Project Ref.	Title	Status	Report Date	Re-Audit	Report Due Date	Results
2020/21-01	Medication Audit (ISR Recs 2-5) : staged approach to medication initiation / evidence of optimisation before change / blood results prior to initiation / ECGs when initiating medications known to affect QTC interval	Data Complete Report to finalise with AR			Mar-21	Results demonstrate no concerns as related to the ISR points 2-5. Adherence to analgesic guidance and observations as expected in support of drug regime / dose regimens. Prescribing followed PCF guidance. Pharmacological bundling was not seen. Records evidence optimal pain management. AR finalising report.
2020/21-02	Non-pharmacological intervention Audit (ISR Recs 2-5) - prevalence / effectiveness monitoring	Deferred to 2021/22 planning			Mar-21	Item incorporated into 2021/2022 planning
2020/21-03	Community patient follow-up within 48-72 hrs when titrating medications	Data Complete Report to finalise with AR			Mar-21	Results show expected follow-up within 48-72 hours of community opioid titration / switch. AR finalising report.
2020/21-04	Pain management survey	Complete			Mar-21	Medical Team led survey complete. Feeds into planning for symptom assessment auditing in 2021.

Project Ref.	Title	Status	Report Date	Re-Audit	Report Due Date	Results
2020/21-05	Community - Carer & relative questionnaires for the Hospice @ Home Service	Ongoing/ Complete	Dec-20	Yes	Aug-21	1) There is a clear indication of the overwhelming benefits experienced by patients and their relatives/carers who have used the service. To a great extent, any success attached to a service is heavily influenced by the skills and dedication of the team of staff providing it. As returns indicate; in the main, they are to be commended. 2) Although numbers should be treated with caution, in 2019, the H@H service was usually introduced to the patient by a higher proportion of Hospice personnel comparatively to previous years – 40% in 2019 (c.f. 22% in 2018 and 28% in 2017). Conversely the number of introductions by Hospital personnel has dropped in 2019 to 21% proportionately (c.f. 54% in 2018 and 43% in 2017). This may have alignment with referral into the service given referral numbers have decreased since 2018. 3) A higher number of returns (93%) has maintained feeling that the timing of introduction to the H@H service was “about right” (c.f. 90% in 2018 and 79% in 2017). 4) Expectation of the help that the H@H service provides maintains a consistent distribution across the years in so far as the service provides comfort measures, advice, emotional support, access to 24 hour telephone support, allow patients to remain at home and allows carers time out from caring. 5) Complete satisfaction with how easy it was to contact the H@H team has improved in 2019 to 76% (c.f. 73% in 2018) but remains short of the 91% level reached in 2017. 6) Pleasingly, there has been a bounce back in regard of how ‘very’ helpful the service had been across a range of criteria that includes comfort measures, emotional support, face to face advice, telephone advice during the day and night, respite sits, enabling the patient to stay at home and dealing with a crisis – 83% in 2019 (c.f. 79% in 2018 and 92% in 2017).

Project Ref.	Title	Status	Report Date	Re-Audit	Report Due Date	Results
						7) 19 (66%) of returns indicate that the patient died at home and all of these reported that this was where they wanted to be. In total, 25 (86%) of the 29 respondents who recorded an answer indicated that the patient had died in their preferred place of death (c.f. 87% in 2018 and 91% in 2017). 8) All 29 (100%) respondents who recorded an answer indicated that they would recommend the H@H service (c.f. 97% in 2018 and 100% in 2017). This reflects well on the service overall. 9) Respondents are encouraged to add general comments on H@H at the end of the questionnaire, and a majority of written comments in this section were positive. The problems alluded to in the critical comments are almost entirely for services that are not under St Raphael's direct control (District Nurses, GPs, hospitals etc.) 10) The survey affirms the value and skill of the service and staff involved. Looking forward the plan is to increase the numbers referred and contacts made into and by the H@H service in supporting the widened scope of the Community service and its promotion of collaboration. H@H have scope for responsive visiting in their working day to increase the responsiveness of the service for those patients rapidly deteriorating. **RECOMMENDATIONS** 1) To keep separate from the VOICES questionnaire and continue as a bespoke survey. 2) To identify and implement measures that would increase referrals into the H@H service from external sources such as Hospitals / GPs / DNs. 3) To explore and re-state what measures are in place to staff in their support of those patients/carers who are profoundly deaf.

Project Ref.	Title	Status	Report Date	Re-Audit	Report Due Date	Results
2020/21-06	Community – Referrals Audit – timeline from request to admission (by source)	Data Complete Report to finalise with AR			Mar-21	AR to finalise report
2020/21-07	IPU - Audit against Audit NICE Guidance NG31 Care of Dying Adults at the End of Life	Data Complete Report to finalise with AR		In 2021	Mar-21	Community arm of data added to Audit in late 2020. AR to finalise report.
2020/21-08	IPU & Community - VOICES survey of bereaved next of kin 3-6months post bereavement	Reported /Ongoing	Sep-20	Yes	Dec-20	Extensive and very positive report highlighting areas for development in NoK recording, working with GPs, raising the awareness of the Hospice's brand, clinical engagement with data, spiritual support on the IPU, suitability of referral to Psycho-social Service, record of patient/family involvement about care decisions.
2020/21-09	IPU – Infection Control : Environment & Hand-washing Audit	Reported /Ongoing	TBA	Yes	Aug -21	Environmental items for improvement are planned to be addressed in 2021's IPU re-fresh project. Hand-washing and environmental auditing on the IPU refreshed in November 2020. Data Monitoring charts established. High levels of compliance maintained.
2020/21-10	IPU - Medicines Management Audit	Reported /Ongoing	On-going	Yes	On-going	Reminder for all queries/interventions to be duly acknowledged via Liveview.
2019/20-11	IPU - Audit of Medication recording on Discharge from IPU : EPR 'Medication Module' vs Discharge Letter	Deferred to 2021			Jun-21	
2020/21-12	IPU - Audit of medication charts to review the number of PRNs given in a 12hour period.	Data Complete Report to finalise with AR			Mar-21	Small cohort Audit showed appropriate PRN administration within accepted levels and frequencies. AR to finalise report.

Project Ref.	Title	Status	Report Date	Re-Audit	Report Due Date	Results
2020/21-13	IPU – Hospital to Hospice Admissions Audit	Data Complete Report to finalise with AR			Mar-21	Actions implemented to improve Admission Score Sheet and align Crosscare prompts for assessment of admission prioritisation. AR to finalise report
2020/21-14	IPU & Community & Psycho-social - Activity Data Dashboards Development to include:-	Ongoing	n/a	n/a	n/a	Index to topics: 1. CMC, 2. NoK, 3. Community Team Responsiveness, 4. Consent to Sharing Information, 5. Safeguarding, 6. Referrals, 7. Referrals to RIP. 8. Active Caseloads.9.Daily Activity Data.10.Referrals by Postcode
2020/21-15	- OACC measures (iPOS, Phase of Illness, Karnofsky performance status)	2020/21 project	n/a	n/a	n/a	Larger re-implementation project to be planned. Commencing with use of Karnofsky and PoI – linked to education.
2020/21-16	- Activity Data	Ongoing	n/a	n/a	n/a	Graphical monitoring covers 1. Referrals, 2. IPU Admissions, 3. IPU Occupancy, 4. IPU Discharges, 5. IPU Deaths, 6. IPU LoS ; Referral Ethnicity; 7. Community First Assessments, 8. Community Visits, 9. Community Telephone Contacts split Patient, HCPs, Family/Carers, 10. Community Medical Team Visits, 11. H@H Referrals, 12. H@H Visits,
2020/21-17	IPU - Re-Audit of Discharge Documentation	Data Collection Period	Feb-20	Yes	Mar-21	Following SIGN discharge document template well. Actions: Discharge letter template to be changed: 1. Add section/heading in the discharge letter on the Action required by the GP; 2. Add section on Advanced Care Planning when discussing resuscitation/CMC; 3. Medication Changes section should be divided into two further headings: Started and Stopped.
2020/21-18	IPU - Patient Satisfaction	Reported /Ongoing	Dec-19	Yes	Dec-21	1. Overall satisfaction is an impressive 96.09% 2) Feedback around care and treatment has been excellent. 3) The structure and detail for some of the questions is too complex and the form needs to be amended towards a more qualitative format for some. Some patients were unable to differentiate the staff groups and so those questions became generalised around professionalism and other staff group questions. Some saw all staff clinical and non-clinical as one team, which in itself is a good piece of feedback and they just wanted to talk in general terms about their stay. 4) Some patients found the lickert scale approach a little clunky so this should be considered in the form's re-design. 5) Interview methodology allowed for direct feedback by the interviewer to the IPU team on shift. Overall satisfaction is an impressive 96.09% **ACTIONS** effected:- 1) Questionnaire re-designed to implement all recommendations. 2) Training delivered to ward volunteers suited to delivering the survey..

Project Ref.	Title	Status	Report Date	Re-Audit	Report Due Date	Results
2020/19	IPU - Risk Assessment Completion	Deferred to 2021	n/a	n/a	Dec-21	Project to commence in 2021
2020/20	VTE Risk Assessment Audit	25-Feb-21 audit day				One day snap shot participation on the IPU on 25 February 2021 as part of a national project assessing compliance with NG89

Clinical Risk Management

Clinical Unexpected Incidents

Overview of incident data for January – December 2020 is shown below:-

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2020	2019	2018	2017	2016
Admissions to IPU	**21**	**21**	**15**	**27**	**17**	**19**	**13**	**11**	**17**	**9**	**12**	**13**	**195**	**212**	**211**	**214**	**236**
Beds	**8**	**8**	**8**	**14**	**14**	**14**	**6**	**7**	**7**	**8**	**8**	**6**					
Bed Occupied Days	**213**	**188**	**195**	**219**	**353**	**292**	**154**	**184**	**179**	**204**	**219**	**161**					
Bed Available Days	**248**	**232**	**248**	**420**	**434**	**420**	**186**	**248**	**210**	**248**	**248**	**186**					
Bed Occupancy (variable beds)	**85.89%**	**81.03%**	**78.63%**	**52.14%**	**81.34%**	**69.52%**	**82.80%**	**84.79%**	**85.24%**	**82.26%**	**88.31%**	**86.56%**					
Bed Occupancy (10 beds)	**68.71%**	**64.83%**	**62.90%**	**73.00%**	**113.87%**	**97.33%**	**49.68%**	**59.35%**	**59.67%**	**65.81%**	**73.00%**	**51.94%**					
CD Medication Incident	1	2	1	1	4	1	1	0	0	0	3	1	**15**	**23**	**27**	**18**	**110**
CD Medication Near Miss	0	0	0	0	0	1	0	0	0	0	0	0	**1**	**1**	**3**	**7**	
Adverse Reaction (Opioid Toxicity)	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**1**	**10**	**8**	**1**
Adverse Reaction	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**1**	**2**	**1**
Non-CD Medication Incident	0	1	0	1	0	0	0	0	0	1	0	1	**4**	**12**	**22**	**27**	**24**
Non-CD Medication Near Miss	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**1**	**5**	**12**	
Pressure Sore on Admission	1	2	2	1	1	3	0	2	1	0	3	3	**19**	**16**	**20**	**23**	**20**
Pressure Sore during Admission	0	0	2	0	0	0	0	1	0	0	0	1	**4**	**3**	**8**	**4**	**12**
Sharps	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**2**	**0**	**0**
Infection	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**0**	**2**	**0**

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2020	2019	2018	2017	2016
Readm <7days	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**1**	**4**	**1**	
Unexpected Transfer	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**2**		
Near Miss(non-medication & non-IG)	0	0	0	0	0	1	0	0	0	0	0	0	**1**	**1**	**2**	**1**	**1**
PE	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**3**	**4**	
Staffing	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**1**	**1**		
IG	0	0	1	0	1	1	0	0	0	0	0	0	**3**	**0**	**7**	**12**	**19**
IG near miss	0	0	0	0	0	0	1	0	0	0	0	0	**1**	**0**	**1**	**4**	
Manual Handling	0	0	0	0	1	0	0	0	0	0	0	0	**1**	**5**	**10**	**2**	
Slips, trips, falls	2	0	0	2	1	6	3	1	2	1	0	2	**20**	**21**	**29**	**18**	
Verbal Violence	1	0	0	0	0	0	0	0	0	0	0	0	**1**	**0**	**0**	**1**	
Bump	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**0**	**2**	
Other - Admin/property/Documentation/Clinical	2	1	1	1	3	2	0	1	1	1	1	0	**14**	**12**	**18**	**15**	**14**
*** Incidents reported to Community – non-SRH**	2	0	0	1	2	0	1	0	0	0	2	0	**8**	**12**	**25**	**24**	
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**	
Total 2016	**14**	**28**	**11**	**18(5)**	**12(5)**	**9(1)**	**14(2)**	**6**	**10(3)**	**17(2)**	**15(3)**	**23(3)**					**177(24)**

Reported clinical incidents in January to December 2020 have decreased on last year despite a spike in May and June coinciding with a busier IPU. Medication incidents are notably less.The number of admissions to IPU in January – December is reduced on last year.

Incident Key

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

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

Clinical Significance	Jan	Feb	Mar	Jan-Mar	Apr	May	Jun	Apr-Jun	Jul	Aug	Sep	Jul-Sep	Oct	Nov	Dec	Oct-Dec	2020	2019	2018	2017	2016
Admissions to IPU	**21**	**21**	**15**	57	**27**	**17**	**19**	63	**13**	**11**	**15**	39	**9**	**12**	**13**	34	**193**	**212**	**211**	**214**	**236**
Bed Occupied Days	**213**	**188**	**195**		**219**	**353**	**292**		**6**	**8**	**179**		**204**	**219**	**161**						
Bed Available Days	**248**	**232**	**248**		**420**	**434**	**420**		**186**	**248**	**210(7)**		**248**	**248**	**186**						
Bed Occupancy	**85.89%**	**81.03%**	**78.63%**		**52.14%**	**81.34%**	**69.52%**		**82.80%**	**74.19%**	**85.24%**		**82.26%**	**88.31%**	**86.56%**						
Fall No Harm				0	2	1	3	6	3	1	2	6	1		1	2	**14**	**15**	**21**		
Fall Low Harm	2			2			3	3				0			1	1	**6**	**6**	**10**		
Fall Moderate Harm				0				0				0				0	**0**	**0**	**1**		
Med Level 0		2	1	3	2	1	1	4				0			2	2	**9**	**13**	**6**		
Med Level 1	1	1		2		3	1	4	1			1	1	2		3	**10**	**21**	**37**		
Med Level 2				0				0				0				0	**0**	**3**	**10**		
Med Level 3				0				0				0				0	**0**	**0**	**3**		
Minor	3	1	1	5		3	4	7	1		1	1	1	1		2	**15**	**19**	**38**		
Moderate			1	1	1	1		2		1		1		2		2	**6**	**2**	**21**		
Serious				0		1		1				0				0	**1**	**1**	**3**		
Pressure Sores	1	2	4	7	1	1	3	5		3	1	3		4	4	8	**23**	**19**	**27**		
Totals 2020	**7**	**6**	**7**	**20**	**6**	**11**	**15**	**32**	**5**	**5**	**4**	**14**	**3**	**8**	**8**	**19**	**85**				
Total 2019	**1**	**14**	**13**	**28**	**7**	**8**	**7**	**22**	**6**	**6**	**5**	**17**	**16**	**10**	**6**	**32**		**99**			
Total 2018	**21**	**14**	**11**	**46**	**10**	**18**	**24**	**52**	**15**	**8**	**13**	**36**	**16**	**17**	**9**	**42**			**176**		
Total 2017	**13**	**11**	**19**	**43**	**15**	**15**	**17**	**47**	**12**	**2**	**16**	**30**	**16**	**15**	**12**	**43**				**163**	
Total 2016	**14**	**28**	**11**	**53**	**18(5)**	**12(5)**	**9(1)**	**39(11)**	**14(2)**	**6**	**10(3)**	**30(5)**	**17(2)**	**15(3)**	**23(3)**	**55(8)**					**177(24)**

* NOTE : Incidents reported to Community – non-SRH are excluded from the clinical significance data	() Near Misses included in Totals for 2016

***The clinical incident reported and classified as Serious from May 2020 concerned the Community Team and the system for follow-up telephone calls. The incident led to an incident reflection meeting led by the Team's Manager which reviewed the incident details and highlighted the expected practice that has been further crystalized in the Community Team's Operational Policy.

Records – Access Requests

- There were 3 access to health record requests in 2020 : 2 x solicitors (July, August) , 1 x nok (September)
- There were 4 sharing requests in 2020 : 3 x GP (June, November (2)), 1 x SWL CCG LeDeR (December)
- In 2021, there has been 1 access to health records request : 1 x wife (January)
- In 2021, there have been 2 sharing requests : 2 x SWL LeDeR (January, February)

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

Clinical Complaints

- There have been 4 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
2020/12	ORAL	Husband	09/11/2020	9/11 - At CNS telephone call , husband of 57 year old patient was very frustrated that he had called the Hospice several times over the weekend and nobody had returned his calls culminating in an early hours visit to A&E by LAS on Monday morning with his wife in abdominal pain. Home same day having been given IV Morphine. Husband's frustration and distress accentuated the following day owing to his wife's deteriorating condition and likely bowel obstruction secondary to peritoneal disease from progressive cancer. 10/11 joint home visit by Consultant & CNS. No bed availability at RMH and no visitors allowed at SHH. Patient and husband decision to stay at home and receive palliative care support. Wished to focus on comfort and have family around. 11/10 early hours t/c to Hospice - pain persists and husband frustrated that can't get through to Sutton DNs. Hospice contacted DN to make contact. They did eventually. RMH actively reviewing if there is bed availability at the RMH and bed offered 11/11. Plan still for Hospice	Clinical - Community Care	1 & 2. Consultant signposted to PALS re SHH & explained patient had likely experienced an acute event of BO causing her extreme symptoms and that this had not been anticipated otherwise the oncologists would not have proceeded with recent treatment. Reassured that the RMH do discuss all deaths in their M&M meetings re RMH complaint. 3. Apology extended and advised that Hospice MDT would investigate and reflect and senior member of the team would be in touch. Reflection undertaken at M&M meeting. Feeling from team that many requests are coming in to the team and this is delaying their response to situations such as this patient's. Telephone calls to Hospice over weekend investigated by IT. No calls on Saturday 7th. One unanswered call on Sunday 8th at 10.30am further to one answered call at 07.56. • TC will email TY regarding DN's and to check GP CCG to which DN's visit (achieved)• RW will liaise the outcome of M+M with the patients CNS at the RMHS as the husband found care disjointed between services ;• We discussed that the patient was on telephone contact for some time and it she had been seen face	Upheld	Closed

ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASS	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE	STATUS
				Consultant to visit and review. Patient died 11/11. Visit by Hospice Consultant felt still to be useful by GP. Visit by Consultant and H@H HCA - family all very distressed and upset. Number of aggrievances outlined by husband. 1. Perceived delay in tx by SHH. 2. Issues with RMH giving chemo - patient wanted to focus on quality not quantity of life - feels previous prognoses not accurate. 3. Lack of support from HCPs since Saturday – no one taking responsibility for helping his wife until yesterday when the Hospice Consultant and CNS attended. Feels that his wife did not have a good death.		to face sooner this may have triggered ACP sooner . We reminded ourselves of our SoPs ; • It was suggested that a daily 2pm hand over / update would be useful to touch base with those working from home etc ;• Phase of illness was discussed and DR AM is going to do some teaching on Thursday and Fridays morning ; • Bereavement team will follow up with patients family. • TC called husband Monday 16th Nov . Meeting held with husband on 10/12/2020 at the Hospice with Community Manager and Clinical Director advising 1. Introduction of a daily handover at 2pm to review any concerns raised earlier in the day ; 2. Lower threshold for face to face visits introduced for patients who have had mainly telephone contact with consideration of earlier Advanced Care Planning conversation and ordering of medications; 3. Reminder to IPU staff which DN teams work in each area in case of a need for visits. Advised that our reflection had also been discussed by TC with Royal Marsden Hospital looking at how they might have done things differently.		
2020/15	ORAL	Daughter	16/12/2020	Concerns raised to CNS at home visit by daughter following her mother's IPU admission re lack of staff compassion, compromised dignity by having to wear a 'nappy', no physiotherapy to help her mobility. Concerns reiterated by the patient	Clinical - IPU Care	Followed up by Clinical Director who made 2 calls to daughter's mobile with message left re contact her if she wished to.	Upheld	Closed

ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASS	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE	STATUS
				along with a lack of information given. Daughter requested contact by telephone to discuss. Passed to IPU Manager 21/12/2020.				
2021/01	ORAL	Daughter	18/01/2021	Patient's daughter spoke with HPoC when telephoned expressing her disappointment with the lack of support from the community and palliative care services. Specific to SRH she questioned why she had not received a phone call on Sunday 18th January following her father's self-discharge from SHH on 17th January. Her father had passed away 00.20 on 18th January at her home following his self-discharge from SHH.	CPCT Comms	MDT discussion on 19th January - agreed to offer bereavement follow up sooner than the standard 4-6 weeks should the daughter want that. Discussed with Clinical Director - for HPoC to call daughter and offer bereavement support. No benefit in Clin Dir. calling her as she would go over the same ground which she herself says she found exhausting. Community Manager informed Clin Dir that there was some work done externally on nhs.mail that weekend and therefore the referral from the HPCT wasn't picked up until Monday morning despite the patient self-discharging on the Sat pm. The patient had discharged himself against hospital advice and deteriorated rapidly that night and died.	Upheld	Closed
2021/02	EMAIL	Great Grand-Daughter	07/02/2021	Inpatient's great grand daughter wrote to make a formal complaint about the communications regarding the patient's discharge on the 5th February. The patient was readmitted within 24 hours. Conversation received from the IPU in advising of both the patient's status and discharge planning had	IPU Care and Communications	Clinical Director wrote to complainant apologising for the distress caused by the patient's discharge and subsequent readmission. Following investigation, Clinical Director further provided apology for what appears to have been a misunderstanding and miscommunication on our part. Reassurance provided that we regard this	Upheld	Closed

ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASS	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE	STATUS
				been inconsistent which heightened the daughter's distress. Patient was COVID+ and was discharged whilst still coughing and variable oxygen saturation levels. Ambulance was called on the morning following discharge that led to readmission. Ambulance driver commented that the patient should never have been discharged. Complainant expressed the emotional turmoil caused on one day receiving advice of how unwell the patient was only to be receiving the patient home the following day. Complainant also alleged that nurses had been entering patient's room wearing only masks and not full PPE.		compliant seriously and a meeting will be held with all staff involved to reflect on what happened, where errors in judgement were made and how we can reduce the risk of such error being repeated. Additional letter sent to patient's daughter thanking her for her time in conversation with the IPU consultant on 08/02/2021 talking through the care of her mother and again extending apology on SRH behalf for the distress we caused and advising the planned actions as detailed in letter to the great grand-daughter.		

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Complaints Overview

2021 - Complaints	CPCT Care	CPCT 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**		
March									**0**			
April									**0**			
May									**0**			
June									**0**			
July									**0**			
August									**0**			
September									**0**			
October									**0**			
November									**0**			
December									**0**			
2021	**0**	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**2**	**1**	**1**	**1**
2020	3	2	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

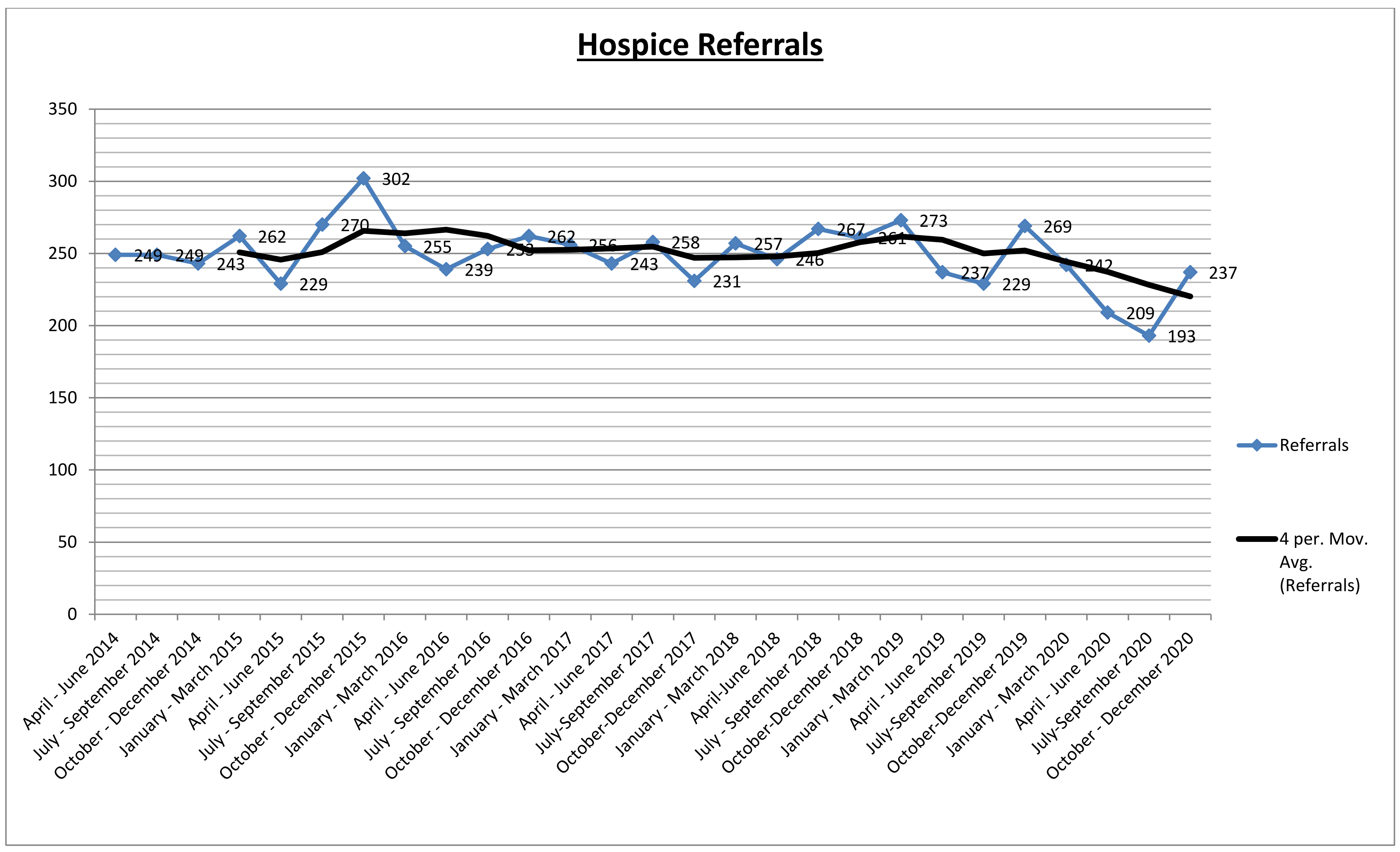
There were 7 serious injury notifications made to the CQC between January and December 2020 all concerning pressure sores grade 3 or above.

