SAINT RAPHAEL'S HOSPICE

MINUTES OF THE CONSULTANTS MEETING

Held on 09.09.2020

In attendance:	Ambreen Akhtar	Specialty Doctor
	Annelise Matthews	Locum Consultant
	Becca Trower	Clinical Director
	Gail Linehan	Joint CEO
	Jan Hallstrom	Locum Consultant
	Jenny Strawson	Consultant
	Donna Kurian	Junior Doctor
	Lynn Jackson	CPCT administrator (minutes)

ITEM 1: Apologies for Absence

1.1 Busi Da Silva, Gaby Rose

ITEM 2: Minutes of the Last Meeting

2.1 Minutes approved.

2.2 Table of outstanding issues

Subject	Next review
Clinical lead role	September 16th 2020
Assignment of link roles • MND • OACC	September 30th 2020
GP masterclass-6 monthly	December 9th 2020

ITEM 3: Rota / staffing for the next three months

3.1 Weekend on Call handover – It is not an expectation that the 1st on call doctor routinely comes on a Saturday morning unless they have to do so. RT will meet with TY to discuss this issue and she will email a copy of the on call SOPS to Doctors. It was discussed that the Doctor on call and the ward have a telephone conversation at approx. 10:00 to review situation.

It is up to the doctors on duty on Friday afternoon to ensure the medical update on the handover is up to date. BDS and AA to complete and email to Pascale Evans (PE)

Electronic prescriptions can be sent. Clear communication must be given. RT to email SOP

3.2 Off Duty – JS and GR to undertake the rota and once complete to email PE for system input.

3.3 Christmas Cover – RT recommended that this should be being discussed and thought about now.

ITEM 4: Clinical Challenges

4.1 JS and JH discussed an IPU challenge with regards a patient who requested palliative sedation. She was not I the dying phase however due to the nature of her disease she could not eat or swallow. They requested a SALT review to ensure all avenues had been covered. Patient had history of anxiety and depression but had declined psychological support. The patient did not wish to return to hospital. Staff would need support with regards this patient.

4.2 AM discussed a complex case whereby a patient had been discharged from SGH with anticipatory drugs to Merton EOLC in April 2020 however the GP thought that SRH had been involved in this patients care from April. This patient has not been visited by the GP however she does have a syringe driver and has had since April. SRH has only recently received the referral and due to the nature of the delay it will be reviewed and reported as an incident.

ITEM 5: Infection Control

5.1 IPU now have access to coveralls.

5.2 CPCT now have uniforms. They change their uniform on return to SRH. Should the doctors require any uniform t-shirts or trousers please let RT know.

ITEM 6: Achievements

6.1 None discussed

ITEM 7: Education

7.1 RT informed the group that she has been in discussion with Prof Craig Gannon from PAH for staff to join in training on Mondays 13:00-14:00 (virtual). Please speak to RT if interested.

7.2 AA informed the group that the medical students have been given the go ahead and we are awaiting further detail.

7.3 JOURNAL CLUB - JS gave a presentation on “Virtual visits in Palliative Care: about time or against the Grain. Virtual visits in palliative care.pptx

ITEM 8: Any Other Business

8.1 None

ITEM 9: **Future Dates**

9.1 Dates of future meetings:

Date	Event	Venue/Time
16.9.2020	**Medical team**	15.30
23.9.2020	**Medical team**	15.30
30.9.2020	**Medical team**	15.30
7.10.2020	**Consultants meeting**	13.00

ITEM 03 ACTION LIST

SAINT RAPHAEL'S HOSPICE
CLINICAL QUALITY & GOVERNANCE SUB-COMMITTEE ACTION LIST
FOR OCTOBER 2020 MEETING

Reference	Lead	Description	Target Date for Completion	Comments
04/01	GL	Performance Management	Nov 2020	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 November 2020.
08/01	GL	Medical Revalidation Policy and Chaperone Policy to construct	Nov 2020	Medical Revalidation Policy is in first draft. Chaperone Policy wip.
08/05	GL	Explore feasibility of facilitating access to the new e-learning system via the Hospice's web site.	Oct 2020	Trustees can access the new learning zone training via a web link http://learningzone.pah.org.uk/ -need to check that each person has been allocated a log in – Education team to arrange.
09/02	GL	Letter to/follow up with complainant who couldn't meet with GL due to COVID outbreak IN March 2020.	Sep 2020	Contact made with complainant by GL. Outcome = complainant will contact GL to arrange a date suitable to herself to meet with GL.

ITEM 03 ACTION LIST

Reference	Lead	Description	Target Date for Completion	Comments
09/03	GL	Performance during COVID – a short paper to highlight the COVID experience.	Oct 2020	Comprehensive report drafted by Practice Educators in August 2020. Included on October 2020 Agenda.
09/07	GL	Discuss with TC – training for Care Home staff and collaborative working with EoLC Team – Sutton & Merton.	Oct 2020	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.
10/01	GL/RT	To consider adequacy of the current on-call support	Oct 2020	Complete
10/02	AR	Progress charts to be included in the format of the CAP	Oct 2020	Complete
10/03	GL/RT	Consideration of Care Home relationships / MDT participation	Oct 2020	No further update.

ITEM 06

Clinical Quality and Governance Report

Contents

Aim

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

Recommendation

The report be noted.

Report

Update on Organisational Response to the Covid 19 Pandemic

The Hospice is currently in tier 2 in terms of Covid rating as Sutton and Merton have moved from low to a high risk alert level. Our infection control practice remains stringent in order to mitigate as much as possible against the spread of Covid 19. Front reception staff continue to monitor temperatures of all staff and visitors entering the building and direct everyone to wash their hands for 20 seconds before allowing access to any other part of the building. A splash screen has been added to the reception desk.
Our Practice Educators have remained a valuable resource in terms of ensuring staff and volunteers feel up to date with infection control protocols.

We are ensuring that we are prepared should the local risk alert level increase to very high by anticipating possible alternative roles for staff unable to work in face to face situations, and considering how absence should be managed and services covered. We are accessing PPE through the recommended channels although there are still some shortages of specific items.
A local charity (Scrubsforepsomsthelier) have provided us with beautiful hand made scrubs, gowns and linen bags which have been invaluable in ensuring that our staff and patients remain protected and have adequate supplies.
We have access to Merton College walk-through centre for Covid testing for staff and are exploring the possibility of purchasing our own small supply of Covid finger-prick tests through a local independent supplier. Last week all staff were offered and encouraged to have flu vaccines which were given at St Bede's.

All patients admitted to the IPU are routinely swabbed and source isolated until we receive negative results. Swab tests are obtained from the testing station at St Anthony's Hospital.

Visiting restrictions have remained at 3 named visitors per patient in total. One visitor for a longer period (09.00 – 20.00), with access for another visitor in the morning and afternoon. No more than two visitors in a patient's room at any time.

The Community Team continue to have a low threshold for supporting patients remotely where possible as well as a visiting service to assess and support patients in their own homes, following a COVID risk assessment. PPE continues to be worn for all visits.

Maura Flint is finalising the Staff Reflections Covid Report and writing a 'scene setter' which will be shared with the Executive team next week and then disseminated via HODs. There will also be posters in staff areas and a full copy available to read on the N Drive. The full report will then be shared with the Advisory Board as part of the November meeting papers.

Our social worker is now working back in the building which is supportive for both staff and patients/relatives and carers and our counsellor will start working one day a week in the building from next week. Steve Molyneux reports that the six students are doing a wonderful job supporting carers with less complex needs and he provides them with weekly supervision.

Sheila Payne presented a great paper to the CEOs on the proposed Wellbeing Model and this will be launched in the Spring of 2021. The new model will provide a greater reach than we have offered previously and we hope to engage with a new cohort of our community, promoting 'Living well' and

enablement for people and their carers. In the meantime, telephone contact with patients and carers is regularly undertaken by Sheila 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. The facility to remotely join meetings is supported by Zoom/Teams.

Recruitment

We have 3 new starters on the IPU, all of whom are full time and another new starter in November. Pauline Morris, our ward sister for 21 years will sadly be leaving us mid-November to relocate.:
We also have 2 new starters in the Community team – both are band 6 development posts and the staff come from ITU and oncology backgrounds respectively. Two of our existing band 6 staff have just moved up to band 7 roles following successfully completing their training posts.

Medical Team

Dr Jan Hallstrom, our locum Consultant, returned to Sweden on 29th September and we were very sad to see him go. However, our two new medical consultants, Jenny Strawson and Gaby Tamura-Rose have now settled into their new roles and have fitted into the team beautifully. We have reworked the medical team budget to accommodate a fulltime or part time third consultant (allowing us to open up to more applicants) and we will be re-advertising again shortly.

Our GPVTS trainee placement starts on November 4th and we have recently been informed that we will have a StR starting with us in January 2021. It is always a pleasure to support medical staff during their training and coupled with our new physician associate role, we feel we will have a wide variety of medical skills and opportunities here at SRH.

Education/Training

The Practice Educators have been supporting training across the hospice and have recently introduced 'Workshop Wednesdays' whereby they bring the training to the staff and choose a pertinent topic each week. They hold a training session in the CPCT office in the morning and on the IPU in the afternoon, making the training more accessible to staff working their shifts.

Capacity Tracker

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

Staff Wellbeing

All teams have continued to work to a very high standard to support all aspects of the hospice service. Staff are actively encouraged to schedule in annual leave to support rest, relaxation and wellbeing.

The environment within which we work is important and the admin offices and corridor have recently been re-carpeted. This has really 'lifted' the appearance of the area and the reception is also scheduled for new flooring on 27th October this week. John Groom, Tracey Young, Steve Cresswell and Becca Trower have been working on the plans for a refresh to the IPU and we are really looking forward to a brighter and more welcoming look over the next few months.

Bed Capacity

We have recently increased our bed capacity on the IPU to 7-8 patients and are becoming more proficient at planning discharges in a timely manner – it is always a difficult balance to discharge patients at the right time and the various processes involved can be subject to delay due to external influences and requirements. However, we are becoming more adept in our planning, meaning that discharge conversations are being addressed more readily.

We are keen to promote staff development as well as ensure that we have robust organisational governance and so we have begun consultations with our IPU staff regarding internal rotation. We are supporting our day and night teams to work opposite shifts (days to nights and nights to days) for one week (pro-rata) every quarter. This way there will be opportunities for learning such as MDT participation, admissions etc as well as a shared understanding of the challenges faced by each shift. This also promotes the 'one team' approach and our practice educators will mentor and sign competencies for staff, assisting revalidation and professional development. We hope this will commence in Spring 2021 and although there are some anxieties amongst staff regarding this new way of working, we are committed to supporting and enabling them to manage these transitions as smoothly as possible.

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	**Jan 20**	**Jan'20**	**Nov'20**
Clinical HoDs	**Oct'20**	**Oct'20**	**Oct'20**
Drugs & Therapeutics	**Jun'20**	**Jun'20**	**Nov'20**
Falls	**Jun'20**	**Jun'20**	**Dec'20**
Incidents	**Mar'20**	**Mar'19**	**Nov'20**
Infection Control	**Jun'20**	**Jun'20**	**Dec'20**
Prescribers	**Oct'20**	**Oct'20**	**Oct'20**
Quality Improvement	**Sep'20**	**Jun'20**	**Dec'20**

Incidents / Accidents / Near Misses

- All incidents are reviewed at the Hospice's Incident Review Meeting. Those that are non-clinical are further reviewed at H&S Committee. Representatives are expected to cascade review information back to their teams.

- Quarterly submission to Hospice UK's Quality Metrics project began in July 2017 for the financial year beginning 2017/18 and are on-going with the latest submission provided in October 2020. 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.

- 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 December 2020. 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 was purchased in 2019 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 was delivered to a small group of Hospice staff in 2019 and will be refreshed before implementation in 2020. User Testing was delayed owing initially to technical issues with Datix and latterly due to competing demand on IT resources. Our testing commenced again in March 2020 but was rapidly overtaken by work to support service delivery during the COVID outbreak. System roll out is unlikely within present timescales until December 2020 although we are back to testing and hope to complete testing this month. Whilst implementation of the new system has been delayed, the established manual reporting system has remained in place. Enthusiasm for the new system maintains and effort is being made to ensure its right and in place as soon as we can

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 first 6 months of the pandemic the meeting has been pended. The meeting will re-commence in November 2020 to focus on the Audit program.

The Audit/Research Programme with timeline is set out on page 8 - Audit/Research 2020/2. The Audit Program was effectively suspended in mid March with the onset of the outbreak and participation re-commenced in June 2020. Data collection has completed for 4 projects (2 medical team and 1 community nurse and 1 inpatient nurse-led) and I have these projects for analysis and draft report. The community arm of the NG31 audit that extended to Community patients is expected to complete its data capture this month.

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 new Year. 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

Quality Account

The Hospice last submitted its **Quality Account** for 2018/2019 to the NHS Choices web site in June 2019:- https://www.nhs.uk/using-the-nhs/about-the-nhs/quality-accounts/quality-account-documents/

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

Deadline for submission of the Quality Account for 2019/2020 has been extended to 15 December 2020. I aim to publish copy early November 2020 and will circulate draft for comment prior to submission.

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 is to convene regularly from October 2020 to populate and keep under review the Key Lines of Enquiry self-assessment document that was initiated prior to our last inspection. This 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. Allied to the workings of this group will be the creation of a depository of examples of excellence that we will sign post within our KLOE self assessment. We hope this will support our evidence base to achieve and maintain an 'Outstanding' rating in the future.

Audit/Research 2020/21

Overview in October 2020

19 projects underway in 2020/2021 : as at 22-10-2020, 7 are reported/ongoing complete, 5 have data collection completed and AR is working on their reports, 4 are in their data collection periods, 3 remain to be planned and 1 is pended.

Engagement with the audit process has been encouraging upto the COVID outbreak and there has been 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 2020/21 and will not only support individual CPD but also improve staff understanding of the connection between input and output. This will require managerial planning and allocation of time to facilitate engagement.

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	Analysis/ Report / Publication expected - AR			Nov-20	Preliminary 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 drafting report.
2020/21-02	Non-pharmacological intervention Audit (ISR Recs 2-5) - prevalence / effectiveness monitoring	Not yet started			Mar-21	
2020/21-03	Community patient follow-up within 48-72 hrs when titrating medications	Analysis/ Report / Publication expected - AR			Nov-20	Preliminary results show expected follow-up within 48-72 hours of community opioid titration / switch. AR to progress final report write up.
2020/21-04	Pain management Audit - embracing use of LANSS tool	Audit Planning / Design			Mar-21	Initial planning meeting held in June 2020. Prospective Audit expected as part of overall review of pain management by the medical team.

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/ 2019 report due Oct 20	Sep-19	Yes	Aug-20	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) It remains interesting that the returns indicated that during all audit periods, the H@H service was introduced most often by non-Hospice staff. It would suggest there is a well-communicated awareness of the service amongst referral sources though the referral is often actually made by the CPCT. 3) Although numbers should be treated with caution, the H@H service was usually introduced to the patient by hospital staff - 38% in 2018 (c.f. 37% in 2017 and 23% in 2016) 4) In 2018 a higher proportion of returns - 26 (90%) of the 29 who recorded an answer - indicated that they felt the timing of introduction to the H@H service was “about right” (c.f. 79% in 2017 and 97% in 2016). 5) There is a high degree of satisfaction with how easy it was to contact the H@H team (either complete or to a large extent) although it is down on previous audit periods – 90% in 2018 (c.f. 100% in 2017 and 97% in 2016). 6) 24 (77%) of returns indicate that the patient died at home and 22 (92%) of these reported that this was where they wanted to be. In total, 27 (87%) of the 31 respondents who recorded an answer indicated that the patient had died in their preferred place of death (c.f. 91% in 2017 and 85% in 2016). 7) 28 (97%) of the 29 respondents who recorded an answer indicated that they would recommend the H@H service (c.f. 100% in 2017 and 100% in 2016). This reflects well on the service overall. 8) Respondents are encouraged to add general comments on H@H at the end of the questionnaire, and all but one of the written comments in this section were positive and the critique that a telephone call rang for 8 times before being answered was unable to be traced to the individual. OOH telephone answering service has since been effected in 2019. 9) The survey affirms that value and skill of the service and staff involved . Looking forward the plan is to truly integrate the H@H team with CPCT to widen the scope of service and promote a collaborative service . H@H now

Project Ref.	Title	Status	Report Date	Re-Audit	Report Due Date	Results
						have scope for a responsive visit in their working day to increase the responsiveness of the service for those patients rapidly deteriorating.
2020/21-06	Community – Referrals Audit – timeline from request to admission (by source)	Report / Publication expected August 2020 - AR			Nov-20	AR to analyse and draft report
2020/21-07	IPU - Audit against Audit NICE Guidance NG31 Care of Dying Adults at the End of Life	IPU - Data Collected Community – Data collection to be complete by Nov 20			Nov-20	AR to analyse and draft IPU report / BDS & AA to draft community arm
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	Sep-19	Yes	Aug-20	Environmental items for improvement are planned to be addressed in 2021's IPU re-fresh project.
2020/21-10	IPU - Medicines Management Audit	Reported /Ongoing	Sep-20	Yes	Dec-20	Reminder for all queries/interventions to be duly acknowledged via Liveview.