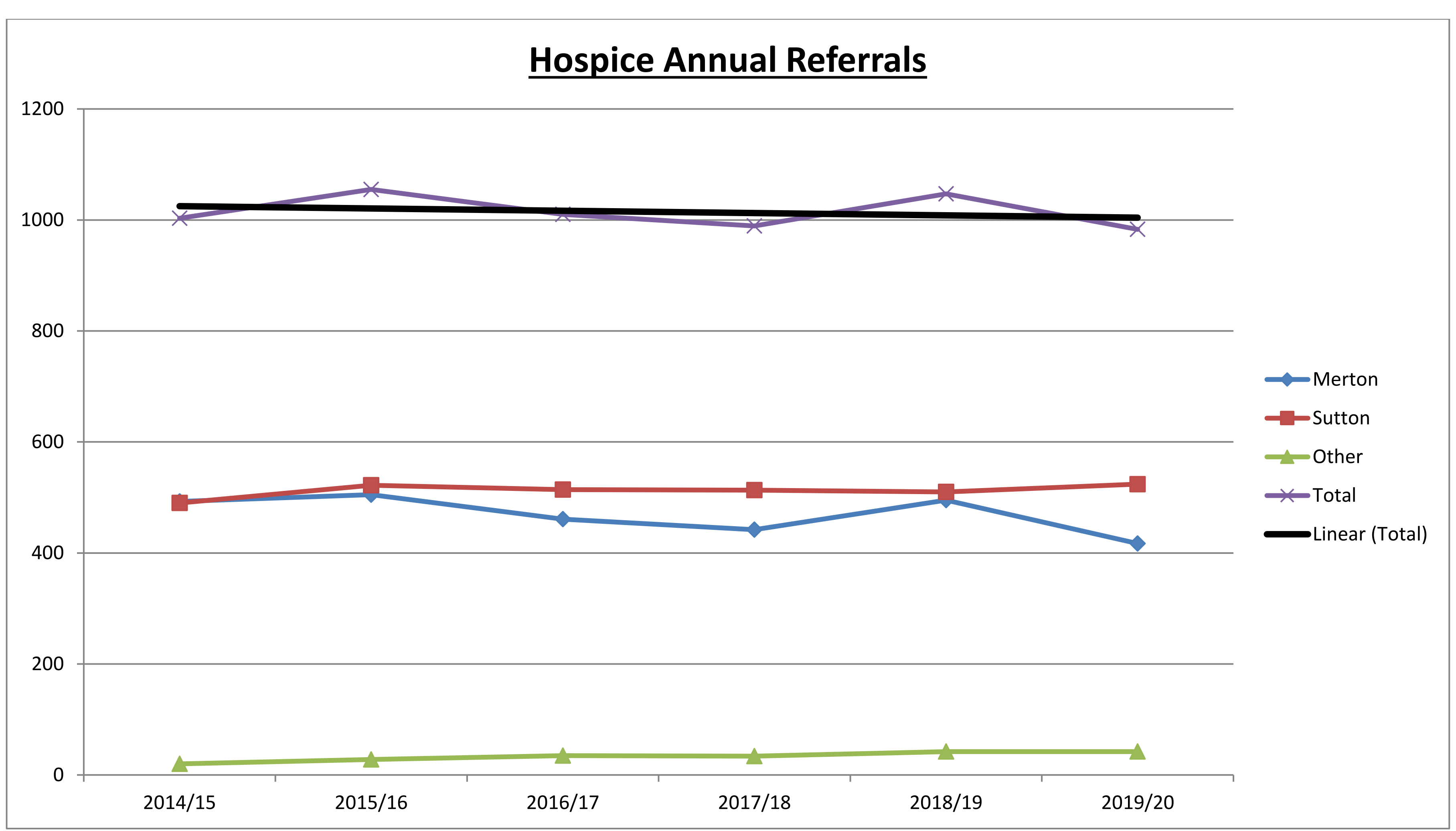
There were 10 safeguarding notifications made to the CQC between January and September 2020: 4 concerning individuals,2 nursing homes and 4 care agencies. All 10 were reported to the local safeguarding teams.

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 Q3 (October - December 2020) was submitted in January 2021. A selection of graphical representations for some of the data items will be incorporated into routine report in 2021. An extract of data provided to the CCGs is included on pages 22-26.

Hospice Referrals




Hospice Annual Referrals
1200
1000
800
600
400
200
0
2014/15
2015/16
2016/17
2017/18
2018/19
2019/20
Merton
Sutton
Other
Total
Linear (Total)

Activity Dataset provided to the Hospice's Commissioners

St Raphael's Hospice
Activity Dataset

	2020 Q1 : April - June			2020 Q2 : July - September			2020 Q3 : October - December			
	Merton	**Sutton**	**Wandsworth et al**	**Merton**	**Sutton**	**Wandsworth et al**	**Merton**	**Sutton**	**Wandsworth**	**Other**
HOMECARE SERVICE										
Hospice Point of Contact										
Number of Referrals Overall	91	109	9	93	91	9	92	125	17	3
Number of Referrals Accepted	81	99	8	85	82	6	76	113	13	1
Referral Doesn't Require SPC				8	9	0	10	9	3	0
Referral Information Outstanding				0	0	1	3	1	1	0
Referred to another Hospice				0	0	2	3	2	0	2
Number of Referrals Cancer	67	76	4	66	57	5	57	91	6	2
Cancer Referrals %	74%	70%	44%	71%	63%	56%	62%	73%	35%	67%
Number of Referrals Non-Cancer	24	33	5	27	34	4	35	34	11	1
Non-cancer Referrals %	26%	30%	56%	29%	37%	44%	38%	27%	65%	33%
Gender Female n=	53	48	3	53	40	3	41	63	7	1
Gender Female %	58%	44%	33%	57%	44%	33%	45%	50%	41%	33%
Gender Male n=	38	61	6	40	51	6	51	62	10	2
Gender Male %	42%	56%	67%	43%	56%	67%	55%	50%	59%	67%
Ethnicity Split of Referrals										
White British	51	78	2	56	67	3	54	90	4	1
White Irish	5	4	1	5	5	1	3	5	0	0
Any Other White	8	3	1	4	2	1	6	6	3	1
Black Caribbean	2	0	1	3	1	2	0	0	4	0
Other Asian	6	1	0	7	1	1	10	4	2	0

Black African	1	1	1	4	1	0	0	2	0	0
Not Stated	13	18	1	8	12	0	8	11	4	0
Far Eastern	0	0	0	0	0	0	0	0	0	1
Chinese	0	1	0	0	0	0	0	1	0	0
Indian	1	1	1	1	1	0	1	2	0	0
Pakistani	1	0	1	1	1	0	2	2	0	0
White Asian	0	0	0	0	0	0	1	0	0	0
Mixed White/Black African	0	0	0	1	0	0	1	0	0	0
Mixed White/Black Caribbean	0	0	0	0	0	0	0	0	0	0
Bangladeshi	0	0	0	0	0	0	2	0	0	0
Black Other	2	0	0	3	0	1	2	1	0	0
Mixed Other	0	0	0	0	0	0	2	0	0	0
Other	1	1	0	0	0	0	0	1	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%	100.0 0%
Coordinate My Care (CMC)										
Based on patient deaths	51	78	2	44	67	3	60	62	4	0
% Based on patient deaths	61.45 %	78.79 %	50.00%	65.67 %	75.28 %	75.00%	67.42 %	63.92 %	57.14%	0.00%

Community Palliative Care Team including HPoC	**2020 April - June**			**2020 Q2 : July - September**			**2020 Q3 : October - December**			
	Merton	**Sutton**	**Wandsworth et al**	**Merton**	**Sutton**	**Wandsworth et al**	**Merton**	**Sutton**	**Wandsworth**	**Other**
1st Assessments (Visits)	46	71	4	68	66	3	67	88	10	0
1st Assessments Cancer	41	58	2	58	52	1	52	68	5	0
1st Assessments Non-cancer	5	13	2	10	14	2	15	20	5	0
FU Visits by CPCT/FPoC CNS	62	112	6	123	201	9	129	156	9	0

Telephone Contacts Patients with CPCT/HPoC CNS/RGN	604	854	38	632	961	44	691	874	33	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
Telephone Contacts Healthcare Professionals with CPCT/HPoC CNS (includes Community Admin from April 2018)	786	1284	76	1124	1427	77	1239	1548	152	8
Homecare service : Telephone Contact Patients / Carers / HCPs Totals	2141	3354	214	2902	3885	220	2940	3910	327	13

INPATIENT SERVICE	**2020**			**2020**			**2020**			
Inpatient Unit	**April - June**			**Q2 : July - September**			**Q3 : October - December**			
	Merton	**Sutton**	**Wandsworth et al**	**Merton**	**Sutton**	**Wandsworth et al**	**Merton**	**Sutton**	**Wandsworth**	**Other**
Total Admissions	30	32	1	9	30	2	11	22	1	0
Cancer Admissions	24	25	1	6	24	2	10	16	1	0
Non-cancer Admissions	6	7	0	3	6	0	1	6	0	0
Total No. of Distinct Patients Admitted	30	31	1	9	30	2	11	22	1	0
Total Deaths	25	19	1	10	18	1	4	14	1	1
Cancer Deaths	20	14	1	8	16	1	3	9	1	1
Non-Cancer Deaths	5	5	0	2	2	0	1	5	0	0
Total Discharges	4	9	0	4	9	0	4	9	0	0
Cancer Discharges	3	9	0	2	6	0	4	7	0	0
Non-Cancer Discharges	1	0	0	2	3	0	0	2	0	0
Cancer Death Total Length of Stay	257	239	12	131	161	2	28	179	16	18
Cancer Deaths Avg LoS	13	17	12	16	10	2	9	20	16	18
Non-Cancer Death Total Length of Stay	21	36	0	25	13	0	19	75	0	0
Non-Cancer Deaths Avg LoS	4	7	0	13	7	0	19	15	0	0
Cancer Discharges Total Length Of Stay	38	119	0	15	65	0	70	89	0	0
Cancer Discharges Avg LoS	13	13	0	8	11	0	18	13	0	0
Non-Cancer Discharges Total Length of Stay	17	0	0	107	30	0	0	56	0	0
Non-Cancer Discharges Avg LoS	17	0	0	54	10	0	0	28	0	0

Cancer Deaths/Discharges	23	23	1	10	22	1	7	16	1	1
Non-cancer Deaths/Discharges	6	5	0	4	5	0	1	7	0	0
Cancer Deaths/Discharges Avg LoS	13	16	12	15	10	2	14	17	16	18
Non-Cancer Deaths/Discharges Avg LoS	6	7	0	33	9	0	19	19	0	0
Deaths/Discharges Total Length of Stay	333	394	12	278	269	2	117	399	16	18

Hospice @ Home	2020 April - June			2020 Q2 : July - September			2020 Q3 : October - December			
	Merton	Sutton	Wandsworth et al	Merton	Sutton	Wandsworth et al	Merton	Sutton	Wandsworth	Other
Referrals	2	14	1	28	40	1	16	37	4	0
Cancer Referrals	2	9	0	19	27	0	10	24	3	0
Non-cancer Referrals	0	5	1	9	13	1	6	13	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
Face to face encounters with Patients	23	59	1	92	136	8	91	250	6	0
Number of Individual Patients - Follow Up Visits Total	14	33	1	32	41	3	31	49	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
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
Number of Individual Patients - Telephone Contacts Patients Total	5	14	0	7	12	1	5	9	1	0
Telephone Contacts Patient Total	19	41	0	9	20	2	16	11	1	0
Number of Individual Patients -Telephone Contacts Family / Carers Total	14	39	2	29	48	4	20	39	3	0
Telephone Contacts Family / Carers Total	20	131	3	50	111	10	35	132	7	0
Number of Individual Patients - Telephone Contacts Healthcare Professionals (HCPs) Total	6	16	1	7	10	0	6	13	1	0
Telephone Contacts HCPs Total	6	22	1	10	13	0	9	29	2	0

DAYCARE SERVICE	2020			2020			2020			
Wellbeing Centre	April - June			Q2 : July - September			Q3 : October - December			
	Merton	Sutton	Wandsworth et al	Merton	Sutton	Wandsworth et al	Merton	Sutton	Wandsworth	Other
No of distinct patients (for attended)	9	12	0	6	15	0	7	9	1	0
No of actual attendances (for attended)	25	47	0	58	112	0	63	74	1	0
Number of Individual Patients - Telephone Contacts Patients	15	29	1	19	26	2	17	32	3	0
Telephone Contacts Patients	46	85	1	54	55	2	30	46	3	0
Number of Individual Patients - Telephone Contacts Family Carers	14	18	2	7	16	2	3	13	1	0
Telephone Contacts Family Carers	19	32	2	13	27	3	4	14	1	0
Number of Individual Patients - Telephone Contacts HCPs	5	7	0	3	2	0	0	1	0	0
Telephone Contacts HCPs	5	7	0	3	2	0	0	1	0	0

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

Clinical Action Plan 2020-2021

Introduction

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

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

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

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

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

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

UPDATE OVERVIEW

DATE	100% Complete	25% / 75% Complete / Incomplete	50% / 50% Complete / Incomplete	25% / 75% Complete / Incomplete	Complete / Incomplete
12-Aug-20	5	11			5
22-Oct-20	5	6	5	2	3
05-Nov-20	7	5	5	1	3
03-Dec-20	8	6	3	2	2
07-Jan-21	9	5	3	2	2
23-Feb-21	9	5	3	2	2

Clinical Action Plan

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP01	**Substantive appointment of Clinical Director**	Professional leadership, management and support of all clinical services within the Hospice To support and develop strategic and operational delivery	Recruitment	Compromise to the strategic and operational delivery	Recruitment	Well-led Effective Safe	Role advertised. Interviews 28-10-2020. July 2020 – January 2021 secondment appointment. R Trower appointed November 2020	100 % Complete
CAP02	**Medical Team Re-structure**	Development of substantive Peer Consultant Team. Rotational medical lead role to support management expertise across team. Prospective integration into local acute Trust Integration of new roles to support innovation in practice.	Recruitment		Recruitment	Well-led Effective Safe	Two substantive consultant appointments made for September / October 2020 Third consultant interview early March 2021 Agency consultant appointment extended to May/June 2021 Physician associate appointment November 2020	25% 75% Complete Incomplete

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP03	**Review of all clinical MDTs**	To ensure all patients are reviewed holistically (physical, psychological, spiritual, social and cultural). To maintain effective and efficient use of clinical time. Empowerment and ownership across clinical disciplines To review CLINSOP01 – purpose / delivery / required frequency / responsiveness / required parameters.	Time to review process Leadership commitment	If not achieved, ineffective MDT, inefficient use of time/personnel and impact on clinical engagement.	Staffing Opportunity	Responsive Safe Effective Caring Well-led	CLINSOP01 Inpatient Multidisciplinary Team Review. Review undertaken in September 2020 CPCT MDT format reviewed and to maintain. IPU MDT format revised and implemented in November 2020	100 % Complete

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP04	**Review suitability of staff support / clinical supervision/reflection mechanisms : consideration of Schwartz rounds**	To facilitate and enable clinical discussion relative to the care of dying patients and their families. To provide a safe forum to support emotions and stresses. To enhance understanding of the professional environment in order to support practice development. To develop the IPU's skill set in undertaking level 1 psycho-social support for patients and families. To reduce silo-working and facilitate inclusivity of all staff in shared learning	Staff protected time External facilitation Psycho-social lead training time	Its not compulsory Staff won't engage with the offer.	Staff and facilitator time Schwartz training and set up.	Caring Effective Well-led Responsive Safe	Clinical supervision for all staff remains ongoing. 100% compliance against plans affected by COVID Psycho-social training to up-skill IPU team to deliver level 1 psycho-social support. Pended post COVID. Educational Updates Schwartz rounds to be prepped for SLT Peer Support being delivered regularly	25% 75% Complete Incomplete

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP05		To ensure consistency of approach and delivery to service provision across 24 hours.	Consultation time for existing staff across day and nights with HR and Clinical Director	Staff will not engage with the process.	Current Staff Costs	Effective	Consultation complete.	
	Rotation of IPU staff across 24 hours					Caring	Implementation commenced January 2021.	
		Assurance of clinical competence via night staff coming on to days for 1 week every 4 months and accessing education, development and competency assessment.	Employment contract updates	Staff will leave.	Possible requirement for identified external training	Well-led		
						Responsive		
		To break down cultural barriers between day and night teams.		Potential for variability in skills and abilities across days and nights.		Safe	Aim to rotate nursing staff from the IPU into community 'for experience' from dtbc.	25% Incomplete, 75% Complete
		All newly recruited staff will have internal rotation across days and nights built into contract.					Incorporated into new recruitment contracts	
		To support the one team approach.					Implementation happening for both days and nights.	
		To ensure that staff across all shifts are accessing education and associated competencies.					Affected by COVID re staff sickness / furlough	
	Provide adequate competent staffing across days and nights	To ensure all staff are being developed and feel part of the wider team.		Staff retention / recruitment				
		Provide opportunity to rotate to Community Team for further development, .						

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP06	**To increase skill sets and support psycho-social service delivery across the MDT** **To ensure psycho-social support is both timely and accessible**	To ensure patients and families receive access to psycho-social support at the appropriate level and time. To optimise well-being for patients and families	Time to design and deliver the training Staffing Time Education	If not achieved : - Less than optimal service delivery to patient and families. Ineffective use of the Psychological Services Team	Time Staffing	Responsive Effective Caring Well-led	July 2020 – Training presentations prepared for staff across the MDT are: - • Psychological Assessment & Referral Criteria (patients and families) • Difference & Diversity (allowing a more sensitive approach to working with colleagues and patients/families) • The Psychology of Death & Dying (to enable Level 1 Psychosocial skills across the teams) To be incorporated into education program : timeline 2021/22 July 2020 : HCA team able to refer to Psychological Services Team August 2020 : Drop in clinic for staff to discuss psycho-social issues. Lead attended training Bereavement due to Covid-19 October 2020. Spiritual Care Lead now present on IPU and full list of local faith leaders to complement this aspect of the patient journey and family care. Extensive list and pathways established for onoward referrals within the statutory and non-statutory sectors.	100 % Complete

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP07	**Increase counselling support for post bereavement care**	To improve responsive access	Volunteer student counsellor recruitment and supervision	Reduced counselling provision by the Head of Psycho-social	N/A	Responsive Effective Caring Well-led	August – October 2020	100 % Complete
CAP08	**Increase establishment of Band 5 nurses on the IPU to facilitate secondment to other clinical departments to support staff development and a 'One Team' approach.**	To develop team of nurses with assurance of palliative care clinical skills. Increasing the establishment to allow flexibility to open more beds routinely in the longer term. Opportunity of secondment to other clinical services to enhance understanding of the wider palliative care practice	HR Recruitment Training Development	Difficulty in recruiting. Loss of momentum subject to recruitment	Cost of Band 5 nurse recruitment	Responsive Effective Caring Well-led	Advert for Band 5s and Band 6s in place for current vacancies.	25% 75% Complete Incomplete

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP09	**CNS Development posts**	For succession planning. To ensure we have replacements for future retirees or those leaving through natural attrition. To ensure the service can operate in the future. To ensure competencies and training allows for development nurses to progress to CNS level and work within all departments	HR Recruitment	Cost to organisation in terms of care delivery if not planned. This could be mitigated by Trust application funding.	Salary costs	Safe Effective Responsive Well-led	July 2020 – successful recruitment to 3 positions : band 7 & 2 band 6s..	100 % Complete
CAP10	**A standardised approach to clinical risk assessments and care planning**	To ensure our planning is individualised and documentation is supportive. Individualised care planning and risk assessment that is comprehensive	Time to train Staff engagement	Sub-standard communication and documentation that supports care delivered / planned. Lack of engagement	None	Safe Effective Caring Well-led Responsive	Audit of risk assessment planned for 2021/22 audit program. Under review - outcome March 2021	50% 50% Complete Incomplete

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP11	**Re-implementation, training and embedding of Outcome Assessment and Complexity Collaborative** (**OACC**)	To measure outcomes and gain feedback and consider KPIs through its use. Some departments using iPOS. All departments using the Australian-modified Karnofsky Performance Status scale & phase of illness. To integrate all aspects of the suite of measures into all 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	Safe Effective Responsive Caring Well- led	Key staff attendance at OACC training in February 2020 (TC,TY&JF). Project re-implementation task and finish group met in December 2020 Draft PoI / Karnofsky February 2021 Review and use of OACC suite of measures for 2021/22 audit program See 3.12 of CQ&G section of Management Plan	Complete Incomplete

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP12	**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	Well led Safe Effective Responsive Caring	2020/21 program to include basic and advanced communication skills training in June 2021 Training delivered to IPU and CPCT colleagues is around communication skills. Practice educators liaising with Steve M re IPU / H@H study day in March 2021	50% 50% Complete Incomplete
CAP13	**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.	Cost of implementation of Datix Time/resource	Safe Effective Responsive	Testing: July – September Training: March 2021 Full implementation – March/April 2021 See 3.13 of CQ&G section of Management Plan	25% 75% Complete Incomplete

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP14	**Systematic competency assurance process for both qualified and HCA nursing staff.**	To ensure a standardised approach to staff induction, support and development.	Continued education and engagement with competency work book.	Poor engagement of staff Less then optimal skill set for specialism across nursing staff Impact on patient care	Mentor time Education	Safe Caring Effective Well led Responsive	On-going annual – linked to appraisal	100 % Complete
CAP15	**To agree outstanding required clinical SOPs that will support the delivery of clinical services**	Practices supported by written procedure that facilitates training and reduces the likelihood of variation in practice.	Time	Variation in practice that is unsupported by agreed approach encapsulated in procedure	None	Safe Effective Responsive Well-led	Mar-21	50% 50% Complete Incomplete
CAP16	**To ensure there is participation in the planning and auditing of clinical practice across all clinical teams (IPU / Community / Psycho-social /Well-being) in line with the Hospice's Clinical Audit program.**	To support the assessment of practice against standards	Time Staff	Deficient assurance evidence	Resource	Safe Caring Effective Well led Responsive	As per clinical audit program for 2020/21 See 3.2 of CQ&G section of Management Plan	100 % Complete

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP17	**Provision of weekly Mortality meetings**	To provide a forum to discuss previous week's deaths from the IPU and highlight any learning	Time Planning	Reduces learning and organisational benefit	None	Well led Safe Effective Responsive Caring	Consultant and Ward Manager established in July 2020	100% Complete
CAP18	**Re-introduce IV therapy competencies**	To enable admissions where hospital setting is not suitable but patient has reversible conditions that would benefit from IV therapy	Time Planning Education	Service could be underutilised – large time involvement in up-skilling and maintaining skills	Training Back fill for training	Safe Effective Responsive	Under discussion Leads to be new consultant and educational team D&TC (11-Nov-20) decision to pend to 2021/22 plan	Complete Incomplete
CAP19	**To enable Band 6 RGNs & Band 7 CNSs to undertake DNAR conversations and completion of the DNAR documentation accordingly.**	Completion of DNACPR documentation in the community To ensure clinical staff are competent to undertake conversation and completion of documentation to support	Education Competency Assessment	Provision of a less than optimal end of life care service.	Resource Cost Time	Well led Safe Effective Responsive Caring	December 2020 for all willing community-cased Band 6 & 7 staff to be assessed as competent. Not a mandatory requirement Difficult to be 100% with staff as not mandated - regarded as 100%	100 % Complete

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP20	**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	Well led Safe Effective Responsive Caring	April 2021 for all Band 6 & 7 staff to be assessed as competent.	25% 75% Complete Incomplete
CAP21	**To take into account and demonstrate compliance with the NICE guidance NG31 Care of dying adults in the last days of life**	Statutory obligation to take NICE guidance into account. Evidence-based approach to the care of dying people supports best practice.	Education Audit Clinical leadership	Increased risk of delivering sub-optimal care if not adhered to	Resource	Well led Safe Effective Responsive Caring	Audit : NG31 audit included in Audit Program for 2020/21. July 2020 : IPU data collected. Community dataset constructed. Data collection for community arm to concluded in December 2020. Report to be	25% 75% Complete Incomplete

12th Meeting of the Clinical Quality and Governance Sub Committee

To be held remotely via Zoom

at 10.00am on 26th February 2020

Agenda

Chair : AC

Item	Description	Purpose[1]	Lead
1.	Apologies for absence	I	AM
2.	Terms of Reference Review	S	AM
3.	Minutes of the last meeting held on 30th October 2020	S	Chair
4.	Action List from previous meetings	I	Chair
5.	Recruitment / Staffing Verbal Update	I	RT
6.	Evidence of Excellent Practice Register	I	GL/RT/AR
7.	Clinical Risk Register	S	RT
8.	Corporate Risk Register	I	AM
9.	Clinical Quality & Governance Report	I	RT/AR
10.	CAP 2020/21 & plans for 2021/22	I	GL/RT/AR
11.	Minutes of Meetings & Other Documents Uploaded (att) • Infection Control – December 2020, February 2021 • Medical Business Meeting : February 2021 • Prescribers – January 2021 • Clinical HoDs – February 2021 • D&TC Meeting : October 2020 • CQC TMA KLOE February 2021 • Quality Account 2019/20 • VOICES Report to Sep 2019	I	GL/RT/ AR
12.	Dates of Future meetings	I	Chair

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

Terms of Reference for Clinical Quality & Governance Committee

St Raphael's Hospice

Scope of Committee remit

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

Committee membership and composition

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

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

Role and responsibilities of the Committee

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

Access

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

Committee Meetings

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

Reporting

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

Renewal

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

Date of last approval: March 2021. Date of next renewal: March 2024.

SAINT RAPHAEL'S HOSPICE

MINUTES OF THE 11TH MEETING OF THE

CLINICAL QUALITY AND GOVERNANCE SUB-COMMITTEE
held on Friday 30 October 2020 at 10.00am
Held at St Raphael's Hospice / by Zoom call

Members: Alan Cogbill (AC) – items 5-10
Dr Caroline Chill (CC)
Dr Joy Tweed (JT)

In attendance: Gail Linehan - Joint CEO (GL)
Alex Rudkin – Quality Development Manager (AR)
Dr Jenny Strawson – Consultant (JS)
Rebecca Trower – Clinical Director (RT)
Dr Gaby Tamura-Rose – Consultant (GT-R)
Miss Anna Machin – Clerk to Trustees (AM)

1. Welcome and apologies Committee members and colleagues were welcomed to the meeting by Dr Joy Tweed who Chaired this meeting. There were no apologies sent to the meeting. There were no declarations of interest in addition to those already on the register of interests.	
2 Minutes of the meeting on 21 August 2020. The minutes of the previous meeting were reviewed and approved as an accurate record of proceedings.	
3 Matters arising 3.1. The matters arising from the previous meeting were reviewed:	
• 04/01 – The Performance Management Policy is being finalised with Kelly Channer to ensure alignment with relevant Hospice policies and will be ready for presentation at next meeting.	11/01(GL)
• 04/08 - The Medical Revalidation Policy is almost finalised, and the Chaperone Policy has been drafted and shared with internal Heads of Department for review and to ensure reflects Hospice practice.	11/02(GL)
• 08/05 – The Education team would be asked to confirm the timeline for sharing training platform logins with Trustees. Trustee training would focus on the Safeguarding, Confidentiality and Information Governance modules. The Education team would also explore opportunities for Trustees to receive Level 3 training by Zoom through the Local Authority or CCG.	11/03(GL)
• 09/02 – Gail Linehan confirmed that a follow up call had been held with the complainant and a Subject Access Request received to obtain patient notes. A follow up call will be held during November.	
• 09/03 – The report on the Hospice's reflections on Covid-19 is subject to final amendments and corrections with a scene-setting introduction to be added. It will be presented at November Board meeting.	
• 09/07 – In terms of collaborative working with Care Homes, the Hospice's Community team maintains strong communications with end of life care teams and a recent meeting was helpful in clarifying processes to support GP referrals. The Hospice also intends to film a training session for Care Home staff as part of education and outreach delivery. The frequency of direct interface with Care	

Homes in past months has been more limited as their staff are primarily focused on internal delivery in current times.

- 10/01 – The review of adequacy of on-call support had been undertaken.
- 10/02 - Progress charts were now included within the Clinical Action Plan.

4 Recruitment/ staffing update

4.1. Gail Linehan provided a verbal update on recruitment and staffing. The Health Care Assistant and RGN vacancies are being advertised for the In-Patient Unit (IPU) and once filled, this team will be at establishment and ready to support a larger cohort of patients. There have been three new appointments in the Community and Palliative Care Team of two Band 6 trainee Clinical Nurse Specialists (CNS), and a Band 7 due to start in December. This means that this team is also at establishment.

4.2. There has been successful recruitment to Consultant team with the appointment of Dr Gaby Tamura-Rose and Dr Jenny Strawson. The third Consultant post will be re-advertised as full-time post (with part-time negotiable) to maximise the pool of potential applicants with interviews expected to be held in January. An agency Locum Consultant is being used in the meantime.

4.3. The Physician Associate is due to start end of November, a GPVTS will start shortly and it is hoped that an STR will join in January. The Wellbeing team will be expanded as planned to support development of the programme being brought together with aim of reopening Wellbeing activities in spring 2021. Ward Sister Pauline Morris will leave in mid-November after being in post for 21 years.

4.4. Gail Linehan confirmed with the Committee that Rebecca Trower had been appointed to the Clinical Director role following the recent interview process. This information is confidential within the Hospice at this present time. The Committee were delighted to welcome Rebecca to St Raphael's and recognised the importance of this role to the Hospice. The Committee reflected on the strength of team that was being built and the shared journey for staff as the Hospice transitioned to become an independent charity.