Project Ref.	Title	Status	Report Date	Re-Audit	Report Due Date	Results
2019/20-11	IPU - Audit of Medication recording on Discharge from IPU : EPR 'Medication Module' vs Discharge Letter	Not yet started			Feb-21	
2020/21-12	IPU - Audit of medication charts to review the number of PRNs given in a 12hour period.	Report / Publication expected - AR			Nov-20	AR to analyse and draft report
2020/21-13	IPU – Hospital to Hospice Admissions Audit	Analysis			Nov-20	AR to analyse and draft 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.
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,
2020/21-18	IPU - Re-Audit of Discharge Documentation	Data Collection Period	Feb-20	Yes	Feb-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.

Project Ref.	Title	Status	Report Date	Re-Audit	Report Due Date	Results
2020/21-19	IPU - Patient Satisfaction	Reported /Ongoing	Dec-19	Yes	Mar-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..
2020/21-20	IPU - Risk Assessment Completion	2020/21 project	n/a	n/a	Feb-21	Planning - December 2020

Clinical Risk Management

Clinical Unexpected Incidents

Overview of incident data for January – September 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	15				159	212	211	214	236
Bed Occupied Days	213	188	195	219	353	292	154	184	179								
Bed Available Days	248 (8)	232 (8)	248 (8)	420(14)	434 (14)	420(14)	186(6)	248(7)	210(7)								
Bed Occupancy	85.89%	81.03%	78.63%	52.14%	81.34%	69.52%	82.80%	84.79%	85.24%								
CD Medication Incident	1	2	1	1	4	1	1	0	0				11	23	27	18	110
CD Medication Near Miss	0	0	0	0	0	1	0	0	0				1	1	3	7	
Adverse Reaction (Opioid Toxicity)	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	1	2	1
Non-CD Medication Incident	0	1	0	1	0	0	0	0	0				2	12	22	27	24
Non-CD Medication Near Miss	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				13	16	20	23	20
Pressure Sore during Admission	0	0	2	0	0	0	0	1	0				3	3	8	4	12
Sharps	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	2	0
Readm <7days	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	2		
Near Miss(non-medication & non-IG)	0	0	0	0	0	1	0	0	0				1	1	2	1	1

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2020	2019	2018	2017	2016
PE	0	0	0	0	0	0	0	0	0				0	0	3	4	
Staffing	0	0	0	0	0	0	0	0	0				0	1	1		
IG	0	0	1	0	1	1	0	0	0				3	0	7	12	19
IG near miss	0	0	0	0	0	0	1	0	0				1	0	1	4	
Manual Handling	0	0	0	0	1	0	0	0	0				1	5	10	2	
Slips, trips, falls	2	0	0	2	1	6	2	1	2				16	21	29	18	
Verbal Violence	1	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	2	
Other - Admin/property/Documentation/Clinical	2	1	1	1	3	2	0	1	1				12	12	18	15	14
* Incidents reported to Community – non-SRH	2	0	0	1	2	0	1	0	0				6	12	25	24	
Total 2020 *excluded	7	6	7	6	11	15	4	5	4				65				
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)

* NOTE : Incidents reported to Community – non-SRH are excluded from the Annual Totals

() Near Misses included in Totals for 2016

Reported clinical incidents in January to September 2020 are comparative to last year despite a spike in May and June coinciding with a busier IPU. The number of admissions to IPU in January – September is similar to last year although Q2 (2020/21) does show a downturn in the number of IPU admissions.

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				0	159	212	211	214	236
Bed Occupied Days	213	188	195		219	353	292		154	184	179										
Bed Available Days	248 (8)	232 (8)	248 (8)		420 (14)	434 (14)	420 (14)		186(6)	248(7)	210(7)										
Bed Occupancy	85.89 %	81.03 %	78.63 %		52.14 %	81.34 %	69.52 %		82.80 %	84.79 %	85.24 %										
Fall No Harm				0	2	1	3	6	2	1	2	5				0	11	15	21		
Fall Low Harm	2			2			3	3				0				0	5	6	10		
Fall Moderate				0				0				0				0	0	0	1		
Med Level 0		2	1	3	2	1	1	4				0				0	7	13	6		
Med Level 1	1	1		2		3	1	4	1			1				0	7	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	2				0	14	19	38		
Moderate			1	1	1	1		2		1		1				0	4	2	21		
Serious				0		1**		1				0				0	1	1	3		
Pressure Sores	1	2	4	7	1	1	3	5		3	1	4				0	16	19	27		
Totals 2020	7	6	7	2	6	11	15	32	4	5	4	13				0	65				
Total 2019	1	14	13	2	7	8	7	22	6	6	5	17	16	10	6	32		99			
Total 2018	21	14	11	4	10	18	24	52	15	8	13	36	16	17	9	42			17 6		
Total 2017	13	11	19	4	15	15	17	47	12	2	16	30	16	15	12	43				16 3	
Total 2016	14	28	11	5	18(5)	12(5)	9(1)	39(11)	14(2)	6	10(3)	30(	17(	15(	23(	55(					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 a dedicated 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 have been 3 access to health record requests in 2020 : 2 x solicitors (July, August) , 1 x nok (September)
- There has been one sharing request from a GP Practice in 2020 (June)

	DSARs	Access To Health Records	Other
2020	0	3	1
2019	1	4	0

Clinical Complaints

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

ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASSIFICATION	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE	STATUS
2020/11	ORAL	Friend	07/08/2020	Relative called to complain about the manner in which she had been spoken to by one of our CNSs. She felt she wasn't listened to and had been dismissive of her request for admission of her relative.	CPCT Comms	CNS spoken to by Clinical Director. Reflected that she hadn't intentionally been dismissive but hadn't been clear about what the GP had asked the complainant to do. Advised would follow up with GP to clarify. CNS reflected that she may have come across irritated and apologised. Discussed with Clinical Director potential for compassion fatigue at the end of the working day. Consideration given to half day triage rather than full day. Two follow up calls made to complainant. No reply. Patient subsequently died peacefully in SRH. Follow up by bereavement team.	Upheld	Closed

ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASSIFICATION	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE	STATUS
2020/10	ORAL & WRITTEN	Mother	07/08/20 & 20/08/2020	Mother was called as part of bereavement follow-up 5 days post her son's death and was critical of her son's pain management on the IPU and a number of comments made by the IPU nurses regarding her son's pain which she felt were inappropriate. Oral complaint raised by the CNS delivering the call.	IPU Pain management & comms	Complainant was telephoned by the Clinical Director 5 days post receipt of oral complaint. Complainant followed up the t/c with letter to provide clarity of her comments. Letter of reply sent by Clinical Director expressing appreciation for her openness and honesty and offering condolences and apology for her feeling at times disappointed with some of the nurses' attitudes towards managing her son's pain on the IPU. Complainants comments were discussed with the staff involved. The patient's pain had been complex but waiting for pain assessment / scoring to be undertaken before management exacerbated her son's and her own distress. Acknowledged how unhelpful, though well-intentioned, our approach had been. Complainant's feedback has been discussed to inform how we can improve the way we manage pain and planned actions were advised to the complainant including : a medical team devised questionnaire to appraise staff assessment of pain / workshop for staff that focuses on pain assessment, pain management and 'myth-busting' regarding stronger painkillers. Clinical Director response also thanked the complainant for her positive feedback following interactions with other members of the clinical and housekeeping teams.	Upheld	Closed