5 Clinical risk register

5.1. The Committee focused attention on the Red risks, which primarily related to challenges brought by the Covid-19 pandemic. Gail Linehan confirmed that the NHS Track and Trace app had been implemented within the Hospice however it is acknowledged that the effectiveness of this government scheme may be limited. The recommended policy to turn off contact tracing whilst wearing PPE had been adopted by the Hospice and a reminder would be clearly communicated to staff.

11/04(GL)

5.2. The Hospice has been preparing for the second wave which London is currently entering in to, with a range of mitigations in place to keep staff, volunteers and patients safe. The Covid-19 Policy is regularly updated to stay in line with current guidance. The Hospice recognises the risk to resilience in staffing levels if staff become unwell or are required to self-isolate. The Hospice leadership have liaised with Princess Alice Hospice with regards to providing reciprocal support in admissions and supporting patients if either organisation experiences a particular challenge with staffing levels.

5.3. Staff are set up to work from home, although it is important to find the right balance of staff being present in the Hospice as it is a service organisation. For example, the Psycho-Social team can work from home but it is important that they attend work in person wherever possible to provide psychological support to fellow colleagues. Assistance is being given to staff during the reintegration process and risk assessments are in place for all staff, which were recently re-issued to take into

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account the second wave for completion by 6th November. For staff in extremely clinically vulnerable groups, it can be more challenging to tailor roles but mitigations are put in place for these colleagues, or staff are able to take sick leave and then statutory sick pay. The Committee received assurance that flu vaccines had been offered to all staff.	
5.4. Gail Linehan confirmed that the Hospice's ability to secure PPE had been better than expected. The Hospice continues to participate in the Greenwich & Bexley Hospice pallet push and contact details have been obtained for two other sources. The Clinical team have been prioritised for use of certain PPE items such as fluid-resistant masks. This means that the Hospice is able to maintain a rolling two weeks' supply. The Hospice has also purchased 15-minute testing sets which will enable staff to return to work as quickly as possible. On this basis the Committee agreed that the residual risk on the risk register would be lowered, but that it would remain a key focus for the team and Committee oversight.	11/05(GL)
5.5. Rebecca Trower highlighted the risk that should night duty staff need to isolate, the team would have very limited capacity. To address this there is a consultation being put in place to move to internal rotation whereby one week per quarter, day and night staff would work on the opposite shift to achieve more flexibility in the team. There is also the option to use agency staff if required although they often do not bring prior experience of working in the specialist Hospice setting. It is harder to recruit Bank staff on night shifts. It was agreed that this would be maintained as an Amber risk and an update given at the next meeting.	11/06(RT)
6 Clinical Quality and Governance Report	
6.1. Becca Trower presented the report and updated on the organisational response to the Covid-19 pandemic. The main change since the last Committee meeting is that London has been moved to Tier 2 reflecting increased cases in the local area. Staff continue to be vigilant day to day, and practice educators are providing up to date training and this has been a strength of the Hospice's response. A local charity provided scrubs and gowns to Hospice, which are also used out in community. The Hospice has continued to implement visiting restrictions and the community team's in-person visits are now delivered by exception, with support primarily provided remotely. Redecoration is supporting improvements in the Hospice environment and the refresh of the IPU is also planned. The Hospice will be moving to a bed capacity of eight patients on Monday 2nd November.	
6.2. Alex Rudkin presented quality metrics data, confirming that incident numbers remain relatively low. No request for mini-MDS data from Hospice UK has been received this year so far – but the Capacity Tracker is being completed on daily basis. The team are nearly at end of testing for Datix project and then will implement training which will be embedded in the Hospice's Education programme. Data Audit projects are underway to broaden engagement with data within the Medical team and the 2021 programme is being planned.	
6.3. Alex Rudkin confirmed that the Quality Account Report would be circulated to the Committee in November for comment prior to submission. The Key Lines of Enquiry Self-Assessment documents are being used by an expanded internal Working Party – this will support the Hospice's evidence base to achieve strong CQC inspection rating. It was agreed that examples of Excellence would be brought to the next meeting as part of a discussion on the evidence base. The Hospice also recently undertook the Voices Survey to understand experiences of patients' relatives six months post-bereavement. The report would be shared with the Committee once completed.	11/07(AR) 11/08(GL, RT, AR) 11/09(AR)

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6.4. The Committee noted that the patient survey showed strong patient satisfaction on IPU at 96%+. Committee members asked how the approach to data review was being embedded in the Hospice. Alex Rudkin confirmed that Data Dashboards have been useful in informing discussions and decision-making, for example to analyse trends in referral numbers which are primarily made electronically through the NHS system. Data analysis also helps to ensure consistency in record-keeping. To ensure liaison and buy-in from colleagues, the Clinical Audit & Activity Data meetings will re-start in November. Work is being done to ensure that the data input process is user-friendly for staff to minimise deterrents particularly when the Clinical team are under time pressures. The Committee suggested that ensuring continued communications to staff around the value of data to drive improvement, and positive stories from the data such as patient satisfaction, would further support this buy-in. 6.5. In terms of Clinical Risk Management data, Alex Rudkin confirmed that there were no areas of concern to report at this time. Two complaints had been added to Complaints Log – both were handled by Becca Trower in line with Hospice process and were now closed. 6.6. The Committee asked for further details on the complaint about the pain management process and actions taken by the Hospice team as a result. Becca Trower confirmed that the complaint had prompted a review of the pain scoring process, and a questionnaire had been sent to staff in follow up to understand how pain scoring was bring approached. It is likely that it will lead to a new approach and tool for pain assessment. The mother had been communicated with on several occasions and reassured that the complaint would be used to make a difference to Hospice practice. The Committee suggested that this process be captured as an example of 'closing the loop' and driving quality improvement. The Committee also asked to be updated at the next meeting on how a new approach to pain scoring was being embedded. 6.7. The Committee thanked the team for the update and noted the visible improvements in the Hospice's approach to capturing and analysing data.	11/10(AR, RT)
7 CAP & Management Plan extract 7.1. The Committee noted that the Completion Rates had been added to the report as an action arising from the previous meeting. The Committee received assurance that actions were generally on track to be completed for planned timelines. The planning cycle for the 2021/22 Clinical Action Plan would commence in spring 2021. The Committee requested that detail on the operational oversight of the plan by the Executive team and Clinical Heads of Department be added to the Introduction.	11/11(AR)
8 Minutes of internal meetings (D&TC June 2020; Infection Control June 2020; Quality Improvement Committee June 2020; Consultants September 2020; Prescribers October 2020; Clinical HoDs October 2020) 8.1. The Committee noted the minutes of internal meetings.	
9 Any Other Business 9.1. Dr Gaby Tamura-Rose and Dr Jenny Strawson were thanked for attending and invited by the Committee to contribute reflections on their initial time at Hospice. Gaby updated that a main focus had been working with the Community team and planning close working with the Education and Data teams. She had been working on Tuesday mornings at St Helier Hospital which had been beneficial in providing continuity in handover of patients. The team had been very welcoming, and the Community team being fully staffed in the current environment particularly when CNS role are difficult to recruit to is a real positive.	

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9.2. Jenny confirmed the friendly and respectful culture in the Hospice, which also enables ideas for improvements to be raised. The care provided on the IPU ward is excellent. Going forwards a key priority is to embed more innovative roles such as the Physician and Nursing Associates, GP trainees and Registrars which will build culture of Education – for example to provide training for local GPs, and micro-training within the internal team to ensure consistent knowledge. 9.3. The Committee thanked Gaby and Jenny for their insights and positive reflections on culture and quality of care and invited them to attend future Committee meetings on a regular basis.	
10 Next meeting The dates of the next meeting in 2021 would be confirmed by email.	11/12(AM)
The meeting finished at 11.45am.	

Approved…………………………………..

Date………………………………………..

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CLIN54 Medical Revalidation Policy

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1.0 Introduction

1.1 St Raphael's Hospice is committed to maintaining the highest possible standards of patient care and safety. This requires sustained commitment to all aspects of clinical governance and strict attention to detail within clinical staff recruitment and performance review processes.

1.2 Revalidation of doctors is the process by which the General Medical Council (GMC) confirms the continuation of a doctor's license to practice in the UK (see Appendix 1 for the GMC revalidation model).

1.3 The purpose of revalidation is to assure patients and the public, employees and other healthcare professionals that licensed doctors are up to date and fit to practice.

1.4 Annual appraisals provide the basis upon which revalidation recommendations are made and more details on the purpose and relevance of medical appraisal can be found in Appendix 2

2.0 Aim

2.1 This policy sets out the manner in which the hospice will fulfil all the requirements of a Designated Body, as defined by the GMC and NHS England.

3.0 Related Policy

- CLIN04 Clinical Governance Strategy
- Clinical Supervision Policy
- OP05 Complaints Policy
- OP06 Protecting Confidential Information Policy
- OP09 Data Protection Policy - Subject Data Access
- HR04 Disciplinary Procedure
- HR03 Raising Concerns - Freedom to Speak Up Policy
- OP01 Unexpected Incident & Near Miss Reporting Policy
- IT08 Information Governance Policy
- IT11 Information Security Policy
- HR11 Occupational Health Policy

4.0 Definitions

Designated Body (DB)- an organisation that employs or contracts it's doctors and is designated in The Medical Profession (Responsible Officer) Regulations 2010.

Prescribed Connection- the formal link between a doctor and their designated body. It is the route by which doctors are able to find their prescribed connection. For doctors working in more than one DB, their prescribed connection is with the organisation where the greatest proportion of their working hours are affiliated.

Responsible Officer- all DBs are required to appoint a Responsible Officer (RO), who are commonly Medical Directors. The RO is responsible for making recommendations for revalidation to the GMC.

5.0 Scope

5.1 This policy outlines the requirements and arrangements for appointing a Responsible Officer, recruitment of medical staff, and conducting the appraisal and revalidation of medical staff working for or at the hospice, as required by the General Medical Council (GMC) and other relevant bodies. In addition, it also covers the process for responding to concerns about medical practice at the hospice.

5.2 The policy itself is not meant to be exhaustive and does not contain all relevant information relating to the duties of the Responsible Officer and

mechanisms for recruitment, appraisal and revalidation. It does, however, identify the key requirements and processes involved.

5.3 Further relevant information will be made accessible via appendices to this policy, and references to other relevant documents and/or websites.

5.4 Strengthened appraisal is a tool to support a decision to revalidate a doctor. Whilst serious concerns about a doctor may be identified during an appraisal, the identification and management of serious concerns about individual doctors remains the function of governance processes outside of appraisal.

6.0 Key Points

Background

6.1 The Medical Profession (Responsible Officers) Regulations 2013 states that all organisations considered to be designated bodies under these regulations (which includes the hospice) should have a Responsible Officer (RO) in place OR formally arrange to link with an RO from another organisation.

6.2 The RO of a designated body is responsible for making recommendations on doctors' fitness to practise every 5 years to the GMC as part of the revalidation process.

6.3 St Raphael's Hospice is currently accessing external RO services from St Helier hospital NHS Trust (SHH) via a Service Level Agreement, which commenced on 31.09.2019 and is reviewed annually.

The named Responsible Officer providing these services via the agreement is **Dr Stephen Hyer**, Responsible Officer at SHH, (contact email address: steve.hyer@nhs.net).

6.4 If a need arises for a change in Responsible Officer this must be agreed at board level and notice given to NHS England and the GMC.

Prescribed Connections to the Designated Body

6.5 All doctors working at St Raphael's Hospice (whether in training, locum or substantive roles) must relate to a defined designated medical body and the hospice RO must maintain a record of this and ensure appropriate information flows to support medical governance and the RO statutory function:-

6.5.1 Any hospice consultant in Palliative Medicine who holds an employment contract with a local acute NHS Trust will relate to that trust as their designated body. Therefore, annual medical appraisals to support revalidation will take place within that acute trust. However,

because they hold practising privileges at the hospice for the majority of their working hours, there will need to be close liaison between the hospice Clinical Director, the hospice RO (currently the St Helier RO) and the Clinical Directors, Medical Directors and ROs at these trusts in order to ensure that a fully informed appraisal process is followed and any concerns raised are shared in an appropriate manner.

6.5.2 All consultants or specialty doctors employed directly by the hospice will relate to the hospice as their designated body.

6.5.3 The doctors working at the hospice as (ST) trainees on the local GP Vocational Training Scheme and Specialist Trainees on the Palliative Medicine Specialty Training Rotation will relate to South Thames Postgraduate Medical Education (Health Education London).

6.5.4 If any locum appointment is agreed at the hospice the designated body for this individual will be agreed prior to the appointment being confirmed.

Appraisals

6.6 Appraisal for revalidation will be based on the principles of Good Medical Practice (GMP) (See GMC Good Medical Practice – A Framework for Revalidation for appraisal: www.gmc-uk.org/doctors/revalidation.asp)

6.7 Appraisal is based on 4 domains of GMP :-

6.7.1 Knowledge, skills and performance

6.7.2 Safety and quality

6.7.3 Communication, partnership and teamwork

6.7.4 Maintaining trust

6.8 Each domain has 3 attributes. It is expected that a doctor would demonstrate evidence of good practice against each attribute during the 5year cycle of revalidation.

6.9 Appraisal should be based on a doctors' whole scope of practice. This would include any academic, voluntary, private or educational activity.

6.10 Production of supporting evidence is key to successful sign off of appraisals.

6.11 Doctors working at the hospice in training posts are not required to have appraisals (as defined within this policy), but the hospice senior medical staff will ensure that all the necessary educational and clinical supervision is

provided to allow them to complete the requirements of their respective e-portfolios and Annual Reviews of Competence Progression (ARCPs).

6.12 All doctors in non-training grade posts will have annual appraisals carried out in a manner which will support all the requirements for revalidation:

6.12.1 A suitably trained appraiser will be agreed to carry out the appraisal.

6.12.2 At least 2 different appraisers will be involved in appraising any individual doctor within a 5-year revalidation cycle.

6.12.3 The electronic appraisal system SARD will be used for the appraisal.

6.12.4 Within a 5-year revalidation cycle the doctor concerned will provide at least 1 multi-source feedback (MSF) report from colleagues, and 1 from patients. A MSF report from patients should include a minimum of 10 responses.

6.12.5 The agreed required supporting information will be prepared by the doctor concerned and sent to the appraiser before the appraisal interview.

6.12.6 Appropriate time/privacy will be agreed for the appraisal interview.

6.12.7 The appraisal should cover the entire scope of practice of the appraisee and should include issues relating to their performance in between appraisals which the RO or Clinical Director has requested to be included.

6.12.8 In addition to the trained appraisers employed by SRH, access to an adequate source of appropriately trained appraisers from SHH is available to the hospice. SRH appraisers will keep up to date via refresher training from SHH every two years, and be available to appraise SHH consultants if needed.

6.12.9 The finalised electronic documentation of the appraisal with its Outputs will be submitted to the RO within 28 days of the appraisal via the SARD system.

The Role of the RO

6.13 The RO for the hospice is responsible for reviewing the summaries relating to the relevant 5-year revalidation cycle, along with other clinical governance data and records of any concerns raised, prior to completion of the revalidation recommendation required by the GMC.

6.14 Recommendation for revalidation will be made in consultation with the Clinical Director at St Raphael's hospice, in a timely fashion.

6.15 The RO for the hospice will also undergo annual appraisals as agreed with NHS England (South) in line with the national recommendations for such

appraisals. Revalidation recommendations for the RO will then be made by the Higher Responsible Officer for NHS England (South).

Governance

6.16 Appropriate employment checks will be made in accordance with the St Raphael's Hospice Recruitment Policy and Procedure for all newly appointed doctors (including locums), and all incoming doctors in training.

6.17 Should any concern be raised within the hospice regarding the performance or fitness to practise of any doctor this will be notified to the supervising senior clinician for that doctor who will escalate to the Clinical Director in order that appropriate measures can be instigated as soon as the concern is identified. In some cases, this might involve carrying out an investigation, contacting the GMC or contacting the South Thames Education team. The Clinical Director will ensure that the RO is informed **(see Appendices 3 and 4)**.

6.18 Following the relevant reporting and review of any concerns an action plan will be agreed for further investigation followed by any appropriate support and/or further training for the doctor/s concerned **(see Appendix 4)**.

6.19 Supporting information can only be accessed by the appraisee, appraiser and the Responsible Officer or their deputy (includes Revalidation administrator). This information must not include any patient identifiable information. The appraisal discussion is confidential to the appraisee and the appraiser, except by prior agreement. The Summary of Appraisal Discussion (Output) and the Personal Development Plan are shared with the Medical Directors Revalidation Team. These documents may be shared with another organisation with the agreement of the appraisee. This may occur when an employee works for more than one organisation or moves to another organisation. All information on revalidation and appraisal will be held electronically on the e-portfolio system which complies with data protection and GDPR regulations.

6.20 Complaints about the appraisal process and conflict between appraisers and appraisees must be made in writing to the RO.

7.0 Responsibility / Accountability

7.1 The hospice is required to have a Responsible Officer (RO) in place and to make available all necessary resources to support the RO in their role. The overall responsibility for this lies with the Joint Chief Executive Officers, who report to the Board of Trustees.

7.2 The RO must attend all necessary training required for the fulfilment of this role, and remain cognisant of all relevant legislation and guidance related to revalidation.

7.3 The RO will be supported by the GMC Employment Liaison Service and will have a named Employment Liaison Advisor from this service available to offer support and

guidance in relation to the revalidation process and performance issues relating to doctors at the hospice. This advisor will meet with the RO at least once a year for a formal review of these issues.

7.4 The Clinical Director and RO will work together to ensure that the necessary regular reporting on appraisals and revalidation recommendations are completed for the hospice within the timelines laid down by NHS England.

7.5 The Clinical Director and the RO will take part in any mandatory reviews such as the Higher Level Responsible Officer reviews carried about by the NHS revalidation team.

7.6 The Clinical Director and RO must ensure that an adequate source of appraisers is maintained to support this policy.

7.7 Via liaison with the relevant senior colleagues at the hospice, the Clinical Director and RO must ensure that adequate data collection, quality and practice improvement and clinical audit measures are in place, along with all other relevant clinical governance procedures; to support the completion of an approved appraisal process for doctors at the hospice.

7.8 Each individual doctor working at the hospice has a responsibility to be aware of their designated body, of this policy and the relevant process defined for appraisal within their designated body.

7.9 Each individual doctor working at the hospice is responsible for preparing adequately for an agreed appraisal and must give appropriate notice of any reason why such an appraisal should be postponed or cancelled.

7.10 Every doctor whose appraisal is organised by the hospice will be expected to provide feedback regarding the quality of the appraisal process via the SARD appraisal system.

8.0 Statutory Requirements References

- https://www.england.nhs.uk/medical-revalidation/ https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation
- http://www.legislation.gov.uk/uksi/2013/391/made
- https://apmonline.org/wp-content/uploads/2017/08/Appraisal-Metrics-for-Consultants-and-SSAS-Doctors-in-Specialist-Palliative-Care-March-2017.pdf

9.0 Education and Training

9.1 SRH and SHH appraisers shall complete initial training with a 2 yearly refresher.

9.2 Appraisees shall remain up to date with professional guidance as set out by the GMC.

10.0 Policy Monitoring and Review

10.1 Appraisal and Revalidation issues will be a regular agenda item at the Quality Improvement Committee.

10.2 Updates on issues relating to appraisal and revalidation will be given by the Clinical Director, via the Clinical Quality and Governance report to the meetings of the hospice Clinical Quality and Governance Sub-committee which, in turn, reports to the hospice Board of Trustees.

10.3 An Annual Organisational Audit will be completed by the medical appraisal lead at SHH, on behalf of the RO, and submitted to NHS England as required by the Quality Assurance Framework.

10.4 An Annual Board Report will be provided by the medical appraisal lead, on behalf of the RO, for submission to the hospice Board of Trustees, following which the chair of Trustees will ensure that a Statement of Compliance is signed and submitted to the Higher Level RO as also required by the Quality Assurance Framework.

10.5 The hospice may be required to cooperate with some form of independent verification of the status of their revalidation systems via a review process determined by the Higher-Level Responsible Officer's team: this is likely to be carried out once per revalidation cycle for each designated body.

APPENDIX 1 – Purpose and Relevance of Medical Appraisal

Purpose

Appraisal is relevant to the **individual** in terms of:

- integral part of medical revalidation process
- providing an opportunity for self-reflection
- providing personal and professional support with a colleague
- providing an opportunity to explore priorities
- providing a way of assessing and planning development needs to improve professional practice
- providing a way of giving feedback to the Trust about the resources and training needed to maintain and improve the service provided to patients
- the alignment of personal, divisional and team objectives with the service need

Medical appraisal is relevant to the hospice in terms of:

- enabling the Responsible Officer to confidently recommend clinicians for revalidation
- ensuring medical staff are equipped with all the skills for their role
- maintaining and improving the quality of patient experience
- identify developmental needs of staff
- complying with the Care Quality Commission and NHLS Litigation Authority Standards

helping to strengthen standards of Patient Safety through links with Clinical Governance

APPENDIX 2 - GMC Revalidation Model

Recommendations for Revalidation
The RO is responsible for making a recommendation to the General Medical Council on or before a doctor's revalidation date.
There are 3 possible recommendations:

1) A positive recommendation

This is based on an enhanced appraisal, conducted according to the principles of Good Medical Practice, accompanied by sufficient evidence including 360 colleague feedback and patient feedback.
The RO will also take into consideration any evidence from other information feeds about a doctor's involvement in:

- Serious Incidents
- Concerns raised about the doctor through the Trust policy for managing capability concerns in doctors and dentists
- Complaints made about the doctor via the complaints department
- Formal litigation against a doctor
- Issues highlighted from Heads of Division or Lead Doctors
- Referrals to General Medical Council

Please note the above are part of the decision made by the Medical Director. Involvement in any of the above do not necessarily mean that a positive recommendation of revalidation cannot be made.
Evidence must include:

- Continuing professional development
- Quality improvement activity
- Significant events
- Feedback from colleagues
- Feedback from patients
- Review and reflection of Complaints and Compliments

2) A deferral request

A deferral request is made by the Responsible Officer to the GMC to provide more time in which to submit a recommendation.
Deferral requests apply to doctors who are:
a) Engaged in the systems and processes that support revalidation but about whom there is incomplete information on which to base a positive recommendation.

b) Participating in an ongoing HR or disciplinary process, the outcome of which the Responsible Officer will have to consider prior to making a recommendation

Deferral can be made for up to 12 months.
Examples of reasonable circumstances that could account for a doctor having incomplete supporting information might include
o Maternity leave

- Sabbatical
- Sick leave
- Period of practice outside UK

3) A non-engagement notification

Notification of non-engagement in revalidation is made by the Responsible Officer when a doctor does not participate in the local processes and systems that support revalidation on an on-going basis.
The Responsible Officer can inform the GMC of non-engagement at any point in the revalidation cycle. The GMC will then remind the Doctor that they are obliged to participate in processes which support revalidation in order to maintain their licence to practice.
If the Doctor does not begin to engage the GMC can bring forward the issue of notice which will bring forward their revalidation submission date.
Note: Non-engagement is not a mechanism through which concerns about doctor's fitness to practice should be raised with the GMC.
If an appraiser has concerns about evidence presented this should be raised with the Medical Director Revalidation Team (the Medical Director or the Associate Medical Director for Revalidation at SHH).
It is anticipated that most doctors will revalidate without problem, however engagement with the enhanced appraisal process is mandatory.

APPENDIX 3 – Process for Identifying and Reporting Concerns

This document outlines the process for identifying and reporting concerns regarding the performance and/or fitness to practice of doctors working at the hospice.

Methods by which concerns may be raised:

- Whistleblowing.
- Critical incident reviews.
- Complaints.
- Routine reviews of clinical data / quality metrics / incident reporting / clinical audits.
- Routine supervision meetings and updating of e-portfolios for training-grade doctors.
- Medical Appraisals for non-training-grade doctors.
- Hospice Individual Performance Reviews for non-training-grade doctors undergoing their appraisal process external to the hospice.
- All concerns raised will be reported to the Clinical Director of the hospice who will escalate concerns to the RO for the hospice as appropriate. If a concern should be raised regarding the Clinical Director this will be reported directly to the Chief Executive of the hospice, who will then determine the need for any further investigation in consultation with the clinical trustees of the hospice and, where appropriate, with the assistance of the RO for the hospice. Where concerns are serious the higher-level RO must also be informed.

Process for agreeing a need for investigation and/or further reporting of these concerns:

1. The severity of the concerns raised will be assessed by the Clinical Director on behalf of St Raphael's Hospice as the Designated Body, following the latest NHS England guidance, in collaboration with any other member of the Senior Medical Team involved in identifying and/or reporting the concerns. The Clinical Director will then discuss with the RO.
2. This assessment will result in a decision about whether or not a further investigation is required.
3. Concerns raised will fall into any or all of 3 categories:
a. Conduct.
b. Capability.
c. Health.
4. If there are conduct and/or capability issues raised which indicate any risk to patient safety it will be necessary to inform the General Medical Council (GMC). If there is doubt about the need for this, contact will be made with the local GMC Employment Liaison Officer in order to clarify the position.
5. Any criminal matters will be referred to the police in parallel with regulatory action via the GMC and internal investigation.
6. If the concern relates to a doctor working at the hospice in a training grade post it will be shared with the Responsible Officer Postgraduate Medical Education at the earliest possible opportunity.
7. If an internal investigation is considered necessary, the format of such an investigation will be determined by the Clinical Director and Responsible Officer in consultation with the hospice HR department and an appropriate individual identified to take this forward.
8. Confidentiality should be maintained throughout this process as far as it is practicable to do so.
9. In the event of a possible conflict of interest or appearance of bias impacting on this process (clearly possible due to the limited size of the medical team at the hospice), an investigating officer may be recruited from UHB. All such investigations will follow national guidance and involve an external trained Case Investigator and Manager if required, sourced from SHH or other local acute Trust as deemed appropriate.

Investigations will be comprehensively documented and necessary information will be shared with the hospice Board of Trustees.

References:

- https://www.england.nhs.uk/medical-revalidation/ro/resp-con/

APPENDIX 4 – Process for Responding to Concerns

Following the acknowledgement of any concerns raised regarding the performance and/or fitness to practise of any doctor working at the hospice, action will be taken to ensure on-going patient safety, all necessary investigations will be carried out and appropriate support will be offered to doctors subsequently identified as being in difficulty.
The hospice will maintain an open and transparent culture of identifying and reporting all actual and potential risks, errors and incidents in all clinical areas and among all disciplines in order to support these principles and processes.

Key principles to be adhered to in responding to concerns:

- Safety and confidentiality of patients must be held to be paramount.
- Confidentiality for the doctor concerned should be maintained as far as possible, with information passed only on a 'need to know' basis.
- Clear separation must be made between contractual and performance issues.
- Processes followed must be fair, transparent and equitable, with all decisions based on objective evidence, in order that, if challenged, would stand up to further scrutiny, including a legal challenge.
- The action taken in response to concerns should be proportionate to the level of concern, considering: the need for supervision of the doctor; the doctor's development and personal needs and the need to place limits on the scope of work of the doctor.
- No discrimination must occur and equality and diversity must be supported.
- The relevant practitioner must be supported and kept informed throughout.

Initial process to be followed in response to concerns:

1. As referred to in Appendix 1 any need for immediate reporting to external agencies will be identified as quickly as possible and, if necessary, may result in suspension of the doctor concerned. Advice on exclusion will be sought from the GMC and/or NCAS (National Clinical Assessment Service) as deemed necessary.
2. Any further remedial action required within the hospice to ensure patient safety will be initiated immediately by the Clinical Director informing the hospice RO.
3. The report from any internal investigation instigated will be submitted for review by a Clinical Performance Panel comprising the Clinical Director and another member of the hospice Executive team and HR.
4. Following this initial investigation/assessment any health matters identified will be referred to Occupational Health and/or any other relevant medical service.
5. If further formal investigation is considered necessary then a suitably qualified case investigator will be appointed – via liaison with SHH or Practitioner Performance Advice (PPA, formerly the National Clinical Assessment Service), a service delivered by NHS Resolution to provide expertise to the NHS on resolving concerns. The terms of reference for such an investigation will be drawn up by the Clinical Director in consultation with the Responsible Officer and the doctor concerned, and the appropriate next steps identified on the basis of all the information available at that time.
6. Following completion of the formal investigation, the case investigator will provide a report for the Clinical Performance Panel, who will then determine what further action is required.