Complaints Overview

2020 - Complaints	CPCT Care	CPCT Comms	CPCT Care & Comms	H@H Comms	Jubilee Comms	IPU Discharge	IPU Care	IPU Comms	IPU Care & Comms	OPD Comms	Bereavement Comms	External- Provider Care / Comms	Fundraising /Shop Comms	HR	Total
January	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
February	0	0	0	0	0	0	1	2	0	0	0	0	1	0	**4**
March	0	0	0	0	0	0	0	1	0	0	0	0	0	0	**1**
April	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
May	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**1**
June	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
July	1	0	0	0	0	0	0	0	0	0	1	0	0	0	**2**
August	1	1	0	0	0	0	0	0	1	0	0	0	0	0	**3**
September	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
October															**0**
November															**0**
December															**0**
2020	**2**	**2**	**0**	**0**	**0**	**0**	**1**	**3**	**1**	**0**	**1**	**0**	**1**	**0**	**11**
2019	0	0	0	1	1	0	3	3	0	0	1	1	2	2	14
2018	2	5	1	0	0	1	10	4	1	1	0	1	1	0	27

	Comms				Dignity	Clin. Tx / Care	Other	Policy				Fundraising / Shops		
2017	12				0	5	1	2				2		22
2016	6				2	5	0	0				0		13

Notifications

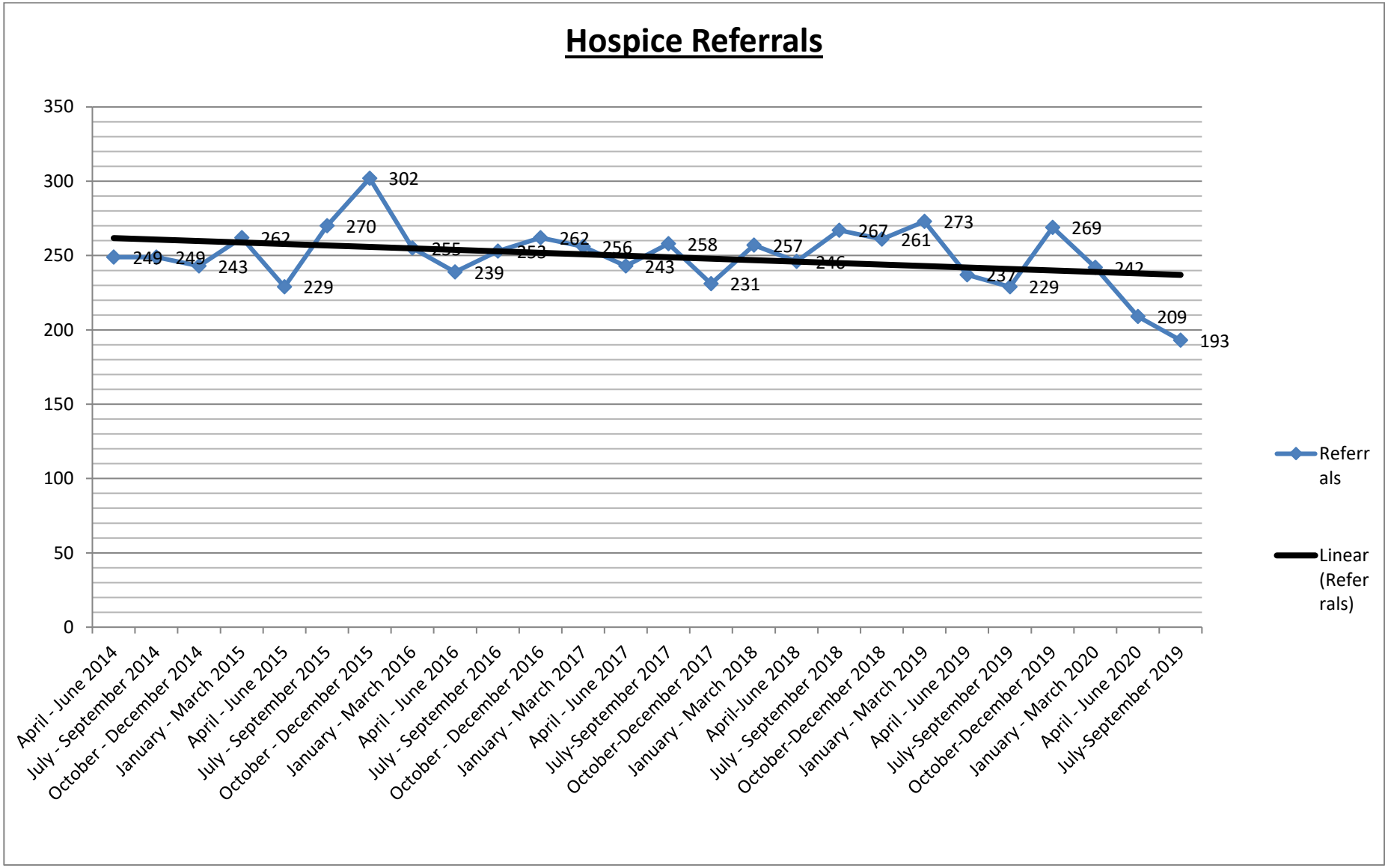
There were 5 serious injury notifications made to the CQC between January and September 2020 all concerning pressure sores grade 3 or above.

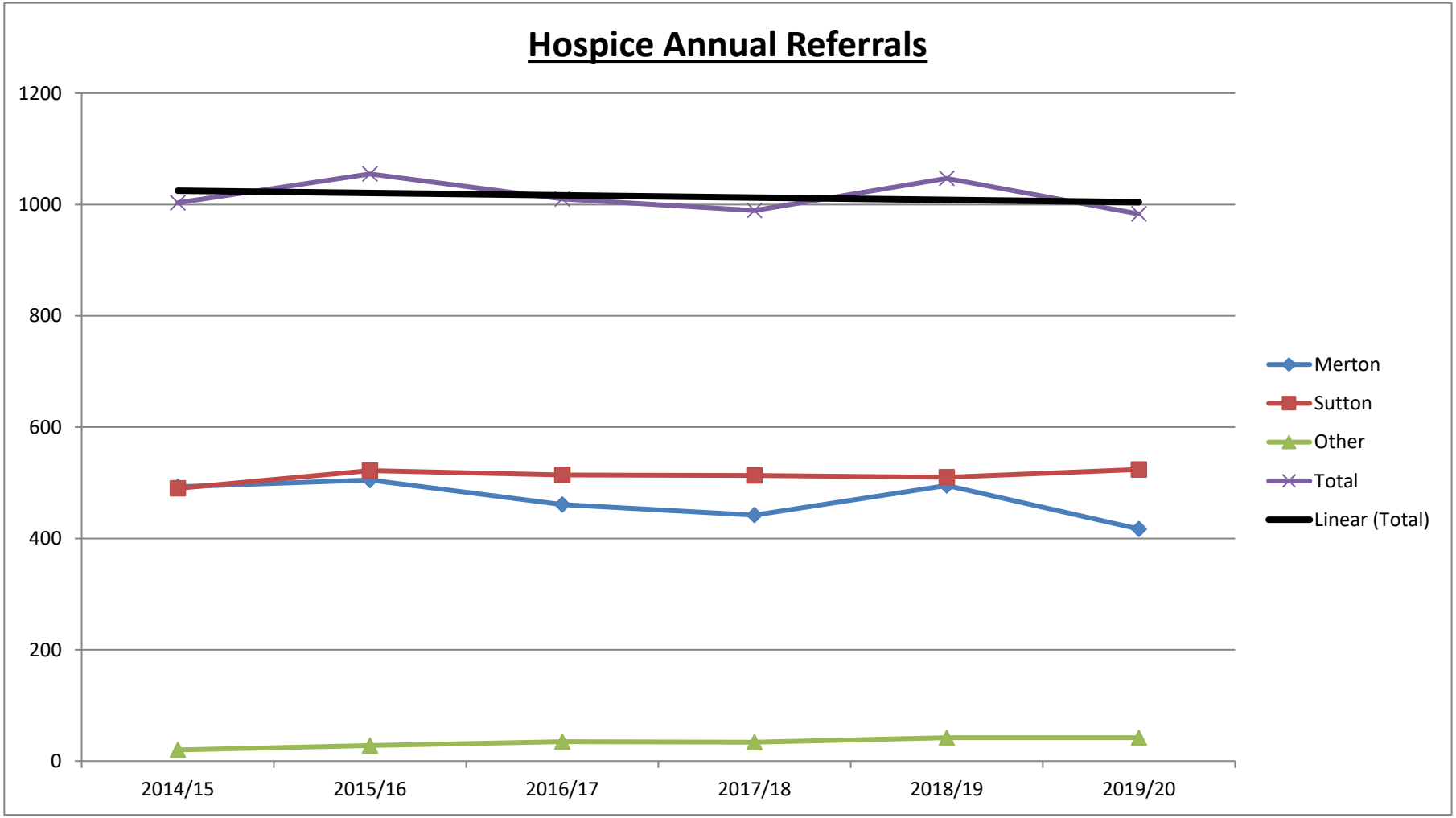
There have been 7 safeguarding notifications made to the CQC between January and September 2020: 4 concerning individuals and 3 care agencies. All 7 were reported to the local safeguarding teams.