Actions to be considered following clarification of/investigation into concerns:

1. Should the investigation bring to light any systemic issues within St Raphael's Hospice that may have contributed to the concerns identified, these will be referred to the hospice Executive Team.
2. Conduct and/or capability issues relating to a doctor in a training grade post will be discussed with the Postgraduate Education team and a course of action agreed jointly between the hospice and the team.
3. Conduct and/or capability issues relating to a non-training grade doctor with practising privileges at the hospice, but under contract elsewhere, will be discussed with the Responsible Officer (RO) for the employing designated body and a course of action agreed jointly between the hospice RO and that designated body.
4. Conduct and/or capability issues relating to a non-training grade doctor under contract to the hospice will be reviewed by the hospice RO and a course of action determined.
5. If deemed necessary, advice will be sought from PPA to determine the appropriate course of action.
6. This course of action will then be clearly documented, agreed with the doctor concerned and any external agencies required/requested to support the course of action.

7. Every effort will be made to ensure that early signs of concern regarding a doctor's performance are identified promptly and responded to effectively, in order to minimise the need for formal disciplinary or regulatory action and facilitate an early return to optimal performance in the doctor concerned.
8. The hospice will maintain registration and/or contact with all relevant external agencies and local NHS organisations that may be required to support the actions that may be deemed necessary.

Provision of remediation and support for doctors with established 'fitness to practise' or 'fitness for role' concerns:
1. Given the relatively small size of the hospice as an organisation it must be recognised that the resources available to support any programme of remediation and support for a doctor in difficulty will be limited, and referral to other agencies may be needed.
2. Any programme of remediation will necessarily be informed by any formal restrictions on practice arising out of referral to, and subsequent investigation by, the GMC. However, if these restrictions are of a nature, in substance or duration, to result in the doctor being unable to meet a significant portion of the job description for their post, then the contract of employment may be terminated.
3. The decision whether or not to support a doctor with a programme of remediation will be decided by the Clinical Performance Panel and will consider the cost of remediation and availability of suitable resources. Where external resources are required for remediation some financial support may be made available at the discretion of the hospice, but the majority of any such expenses will need to be met by the doctor concerned.
4. If remediation is viewed as not affordable or in the best interests of the hospice, consideration will be given to terminating the doctor's contract in accordance with employment policies and law.
5. Remediation may include:
a. Occupational Health referral (if not already initiated).
b. Specific training.
c. Provision of opportunities to develop experience.
d. Supervised practice.
e. Mentoring.
f. Specialist interventions.
g. Behavioural coaching.
h. Amendment/restriction of aspects of scope of work.
6. Progress with an agreed programme of remediation will be monitored by the medical director and where clinical exclusion or agreed absence has been involved, a strategy for return to work will be formulated.

References:

 "Staying on course – supporting doctors in difficulty through early and effective action" (NHS Employers, June 2012).
 "Handling concerns about a practitioner's health – a guide for managers" (NCAS, January 2011).
 "The Back on Track framework for further training; restoring practitioners to safe and valued practice" (NCAS, December 2010).
 "Handling concerns about the performance of healthcare professionals: principles of good practice" (Department of Health, October 2006).

CLIN56 Chaperone Policy

1.0 Introduction

St Raphael's Hospice is committed to providing a safe, comfortable environment where patients and staff can be confident that best practice is being followed at all times and the safety of everyone is of paramount importance.

This Chaperone Policy sets out guidance for the use of chaperones during procedures undertaken at clinical consultation, examination, investigation and intervention, particularly in relation to intimate procedures.

The Chaperone Policy is clearly advertised through the Hospice website and can be accessed at the Hospice upon request. The availability of chaperones, if required by the patient, is clearly displayed in the Hospice Out-patient examination rooms and Inpatient rooms.

All patients are entitled to have a chaperone present for any consultation, examination or procedure where they consider one is required. The healthcare professional may also require a chaperone to be present for certain consultations.

2.0 What is a Chaperone

2.1 There is no common definition of a chaperone and their role varies considerably depending on the needs of the patient, the healthcare professional and the examination being carried out.

2.2 The chaperone may be a family member or friend, but there are situations where a formal chaperone, for example a nurse or other clinical member of the team, may be preferred.

2.3 Their role can be considered in any of the following areas:

- Emotional comfort and reassurance to patients
- Assist in examination
- Assist in undressing
- Act as an interpreter
- Protection to the healthcare professional against allegations/attack

2.4 Click here to link to the latest GMC guidelines for intimate examinations

2.5 Appendix A – Guidelines for Chaperones provides a Guideline for Chaperones which is aimed at staff members who may be called upon to undertake this function.

3.0 Checklist for consultations involving intimate examinations

3.1 The Clinician must establish the need for a chaperone before examining a patient.

3.2 Always offer a chaperone if the examination can be considered ‘intimate’. **This is irrespective of the gender of the clinician.** Clinicians are at increased risk of actions being misconstrued or misrepresented if an intimate examination is conducted where no other person is present.

3.3 Family, friends or partners may not be suitable chaperones as they must have nothing to gain by mispresenting the facts and chaperones should be familiar with the procedures involved in an intimate examination. Chaperones will predominantly be clinical members of staff in the hospice setting.

3.4 If a chaperone is necessary and not available then the clinician should arrange a follow up appointment. Rarely would an intimate examination be that clinically urgent within a hospice care setting that it could not wait until another day.

3.5 Obtain appropriate valid consent for examination and document in the patient record.

3.6 If a chaperone has been present, record that fact and the identity of the chaperone in the patient’s electronic record.

3.7 The chaperone should be introduced to the patient and remain present throughout the examination, be on the same side of the curtain as the patient and should remain in the room until the patient has got dressed. Explain to the patient what the examination involves whilst the chaperone is present.

3.8 **Clinicians or chaperones should not** assist the patient with undressing unless they have clarified that their assistance is required. Keep the patient covered up as much as possible to maintain their dignity.

3.9 The clinician should explain what they are doing at each stage of the examination, and be mindful of the patient’s privacy and dignity.

3.10 The chaperone should be sensitive and respectful of the patient’s dignity and confidentiality and be prepared to reassure the patient if they show signs of distress or discomfort and alert the clinician if the clinician is not aware.

3.11 The chaperone **must** be prepared to raise concerns about a clinician if misconduct occurs and raise this immediately with the appropriate clinician.

3.12 Both clinician and chaperone should record all relevant issues and any concerns immediately following the consultation.

Appendix A – Guidelines for Chaperones

1. These guidelines should be read in conjunction with the Chaperone Policy. They are intended as an information resource for staff who may be asked to become chaperones, either on a casual (one-off) basis or as a routine role.

2. All examinations will place patients in a situation in which they may feel uncomfortable, and this may be compounded further by the need to undress, consent to intimate touching or intrusive examination. The presence of a third party may alleviate some of these concerns and provide protection for both patient and clinician.

3. Where a chaperone is not routinely provided, patients must be aware that they are able to ask for one without feeling difficult.

4. It is often not known prior to an examination commencing whether a chaperone will be desirable. Often, staff may be called upon to undertake this role without prior warning. It is essential therefore that chaperones are familiar with what is expected of them in carrying this out, and understand the support aspects of the role for the patient.

5. Ideally, the clinician will have explained the nature of the examination, the reasons for it, what is involved prior to it commencing and will have given the patient the opportunity to have a chaperone present. Alternatively, the clinician may themselves have elected to have a chaperone present for their own security. Either way, it is important for at least one of the persons present that the third party is also there.

Role

1. This will vary a great deal, and may be passive (simply a presence in the room) or active (assisting with patient preparation or the procedure itself). It may involve:

- Providing patient reassurance
- Helping the patient to undress or prepare, or helping with clothing or covers
- Assisting with procedures (if a nurse or healthcare assistant)
- Helping with instruments (if a nurse or healthcare assistant)
- Witnessing a procedure
- Providing a supportive presence for a clinician
- Being able to identify unusual or unacceptable behaviour relating to a procedure or the consultation
- Being able to identify whether the implied or implicit consent given at the start of the procedure remains valid throughout, and determine whether the attitude of the patient or the clinician has changed

2. It is essential that the chaperone thoroughly understands what is expected from them, not only what the Hospice / the Healthcare professional may expect, but also what a patient may reasonably expect by virtue of their presence.

3. In the Hospice setting, clinical staff (Dr/RGN/HCA) are the group identified to undertake the chaperone role, as they would be able to interpret the procedure / examination, and form a judgement as to whether the actions are appropriate to the investigation or not. This is a fundamental part of the ability to reassure the patient.

4. The chaperone should bear in mind that the patient may decline their presence (as an individual) whilst still requiring a chaperone generally. This is within the rights of the patient and should be considered as usual, and not a personal slight on the chaperone's abilities.

5. The use of "informal", casual or one-off chaperones drawn from the non- clinical staff is discouraged.

Competencies

1. The chaperone should be comfortable in their role across a range of examination types, and if they do not feel confident in what they are being asked to observe, or how to do it, they should ask for guidance.

    - Understand their duties
    - Understand where they are expected to be at each stage of the examination, and what they are expected to hear and observe
    - Understand the rights of the patient relating to their presence and their ability to halt an examination
    - Understand how to identify concerns and raise them with their line manager to ensure a fair hearing in an objective manner, perhaps with other clinicians, without causing offence. This should be done immediately following the consultation.

Considerations

1. In some cultures, examinations by men (on women) may be unacceptable. Some patients may be unwilling to undress, or raise concerns related to culture. All concerns should be respected and recorded, and in a similar way, if there is a language difficulty, it may be best to defer an examination until an interpreter is available.

2. Where mental health patients are concerned or those who may have difficulty in understanding the implications of an examination, it may be inappropriate to proceed until more secure arrangements can be made.

3. There may be instances where the chaperone may be required to act in this capacity outside the hospice (e.g. on a home visit). Where a healthcare professional wishes to examine a patient in their own home where another family member may not be present, it may be more important that a chaperone is present, and they need to be aware of their responsibilities in these circumstances. The visiting clinician (Doctor/Clinical Nurse Specialist) will discuss this with the chaperone prior to the visit.

Appendix B – Staff training : intimate examinations

Clinical staff are trained in the following areas:

Intimate exams training

- Genital examination
    - PR examination
    - PV examination
    - Male Genital

- Abdominal examination

- Lower back/thigh examination

- Breast examination

- Chest examination

- Any exam that “feels” intimate

Meeting: **Clinical HODs Meeting**			
Date: 02.02.2021		Time: 14:00 – 15:30	
Chair: Rebecca Trower			
Present: Tracy C, Maura F, Laura B, Dr Jenny S, Dr Gaby TR, Julie F IPU, Steve M, Alex Rudkin, Sara Jane W, Emily N, Kelly C			
Apologies: CEO's Gail L, Nick S**,** Tracy Y			
Agenda item	**Discussion**	**Actions & by whom**	**Anticipated date for completion**
Review of previous minutes	Dr JS explained that the bladder scanner requested is an essential piece of equipment & therefore should be funded by hospice & not fundraising? It was discussed that the weight pat slide requested also, may be funded by fundraising. EN informed meeting that fundraising could put request to a trust for grant to purchase this item. SJ also suggested that maybe fundraising could be informed of any requests before equipment stops working.	TY looking into bladder scanner purchase SJW/EN/RT/TY SJW/ RT/ TY	April 2020
Matters Arising			
Topic			
Infection Prevention	FIT mask training has been completed. 1 staff member failed & 1 member of staff felt unwell after the training. **OUTBREAK STATUS** Due to the declaration of SRH by PHE being an outbreak centre the following actions have/are being taken. Rt and education staff MF & LB are working closely with Debbie Calver SWL Infection Control Nurse & Carolyn Moore – Public Health Sutton during this time • 6 staff have tested Covid positive & 2 are isolating for other reasons. • No admissions to IPU • Medical Cover – Dr's are not moving between areas • Housekeeping are not moving between areas. Paula Di Palma is NOT patient facing & therefore is cleaning	MF/LB GL/RT/TC/TY ALL STAFF	Ongoing

	reception area once a day with evening housekeeper cleaning in evening. Reception staff are high touch cleaning the reception toilets every hour. • Changing rooms are cleaned twice a day **TESTING** • All appropriate staff are to continue the weekly Monday PCR testing. • **All staff** who are currently working on Hospice Grounds are to participate in LFD daily testing for the next 2 weeks, starting 04.02.21. Guide & video link supplied along with tests. They are to record their results on the record sheet provided & hand it in weekly with their PCR test on Mondays. This is to continue twice weekly once out of outbreak mode. • All staff are to test negative for 2 weeks to achieve out of outbreak mode. Update since: CCG/LA decision to reopen once all patients are no longer on the unit and a deep clean has been undertaken **IPU** • Ward is currently closed to admissions due to Outbreak status • 1 patient currently on ward. • PPE – Googles & Visors are to be one use only • If/when? ward closes as patient discharged a deep clean will be undertaken. • Staff will be informed of shift patterns & allocated roles/jobs e.g COVID teaching updates, Audits, Policy reviews, completion of mandatory training & competencies & Dr Training. • Consideration for OOH cover & lone working policy	All appropriate staff RT/ JF to have meeting re IPU All Staff	Ongoing 05.02.21 Ongoing
Medical Devices			
Medicine Management			
Incidents & Accidents/RCA's			
Complaints			
Health & Safety			

New Policies/ Guidelines			
Documentation/ Crosscare			
Audit/Research			
Education/Training Reflective Forums			
Recruitment/ Staffing			
CQC/PIR	.		
AOB			

Date next meeting: TBA

MINUTES OF THE
DRUGS & THERAPEUTICS COMMITTEE

Held on 11th November 2020
in St Bede's Conference Centre / Zoom

Attending

(RT) Rebecca Trower – Clinical Director / Chair (Dr JS) Dr Jenny Strawson, Hospice Palliative Care Consultant (TC) Tracy Christmas – Community Services Manager NMP (AM) Dr Annelise Matthews - Hospice Palliative Care Consultant (LB) Laura Briant – Practice Educator (AR) Alex Rudkin – Head of Quality and Improvement / Mins	(MG) M Gibbs - Ashton's Pharmacist (GL) Gail Linehan – Joint CEO (HT) Hai To - Sutton CCG Care Home Pharmacist (TY) Tracey Young - IPU Manager (KH) Kevin Hobson - CNS NMP

ITEM 1: Welcome

1.1 RT extended welcome

ITEM 2: Apologies for Absence

(HH) Heather Howell - Advisory Committee Member, (BG) Bernadette Griffin -CNS, NMP, (MF) Maura Flint – Practice Educatort, (JS) Jill Smith -CNS, NMP

ITEM 3: Minutes of the Last Meeting

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

ITEM 4: Matters Arising

a) AM's review of the IPU medication stock list has had recent discussion with the new consultant team and will be discussed at the medical team meeting. JS expressed her surprise that the stock list hadn't included NSAIDs. AM will complete the review and a stock list will be agreed and published. — AM

b) Use of Abstral requires no further discussion. MG advised that the PCF doesn't advocate Abstral use. She has observed variable effectiveness in its titration in other Hospices and is happy to provide titration guidance if required.

c) PRN administration in the community by carers was a subject that TC had began considering pre-Covid and remains on hold. She has reflected that extending carers' involvement in medication administration in end of life care won't lessen the support that they will require and will likely be only useful to a minority. She will take forward the drafting of policy in liaison with Practice Development once the pandemic has subsided. She expressed that it still remains a large piece of work and support for those families affected will be considerable. — TC/LB

d) AM is still to review the Hospice's Diabetic Guidelines last reviewed in November 2018 to reflect desired changes. She will liaise with the MDT in making revision and let AR know once complete. AM

e) No update on supplement prescribing guidance that HT is exploring. HT

f) The education session to be delivered by Caroline , a colleague of Michelle Philpott, on nutritional supplements is planned for 26 November 2020. LB

g) Provision of IV therapies on the IPU remains a subject for discussion within the clinical team. Dr JS advised that it was rare to require IV antibiotics in EoLC. Training to ensure and maintenance of IV competency is a service development initiative but needs to be properly considered. It will be an item for considered inclusion in 2021/22's clinical action plan (CAP). RT

ITEM 5: Pharmacy Update

5.1 MG stated that reviewed practice is almost exemplary. Between July and September 2020 all audits went well and no issues were raised. There is an anomaly within the Live view system in its determination that just 62% of comments have been acknowledged given the routine review by clinical and managerial staff. MG considers it to be a blip in the system. MG

5.2 Other than on-line training via Zoom, there has been no hands on training delivered on the IPU by Ashton's in the last two quarters. Training sessions plans are for Diabetes and Parkinsons at EoL. MG

5.3 No issues at all with controlled drugs.

5.4 1,112 prescribed items reviewed yielding evidence of 3 interventions which is very low and benchmarks SRH very highly amongst other Hospices.

5.5 Alfentanil is being prescribed a bit more but there are no concerns on the general medication usage or spend.

5.6 RT expressed that it made greater sense to have morphine in stock rather than diamorphine and it was agreed that the stock drugs will be morphine sulphate and alfentanil. Ordering of diamorphine for injection is to cease. Prescribers

5.7 HT confirmed that lidocaine patches aren't prescribed in primary care for Sutton and Merton nor any area under SWL CCG.

ITEM 6: Guidance for Prescribing and Administration of Continuous Furosemide for Adults with End Stage Heart Failure in the Community

6.1 New joint guidelines have been developed by Central London Community Healthcare Trust SW Division, St Raphael's Hospice, Royal Trinity Hospice and St George's Hospital Heart Failure Team that are much clearer. Fundamentally the guidance is to support symptom control in the last months of life and so reduce admission to Hospital. Agreed to incorporate into the Hospice Policy Manual as is. AR

ITEM 7: End of Life Prescribing

7.1 CLIN29 Preparing and Administering Injectable Medications Guidelines Appendix 1 Community Guidance remains to be signed off by the local MMC. JS expressed some queries over the doses in the Appendix and TY volunteered to take on its review with JS. Once agreed the appendix will be available for circulation as it iterates SRH current advice and will have the CCG logos removed from it. They can be reapplied once it has been agreed at MMC.

TY/JS

GL

ITEM 8: Update on Medication Policy review

8.1 There has been 1 published update to medication policy / guidance since the last meeting between July and November 2020:-

OP01a Managing and Supporting Staff Following a Medication Error N:\Policy Manual\OP\OP01a Managing and Supporting Staff Following a Medication Error.pdf v2 issued 18-09-2020 (minor updates throughout to roles/responsibilities

8.2 Medication policy / guidance overdue for review are:-
CLIN27 IV Administration – Dr Akhtar lead — AA
CLIN25 Controlled Drugs - GL Lead — GL
CLIN26 Generic Drugs – M Flint Lead — MF
CLINSOP03 Inpatient Unit Medication Rounds – T Young / M Flint — TY/MF

ITEM 9: Serious Medication Incidents

9.1 A prescribing incident involving miscommunication over rationale for calculation involving MST and morphine MXL in July 2020 was discussed noting the reflection and learning documented at the time and resultant clarification in policy. The incident wasn't in fact regarded as serious.

ITEM 10: Update on CAS/MHRA Alerts

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

10.2 There has been 1 alert relevant as listed.

Reference	Title	Date	Action
EL (20)A/34	Abstral 200 mcg sublingual tablets report of two tablets in single blister 29-7-2020	29/07/2020	Stock checked on IPU and not included in this recall – notice to IPU RGN on CD cupboard to check any new stock and act accordingly. Email to all clinical team.

ITEM 11: Any other business

11.1 AM to present information on antimicrobial stewardship at Journal Club — AM

11.2 Existing documentation supporting ketamine and that which is required to support methadone monitoring will be reviewed by the medical team. — JS

11.3 Changes to be incorporated into CLIN33 Non-medical Prescribers Policy and re-published. — AR

11.4 MG reminded that Ranitidine remained unavailable at the moment.

11.5 Immediate Release or Modified Release should be written in full to make documentation as clear as possible.

ITEM 12: Future Dates

12.1 Dates of future meetings in 2020:

Date	Event	Venue/Time
TBC	Drugs and Therapeutic Committee	St Bede's 14.30

VOICES QUESTIONNAIRE

2019

Compiled by: Audit Office

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Your Local Hospice

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INTRODUCTION

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

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

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

AIMS

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

METHODOLOGY

The questionnaire used in this survey is taken from the National Survey of Bereaved People (VOICES) questionnaire. The next of kin / main carer of those Hospice patients that died during the period 1st April 2019 to 30th September 2019 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 dataset with earlier audit from 2018/19.

Executive Summary

a) The number of returned questionnaires has decreased to 25% in 2019 (c.f. 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 10). 6% of respondents considered that relief for other symptoms was not provided (c.f. 9% in 2018/19) (see page 11).

c) Definite assertion of the adequacy of emotional support decreased to 68% in 2019 from 2018/19's 78% (page 11), whilst definitive assertion of the adequacy of religious/spiritual support decreased to 55% from 2018/19's 84%.

d) Support regarding financial concerns or other practical problems was considered to be of lower need – 3 respondents (14%) in 2019 (c.f. 21% in 2018/19). That need was considered to have been definitely met by 1 (33% in 2019 c.f. 67% in 2018/19).

e) Definite assertion that symptoms other than pain in the IPU had been relieved has decreased to 67% (c.f. 73% in 2018/19) although 95% recorded either definitely or to some extent in 2019 (c.f. 91% in 2018/19).

f) Support regarding family concerns was considered to be of greater need – 48% in 2019 (c.f. 43% in 2018/19). That need was considered to have been definitely met by 90% in 2019 (c.f. 100% in 2018/19).

g) Pain relief in the IPU has improved significantly with it being reported to have been relieved completely, 'all of the time' by 79% in 2019 (c.f. 54% 2018/19), 'some of the time' by 11% in 2019 (c.f. 12% in 2018/2019) and 'partially' by 5% in 2019 (c.f. 19% in 2018/19) (Page 12). This is a firm improvement.

h) 80% in 2019 (c.f. 82% in 2018/19) of family members of IPU patients were always kept informed of the patients' condition. 15% considered family members were usually kept informed (c.f. 7% in 2018/19). The percentage of respondents who considered the language used by doctors and nurses to explain the condition to be 'very easy' to understand has decreased to 55% in 2019 (c.f. 76% in 2018/19). (Page 13) with shift to classification as 'fairly easy to understand' at 40% in 2019 (c.f. 16% in 2018/19)

i) The number of respondents that felt that decisions were made about the patients' care/treatment that they wouldn't have wanted has increased to 24% in 2019 (c.f. 12% in 2018/19).

j) Always treating patients with respect and dignity was considered highly for both doctors and nurses – 90% for nurses and 89% for doctors (c.f. 96% for nurses and 93% for doctors in 2018/19)

k) Definite assertion that the Hospice worked well with patient GPs and other external services has maintained at 47% in 2019 (c.f. 48% in 2018/19)

l) A slightly decreased proportion of respondents regarded that being able to stay overnight in the Hospice was important – 55% (c.f. 57% in 2018/2019) (page 15. Question 11).

m) There has been a significant decrease in respondents considering that they had 'definitely received sufficient emotional support' – 62% in 2019 (c.f. 85% in 2018/19) (page 15), with the shift to 'Yes to some extent' – 33% in 2019 c.f. 4% in 2018/19. Taken together, there is a positive increase in 2019 – 95% being reflective upon the adequacy of emotional support as either definite or to some extent c.f. 89% in 2018/19.

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 show a shift from 'Exceptional' to 'Excellent.' 40% considered doctor care on admission to be 'Exceptional' (c.f. 64% in 2018/19),' 50% considered it to be 'Excellent' (c.f. 24% in 2018/19) and 10% considered it to be 'Good' (c.f. 4% in 2018/19) and 0% considered it 'Fair' (c.f. 8% in 2018). Taking 'exceptional' and 'excellent' together there is appositive increase in 2019 – 95 c.f. 88% in 2018/19. Responses relating to nursing care include 57% rating nursing care as 'Exceptional' (c.f. 76% in 2018/19) and 38% as 'Excellent' (c.f. 12% in 2018/19) and 5% as 'Good' (c.f. 8% in 2018/19) and 0% as 'Fair' (c.f. 4% in 2018/19) (Page 15-16). Again, taking 'exceptional' and 'excellent' together, there is a positive increase in 2019 – 95% c.f. 88% in 2018./19.

o) Regarding the food provided on the IPU in 2019, all ratings were positive ranging from Good – Exceptional.. 12% rated the food as 'Exceptional' in 2019 (c.f. 17% in 2018/19), 65% 'Excellent' (c.f. 33% in 2018/19), 24% 'Good' (c.f. 39% in 2018/19), 0% 'Fair' (c.f. 0% in 2018/19). (Page 17) and 0% recorded 'Don't know' (c.f. 11% in

2018/19). Combining 'exceptional' and 'excellent' ratings again there has been a positive increase in 2019 – 77% c.f. 50% in 2018/19.

p) 57% of respondents rated the patient bedroom as 'Excellent' which is a small decrease from 62% in 2018/19. The en-suite bathrooms were rated 'Excellent' by 60% in 2019 (c.f. 76% in 2018/19) (Page 18) which is a greater decrease.

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 increased – 87% (c.f. 85% in 2018/19); 'Yes definitely' answers for emotional support have maintained constant – 73% (c.f. 73% in 2018/19); Religious or spiritual support decreased – 50% (c.f. 71% in 2018/19), but that question has a smaller data cohort, since fewer respondents consider religious/spiritual support to be necessary.

r) A greater proportion felt that the patient required help with urgent problems during the evenings, between 5pm and 11pm, – 64% (c.f. 49% in 2018/19) and of those, a decreased proportion – 61% (c.f. 67% in 2018/19) felt definitely that enough support had been received. (page 21)

s) A lower proportion felt that the patient required help with urgent problems during the night (7pm – 9am) – 28% (c.f. 44% in 2018/19) and of those, a slightly lower proportion – 63% (c.f. 67% in 2018/19) felt definitely that enough support had been received.

t) 27% of respondents considered that the patient's pain had been completely relieved all the time (c.f. 31% in 2018/19) (page 22). [Note – complete pain relief on the IPU improved during this audit period – it was 79% (c.f. 54% in 2018/19)]

u) 9% (c.f. 6% in 2018/19) felt that they didn't get enough help and support from the Hospice CPCT

v) The way in which the CPCT team explained the patient's condition, treatment or tests was considered 'Very easy' to understand by 69% - a slight increase in 2019 (c.f. 66% in 2018/19) and 'fairly easy' by 21% (c.f. 24% in 2018/19).

w) Regarding care received from the CPCT altogether - 41% rating it as 'Exceptional' (c.f. 48% in 2018/19), 3% rated it as 'Poor' (c.f. 2% in 2018/19) (Page 23). Overall care as a whole provided by the CPCT was considered as either 'Exceptional', 'Excellent' or 'Good' by 97% (c.f. 98% in 2018/19).

x) CPCT involving family/carers in decisions about the patients; treatment has decreased slightly to 88% in 2019 (c.f. 92% in 2018/19).

y) Patient's explicit statement on their preferred place of death has maintained similar figures: Home – 66% (c.f. 64% in 2018/19) Hospice – 31% (c.f. 31% in 2018/19).

z) 90% of respondents believed the patient died in the right place (c.f. 82% in 2018/19) (page 29).

aa) 63% felt the patient achieved their preferred place of death (c.f. 62% in 2018/19) (page 26).

bb) Bereavement support was considered definitely enough by 82% - a decrease on 2018/19's . 92% .

cc) 71% felt able to talk to someone from the Hospice as soon as they wanted about their bereavement (c.f. 82% in 2018/19) and 5% wanted it sooner (c.f. 5% in 2018/19).

dd) Following receipt of the bereavement leaflet – a lower proportion - 62% found it either definitely helpful or helpful to some degree (c.f. 67% in 2018/19). 32% did not receive the leaflet (c.f. 22% in 2018/19).

ee) The proportion of respondents that considered contact from the bereavement team was either definitely helpful or helpful to some degree has increased slightly to 66% (c.f. 64% in 2018/19). 5% felt the contact was unhelpful (c.f. 5% in 2018/19). However, response stating that contact wasn't received has increased to 21% (c.f. 16% in 2018/19).

ff) Responding to the Friends & Family question, an increased proportion of respondents (93%) would be either extremely likely or likely in 2019 to recommend St Raphael's Hospice to their friends and families (c.f 90% in 2018/19)-
77% in 2019 (c.f. 78% in 2018/19) would be 'Extremely Likely' to recommend the Hospice to their friends and family. 16% (c.f. 12% in 2018/19) would be 'Likely,' 0% (c.f. 4% in 2018/19) 'Neither Likely or Unlikely,' and 0% (3% in 2018/19) 'Extremely Unlikely.' *(There is no rating on the questionnaire for the milder negative response of 'Unlikely.')*

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 2016 - 2019

Recommendations

a) To continue the routine and monthly mailing of VOICES questionnaires in A3 format but 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.
c) To progress the review of the bereavement leaflet and its provision.
d) To audit bereavement contact as recorded in Crosscare.
e) To achieve the patient room re-fresh project in 2020.