Clinical Commissioning Group (CCG) Data

Submission of Activity data for the preceding quarterly period is routinely supplied to the CCGs prior to their review meetings. The latest data period Q2 (July – September 2020) was submitted on 20th October 2020. A selection of graphical representations for some of the data items will be incorporated into routine report. 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			2020		
	Q1 : April - June			Q2 : July - September		
	Merton	Sutton	Wandsworth et al	Merton	Sutton	Wandsworth et al
HOMECARE SERVICE						
Hospice Point of Contact						
Number of Referrals Overall	91	109	9	93	91	9
Number of Referrals Accepted	81	99	8	85	82	6
Referral Doesn't Require SPC				8	9	0
Referral Information Outstanding				0	0	1
Referred to another Hospice				0	0	2
Number of Referrals Cancer	67	76	4	66	57	5
Cancer Referrals %	74%	70%	44%	71%	63%	56%
Number of Referrals Non-Cancer	24	33	5	27	34	4
Non-cancer Referrals %	26%	30%	56%	29%	37%	44%
Gender Female n=	53	48	3	53	40	3
Gender Female %	58%	44%	33%	57%	44%	33%
Gender Male n=	38	61	6	40	51	6
Gender Male %	42%	56%	67%	43%	56%	67%

	2020			2020		
	Merton	**Sutton**	**Wandsworth et al**	**Merton**	**Sutton**	**Wandsworth et al**
Ethnicity Split of Referrals						
White British	51	78	2	56	67	3
White Irish	5	4	1	5	5	1
Any Other White	8	3	1	4	2	1
Black Caribbean	2	0	1	3	1	2
Other Asian	6	1	0	7	1	1
Black African	1	1	1	4	1	0
Not Stated	13	18	1	8	12	0
Far Eastern	0	0	0	0	0	0
Chinese	0	1	0	0	0	0
Indian	1	1	1	1	1	0
Pakistani	1	0	1	1	1	0
White Asian	0	0	0	0	0	0
Mixed White/Black African	0	0	0	1	0	0
Mixed White/Black Caribbean	0	0	0	0	0	0
Bangladeshi	0	0	0	0	0	0
Black Other	2	0	0	3	0	1
Mixed Other	0	0	0	0	0	0
Other	1	1	0	0	0	0
Advanced Care Planning Offered						
Based on patient deaths	93.33%	89.89%	100.00%	94.83%	93.90%	100.00%
Coordinate My Care (CMC)						
Based on patient deaths	51	78	2	44	67	3
% Based on patient deaths	61.45%	78.79%	50.00%	65.67%	75.28%	75.00%

	2020			2020		
Community Palliative Care Team including HPoC	**April - June**			**Q2 : July - September**		
	Merton	**Sutton**	**Wandsworth et al**	**Merton**	**Sutton**	**Wandsworth et al**
1st Assessments (Visits)	46	71	4	68	66	3
1st Assessments Cancer	41	58	2	58	52	1
1st Assessments Non-cancer	5	13	2	10	14	2
FU Visits by CPCT/FPoC CNS	62	112	6	123	201	9
Telephone Contacts Patients with CPCT/HPoC CNS/RGN	604	854	38	632	961	44
Telephone Contacts Family / Carers with CPCT/HPoC CNS (includes Community Admin from April 2018)	751	1216	100	1146	1497	99
Telephone Contacts Healthcare Professionals with CPCT/HPoC CNS (includes Community Admin from April 2018)	786	1284	76	1124	1427	77
INPATIENT SERVICE	**2020**			**2020**		
Inpatient Unit	**April - June**			**Q2 : July - September**		
	Merton	**Sutton**	**Wandsworth et al**	**Merton**	**Sutton**	**Wandsworth et al**
Total Admissions	30	32	1	9	30	2
Cancer Admissions	24	25	1	6	24	2
Non-cancer Admissions	6	7	0	3	6	0
Total No. of Distinct Patients Admitted	30	31	1	9	30	2
Total Deaths	25	19	1	10	18	1
Cancer Deaths	20	14	1	8	16	1
Non-Cancer Deaths	5	5	0	2	2	0
Total Discharges	4	9	0	4	9	0
Cancer Discharges	3	9	0	2	6	0
Non-Cancer Discharges	1	0	0	2	3	0
Cancer Death Total Length of Stay	257	239	12	131	161	2
Cancer Deaths Avg LoS	13	17	12	16	10	2
Non-Cancer Death Total Length of Stay	21	36	0	25	13	0
Non-Cancer Deaths Avg LoS	4	7	0	13	7	0
Cancer Discharges Total Length Of Stay	38	119	0	15	65	0

INPATIENT SERVICE	2020			2020		
Inpatient Unit	**April - June**			**Q2 : July - September**		
	Merton	**Sutton**	**Wandsworth et al**	**Merton**	**Sutton**	**Wandsworth et al**
Cancer Discharges Avg LoS	13	13	0	8	11	0
Non-Cancer Discharges Total Length of Stay	17	0	0	107	30	0
Non-Cancer Discharges Avg LoS	17	0	0	54	10	0
Cancer Deaths/Discharges	23	23	1	10	22	1
Non-cancer Deaths/Discharges	6	5	0	4	5	0
Cancer Deaths/Discharges Avg LoS	13	16	12	15	10	2
Non-Cancer Deaths/Discharges Avg LoS	6	7	0	33	8.6	0
Deaths/Discharges Total Length of Stay	333	394	12	278	269	2
Hospice @ Home	**April - June**			**Q2 : July - September**		
	Merton	**Sutton**	**Wandsworth et al**	**Merton**	**Sutton**	**Wandsworth et al**
Referrals	2	14	1	28	40	1
Cancer Referrals	2	9	0	19	27	0
Non-cancer Referrals	0	5	1	9	13	1
First Assessment Visits (Not an accurate fig as 1st assessments are also done by CPCT under Homecare Service)	0	3	0	6	10	2
Face to face encounters with Patients	23	59	1	92	136	8
Number of Individual Patients - Follow Up Visits Total	14	33	1	32	41	3
Follow Up Visits Total (Face to face encounters with patients minus First Assessment Visits)	23	56	1	86	126	6
Average Number of Follow Up Visits per patient	1.64	1.70	1.00	2.69	3.07	2.00
Number of Individual Patients - Telephone Contacts Patients Total	5	14	0	7	12	1
Telephone Contacts Patient Total	19	41	0	9	20	2
Number of Individual Patients -Telephone Contacts Family / Carers Total	14	39	2	29	48	4
Telephone Contacts Family / Carers Total	20	131	3	50	111	10
Number of Individual Patients - Telephone Contacts Healthcare Professionals (HCPs) Total	6	16	1	7	10	0
Telephone Contacts HCPs Total	6	22	1	10	13	0

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

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

11th Meeting of the Clinical Quality and Governance Sub Committee
To be held remotely via Zoom

at 10.00am on 30th October 2020

Agenda

Chair : JT

Item	Description	Purpose[1]	Lead
1.	Apologies for absence	I	AR
2.	Minutes of the last meeting held on 21st August 2020	S	Chair
3.	Action List from previous meetings	I	Chair
4.	Recruitment / Staffing Verbal Update	I	GL/RT
5.	Clinical Risk Register	S	GL
6.	Clinical Quality & Governance Report	I	GL/RT/AR
7.	CAP	I	GL/RT/AR
8.	Minutes of Meetings (att) • D&TC Meeting : June 2020 • Infection Control – June 2020 • Quality Improvement Committee – June 2020 • Consultants Meeting : September 2020 • Prescribers – October 2020 • Clinical HoDs – October 2020	I	GL/RT/ AR
9.	Dates of Future meetings:	I	Chair

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

SAINT RAPHAEL'S HOSPICE

MINUTES OF THE
INFECTION CONTROL COMMITTEE

Held on 30th June 2020
at St Bede's Conference Centre and via Zoom

Members in Attendance

(Dr JS) Dr J Stephenson, Consultant Microbiologist -SHH, SSAH - Chair
(NS) N Stevens – Joint CEO
(GL) G Linehan – Joint CEO
(MF) M Flint – Practice Educator
(JH) Dr J Hallstrom – Consultant
(LB) L Briant – Practice Educator
(TY) T Young – IPU Manager
(DS) D Saunders – Housekeeping
(LI) L Ibrahim – Occupational Health
(AR) A Rudkin – Quality (Minutes)

Apologies

(SC) S Cresswell – Facilities Manager
(SD-E) S Davies-Evans – Housekeeping
(TC) T Christmas – Community Team
(PM) P Morris – IPU – I C Lead Nurse

ITEM 1: Welcome

Dr JS extended welcome to all present.