Post-Key Staff Comments : Proposed Actions for Sign Off at CHoDs 03-December-2020

a) All Recommendations agreed.
b) Audit Program 2021/22 : to agree symptoms (other than pain) for assessment and treatment audit *(RT) : breathlessness management potentially : Audit Mtg Jan 2021*
c) Education : to source and deliver communication skills training annually to clinical staff *(GL) 2021/22 education program*
d) 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*
e) 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 April – September 2019, there were 198 questionnaires mailed and 50 questionnaires returned, making a return rate of 25% (c.f. 29% in 2018-2019 & 34% in 2018 & 32% in 2017/18 & 28% in 2017).

Demographics:

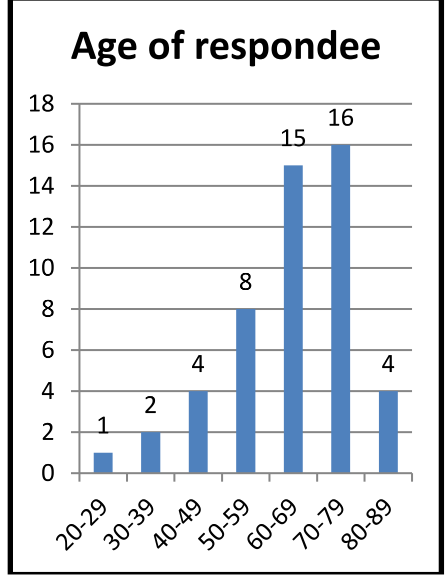
Gender of Respondent

Period	Male	Female	n/r
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*

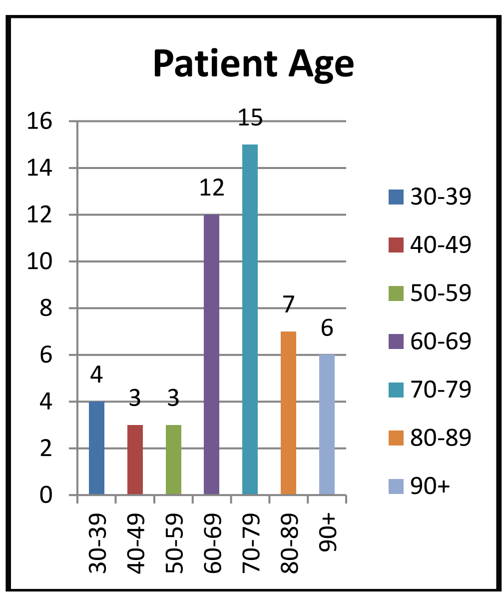
Gender of Patient

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

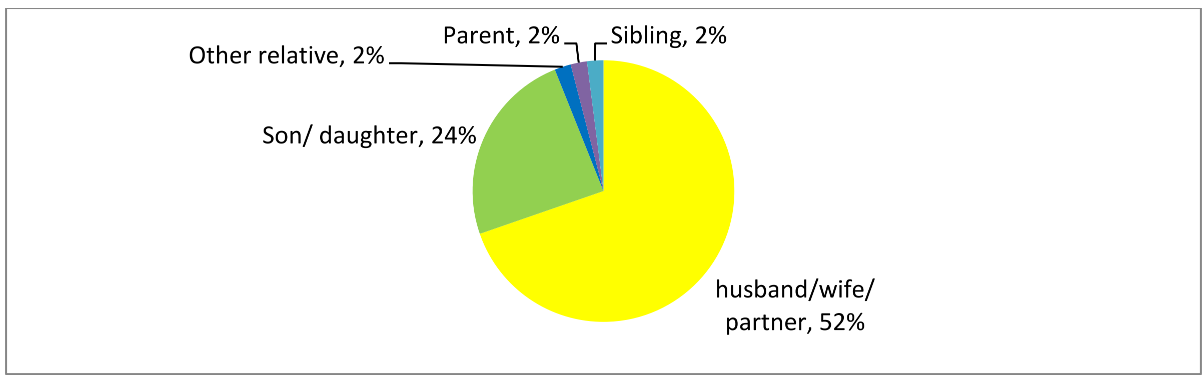
Age of respondent



Age of deceased



Respondent's relationship to patient

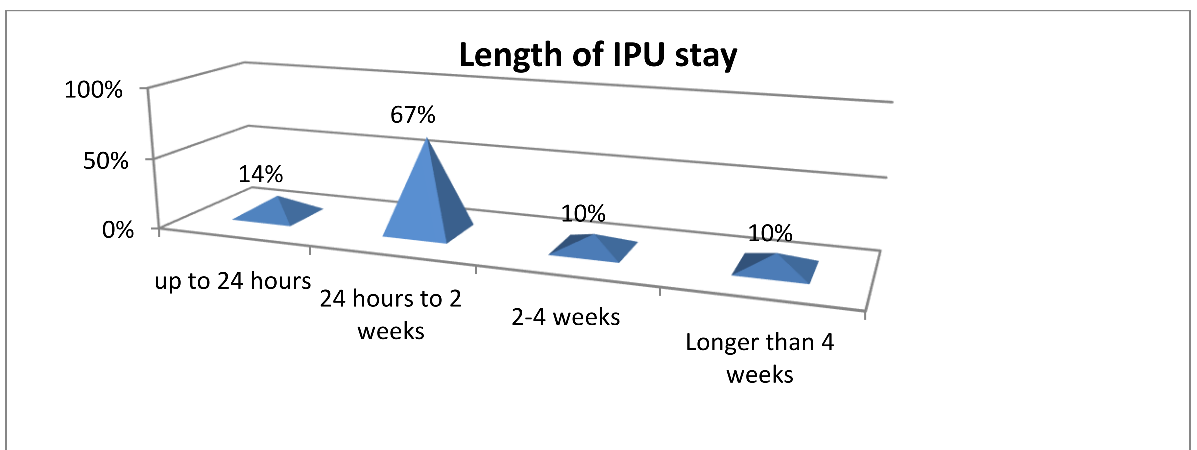


42 (84% c.f. 86% in 2018-2019) of the 50 respondents who answered the question identified themselves as being 'White' (British/Irish/Other) with the remaining 8 (16%) identifying themselves as "Asian Indian," "Asian Other," "Black Caribbean" and "Mixed White and Black African." 40 (89% c.f. 83% in 2018-2019) of the 45 patients who had the question answered on their behalf were identified as being white and the other 5 (11%) as 2 "Black Carribean," 2 "Asian Indian" and 1 "Mixed White and Black Carribean."

Inpatient Care on Hospice Ward

Inpatient Stay

Q2) 21 (42% c.f. 41% in 2018-2019 and 50% and 2018 & 37% in 2017-2018) of the 50 respondents stated that the patient had stayed in the IPU at some point. Of these, 14 (67% c.f. 61% in 2018-2019) had stayed between 24 hours and two weeks, 2 (10% c.f. 18% in 2018-2019) stayed between two and four weeks and 2 (10% c.f. 7% in 2018-2019) stayed for longer than 4 weeks. Only 3 (14% c.f. 14% in 2018-2019) stayed for less than 24 hours. None (0% c.f. 0% in 2018-2019) did not record an answer.



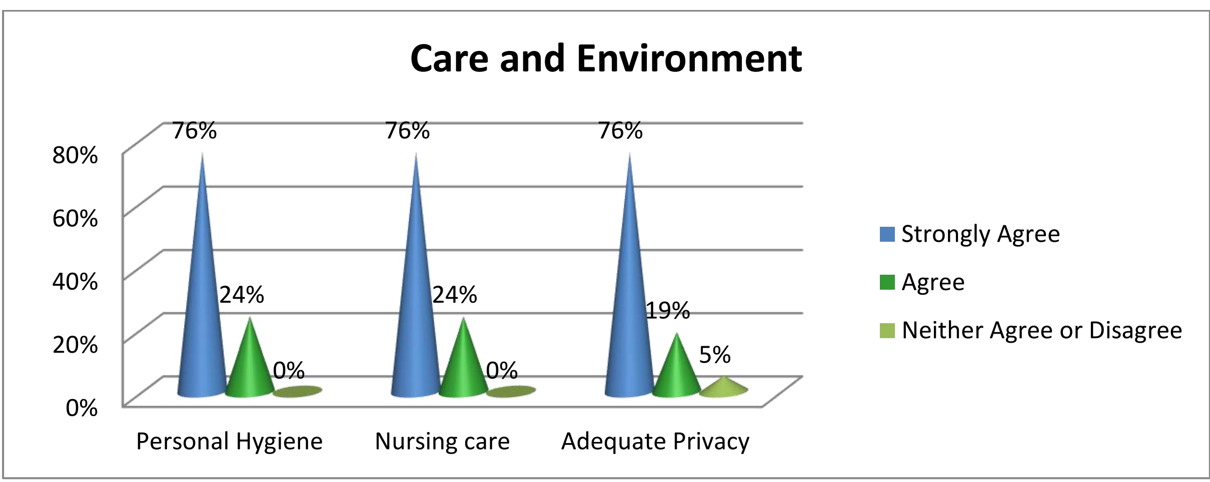
Care and Environment

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) 76% 'strongly agreed' that there was enough help with personal care such as washing, personal hygiene and toileting needs (c.f. 71% in 2018-2019) , 24% 'agreed' (c.f. 25% in 2018-2019) and none (0% c.f. 4% in 2018-2019) neither agreed nor disagreed.).

Q3B) 76% '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. 71% in 2018-2019), a further 24% 'agreed' (c.f. 25% in 2018-2019) and none (0%, 4% in 2018-2019) 'Neither agreed nor disagreed.

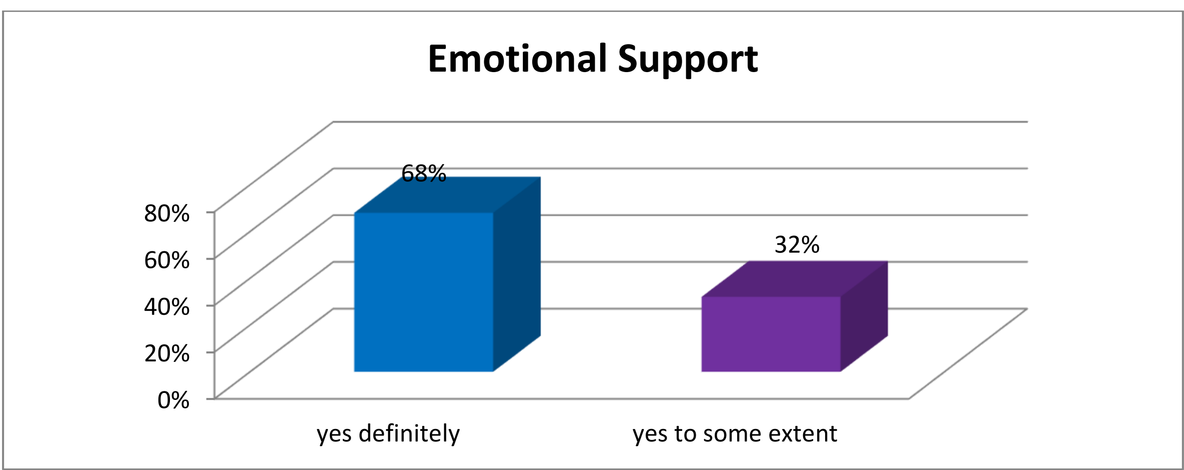
Q3C) With regards to the surrounding environment and bed area providing adequate privacy 76% 'strongly agreed' (c.f. 86% in 2018-2019) and the other 19% 'agreed' (c.f. 14% in 2018-2019) and 5% 'disagreed' (c.f. 0% in 2018-2019).



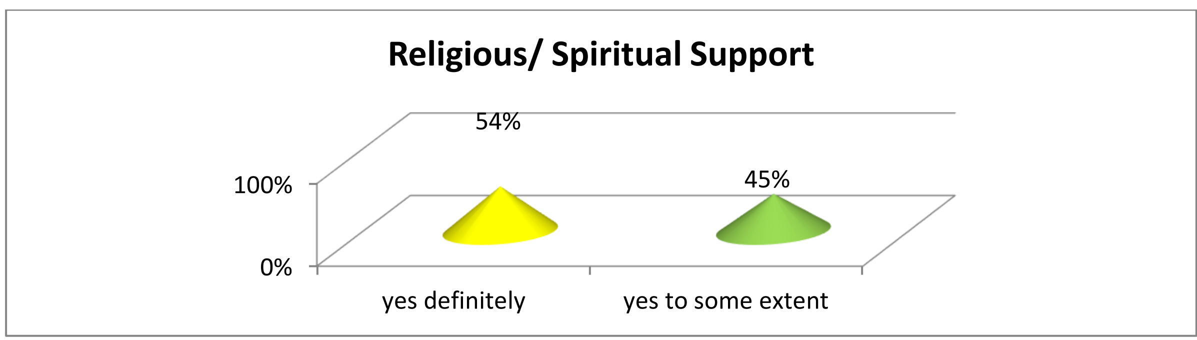
Support

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, 90% of respondents responded with a definite yes/no answer (c.f. 83% in 2018-2019). Of these, 68% responded 'Yes definitely' (c.f. 78% in 2018-2019) and 32% responded 'Yes to some extent' (c.f. 17% in 2018-2019). None (0%, 4% in 2018-2019) responded 'No.'



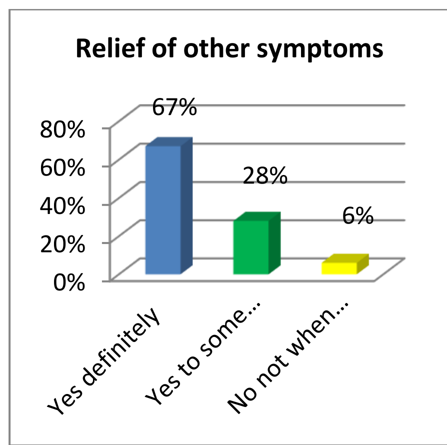
Q4B) Thirteen respondents felt the patients required religious/spiritual support. In answer to whether they received enough, 55% replied 'Yes, definitely' (c.f. 84% in 2018-2019), 45% replied 'Yes, to some extent' (c.f. 16% in 2018-2019), and none responded with 'No, not when needed' (c.f. 0% in 2018-2019). 15% responded with 'Don't Know' (c.f. 10% in 2018-2019)

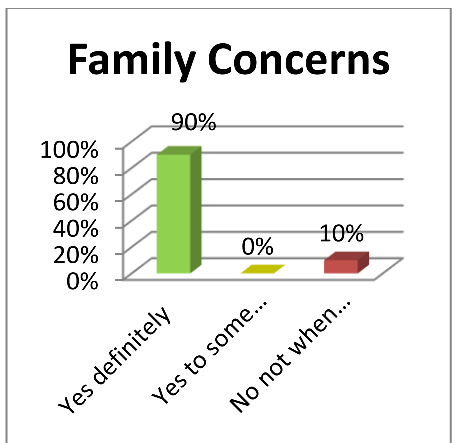


Q4C) 3 (14% c.f. 21% in 2018-2019) respondents considered the patient to be in need of support regarding financial concerns or other practical problems. 1 (33% c.f. 67% in 2018-2019) believed there was definitely enough support available and two (67% c.f. 0% in 2018-2019) believed there was some support available. None (0% c.f. 33% in 2018-2019) believed there was definitely not enough support available.

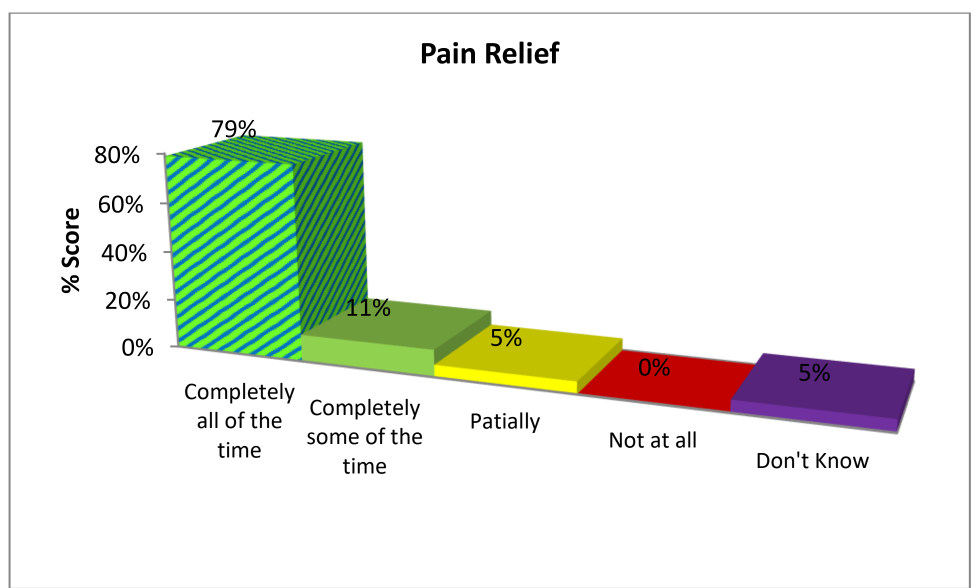
Q4D) With regard to enough support for relief of symptoms other than pain, 86% of respondents responded either 'Yes' or 'No' (c.f. 79% in 2018-2019). Of these, 67% considered there to have definitely been enough support (c.f. 73% in 2018-2019), 28% answered 'Yes, to some extent' (c.f. 18% in 2018-2019) and one answered 'No, not when needed' (6% c.f. 9% in 2018-2019).

Q4E) 48% of respondents considered that there was a need for support in family concerns (c.f. 43% in 2018-2019). Of these, 90% considered there was definitely enough support (c.f. 100% in 2018-2019) and 0% replied 'Yes, to some extent' (c.f. 0% in 2018-2019) and 10% replied 'No, not when needed' (c.f. 0% in 2018-2019).





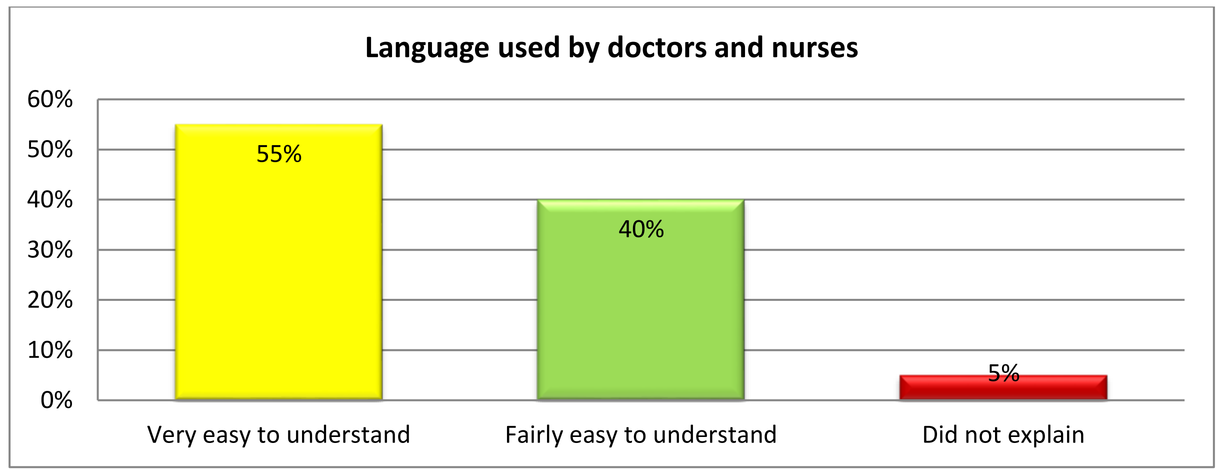
Q5) Respondents were asked how well the patient's pain was relieved during their inpatient stay. One did not record an answer. 2 (10% c.f. 4% in 2018-2019) said that the question did not apply because the patient had no pain. Of the 19 inpatient respondents who answered the question, 5% did not know the answer (c.f. 12% in 2018-2019), 79% replied that the pain was relieved completely all of the time (c.f. 54% in 2018-2019), 11% that it was relieved completely some of the time (c.f. 12% in 2018-2019) and 5% considered it to have only been partially relieved (c.f. 19% in 2018-2019). None (0% c.f. 4% in 2018-2019) recorded that the patient's pain had not been relieved at all.



Communication and involvement

Q6) Relevant to 21 patients who stayed in the Hospice inpatient unit, there were 20 responses to this question. 16 (80% c.f. 82% in 2018-2019) reported that family members were always kept informed of the patient's condition, 3 (15% c.f. 7% in 2018-2019) responded that this was usually the case and 1 (5% c.f. 4% in 2018-2019) responded that this was sometimes the case. None (0% c.f. 4% in 2018-2019) responded that this was occasionally the case and that the respondee had to ask specifically. None (0% c.f. 4% in 2018-2019) responded that this was never the case. None (0% c.f. 0% in 2018-2019) 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 55% of respondents (c.f. 76% in 2018-2019), fairly easy to understand by 40% (c.f. 16% in 2018-2019). None (c.f. 4% in 2018-2019) reported that the doctors and nurses were very difficult to understand. 5% (c.f. 4% in 2018-2019) reported that the doctors and nurses did not explain to them.

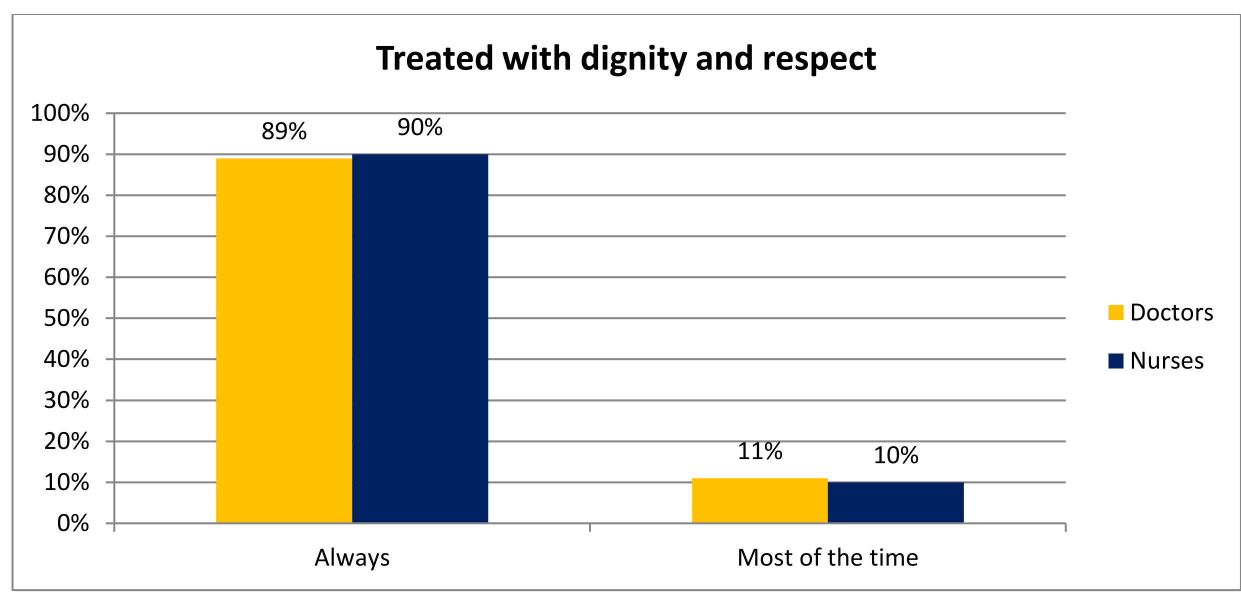


Q8) When asked the question: "During this admission, were there any decisions made about his/her care or treatment that s/he would not have wanted?" 67% responded with a positive 'No' (c.f. 80% in 2018-2019), 10% replied that they did not know (c.f. 8% in 2018-2019) and 24% replied with a negative 'Yes' (c.f. 12% in 2018-2019).

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, 89% said 'Always' and 11% said 'most of the time.' (c.f. 93% said Always and 7% said most of the time in 2018-2019). For the nurses, 90% said Always and 10% said 'some of the time.' (c.f. 96% said 'Always' and 4% said 'some of the time in 2018-2019.')



Q10) Answering the question as to whether the respondent felt that the Hospice worked well with the patient's GP and other external services : 47% stated 'Yes definitely' (c.f. 48% in 2018-2019) and a further 35% agreeing 'Yes to some extent' (c.f. 19% in 2018-2019). 6% answered 'Don't know' (c.f. 21% in 2018-2019), 2 (12%) recorded 'No' (c.f. 7% in 2018-2019) and 0% recorded that they did not work together (c.f. 4% in 2018-2019).

One of the respondents who responded 'No' recorded the following comment:

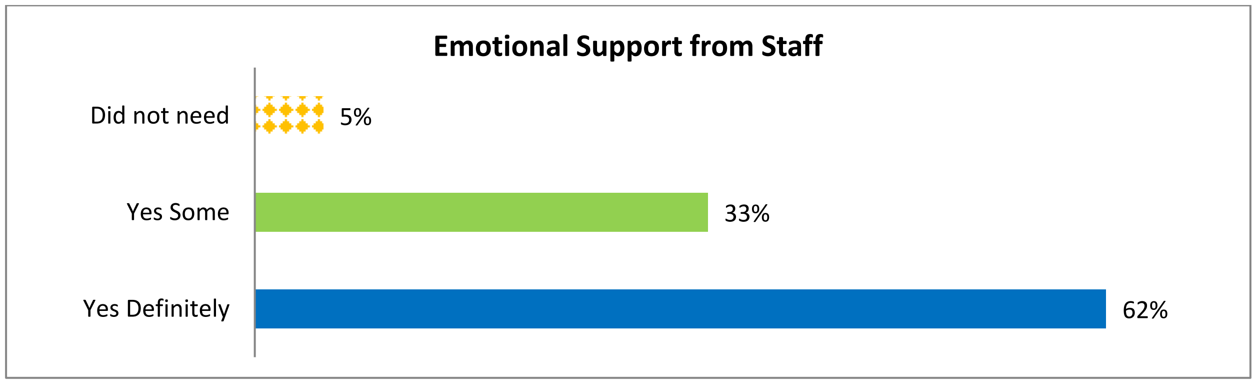
> 'my mum's gp was not interested in her care. I informed him she was in hospice and also of her death. Informed as told receptionist never spoke to her GP.' – Daughter of patient

Q11) Being able to stay in the Hospice overnight with their loved one was seen as important to 55% of respondents (c.f. 57% in 2018-2019). Of these, 91% stayed and found it helpful (c.f. 88% in 2018-2019).

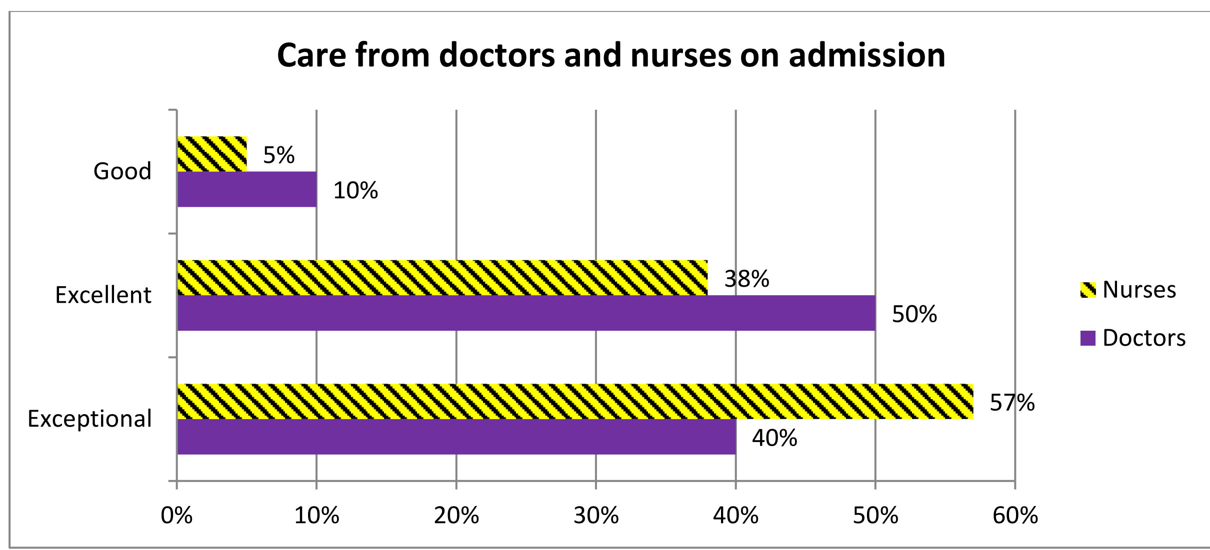
Comments on the subject of staying overnight:

> 'I didn't feel it was necessary as I felt confident with the staff. I went home to rest after being with mum all day.' – Daughter of patient
>
> 'For a week I became my wife's wife and not her carer. We had time for ourselves.' – Wife of patient
>
> 'She died of nicotine poisoning and would have wanted me to keep giving her fags.' – Husband of patient
>
> 'I stayed with Mum a few night including the night she died. I found this a great comfort.' – Son of patient

Q12) Respondents were asked whether they felt that they had received sufficient emotional support from the Hospice staff. Responses showed 62% answering 'definitely yes' (c.f. 85% in 2018-2019), 33% answering 'yes, to some extent' (c.f. 4% in 2018-2019), and 5% replying that they did not require this kind of help (c.f. 8% in 2018-2019). None (0% c.f. 4% in 2018-2019) 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. 40% considered doctor care on admission to be 'Exceptional' (c.f. 64% in 2018-2019), 50% considered it to be 'Excellent' (c.f. 24% in 2018-2019) and 10% considered it to be 'Good' (c.f. 4% in 2018-2019). 0% considered it to be 'Fair' (c.f. 8% in 2018-2019). Responses relating to nursing care were even higher, with 57% rating nursing care as 'Exceptional' (c.f. 76% in 2018-2019), 38% as 'Excellent' (c.f. 12% in 2018-2019) and 5% as 'Good' (c.f. 8% in 2018-2019) and 0% as 'Fair' (c.f. 4% in 2018-2019).



Food and Catering

Q14) It should be noted that 11% 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. 28% in 2018-2019). Of those who replied that their loved one did partake of hospice food, 12% answered that the food was 'Exceptional' (c.f. 17% in 2018-2019), 65% that it was 'Excellent' (c.f. 33% in 2018-2019), 24% that it was good (c.f. 39% in 2018-2019), 0% that it was 'Fair' (c.f. 0% in 2018-2019) and 0% of the respondents (c.f. 11% in 2018-2019) did not know what rating to give it.

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

‘I feel they are angels.’ – Wife of patient

‘To be honest I could not fault the accomodation and the staff in most cases were very helpful and I was happy with treatment my wife was getting under very difficult circumstances.’ – Husband of patient

‘She ate very little while at the hospice, but something was always readily available if she wanted it, usually ice cream or yoghurt. She said it was as good as staying in a five star hotel with all the care and attention she received!!!’ – Husband of patient

‘Exceptional and with the utmost respect and care.’ – Other relative of patient

‘The care patient received was exceptional, but as a family we were all given the same love and care.’ – Wife of patient

‘The doctors, nurses and volunteers were all amazing and provided myself and my family with care and support through a difficult period. Mum was well looked after in the end and treated with the dignity she deserved.’ – Son of patient

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

‘After she was told that she would be admitted she was told it was strictly no smoking. And told us that she would be dead in two days as there was no point in living without her beloved fags. However, as she slipped away, she was told she could in fact smoke and was fine again to the fact that after two weeks she was sent to Orchard House where the smoking was limited and she took two weeks to die on April 4th. I am convinced that had she not been allowed to smoke, she would have slipped away and not put us through three weeks of turmoil.’ – Husband of patient

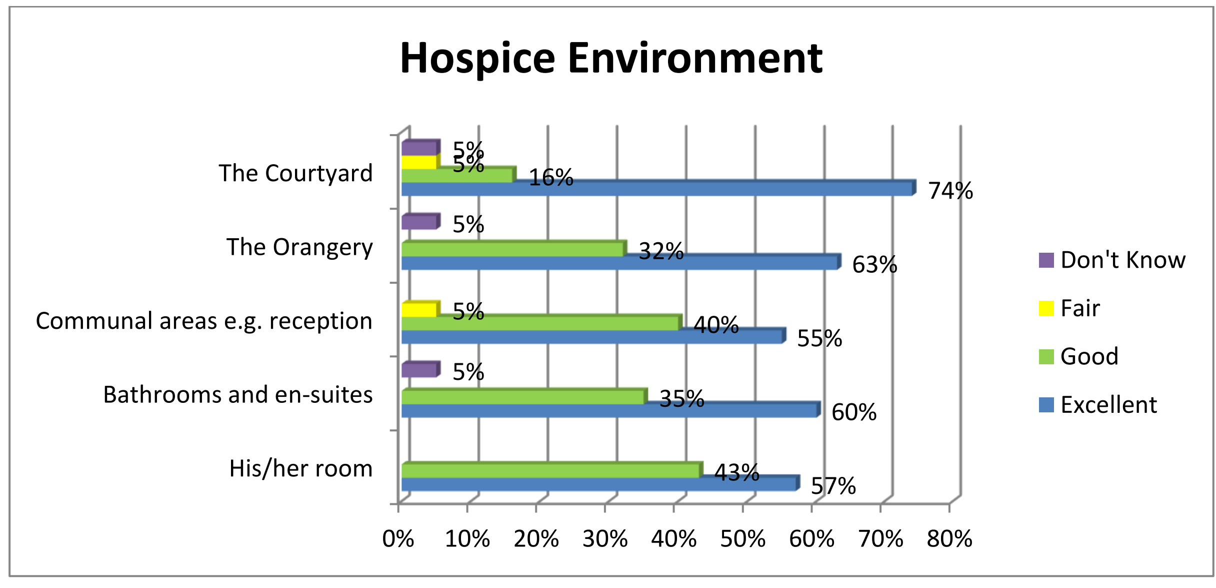
Q15 A-E) Respondents were asked to comment on different aspects of the Hospice.

The patient's room was considered to be 'Excellent' by 57% (c.f. 62% in 2018-2019) and the remaining 43% rated the room as 'Good' (c.f. 35% in 2018-2019). 0% considered it to be fair (c.f. 4% in 2018-2019). 60% of respondents considered the en-suite bathrooms on the IPU to be 'Excellent' (c.f. 76% in 2018-2019), 35% rated them as 'Good' (c.f. 16% in 2018-2019), 0% rated them as 'Fair,' (c.f. 4% in 2018-2019) and 5% recorded that they did not know the answer to this question (c.f. 4% in 2018-2019).

When asked to rate the communal areas of the Hospice, such as the Reception, 55% of respondents rated them as 'Excellent' (c.f. 68% in 2018-2019), 40% rated them as good (c.f. 32% in 2018-2019) and 5% rated them as fair (c.f. 0% in 2018-2019).

When asked to rate the Orangery, 63% rated it as 'Excellent' (c.f. 64% in 2018-2019), 32% rated it as 'Good' (c.f. 20% in 2018-2019) and 5% answered that they did not know (c.f. 16% in 2018-2019).

When asked to rate the courtyard, 74% rated it as 'Excellent' (c.f. 64% in 2018-2019), 16% rated it as 'Good' (c.f. 16% in 2018-2019), 5% rated it as 'Fair' (c.f. 0% in 2018-2019) and 5% did not know how to rate the courtyard (c.f. 20% in 2018-2019).



St Raphael's Community Services

Q16) 35 of the total 50 respondents, 70% (c.f. 77% in 2018-2019) stated that the patient received care from the St Raphael's Hospice Community Palliative Care Team's (CPCT) Clinical Nurse Specialists, four were unsure whether they had or not, 8 answered 'no' they had not, and 4 simply left the entire section blank. The following data is extracted from responses relating to the 35 patients (70%) who were recorded as having definitely received care. The total number of respondents varies slightly per question, since not all respondents answered every question.

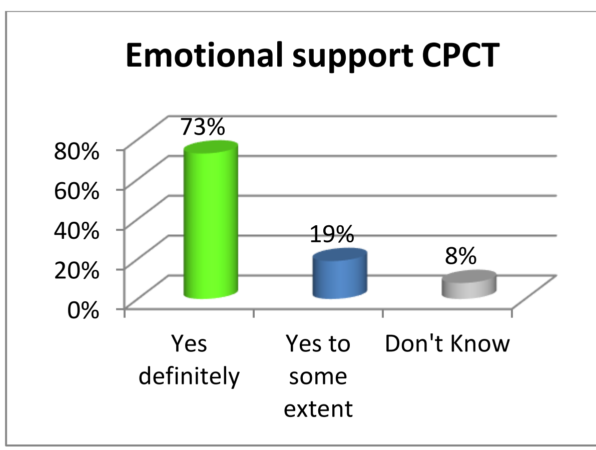
Responsiveness

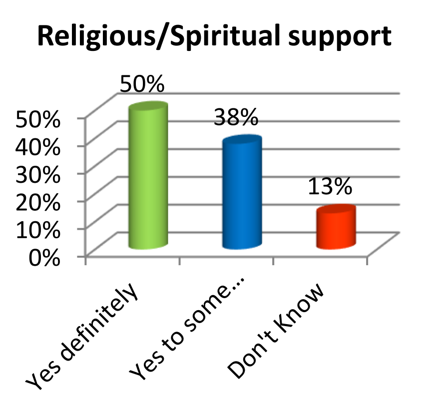
Q17) Most respondents felt that the team visited as often as needed - 87% (c.f. 85% in 2018-2019) and 13% felt that the team 'only sometimes' visited as often as needed (c.f. 9% in 2018-2019).

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, 26 (74% c.f. 83% in 2018-2019) of the 35 respondents acknowledged that the patient had a need for emotional support and of these, 73% replied 'Yes definitely' (c.f. 73% in 2018-2019), 19% 'Yes to some extent' (c.f. 20% in 2018-2019), 0% recorded 'No, not when needed' (c.f. 5% in 2018-2019) and 8% recorded 'Don't know' (c.f. 2% in 2018-2019).

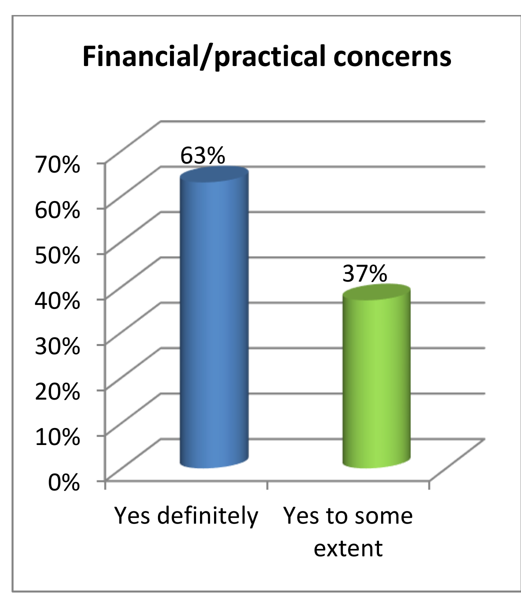
Q18B) 8 (23%) of the 35 respondents who answered the question stated that the patient did require some kind of religious or spiritual support. In response to whether they received enough religious or spiritual support from the CPCT, 4 of these (50% c.f. 71% in 2018-2019) answered 'Yes definitely' and 3 (38%) replied 'Yes to some extent' (c.f. 17% in 2018-2019), none (0%) replied 'No, not when needed' (c.f. 0% in 2018-2019) and 1 (13%) replied 'Don't Know' (c.f. 13% in 2018-2019). All IPU responses were either'Yes definitely' or "Yes to some extent."

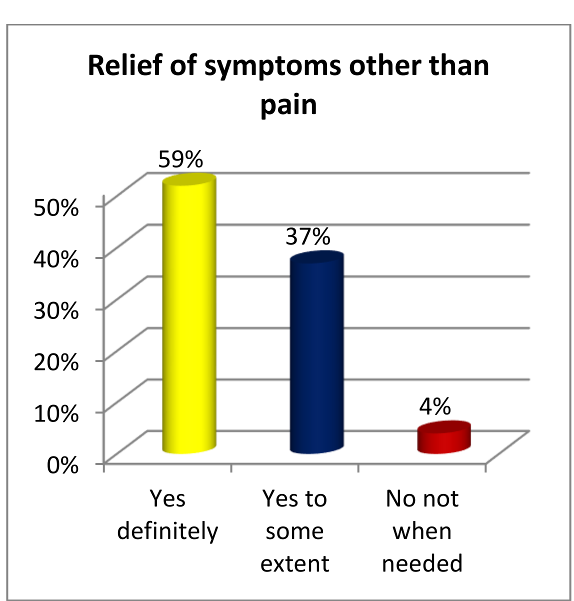




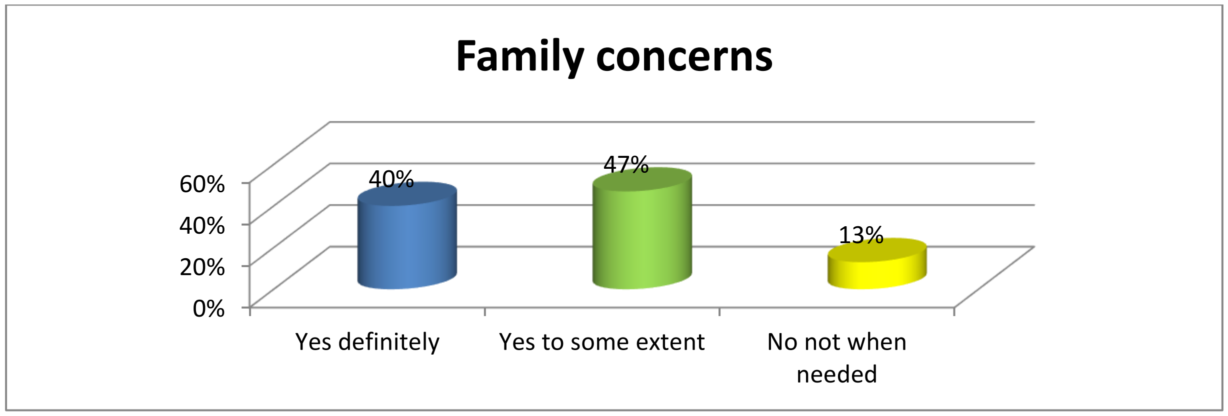
Q18C) 63% of respondents felt that the patient did not require help with financial concerns and other practical problems (c.f. 65% in 2018-2019) and two respondents (7% c.f. 0% in 2018-2019) did not know. Only 8 respondents felt that this support was needed and, of these, as to whether enough support was received, 63% replied 'Yes definitely' (c.f. 59% in 2018-2019), 37% 'Yes to some extent' (c.f. 29% in 2018-2019) and 0% 'No not when needed' (c.f. 12% in 2018-2019).

Q18D) 17% of respondents felt that the patient did not require help with relief of symptoms other than pain (c.f. 18% in 2018-2019) and no respondent (0% c.f. 6% in 2018-2019) did not know. 27 respondents felt that this support was needed and of these, as to whether enough support was received, 59% replied 'Yes definitely' (c.f. 66% in 2018-2019), 37% 'Yes to some extent' (c.f. 29% in 2018-2019) and 4% 'No not when needed' (c.f. 5% in 2018-2019).

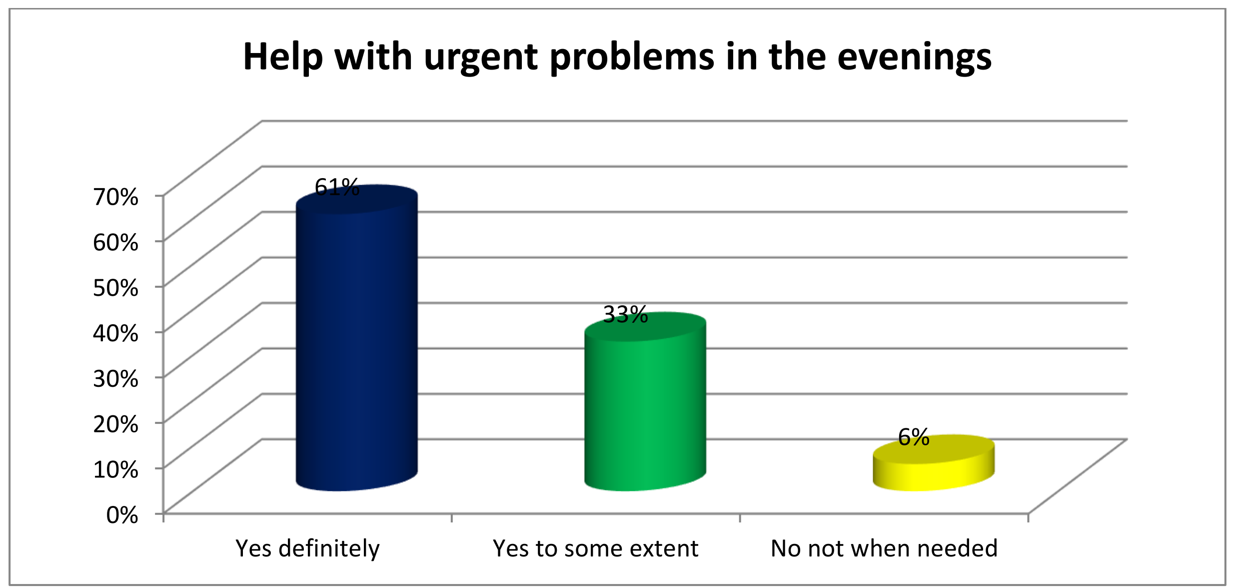




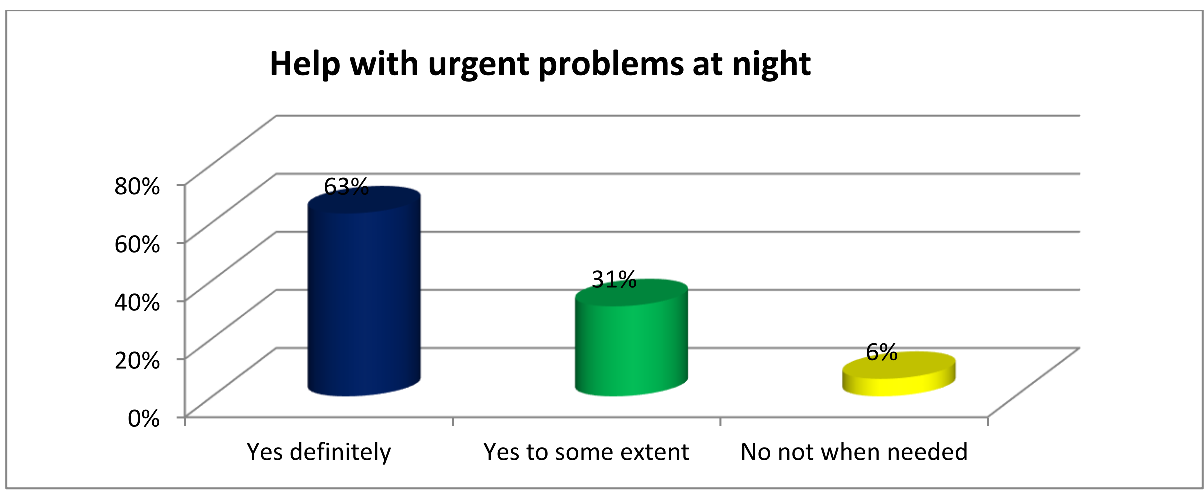
Q18E) 50% of respondents felt that the patient did not require help with family concerns (c.f. 52% in 2018-2019) and one respondent (3% c.f. 4% in 2018-2019) did not know. 13 respondents felt that this support was needed and of these, as to whether enough support was received, 40% replied 'Yes definitely' (c.f. 71% in 2018-2019), 47% 'Yes to some extent' (c.f. 24% in 2018-2019) and 13% 'No not when needed' (c.f. 5% in 2018-2019).



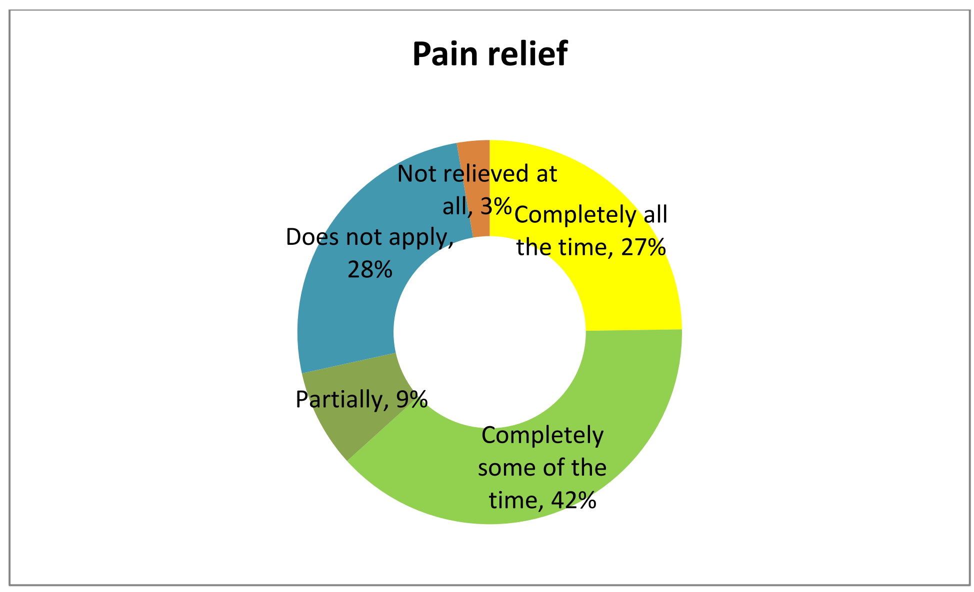
Q18F) 21% (c.f. 41% in 2018-2019) of respondents felt that the patient did not require help with urgent problems during the evenings (between 5 PM and 11 PM) and another four respondents (14% c.f. 10% in 2018-2019) did not know. 18 (64% c.f. 49% in 2018-2019) respondents felt that this support was needed and of these, as to whether enough support was received, 61% replied 'Yes definitely' (c.f. 67% in 2018-2019), 33% 'Yes to some extent' (c.f. 29% in 2018-2019) and 6% 'No not when needed' (c.f. 4% in 2018-2019).



Q18G) 28% of respondents felt that the patient did not require help with urgent problems during the nights (between 7 PM and 9 AM) (c.f. 44% in 2018-2019) and 17% respondents (c.f. 13% in 2018-2019) did not know. 16 respondents - 55% (c.f. 44% in 2018-2019) felt that this support was needed and, of these, as to whether enough support was received, 63% replied 'Yes definitely' (c.f. 67% in 2018-2019), 31% 'Yes to some extent' (c.f. 29% in 2018-2019) and 6% 'No not when needed' (c.f. 5% in 2018-2019).



Q19) 33 of the 35 respondents answered the question relating to their loved one's pain relief provided by the CPCT. 27% reported that the pain was relieved 'Completely all the time' (c.f. 31% in 2018-2019), 42% 'Completely some of the time' (c.f. 33% in 2018-2019) and a further 9% considered that pain was only ever partially relieved (c.f. 18% in 2018-2019). One (3% c.f. 2% in 2018-2019) replied that the pain was not relieved at all. Furthermore, 0% did not know (c.f. 6% in 2018-2019) and 18% responded that this did not apply because the patient had no pain (c.f. 10% in 2018-2019).



Q20) 34 of the 35 respondents answered the question relating to whether they and their family got enough help and support from the Hospice CPCT. See table below.

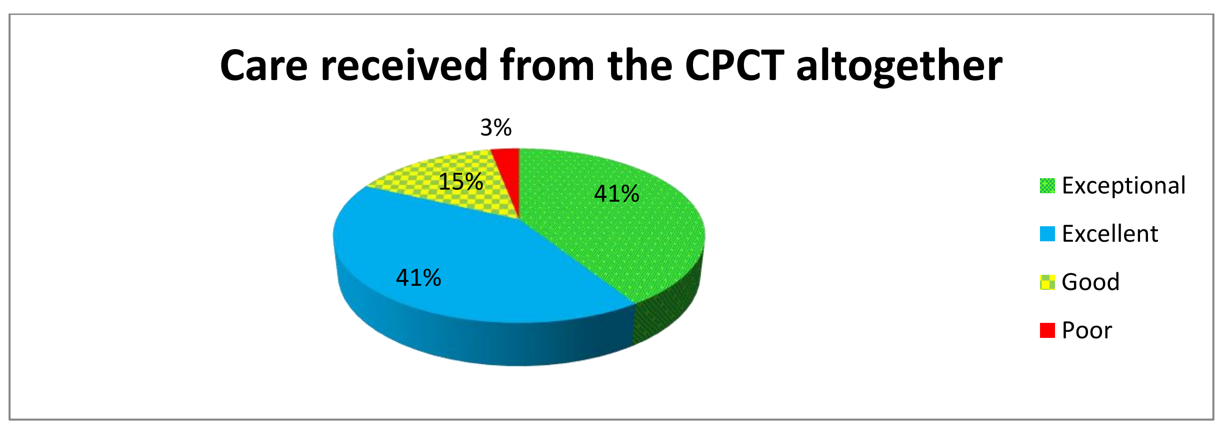
	2019	2018-19	2018	2017- 18	2017
Yes as much as we wanted	82%	85%	79%	78%	83%
Yes, some, but not as much as we wanted	9%	8%	12%	7%	17%
No, tried to get more	6%	2%	4%	6%	0%
No, did not ask for more	3%	4%	5%	7%	0%
Did not need	0%	2%	0%	2%	0%

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 69% of respondents (c.f. 66% in 2018-2019) and 'fairly easy' by 21% (c.f. 24% in 2018-2019), 'fairly difficult' by 3% (c.f. 2% in 2018-2019) and 6% recorded that they did not explain anything (c.f. 6% in 2018-2019). None (0% c.f. 2% in 2018-2019) recorded that they never spoke with the team. 33 of the 35 respondents answered this question.

Q22) 32 of the 35 respondents answered the question relating to whether the CPCT team had time to listen to them and 84% responded 'Yes, all the time' (c.f. 87% in 2018-2019) and 9% responded 'Yes, some of the time' (c.f. 9% in 2018-2019), just one (3% c.f. 2% in 2018-2019) recorded 'No, not when needed,' and one (3% c.f. 2% in 2018-2019) 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, 34 of the 35 respondents recorded an answer and of these, 41% recorded 'Exceptional' (c.f. 48% in 2018-2019), 41% 'Excellent' (38% in 2018-2019), 15% 'Good' (12% in 2018-2019), 0% 'Fair' (c.f. 0% in 2018-2019), and 3% recorded 'Poor' (c.f. 2% in 2018-2019).



Q24) 33 of the 35 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. 92% in 2018-2019), 9% recorded that they would have liked to have been more involved (c.f. 2% in 2018-2019), 3% (c.f. 6% in 2018-2019) recorded 'Don't know.'

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

Relationship to patient	24 CPCT COMMENT
Husband	She received a lot of help from bathroom and toilet equipment provided to help her needs and condition.
Wife	Everyone was so kind
Daughter	The CPCT was a great support to me while looking after my mum. All phone calls were very helpful and always got prompt response if leaving a message.
Wife	Very understanding, listening and helpful
Daughter	Communication was excellent, they were compassionate, kind and caring, on several occasions the staff covered night shifts, so that i could get a respite.
Husband	Pain relief and any nursing was undertaken by LA health care team, but we had regular weekly visits from St Raphael's to discuss progress etc. which is comforting in preparing us for what might evolve.
Wife	I would like to say that I felt supported at all times. I was also confident that the CPCT would advise us when the time was right for patient to go into the hospice as that what his wish.
Wife	The care my husband received from CPCT was good - however, communications between district nurse - doctor - hospital supplies could have been better.