ITEM 2: Apologies for Absence

Apologies had been received from SC, TC, SD-E & PM

ITEM 3: Minutes of the last meeting held on 26 November 2019

3.1 These were accepted.

ITEM 4: Matters Arising

4.1 FFP3 Masks – GL advised that FFP3 masks were not in use as the Hospice was not undertaking any aerosol generating procedures. The Hospice is not admitting patients with TB. Agreed to ensure incorporation into the RA. GL

Future requirement for FFP3 training and access to stock is pended as plan had been to access via SSAH who would hold stock and SRH would seek to into training delivered by SSAH subject to agreement with SSAH Matron. . GL

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

5.1	GL advised that the Hospice has admitted suspected and positive COVID-19 patients. A baseline swab of all clinical staff and patients on 9th May 2020 returned negative results. Two swabs taken for patients last week both returned negative result from SGH.	
5.2	No staff nor patient contraction to date. Full PPE in use in patient rooms alongside hand-washing protocol. IIR masks in routine use in the ward environment. Masks to be worn where social distancing at 2 metres can't be met throughout Hospice main building. Adherence to all government advice and protocols. COVID Management policy in place.	
5.3	OH and TY coordinating RA for BEM staff : agency staff have responsibility for their staff. JS advised that at SHH **all** staff have to undertake an individual RA. Agreed that individual RA will be required of **all** SRH staff.	LI/Human Resources
5.4	JS will send on copy of the SHH individual RA to LI	JS
5.5	GL advised that we are 100 days into the pandemic and a reflection exercise is to be established and led by the Practice Developers that will draw out the strength, weaknesses, opportunities and threats experienced by staff over that period. Such feedback will feed into preparation for a second wave. JS encouraged SRH's approach.	GL
5.6	JS advised that there is professional concern over the coming Flu season and a resurgence of COVID-19 infections.	
5.7	No new information on the development of a vaccine. Over 100 research studies on-going. Could be at least 9 months away from a vaccine if not longer.	
5.8	GL advised that visiting arrangements had been revised with one all day visitor, one morning and one afternoon visitor permitted on the IPU per patient. PPE and social distancing in place.	
5.9	Dr JH expressed that there had not been many cases of COVID seen and that on a personal note he had not had much experience of the illness.	
5.10	JS advised that there had been a big push in nursing homes for staff to undertake the antibody testing. GL reiterated that SW London testing will be undertaken on site for staff who want to receive it. 100 out of 160 staff have applied. Agreed that the exercise is more of an academic exercise as even if there is positive antibody to the virus there is no guarantee that COVID-19 can't be caught nor would a positive antibody test alter the protection needs that individuals must maintain. JS advised that there were staff at SHH who had tested positive for COVID-19, yet they hadn't made any antibody and are fit and well. LI expressed that it needs to be made very clear that positive antibody testing results don't remove or lessen the precautions and protection that must be maintained.	
5.11	GL remarked that the individual consent form for antibody testing had been received but it was missing its full introduction that explains exactly what is being consented to. JS to forward SHH copy of the consent document.	JS

ITEM 6: Sharps Injuries & Body Fluids

6.1 Nil Sharps to report.

6.2 One incident involved a body fluid splash (urine) on the IPU that was followed up via OH. No further action.

ITEM 7: Alert Organisms Surveillance

7.1 Nil to report.

ITEM 8: Water Assessment and testing

8.1 Water Assessment and testing is a routine agenda item at Health & Safety Committee that last met on 21st May 2020

8.2 Latest visit took place on 8th June. Low level legionella reading taken from one tap and remedial action effected same day.

ITEM 9: Occupational Health Update

9.1 LI reported that she was aware that antibody testing of staff at another healthcare provider had returned about 25% positives based on 250 clinical staff tested. General population figure is returning 10-15%. GL reported that antibody testing will be available to all staff in two weeks' time and that results will be fed back to HR.

9.2 Flu vaccines have been organised with a local Pharmacy. JS emphasised the importance of having the flu vaccine and its promotion to staff.

ITEM 10: Any Other Business

10.1 No other business.

10.2 JS hopes to deliver a presentation at the next meeting on topic that he feels most relevant. The topic will be of interest to Doctors as well as other members of the clinical team and he encouraged medical team attendance. GL

ITEM 11: Future Dates

11.1 Dates of future meetings:

Date	Event	Venue/Time
Tues 8th December 2020 (TBC)	**ICC Meeting**	1pm - St Bedes

SAINT RAPHAEL'S HOSPICE

MINUTES OF THE 10TH MEETING OF THE

CLINICAL QUALITY AND GOVERNANCE SUB-COMMITTEE
held on Friday 21 August 2020 at 10.00am
Held at St Raphael's Hospice / by Zoom call

Members: Alan Cogbill (AC)
Dr Caroline Chill (CC)
Dr Joy Tweed (JT)

In attendance: Gail Linehan - Joint CEO (GL)
Rebecca Trower – Clinical Director (BT)
Alex Rudkin – Quality Development Manager (AR)
Miss Anna Machin – Clerk to Trustees (AM)

1. Welcome and apologies

Committee members were welcomed to the meeting by Dr Carrie Chill 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 12 June 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 updated draft will come to a future meeting along with related policies from HR
- 04/08 - The Hospital to Hospice Audit will be shared in September
- 07/01 - Gail will circulate the ISR update once completed in the next fortnight along with the Medical Revalidation and Chaperone Policies
- 08/05 - The login details for the e-learning site will be shared with Trustees and it will be checked if the training is already offered to volunteers
- 08/08 - The Management Plan is for consideration at this meeting
- 09/01 - The CQC Inspection Report has been circulated
- 09/02 - Gail has followed up on the 2020/05 Complaint, but there has not been a response. It was agreed that Gail would draft a letter to the complainant. **GL**
- 09/03 - The Practice Education team have brought together a thorough set of reflections on COVID-19 experiences, to be brought as an agenda item to the next meeting. **GL, BT, AM**
- 09/06 - The discussions on continuation of extra beds has been covered at the July Board meeting.
- 09/07 - There is ongoing communication regarding training for Care Home staff and the logistics for delivering it.
- 09/08 - BAME risk assessments have been undertaken and reviewed for all staff, including agency staff. There have been no requirements to redeploy or alter roles. One non-BAME staff member has changed timing of shots due to higher health risk factors. A few staff are now having to quarantine who have been away and so rotas are being adjusted.

4 Recruitment/ staffing update 4.1. Gail Linehan and Rebecca Trower provided an update on staffing. Two substantive consultants are joining in the autumn and the final post is being advertised this week. The autumn will involve some cover but by December the full set of positions will be filled with a strong and solid team. Rebecca Trower commented that it is positive that the Hospice does not find it challenging to recruit nurses through different routes. A Health Care Assistant role has been appointed to by a Band 2 post-holder who it is expected will bring real passion to the role. The Physician Associate role is a new, innovative post that will report to a Consultant, to work across the IPU and Medical Team. She currently works on a Strokes Unit and has undertaken a European Certificate in palliative care. 4.2. Committee members were supportive of these innovations and recognised the strong oversight of Gail Linehan and Rebecca Trower in managing this change to bring together an expert team. They asked about the on-call arrangements for the GP trainee to ensure the Hospice is providing the right support. It was confirmed that there is always a second on call in place, and that any further support needs would be given consideration by the team.	**GL, RT**
5 Clinical risk register 5.1. Committee members reviewed key risks on the Clinical Risk Register, focusing on those with the highest risk rating. Staff wellbeing will remain on the risk register throughout this period of Covid-19, particularly with the potential of a second wave. Committee members mentioned the risk that staff may be coming into the autumn with higher levels of exhaustion. Gail Linehan confirmed that staff have been working hard due to the additional shifts needed through the first wave of the virus. The challenges with summer holidays and quarantine requirements have also reduced the opportunity for staff to relax and refresh. Staff remain positive and cohesive, but the wider environment remains challenging. The Hospice has a policy that pay would not be given if staff went away and then had to quarantine at home, if it was known at the point at which they went away that quarantine was in place for their country. Staff needed to adapt to this, although the overall rationale was recognised and understood. In the event of a second wave, it was noted the support that would be needed by staff is quite individualised as people cope and respond in different ways. Certain staff within the Hospice team are being trained as mental health first aiders. If staff have particular anxiety, the psycho-social team can support them, and leadership are also trying to recognise the team's commitment. Committee members were supportive of these efforts. 5.2. The Brexit medicine shortage risk is still being actively monitored and assurance has been received that stocks from current providers remain high. 5.3. The requirement to appoint the substantive Clinical Director post remains, and the presence of Rebecca Trower has made a real difference within the Hospice and to Gail's time. 5.4. Covid risks are being actively managed and are strongly integrated into Hospice practices, for example through visitor processes and temperature checks. All visitors are also included in Track and Trace processes. PPE stock levels are being monitored across staff departments – stocks of 500ml bottles of antibacterial gel through the NHS and Pallet Push of 500ml are low currently. The Hospice has other forms of gel and also antibacterial spray, and all other PPE stocks are in good limits. Accessing supplies of PPE is a Red risk as accessing stocks if becoming harder which is an	