Two comments were neither complimentary nor critical.

Relationship to patient	24 CPCT COMMENT
Daughter	During the time they cared for my dad, I never ever spoke to any of the hospice team, but the home Southdown were amazing and thankfully they administered the medication you decided was necessary. We live in Oxford, too far to be there every day and both my husband and i have cancer and are receiving treatment
Husband	Supplied her fags and sat guard - that was all she wanted me for.

One had praise mixed with an element of criticism:

Relationship to patient	24 CPCT COMMENT
Daughter	They were a great source of practical and emotional support for all the family as well as the patient. Some confusion, especially initially as who to call – district nurses or CPCT (Hospice) and not much communication between the two. Found it incredibly frustrating that patient's GP continually ignored requests from the palliative care experts (CPCT)

Two comments were definitely critical

Relationship to patient	24 CPCT COMMENT
Wife	After death we did not hear from the person who had been most involved with the care. This was a shame as had been very supportive. I would have liked to speak with them.
Wife	We did not review the end of life care plan ie "do not resuscitate." It would have been helpful to have been reminded that circumstances change - reminded to look at it again (revisit it).

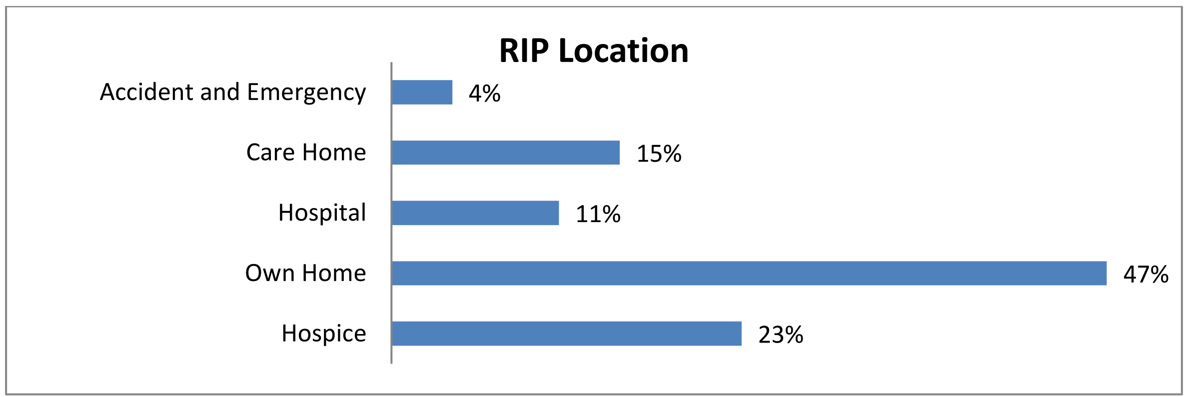
St Raphael's Hospice Jubilee Centre

Q25) & Q26) 6 of the 50 respondents said that the patient had visited the Jubilee Centre (c.f. 4 of the 69 in 2018-2019). Of these, 4 recorded that their loved one always benefitted from the experience, 1 that they usually did, and 1 did not record an answer.

Circumstances surrounding his/her death

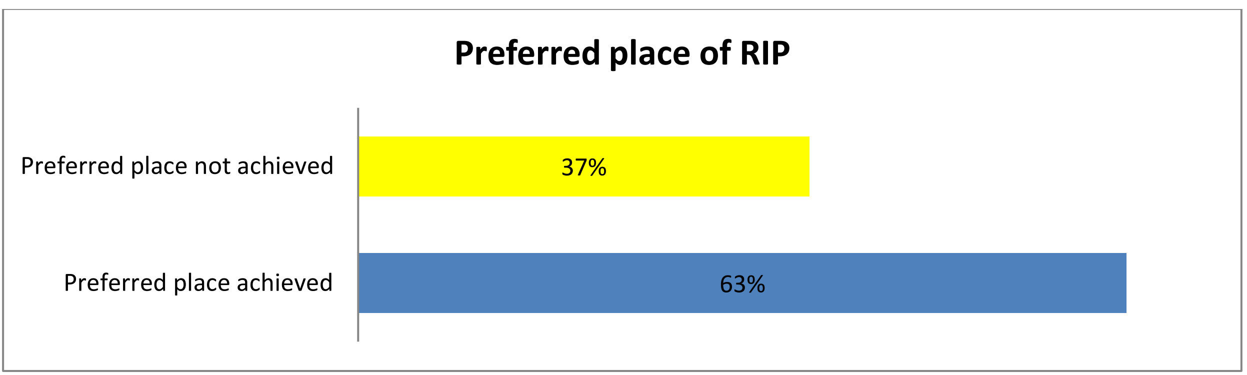
This section presents the views of the respondents regarding the circumstances of the patient's death and any expressed wishes. The questions were asked of all respondents.

Q27) Of the 50 respondents, 3 did not record an answer to this question. Of the remaining 47, 23% reported that their loved one died in the Hospice (c.f. 39% in 2018-2019), 47% that they had died in their own home (28% in 2018-2019), 11% that they had died in hospital (c.f. 23% in 2018-2019), 15% that they had died in a care home (c.f. 7% in 2018-2019) and one patient (4% c.f. 2% in 2018-2019) died in Accident and Emergency.



Q28) 37 respondents said that their loved ones explicitly stated where they wanted to die, 15 did not say, 2 were unsure and 11 recorded no answer. Of the 37 who recorded that the patient stated their preferred place of death, 1 - 3% said they preferred a care home (c.f. 2% in 2018-2019), 11 – 30% said they preferred a hospice (c.f. 29% in 2018-2019) and 23 (62% c.f. 61% in 2018-2019) their own home. Two (5%) changed their mind.

Q29) Of the 35 respondents who recorded that the patient had explicitly stated a specific preferred place of death (so not including the two who recorded "changed mind"), this was achieved in 22 (63%) of cases (c.f. 62% in 2018-2019).



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

Preferred place	Achieved 2019	Not Achieved 2019	Achieved 2018-19	Not 2018-19	Achieved 2018	Not 2018	Achieved 2017-18	Not 2017-18
Hospice	**4**	**7**	**9**	**3**	**12**	**3**	**6**	**5**
Either Home or Hospice	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**
Own Home	**17**	**6**	**13**	**12**	**19**	**10**	**12**	**10**
Friend/Family Member's Home	**0**	**0**	**1**	**0**	**1**	**0**	**0**	**1**
Son's Home	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Daughter's Home	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**
Hospital	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**
Care Home	**1**	**0**	**1**	**0**	**1**	**0**	**2**	**0**
TOTAL	**22**	**13**	**24**	**15**	**34**	**14**	**21**	**16**

Q30) Respondents were asked whether their loved ones had enough choice about where they died. Of the 35 that did say where they wanted to die, 29 – 83% reflected their loved one had had enough choice about where they died (c.f. 79% in 2018-2019), 0% were 'Unsure' (c.f. 5% in 2018-2019) and 6 (17% c.f. 15% in 2018-2019) said they did not have enough choice.

Actual place of death	Yes	No
Accident & Emergency	1	
Care home	2	3
Hospice	4	
Hospital	3	2
Family / Friend House	0	
Own home	17	1

Not Recorded	2	
Total	29	6

Three of the six respondents who believed the patient did not have enough choice recorded the following comments:

Did not have enough choice
‘Symptoms too bad to be looked after at home as she wished she did not want to go into hospice’ – Husband of patient
‘Not at all, my dad died just over a week after he was moved. He was distraught and to be moved, it was totally cruel and unnecessary for him and me’ – Daughter of patient
‘Bed unavailable at St Raphael's’ – Husband of patient

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

Did have enough choice
‘On seeing the wonderful care my mum receieved in the hospice in May 2015, patient always knew that this was where he wanted to be’ – Wife of patient
‘Although we and she felt pressured to go to the hospice, which upset her’ – Daughter of patient
‘Would have preferred to die in a hospice as she felt it would make surviving family uncomfortable with their home if she died at home’ – Husband of patient
‘Dad thought that Southdown was his home, as he has vascular dementia and really loved it there and the staff. The Home wanted to have him back from St Helier so they could care for him. They were amazing.’ – Daughter of patient
‘My mother wanted to die in her home and died in her sleep at home.’ – Daughter of patient
‘The help received was very good. Unfortunately the care plan was not in place before it was critical, so everything was on catch up. They did their best in the circumstances. Link between bed delivery/ district nurses/ hospice could have been more joined up.’ – Wife of patient

Q31) On balance, when responding to the question of whether the patient died in the right place, 49 answered the question and of these, 44 replied that they did – 90% (c.f. 82% in 2018-2019), none (0% c.f. 3% in 2018-2019) were unsure, and 5 – 10% replied that they did not (c.f. 15% in 2018-2019).

Actual place of death	Yes	No
Accident & Emergency	1	1
Care home	4	2
Hospice	11	0
Hospital	4	1
Own home	21	1
N/R	3	0
Total	44	5

Three of the five respondents who felt their loved ones died in the wrong place recorded comments.

DIED IN RIGHT PLACE	31 COMMENT ON PLACE	Relationship to Patient
NO	He hated where he was moved to. It was difficult for me to travel to as a non driver. It was two bus journeys and a long walk. I was unable to bring my children in to see him and because of this i saw him less	Daughter
NO	We really needed help at the end and my husband needed to be in St Raphael's but there were no beds abailable. It was very traumatic for his young son and myself and still haunts us to this day.	Wife
NO	She was left to die	Husband

One respondee who did not record an answer recorded the following comment:

DIED IN RIGHT PLACE	31 COMMENT ON PLACE	Relationship to Patient
RECORDED NOT	She was not bothered where she died, she couldn't smoke any more (lung had given out)	Husband

Seven of the 43 respondents who believed the patient had died in the right place recorded comments:

DIED IN RIGHT PLACE	31 COMMENT ON PLACE	Relationship to Patient
YES	So grateful patient got his wish	Wife
YES	He was in hospital for only three days. He was admitted by a nurse from hospice who visited him.	Sister
YES	Considering condition	Wife
YES	It felt right with his family around and familiar surroundings	Husband
YES	But should have had air mattress weeks before she died and not the day before!	Wife
YES	Mum died peacefully in her home, which is what she always wanted	Daughter
YES	He died at home	Wife

Bereavement Support

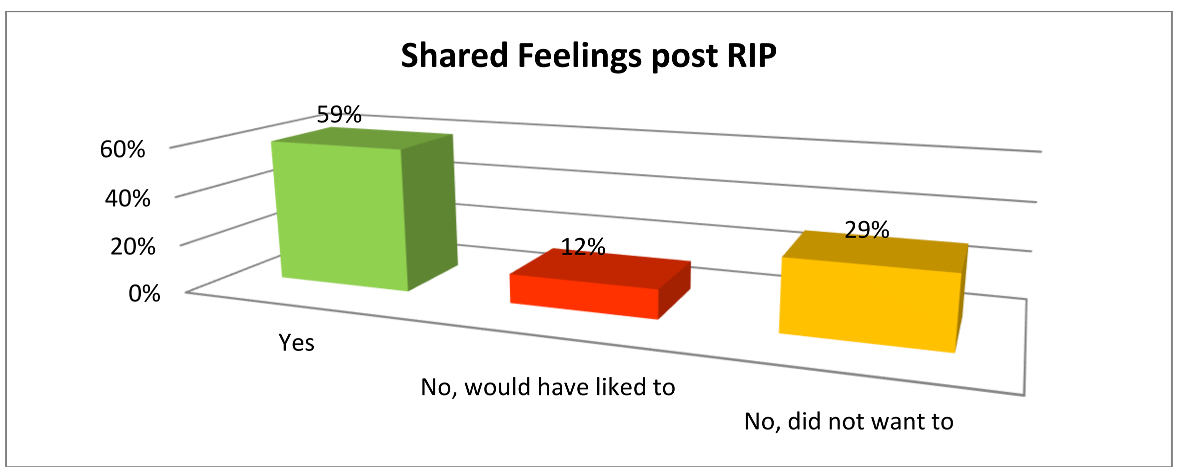
Q32) Of the 11 respondents who responded their loved ones died in the Hospice, 82% felt that they were definitely given enough support by staff (c.f. 92% in 2018-2019), 18% replied 'Yes, to some extent' (c.f. 8% in 2018-2019), and 0% responded 'No, not at all' (c.f. 0% in 2018-2019).

Two respondents recorded comments:

Family given support	Relationship to patient	Comment
Yes definitely	Wife	Amazing support given
Yes definitely	Son	Fantastic care and support shown at all times.

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.

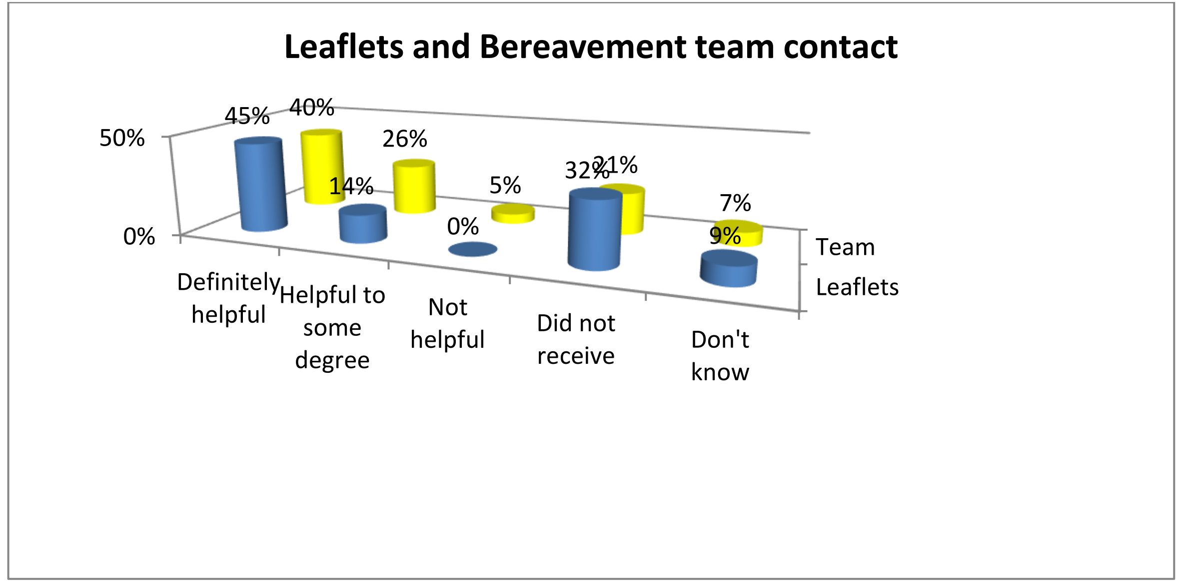
15 of the 50 respondents had not spoken to anyone, and said that it had been their choice. 6 replied that they would have liked to and 29 replied that they had (c.f. 22/69 respondents had in 2018-2019). Of these 29, 9 (31%) spoke with a bereavement service volunteer, 10 (34%) spoke with a counsellor, 3 (10%) spoke with nurses, 1 (3%) spoke with a doctor and 'other,' 1 (3%) was unsure who they spoke to and 5 (17%) 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, 15 (71% c.f. 82% in 2018-2019) responded that they had talked to them as quickly as they wanted to, 1 (5%) said they wanted it sooner (c.f. 5% in 2018/19), 4 (19% c.f. 14% in 2018/19) were unsure, and 4 did not record an answer (c.f. 0 in 2018-2019).

Q36 A) When respondents were asked whether they had received a leaflet from the Hospice giving information about what to do after their bereavement, 6 did not record an answer, and of the 44 who did record an answer, 20 (45% c.f. 48% in 2018-2019) found it 'Definitely helpful,' 6 (14% c.f. 19% in 2018-2019) 'Helpful to some degree,' 4 (9% c.f. 10% in 2018-2019) did not know, 0 (0% c.f. 0% in 2018-2019) found it 'Not helpful' and 14 (32% c.f. 22% in 2018-2019) did not receive it.

Q36 B) When respondents were asked whether they had received contact from the Hospice Bereavement Team, 8 did not record an answer and of the 42 who did record an answer, 17 - 40% found it 'Definitely helpful (c.f. 47% in 2018-2019) ,' 11 - 26% 'Helpful to some degree (c.f. 17% in 2018-2019),' 3 -7% did not know(c.f. 16% in 2018-2019), 2 - 5% found it 'Not Helpful' (c.f. 5% in 2018-2019)and 9 - 21% did not receive contact (c.f. 16% in 2018-2019).



Bereavement Comments

Four respondents had distinct criticisms to make in this area:

Bereavement Comments	Relation to patient
Would have been helpful if I had some counselling from bereavement team	Wife
When support phoned, I could not talk as was at work and was not ready to talk then, now, six months later, I need the support.	Wife
I only received one voice mail message from the bereavement team saying they were just making contact. This was about one month after my husband died. No follow up contact has been received so far, nearly six months later.	Wife
I would have appreciated a call from the nurse who visited many times. But i know she is busy so I don't hold it against her!	Wife

Five respondents had compliments to make surrounding bereavement services:

Bereavement Comments	Relation to patient
Everyone was just very kind	Sister
St Raphael's bereavement/ psycho-social care team contacted me on more than one occasion after my wife died and made it abundantly clear that help and support were available should i need it. Fortunately for me, family and friends have provided all the support I've needed	Husband
Both myself and my daughter are receiving counselling at the hospice. I feel very supported and loved.	Wife
The help and support my wife received at St Raphael's was superb. She was quite sure she would die there in two days as she wouldn't be allowed to smoke, after a nurse said she could, she seemed recovered and I had to sit with her the whole time she was smoking, after 51 years of having smoke blown in my face. Sorry about this, but until you have experienced this, you haven't a clue what I went through	Husband
Did contact and offer support if needed. Felt I was okay. But help was available.	Husband

There was one other comment:

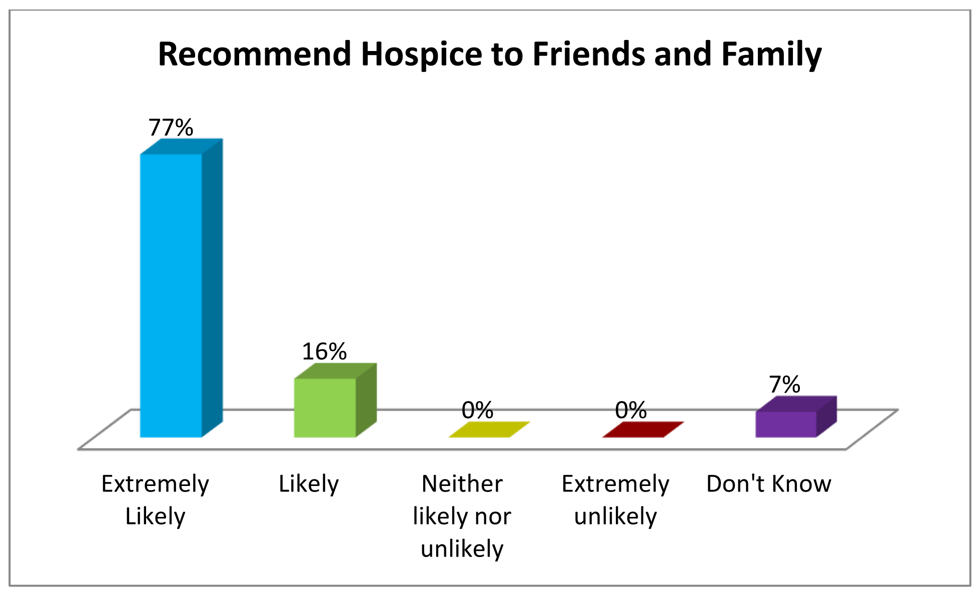
Bereavement Comments	Relation to patient
Got information from the hospital as he died in the hospital	Wife

Q36 a)

Friends and Family section

NB: During this audit period, the categories for this question changed. Therefore the data cohort of "Extremely Likely" to "Extremely Unlikely" to recommend is only 43.

When respondents were asked whether they would be likely to recommend the Hospice to their friends and family, 1 of the 43 respondents did not record an answer. Of the 42 who did record an answer, 33 (77% c.f. 78% in 2018-2019) said they would be 'Extremely Likely' to recommend the Hospice , 7 (16% c.f. 12% in 2018-2019) said they were 'Likely', 0 (0% c.f. 4% in 2018-2019) said they were neither likely nor unlikely to recommend the Hospice , 0 (0% c.f. 3% in 2018-2019) said they were extremely unlikely to, and 3 (7% c.f. 3% in 2018-2019) did not know the answer to this question.



Id	Recommend Hospice?	36a friends and family comment	Relationship to patient
6	Extremely likely	I feel that everything that was possible was called out in a very positive and professional manner and the hospice building was pleasant and beautiful hospice grounds!	Husband
7	Extremely likely	The hospice is special because of the amazing staff, but sadly there are not enough beds available which is not the Hospice's fault, but funding.	Wife
9	Extremely likely	St Raphael's Hospice were our saviours. At last Mum was cared for with dignity and in calm, peaceful surroundings. My brother and I could go home with peace of mind that she was in an amazing place.	Daughter
12	Extremely likely	Because of the care my husband received at home a few weeks before, and the evening of, the day he died. The medication he was given just one hour before death meant he had a calm and peaceful end at home which was through the district nurses.	Wife

Id	Recommend Hospice?	36a friends and family comment	Relationship to patient
13	Extremely likely	Our dealings from initial visit to seeing doctors and attending Jubilee Centre were all very good.	Husband
14	Extremely likely	We had an excellent GP and community team for my husband's care/ but St Raphael's was there for me.	Wife
19	Extremely likely	I've dealt with the Hospice and St Anthony's for over fifty years and have always found kindness and caring and good facilities. I hope I can find the same when my time approaches.	Husband
20	Extremely likely	Although I never asked for support, it was offered on a number of occasions which I turned down because I already had tremendous support from family, friends and the neighbours. The offer from St Raphael's Hospice was very, very kind and I believe people without the support I had from family etc. would appreciate it.	Husband
21	Extremely likely	Very helpful, straightforward information and support received.	Wife
22	Extremely likely	You have dealt with three members of my family and have always been of help.	Wife
23	Extremely likely	They have all been very supportive throughout when we needed to see someone they saw us as quickly as possible. Despite what must be a very busy workload they always had plenty of time - we never felt rushed.	Wife
24	Extremely likely	The staff were very kind and caring, after my mother died, they contacted me and were extremely supportive and helpful, I would recommend St Raphael's Hospice every time.	Daughter
25	Extremely likely	Quite simply, the care, support and attention given to my wife during her last days was absolutely exceptional, and I cannot praise too highly the quality of all the staff involved with her care.	Husband
26	Extremely likely	The care and respect given to my wife was a blessing. The fact I could stay with her meant a lot to us both. For a week I was her wife and partner rather than her carer. Thank you, St Raphael's.	Wife
27	Extremely likely	Having the support from the palliative nurse and home visit service to allow myself time away for a few hours knowing my wife was in safe hands.	Husband
29	Extremely likely	The Hospice is an amazing place. Very peaceful	Wife
30	Extremely likely	I cannot speak highly enough of the whole Hospice and team. An oasis of love and care in a time of need. Support before, during and after a very sad and emotional time. I will tell the whole world if necessary how wonderful St Raphael's is!	Wife
31	Extremely likely	Staff very kind and friendly and nothing was too much to do to help my wife	Husband
32	Extremely likely	Because the person that came to talk and arrange things my husband thought was very calming	Wife
36	Extremely likely	I cannot fault the standard of care provided to Mum and our family. Everybody we came into contact with provided us with support, kindness and compassion and for that reason I would recommend St Raphael's.	Son

Id	Recommend Hospice?	36a friends and family comment	Relationship to patient
37	Extremely likely	Overall the care he received was very good whilst he was in the Hospice and I would certainly recommend it to others.	Wife
39	Extremely likely	Named nurse was excellent and always called me regarding patient's progress and offered all the support. A valuable member of your team!	Husband
42	Extremely likely	You are all simply outstanding	Husband
10	Likely	My mother always supported St Raphael's financially	Daughter
11	Likely	As a non-christian it was a bit overwhelming to be met by so many religious symbols in the entrance space. We know it is a religious based establishment and appreciate that it is inclusive and welcoming, but it was uncomfortable.	Mother
18	Likely	Only if someone I knew lived in the area.	Sister
34	Likely	St Raphael's Hospice can give you support - friendly.	Husband
41	Likely	I appreciated being allowed a few hours respite while my wife was being looked after in our home. Also appreciate the care by your nurses and pain management doctor.	Husband
46	Good	The medical team were very good	Daughter
48	Very good	We found contact good at a very difficult time	Wife
50	Very good	Would have put excellent if given the choice. Caring, friendly, compassionate, but professional. Never intrusive, but always on end of phone when needed. When visited at home – always had time to listen to concerns of family, but also patient. Never felt rushed. Able to advise on all aspects of care, medication, personal care etc. One thing the hospice should do better: - Force the patient’s GP to act on requests. Advice of CPCT (nurses and doctor) especially regarding medication.	
1	Don't know	Because I need someone to talk to at the passing of partner	Wife
33	Don't know	Can't really decide, as I never ever had any contact, just one call after Dad died to raise funds for the hospice. I am sure you do an amazing job, but I have to say we were served by the fantastic team at the nursing home, however we thank you for the help that you gave Southdown with my dad, it was nice to know he was pain free!	Daughter
38	Don't know	The nurses were kind and amazing. My Dad was on the whole comfortable there. We were put under pressure for him to move to a nursing home even though we were told he only had a short time to live. We were given limited choices of nursing homes and I had to walk around Sutton visiting him when I should have been spending precious time with my dad. He had only me to visit him.	Daughter

Two survey returns referred to need for additional bereavement support. Both received further follow up from the Bereavement Team.

2019 IPU Manager Comments

The Voices questionnaire is a very useful tool for the teams to improve on areas we are not doing so well at and continue to strive for those areas of excellence in the things we are doing. There were fewer respondents this year to previous years but the content of their comments remain valuable.

Out of 50 returned questionnaires , 21 of the relatives had spent some time on the In patient Unit (IPU). The care received by the relative was a positive one for personal hygiene, dignity and privacy which is attributed to the team of Nurses and Doctors on the unit.

Nursing Care including symptom control with medications and repositioning to prevent pressure damage was seen to be exceptional and no one responded negatively.

The environment was seen as excellent to good and the Hospcie will be seeing a refresh of the IPU rooms, patio areas, main IPU corridor and Hospice reception area so we will hopefully be able to see responses in the future increase to exceptional.

There was a question asked of respondents which was -"During this admission, were there any decisions made about his/her care or treatment that s/he would not have wanted?". The majority responded with a positive 'No' but there was a negative 'Yes' noted and comment left and I felt compelled to answer this. We are not a long stay facility but a specialist palliative care unit who meets the specialist needs of the local community. The response received which was not so positive was within the context of discharging the patient to another care environment. We, as a team endeavour to include patients and next of kin where possible on the discharge to another care facility. We encourage families to visit the identified care facilities and make a decision which is best for them and their loved ones – unfortunately we cannot predict the timing of death and it was indeed a sad occasion when the patient died a short time after transfer.

There was a decrease in emotional support, from definitely to some extent which is slightly disappointing given the role we have in the Hospice where there would be an expectation of our skilled and expert team being able to provide this level of support. Although we are reassured that there was no negative responses noted., it is an area of support that we will actively review and continue with plans in place to deliver training to support staff in delivering informal emotional and psychological support.

Overall the responses show a positive interaction with the IPU team during the care of those important to the respondents but will continue to aim higher for our future patients and families.

2019 Community Team Manager Comments

A small downward trend cannot be ignored and we need to continue to strive to ensure that our branding and corporate identity is easily recognised/ establish – "who we are and what we do". This must be considered when we review our literature and the language used within them.

"They were a great source of practical and emotional support for all the family as well as the patient. Some confusion, especially initially as who to call – district nurses or CPCT (Hospice) and not much communication between the two. Found it incredibly frustrating that patient's GP continually ignored requests from the palliative care experts (CPCT)"

The above comment : Who to call ? is often a familiar scenario and it maybe worth considering having simple and clear patient / family guidance in the future .

Interestingly our responsive visiting outcome increased yet contradictory a higher percentage felt they didn't get enough help. We continue to have two CNS on triage Mon – Fri when capacity allows with a urgent responsive visiting element to the role if required. Our aim is to continue increasing responsiveness with the team capacity improving patient and family experience. It must be noted at weekends we cannot provide the same level of responsiveness with only one CNS on duty and the capacity of team doesn't allow two CNS.

A greater proportion felt that the patient required help with urgent problems during the evenings, between 5pm and 11pm, yet there was a downward trend that the need was met . It is difficult to comment on this however there is feeling from the team that OOH calls have increased over time and calls can often be complex. As an organisation it maybe worth considering if training or further support is required for the night staff to help them with what can be complex calls.

Overall the comments were positive and the team are invested in the service to provide the care that they do within the staffing capacity they have .

2019 Head of Psycho-social Team Manager Comments

Once more, I can only comment on the data and not the experience (not being in post during this time). However:

Definite assertion of the adequacy of emotional support decreased to 68% in 2019 from 2018/19's 78% (page 11), whilst definitive assertion of the adequacy of religious/spiritual support decreased to 55% from 2018/19's 84%. – *We have been working tirelessly, pre-Covid to ensure Sr Ann has a daily presence on the IPU and the IPU Manager and I have set up a system whereby IPU staff can speak with me directly so that referrals for emotional care can be facilitated and are not overlooked.*

Bereavement support was considered definitely enough by 82% - a decrease on 2018/19's . 92% - *ambitious as it may be, I am aiming to have this feedback closer to 100% than 80%. We now have 6 students delivering bereavement counselling, reducing waiting times. The Bereavement Support Group will add to the menu of support services and the Volunteer Bereavement Callers will be back in action in the next month or so. This should mean no relative falls through the gaps.*

Following receipt of the bereavement leaflet – a lower proportion - 62% found it either definitely helpful or helpful to some degree (c.f. 67% in 2018/19). 32% did not receive the leaflet (c.f. 22% in 2018/19). *I would like to review all literature that is sent out as well as the website by the end of 2020 to ensure access to services is clear and empowers relatives to be pro-active in accessing care (as we can not check in with them all on a week to week basis).*

The proportion of respondents that considered contact from the bereavement team was either definitely helpful or helpful to some degree has increased slightly to 66% (c.f. 64% in 2018/19). 5% felt the contact was unhelpful (c.f. 5% in 2018/19). However, response stating that contact wasn't received has increased to 21% (c.f. 16% in 2018/19). *It is well researched that during the first months of grief, a family member will be forgetful, unsure as to what has been communicated and offered. We have robust systems in place that ensures 100% of NOK are written to offering them Bereavement Therapy and that they can choose when to contact the hospice. It is explicit – there is no expiry date. Follow up calls are also made to those who do not initially engage (whether they answer the phone is one problem but we always call back and try on at least three occasions).*

I concur with the findings:

To progress the review of the bereavement leaflet and its provision *(and website)*

To audit bereavement contact as recorded in Crosscare.

I would also like to enquire if we can look to audit the pre-bereavement work we do with families via VOICES?

Regarding comments received:

"Would have been helpful if I had some counselling from bereavement team" – it is offered robustly in the first three months and again at the 6 and 12 month anniversaries via the memorial invites. However, perhaps the literature needs to make it clear that the family member can contact us at ANY point.

"When support phoned, I could not talk as was at work and was not ready to talk then, now, six months later, I need the support". Again we can not keep calling to enquire but we can make it clear that the door is always open for the relative to contact us.

"I only received one voice mail message from the bereavement team saying they were just making contact. This was about one month after my husband died. No follow up contact has been received so far, nearly six months later". Calls are actually done 3 months post the death. But we need to empower relatives to take the initiative and empower them to call us.

2019 Clinical Director Comments

As in previous years the results are generally favourable with particular areas scoring more highly than previously (such as effective pain relief on the IPU and responsive visiting in the community). However, it is important to acknowledge that there is a general downward trend. Surveys and questionnaires are becoming more common place with a growing social culture of rating 'customer service' to provide honest feedback and we need to ensure that we use this opportunity to further improve what we do well, and address those areas where we have not scored as highly as in past years.

Communication in terms of language that is easy to understand and keeping family members informed requires address; it can be easy to become absorbed in the 'job in hand', particularly when we are busy. We need to ensure that patients and those close to them are aware of and understand what is happening on a day to day basis. It's difficult to know whether the proportion of those who felt unwanted decisions were made, did not agree with those decisions or purely didn't have enough opportunity to discuss and question the rationale behind the decisions. Undertaking Advanced Communication skills training on a more regular basis might be beneficial to staff instead of the one-off opportunity provided historically.

In terms of help with symptom relief other than pain, there is again a downward trend compared to the previous year. It is difficult to comment on why this might be without further detail, although we know that people are living longer with more co-morbidities and therefore a number of influences may have affected this outcome. This area requires further investigation and it is essential that we undertake audits/ service evaluations and apply outcome measures going forward to gain a better understanding of where we might improve.

We must also acknowledge areas in which we have done well and as previously highlighted, the overall care and provision of support and advice is positive. Staff work hard to provide the service that they do, despite the high level of emotional burden, palliative and hospice care are known to bring. The passion and commitment that I have witnessed in the short time that I have been here at SRH have been overt and I feel the right components are all in place to make SRH even stronger.

2019 Joint CEO Comments

Questionnaires always provide valuable insights into how those who use our services reflect how we are performing. Although it is disappointing that the percentage response to the questionnaire has decreased this year, there is valuable information that has been shared by those who did respond which we need to consider and learn from to support improvement.

It is positive that respondents reported that overall the care delivered met their needs. This is an area that we need to actively support going forward as we aim to ensure all our delivered care is seen as being excellent. As an organisation we are investing in our staff training and recruiting to ensure that across all our services we have the capacity and expertise to deliver the care people can come to expect from us. This expectation is reflected in the percentage of respondents who would recommend our services to their friends and family.

The provision of psychosocial support was an area that respondents reported they did not get access to in the timeframe or way they had expected or wanted. The responses highlight the importance of having services responsive to need as well as the importance of people having the information about a service to manage their expectations and inform how they can access it. Conversely, as an organisation, if we inform people of what we can provide we need to deliver on this to avoid disappointment. In recent months, the psychosocial team has had a change in leadership which is developing and supporting increased delivery of bereavement support and reduction in waiting times for access to counselling services. Hopefully, this response will be positively reflected in the next Voices survey.

Communication and language were also points of comment from respondents. Communication is a central tennent of palliative care with information sharing needing to be clear and unambiguous. Consideration of further education and support with communication skills remains high on the education agenda across all clinical teams. This could be aligned with an increase to 24%, in the perception that patients and families do not feel included in decisions about their treatment/care options.

It reflects well that the environment was well evaluated, with people feeling comfortable and their privacy respected. We are aware that there is a need to refresh and update the IPU to ensure we continue to meet peoples needs.

As with all questionairres it is easy to focus on the negative points raised, from which much can be learned, however we need to recognise the overall good standard of care delivered to people referred to and using our services by our dedicated and committed teams.

Prescribers Meeting - 20th Jan 2021

Present –

CNS's Kevin Hobson, Tracy Christmas, Jill Smith, Bernadette Griffin,
Dr. Jenny Strawson

Community team Prescribing

- CNS's reviewed prescribing practice since last meeting.
- Prescribing tends to be more out of hours (weekends / late week evening).
- Prescribing injectable meds can be very time consuming and pressurised.

Jenny reminded team that on call consultant always available to check / run things by over the phone if needed.

- We discussed writing controlled drugs prescriptions to include 24hr deliver via Syringe Drivers

A valuable supportive, supervision session which is how the team would like to go forward with future meetings (which may include teaching / update element). Jenny agreed that she or Gaby will attend each meeting in future.

Prescribing Competencies

Blank forms accessible on N-Drive – Clinical – CPCT – NMP Competencies
Forms can be completed on computer and saved – don't forget to add you name and NMC number!
Kevin to sign off individually after discussion with each NMP.
We can discuss any issues / problems with Competencies at dedicated Prescribers meeting.

Community s/c Guidelines

Apologies for recurring item!
Jenny and Gaby have kindly reviewed and rewritten (long version and short pocket guide!) and are going to write a flow chart for G.P. guidance.
Jenny will forward to us to check / make comments.

MAAR Charts

Tracy shared new injectable meds charts for prn and Syringe drivers.
New charts to be introduced this year across both boroughs.
Power Point presentation will be available nearer time.
Charts are more detailed but look safer and easy to use.

Next meeting will be in March (Kevin will email with date once off duty is complete)

QUALITY ACCOUNT
2019-2020

"QUITE SIMPLY, THE CARE, SUPPORT AND ATTENTION GIVEN TO MY WIFE WAS ABSOLUTELY EXCEPTIONAL AND I CANNOT PRAISE TOO HIGHLY THE QUALITY OF ALL THE STAFF INVOLVED WITH HER CARE" (2019 VOICES SURVEY)

~

Part 1

What is a Quality Account?

The Quality Account for St Raphael's Hospice covers the period from 1 April 2019 to 31 March 2020 and is a record of the cycle of continuous quality improvement as we strive to deliver excellent specialist palliative care. It provides an opportunity for us to share best practice and is driven by the experiences of both those providing and receiving our services. It allows us to demonstrate our commitment to engage with evidence-based quality improvement and to outline our progress to the public. We hope that our Quality Account will deliver an opportunity for scrutiny, debate and reflection as well as provide the public, our regulator and our commissioners, assurance that we are routinely evaluating our services and concentrating on those elements that require the most attention.

St Raphael's Hospice

St Raphael's is a voluntary organisation which, until 31st October 2020, was part of the registered charity of the English Province of the Congregation of the Daughters of the Cross of Liege (charity number 1068661, company number 03492921). Its independent registered charity status began on 1st November 2020 as St Raphael's Hospice (charity number 1182636, company number 11732567) and it continues to provide an adult end of life and specialist palliative care service to our community.

Since 1987, St Raphael's has offered the special skills of Hospice care to those facing life-limiting illness living in the boroughs of Merton and Sutton. The service is free of charge to all who use it and provides high quality medical and nursing care delivered in our own 14-bed unit or in patients' own homes, as well as psychological support, wellbeing and related services, to patients, their families and friends. St Raphael's fully recognises and respects cultural, ethnic and religious differences and patients of all faiths, or none, are welcome.

Hospice care is tailored to the individuals' needs and the St Raphael's team are expert in enabling patients to maximise the quality of their life within the constraints of their disease. . Services include:

- **Specialist clinical care provided by doctors and nurses in our in-patient unit or in the patients' own homes**
- **Hospice at Home service offering relief to carers**
- **A Wellbeing Centre providing social and creative opportunities together with practical information and complementary therapies.**
- **Pastoral care and spiritual support**
- **Psychological support for patients as well as counselling and bereavement support for family members (including children) and other loved ones.**
- **Specialist education and information for patients, carers and other professionals**

Costs associated with the running of St Raphael's Hospice and the services it delivers are about £6 million every year. We receive a grant of around 25% of these costs from NHS sources, but we are reliant on the generosity of our local community through charity fundraising, donations and legacies, our lottery and charity shops to raise the remaining 75% to allow us to continue providing high quality care.

Statement from the Joint Chief Executives

The philosophy and values of St Raphael's Hospice are based on the Christian Ethos of respect for all human life and for a recognition of the unique value of each individual. We therefore welcome, respect and support patients, staff and volunteers of any or of no faith and without discrimination on any other basis. We aim to meet the physical, emotional, spiritual and social needs of patients, their families and friends. Bereavement support is offered and accessible to all relatives of patients known to the hospice service.

We value the contribution of each member of staff and Hospice volunteer through whose efforts our services are delivered. We offer training and education in the principles of specialist palliative care, both within the Hospice and the wider community.

We serve the whole community in the London Boroughs of Merton and Sutton. Alongside our desire to provide expert care to all who need it, we have a subsidiary desire to provide re-assurance to the whole population of around 400,000 people, giving confidence that, should they ever need us, we will be there and we will be excellent.

Quality is integral to the excellent services that we aim to provide. Its assurance is communicated every 2 months via our Advisory Committee to the Trustees of the Charity (and, since independence, is communicated directly to the Trustee Board itself) through a number of reports on aspects of clinical, corporate and financial governance and we are very grateful to those who compile and review these reports, acting as gate-keepers to the qualities we all aspire to.

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

Gail Linehan and Nick Stevens
Joint Chief Executives

St Raphael's Hospice

Part 2

1. Priorities for improvement 2020 – 2021

St Raphael's Hospice is fully compliant with the Fundamental Standards of Quality and Safety that support the section 20 regulations of the Health and Social Care Act 2008 and its subsequent amendments. Consequently, there were no areas of shortfall to include in its priorities for improvement in 2019-2020. Effective from 1st April 2015, has been our responsibility to meet two groups of regulations:

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

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

The Advisory Committee and/or its Sub-committees have endorsed the Management Plan for 2020/21 and considers that its top three quality improvement priorities are:

Future planning priority 1 : Datix Risk Management System

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

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

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

Review: Clinical Quality and Governance Sub-committee

Future planning priority 2:

An improvement priority to support counselling for post bereavement care

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

Measure: Psychological Update Report

Review: Clinical Quality and Governance Sub-committee

Future planning priority 3:

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

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

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

Review: Clinical Audit Review Meeting

2. Statements of Assurance from the Hospice Board of Trustees

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

2.1 Review of Services

During 2019/2020, St Raphael's Hospice provided 5 NHS funded services:

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

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

The income generated by the NHS services reviewed in 2019/2020 represents 100% of the total income generated from the provision of the NHS funded services by St Raphael's Hospice for 2019/2020.

What this means

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

2.2 Participation in national clinical audits and confidential enquiries

During 2019/2020, no national clinical audits and no confidential enquiries covered NHS services provided by St Raphael's Hospice.

What this means

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

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

2.3 Participation in local clinical audits

The undertaking of clinical audits at a local level feeds into the management planning round for St Raphael's Hospice. Details of projects undertaken in 2019/2020 can be found at section 3.2.1.

2.4. Participation in clinical research

There has been one clinical research project commenced in 2019/2020 initiated by a member of the Hospice's medical team in support of her MSc in Palliative Medicine. It was a qualitative study of self-perceived burden (SPB) in lung cancer patients with limited life expectancy.

2.5 Goals agreed with commissioners

St Raphael's Hospice's income in 2019/2020 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework.

2.6 What others say about us

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

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

The Care Quality Commission has not taken enforcement action against St Raphael's Hospice during 2019/2020.

St Raphael's Hospice has not participated in any special reviews or investigations by the CQC during the reporting period.

2.7 Data quality

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

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

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

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

St Raphael's Hospice submitted its self assessment to service compliance with the NHS Digital Data Security and Protection Toolkit (DSPT) in March 2020.

Part 3

3. Quality Review

3.1 Review of quality performance in 2019/2020

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

Past planning priority 1 : Datix Risk Management System

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

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

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

Review: Implementation of the Datix Risk Management software has rolled over into 2020/21's planning.

Past planning priority 2: Implement a Clinical Audit and Activity Data Committee

- **An improvement priority to support clinical audit, research, activity data monitoring and clinical dashboard development**

Standard: To develop a dedicated forum to steer, support and scrutinise the Hospice's clinical audit and research programme, its review of Activity Data and feed into clinical dashboard development, maintenance and utilisation.

Measure: Clinical Audit and Activity Data Committee

Review: Clinical Audit and Activity Data Committee established in October 2019.

Past planning priority 3 : QTC interval measurement

- **An improvement project to support clinical decision-making in the Inpatient unit**

Standard: To provide a mechanism of monitoring that supports clinical decision-making associated with cardiac arrhythmia.

Measure: Introduction of a tool and training to measure and interpret QTC interval

Review: Project pended following considerable clinical input and investigation. Agreed at the Hospice Drugs and Therapeutics Committee that the project may be re-visited in the future but further research is required. Whilst innovative and understood to be the first of its kind amongst Hospices, it was felt that its introduction created a number of ethical and practical issues that required resource that presently the Hospice does not have.

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3.2 Quality Management

Quality Improvement Committee

The Hospice's Quality Improvement Committee steers the Hospice's approach to quality assurance and improvement. Chaired by the Head of Quality & Improvement, it meets every 2-3 months. Its membership includes the Joint Chief Executive Officers, the Clinical Director, Palliative Care Consultant representation, the Community Services Team Manager, the Inpatient Unit Manager, a Practice Development Nurse and the Audit Support Officer. Standing items for this Committee include Clinical Risk Management, Clinical Audit, Clinical and Corporate Effectiveness including Policy Development, Information Material, Practice Development and NICE Quality Standards / CAS /MHRA clinical safety alerts, Patient/User Feedback, Organisational and Regulatory Assurance, Infection Control and Complaints.

Training & Development Committee

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

Drugs & Therapeutics Committee

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

Health & Safety Committee

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

Infection Control Committee

The Hospice's Infection Control Committee steers the Hospice's approach to infection control. Chaired by a Consultant Microbiologist, it meets twice per year. Its membership includes the Joint CEO, the Clinical Director, the Inpatient Unit Manager, the IPU IC link nurse, the Practice Development Team, the Facilities Manager, the Head of Quality and Improvement and the Housekeeping Manager. Standing items for the Committee include Water Management, Infection Control Issues, Sharps Injury & Body Fluid Exposure, Alert Organisms Surveillance, Occupational Health Update and Regulatory/Best Practice Requirements.

Developments in 2019/20

The new layer of governance that was introduced in 2018/19 over the broad areas of Clinical Quality and Governance; Finance and Resources; Communications and Fundraising, and Human Resources has established sub-committees in place that maintain the level of assurance required by the Hospice's Advisory Committee.

3.2.1 Clinical Audit

During 2019/2020, the Hospice undertook a number of clinical audit projects, amongst which were:

Project	Results/Actions/Comments
Prescription Chart Documentation	Weekly audit by the Hospice's Clinical Pharmacist shows 300 charts assessed in 2019/20 (c.f. 307 in 2018/19) comprising 5120 prescription items (c.f. 5744 in 2018/19) and a respective evident prescription writing and error rate of 0.3% (c.f. 0.5% in 2018/19).
Inpatient Satisfaction	Inpatient Survey re-designed. Volunteer led interview methodology implemented yielding an overall satisfaction rate of 96.09%. Survey design re-engineered following constructive feedback to facilitate increased qualitative feedback.
Hospice @ Home Carer/Relative Satisfaction	2019 results continue to show that 100% of respondents would recommend St Raphael's Hospice @ Home service with particular regard for how 'very' helpful the service had been across a range of criteria that includes comfort measures, emotional support, face to face advice, telephone advice during the day and night, respite sits, enabling the patient to stay at home and dealing with a crisis.
SHARPS Audit	2019 results showed 100% compliance in Clean Utility and 95.83% on the IPU across 8 criterion. Area for improvement associated with temporary closure not being in use when left unattended.
Discharge Summary Audit	November 2019's audit showed 100% compliance against the SIGN discharge document with recommendation to enhance the discharge letter template to include explicit prompting for required action by the GP, design change to the medication section and additional section on ACP.
Appropriateness of PRN Opioid administration on the IPU within 24 hour period	December 2019's audit supported and provided assurance regarding clinical practice in meeting the standards that:- PRN opioid administrations do not exceed the maximum dose within a 24 hour period. All PRN administrations should have rationale recorded on EPR. All PRN administrations should have resulting effect recorded on EPR All PRN administrations that exceed maximum dose should have discussion with Doctor recorded on EPR. All PRN administrations that have exceed Maximum dose have Doctor review within 24 hours recorded on EPR.
Community Patient Opioid Titration Follow Up Audit	June to December 2019's audit supported clinical practice effected by the community team members in delivering the appropriate follow up to patients following changes to their opioid medication, ie all patients receive follow up within 72 hours of opioid medication changes and there is evidential record of medication efficacy.

Project	Results/Actions/Comments
VOICES Survey	The National Survey of Bereaved People (VOICES, Views of Informal Carers – Evaluation of Services) collects information on bereaved people's views on the quality of care provided to a friend or relative in the last 3 months of life. The survey was commissioned by the Department of Health in the NHS in 2011. Nationally, VOICES data provides information to inform policy requirements, including the End of Life Care Strategy, that promote high quality care for all adults at the end of life The information given in response to the survey supports us to improve people's experiences of care at the end of life. Results in 2019:- 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. Definite assertion that symptoms other than pain in the IPU had been definitely or to some extent relieved has increased to 95% in 2019 (c.f. 91% in 2018/19). Pain relief in the IPU has improved significantly with it being reported to have been relieved completely, 'all of the time' by 79% in 2019 (c.f. 54% 2018/19). 80% in 2019 (c.f. 82% in 2018/19) of family members of IPU patients were always kept informed of the patients' condition. 15% considered family members were usually kept informed (c.f. 7% in 2018/19). Always treating patients with respect and dignity was considered highly for both doctors and nurses – 90% for nurses and 89% for doctors (c.f. 96% for nurses and 93% for doctors in 2018/19) Respondents were asked to rate care given to the patients by doctors and nurses on admission to the IPU. Taking 'exceptional' and 'excellent' together there is a positive increase to 95% in 2019 (c.f. 88% in 2018/19). Responses relating to nursing care show regard at 'exceptional' or 'excellent' levels increase to 95% in 2019 (c.f. 88% in 2018/19). Regarding the food provided on the IPU in 2019, all ratings were positive ranging from Good – Exceptional. Responsiveness of community visit is slightly increased in 2019 – 87% (c.f. 85% in 2018/19). Overall, care provided by the CPCT was considered as either 'Exceptional', 'Excellent' or 'Good' by 97% in 2019 (c.f. 98% in 2018/19). The proportion of respondents that considered contact from the bereavement team was either definitely helpful or helpful to some degree has increased slightly to 66% (c.f. 64% in 2018/19). 5% felt the contact was unhelpful (c.f. 5% in 2018/19). However, response stating that contact wasn't received has increased to 21% (c.f. 16% in 2018/19). Responding to the Friends & Family question, an 93% would be either extremely likely or likely in 2019 to recommend St Raphael's Hospice to their friends and families (c.f 90% in 2018/19).

Risk Management

Project	Actions
Non-patient Accidents & Incidents	100% of reported non-patient accidents or incidents showed evidence of action taken consequential to occurrence. The number of reported non-patient accidents has maintained in 2019/20 to provide continued assurance with engagement with the reporting system. There were no non-clinical incidents nor accidents that required report to the CQC in 2019/2020.
Clinical Unexpected Incidents & Near Misses	Significant reduction in reported incidents in 2019 particularly across medication related incidents supported practice and practitioner change. In 2019, medication incidents constituted 38% of all clinical incidents that overall reduced in total by 44% on 2018. The patient fall rate per 1000 bed days is 5.48 in 2019, lower than 7.82 recorded in 2018 and injurious falls in 2019 is at 1.56 per 1000 occupied bed days c.f. 3.26 in 2018. Notifications to the CQC in 2019 totalled 5 pressure sore notifications in 2019 and 7 safeguarding There were 2 notifications made to the Care Quality Commission in 2018/19.
CQC notifications	In 2019 there were 5 pressure area and 7 safeguarding notifications made.
Continuous Improvement Log	In compliance with information governance requirements to log information incidents. 3 incidents were logged in 2019 (c.f. 10 incidents in 2018).
Subject Access Requests or Requests made under the Health Record Act 1990	There were 5 data subject access requests serviced in 2019 (c.f. 5 in 2018)

3.2.3 Clinical Effectiveness

Clinical policy and guidelines are incorporated into the central system of policy document management. As with all policy, review lead ownership is attributed to individual members of the multi-disciplinary team. There were 24 clinical policy/guideline reviews in 2019/20:-

CLINICAL	TITLE	ISSUE DATE
CLIN01	Admissions	14/10/2019
CLIN02	Care after Death	09/11/2019
CLIN04	Clinical Governance	02/10/2019
CLIN05	Consent	14/10/2019
CLIN06	Wellbeing Centre Referral and Attendance	14/10/2019
CLIN09	Referral to Hospice Services	15/10/2019 & 25/11/2019
CLIN09a	Summary Guidance for Referral	15/10/2019
CLIN10	Research and Writing for Publication Governance	01/07/2019
CLIN14	Safeguarding Adults	15/11/2019
CLIN21	Anaphylaxis Management	04/10/2019
CLIN25	Controlled Drugs	30/10/2019

CLINICAL	TITLE	ISSUE DATE
CLIN26	Generic Drugs	03/10/2019
CLIN28	Ketamine – Monitoring	14/10/2019
CLIN29	Preparing and Administering Injectable Medications	01/10/2019 & 23/03/2020
CLIN33	Non-medical Prescribers	26/09/2019
CLIN42	Tracheostomy	17/10/2019
CLIN46	Complementary Therapy Operational	11/06/2019 & 19/09/2019
CLIN47	Being Open (Duty of Candour)	01/10/2019
CLIN49	Security of Patient Valuables	07/10/2019
CLIN50	Administration of S/C Fluids	25/11/2019
OP01a	Managing and Supporting Staff following a Medication Error	05/11/2019

Education is an on-going activity and is vitally significant to the care delivered at St Raphael's. There is a considerable amount of formalised and informal clinical education delivered across all service areas. Whilst not an exhaustive list, the clinical training delivered in 2019/20 included:

Medical team training:

Medical Journal club presentations:

- How to prescribe loop diuretics in oedema
- Palliative medicine physicians: doomed to burn?
- Drug safety update
- Palliative care for end stage chronic heart failure
- Ambition for palliative and end of life care
- "Art on Behalf": Introducing an accessible art therapy approach used in palliative care
- Noisy upper respiratory tract secretions: pharmacological management
- CBT in palliative care
- Psychosocial team
- Patients' self-care
- Opioids for breathlessness: a narrative review

Clinical team training:

- Anticipatory Prescribing
- Acute & General Medicine
- Appraiser course
- AVSM Conference 2019
- Caldicott Guardian conference

- Cancer immunotherapy
- Caring for people at home at EOL
- Covid Policy Updates
- Digital training
- End of Life Care in 2019
- Ethical-legal challenges of the contemporary consultant
- European Certificate in Essential Palliative Care
- Guildford Advanced pain and symptom control
- Hospital/community divide at the end of life
- IPC Link Practitioner and Champions course
- IPC Staff Updates
- Liberty protection safeguards
- Making a successful charitable application
- Managing neuro-palliative conditions
- Mentor preparation for HCPs
- NAHH Conference 2019
- Namaste training
- NMP update
- Palliative Care and Symptom management
- Palliative Care update
- Physical assessment and clinical reasoning
- PPE training
- POS workshop
- Psychiatry and Palliative care
- Rehabilitative Palliative Care
- Safeguarding Adults L3
- Safeguarding Children L3
- Social worker conference
- Starting conversations about money

3.2.4 Mandatory Training

Whist the importance attached to clinical education is particularly high, all staff at St Raphael's and volunteers undertaking specific roles are required to undertake mandatory training. E-learning across the required mandatory training is complemented by 'hands-on' training as the topic requires. Training effected in 2019/2020 included the following topics:

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

3.2.5 Clinical Research

The Hospice has supported in clinical research in 2019. See 2.4.

3.2.6 Complaints Management

In 2019/20, there have been 15 complaints received : 7 written and 8 oral complaints (c.f. 23 in 2018/19 : 9 written complaints and 14 oral complaints). All have been investigated by a senior member of staff and reviewed by the Senior Management Team. All complaints received in 2019/20 have been closed.

3.2.7 User Feedback

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

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

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

3.2.8 Information Governance

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

3.2.9 The National Minimum Dataset

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

3.2.10 Organisational Development

St Raphael's Hospice was established in 1987 and was operated by the Congregation of the Daughters of the Cross of Liege until 31 October 2020, at which point it became its own independent charity.

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

Organisational development is very much part of the management plan for the Hospice as it builds its independent identity and strives towards achieving its strategic vision (EVE). The strategy promotes **Excellence** in all aspects of hospice service delivery, aims to increase **Visibility** across our community providing assurance that the hospice is there to provide quality services when needed and improves **Engagement** with users and external stakeholders who we depend upon to raise funds to support the works of the charity – a virtuous circle focussing first on excellence.

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

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

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

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