experience that has also been echoed by other Hospice CEOs in London. The Hospice does not have to pay for the Pallet Push but if this does not continue to be forthcoming it would need to be purchased. 5.5. There is also a risk of staff being told to self-isolate if they have been contacted by Track and Trace from contact outside work. In this situation the staff member would be paid as (unlike with the known risk of going on holiday to certain locations) it is not a choice but if it happened to several staff at once it would affect levels of staff cover needed in Hospice. 5.6. Committed members thanked the team for this comprehensive update and felt that the right risks had been identified as a priority.	
6 Clinical Quality and Governance Report 6.1. The Report was reviewed and key points not yet covered in the meeting discussed as a focus. The online learning module has been rolled out with staff doing safeguarding and infection control modules this month. 6.2. Two patients were tested for Covid recently, and now all new patients are being swabbed and cared for carefully until it is confirmed they are negative. 6.3. Wellbeing activities are being delivered remotely and some patients have indicated a willingness to return in person in due course. The bereavement team have had bereavements themselves so capacity in this team is reduced for now. 6.4. 6 beds are currently operating and this being reviewed on a regular basis. There hasn't yet been a formal response from the CCG on the Capacity Tracker and it continues to be updated accurately on a regular basis. It is a significant task to continue filling this, although it does enable a regular review of the Hospice's data. The July Hospice UK grant has now been received. 6.5. The Datix system delay has been recognised and initial testing will be planned in September. 6.6. In the audit report there has been positive feedback on Hospice at Home which could feed in to referrals of new patients. 6.7. The Clinical Complaints data was reviewed and it was confirmed that the team have reflected on the complaints to feel in to practice.	
7 CAP & Management Plan extract 7.1. Committee members next reviewed the Management Plan which contains all aims for this and next year, which is then reflected in the summary Management Plan. The Committee asked for an update on if the actions are progressing according to planned timelines, and asked for this to be added to the document along with the extent of project completion. 7.2. With regards to Action 3.7, 'Training for clinical staff in identifying need and measuring QTC interval and in understanding bloods and when to request them', Gail Linehan and Rebecca Trower updated that it was felt that this was not felt to be a priority, and may add additional complexity for staff. It was proposed that this be taken off the Action Plan. Committee members were given full assurance that patients are able to access an ECG when needed. It was agreed that this be taken off the Action Plan.	**GL, AR**

8 Minutes of internal meetings (Clinical HoDs meeting August 2020; Prescribers meeting July 2020; Falls meeting June 2020; Consultants meeting August 2020) The minutes of the internal meetings were noted by Committee members, and recognised as a useful insight into the Hospice's activities and approach to the structure and development of the medical team. It was confirmed that examples of Outstanding practice are being recorded on an ongoing basis. There were no matters of concern for escalation to the Committee. In reference to earlier conversations, relationships with care homes would be added as an agenda item arising. Dr Carrie Chill updated that a new DES was coming into place for Care Homes to have clinical leads, and also for more multi-disciplinary meetings to take place between care homes and other health providers. Gail Linehan and Rebecca would look into this further.	**AM** **GL, RT**
9 Any Other Business It was agreed that it would be kept in mind to add a further member to this Committee. An additional member of the medical team would also attend in future. The Committee expressed their thanks for all the work being carried out by the Hospice team.	**GL, RT, AM**
10 Next meeting The next meeting date was confirmed as 30th October 2020.	
The meeting finished at 11.45am.	

Distribution: Trustees and Auditors.

Approved……..

Date……..

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).

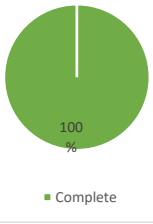
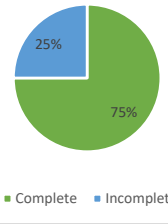
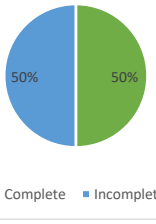
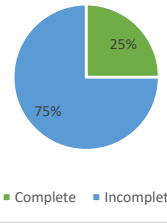
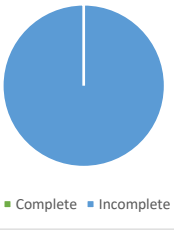
The Hospice deploys a Multidisciplinary Team (MDT) model to the delivery of its clinical services to achieve excellence. This necessities all levels of clinical staff embracing an inclusive, proactive approach where responsibility and accountability are enabled and supported. Every voice and contribution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

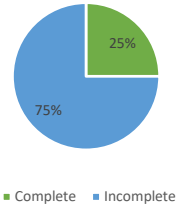
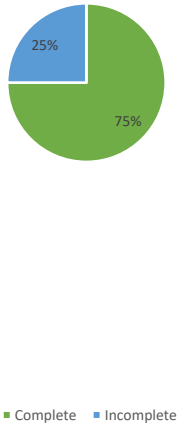
High importance is placed on the well-being of staff, recognising that staff are the Hospice's most valuable resource. The organisation actively supports education and training opportunities for people at all levels to learn and develop to achieve their full potential. This further supports our aim to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

UPDATE OVERVIEW

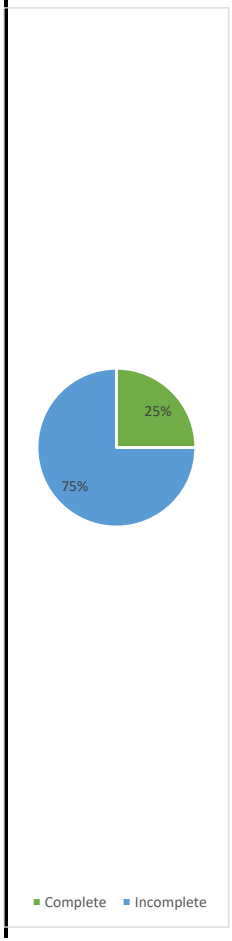
DATE					
12-Aug-20	5	11			5
22-Oct-20	5	6	5	2	3

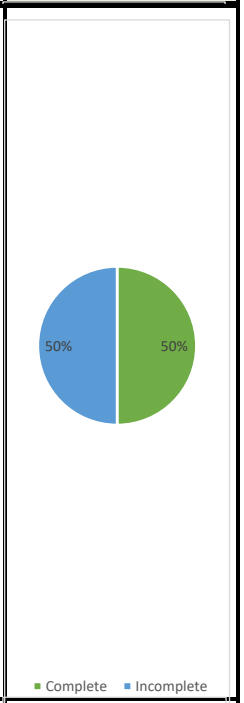
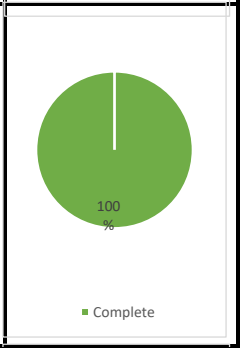
Clinical Action Plan

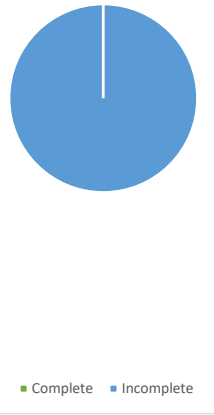
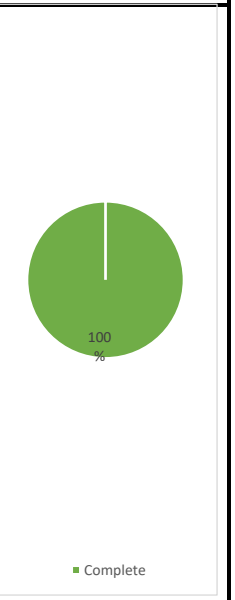
Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP01	**Substantive appointment of Clinical Director**	Professional leadership, management and support of all clinical services within the Hospice To support and develop strategic and operational delivery	Recruitment	Compromise to the strategic and operational delivery	Recruitment	Well-led Effective Safe	Role advertised. Interviews 28-10-2020. July 2020 – January 2021 secondment appointment.	
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 Physician associate appointment November 2020 Third consultant post out to advert in November 2020	

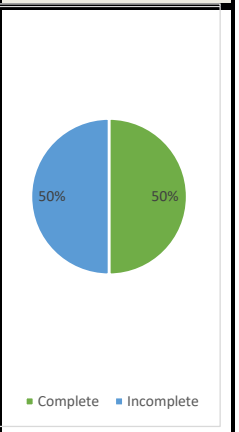
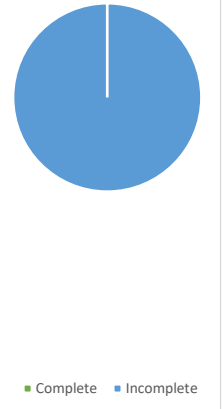
Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP03	**Review of all clinical MDTs**	To ensure all patients are reviewed holistically (physical, psychological, spiritual, social and cultural). To maintain effective and efficient use of clinical time. Empowerment and 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 format to be revised and implemented in November 2020	

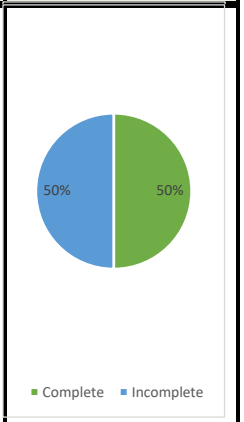
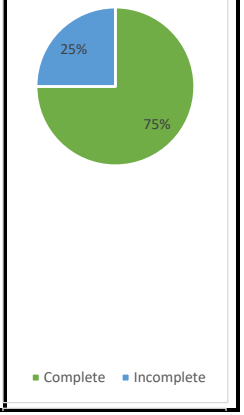
Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP04	**Review suitability of staff support / clinical supervision/reflection mechanisms : consideration of Schwartz rounds**	To facilitate and enable clinical discussion relative to the care of dying patients and their 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. Psycho-social training to up-skill IPU team to deliver level 1 psycho-social support. Planned for	

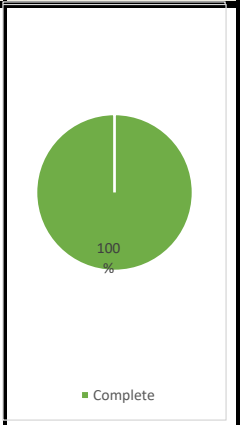
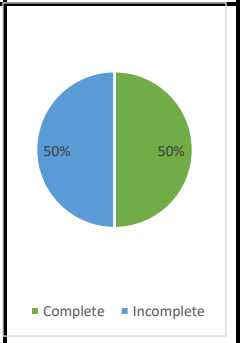
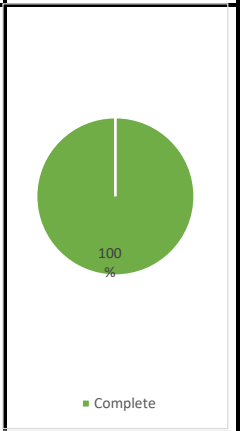
Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP05	**Rotation of IPU staff across 24 hours**	To ensure consistency of approach and delivery to service provision across 24 hours.	Consultation time for existing staff across day and nights with HR and Clinical Director	Staff will not engage with the process.	Current Staff Costs	Effective	Consultation process dates September – December 2020.	
						Caring	Implementation January 2021.	
		Assurance of clinical competence via night staff coming on to days for 1 week every 4 months and accessing education, development	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.	
		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.						
		To ensure that staff across all shifts are accessing education and associated competencies.						
	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, .						

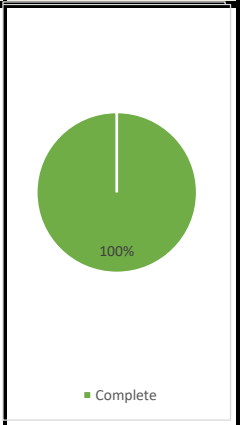
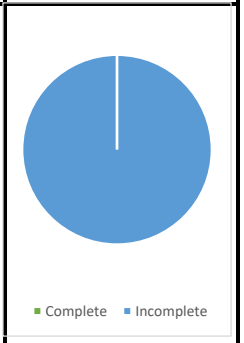
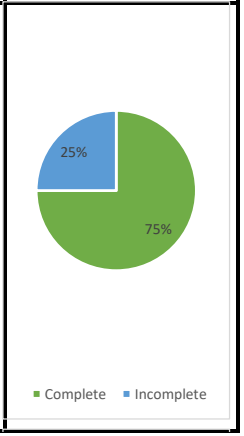
Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP06	**To increase skill sets and support psycho-social service delivery across the MDT** **To ensure psycho-social support is both timely and accessible**	To ensure patients and families receive access to psycho-social 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 Psycho--social 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 • The Psychology of Death & Dying (to enable Level 1 Psychosocial skills across the teams) To be incorporated into education program / timeline 20/21 July 2020 : HCA team able to refer to PT August 2020 : Drop in clinic for staff to discuss psycho-social issues	
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	

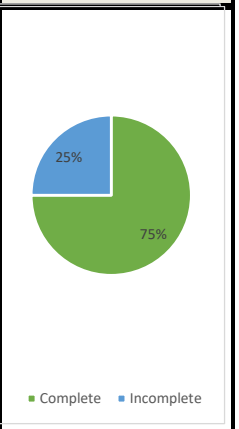
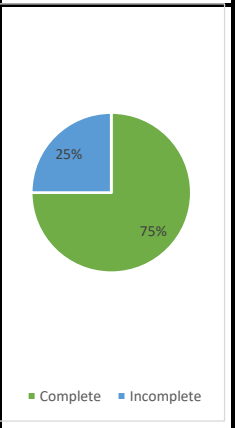
Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
CAP08	**Increase establishment of Band 5 nurses on the IPU to facilitate secondment to other clinical departments to support staff development and a 'One Team' approach.**	To develop team of nurses with assurance of palliative 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 in place for current vacancies.	
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..	

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Completion Status
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 2020/21 audit program.	
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 planned for October/November 2020. Review and use of OACC suite of measures for 2020/21 audit program See 3.12 of CQ&G section of Management Plan	

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	
CAP13	**Implementation of Datix to manage Incident/complaint/compl ements**	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: October 2020 Full implementation – Nov/Dec 2020 See 3.13 of CQ&G section of Management Plan	

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	
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	Oct-20	
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	

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	
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	
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 DNACPR	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 Band 6 & 7 staff to be assessed as competent.	

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	December 2020 for all Band 6 & 7 staff to be assessed as competent.	
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. Dat collection for community arm to conclude in October 2020.	

Meeting: **Clinical HODs Meeting**			
Date: 01/10/2020		Time: 11.30	
Present: Tracy Christmas, Maura Flint, Laura Briant, Alex Rudkin, Steve M , Gail Linehan, Rebecca Trower			
Apologies: Tracey Young			
Minutes: Lynn Jackson			
Agenda item	**Discussion**	**Actions & by whom**	**Anticipated date for completion**
Review of previous minutes	Correct		
Matters Arising	**CPCT** – TC will be working 3 days per week in October/November whilst undertaking her course. Annette N & Nora K to work non face to face. Karen F – does not work weekends & term time only Marnie Prior – new starter		
Topic			
Infection Prevention	COVID training The orangery – social distance rules apply	Staff ALL STAFF	Ongoing Ongoing
Medical Devices	None discussed		
Medicine Management	Pain Assessment Study to take place		
Incidents & Accidents/RCA's	None discussed		
Complaints	One informal CPCT complaint	TC	Closed

Health & Safety	Face covering guidelines to be emailed to all staff PPE supply at risk – to keep 2 week stock supply. Clinell wipes for medical use only.	MF/LB GL/NS/TC/TY Housekeeping to access "other" wipes & retail to access their own	October 2020 Ongoing
New Policies/ Guidelines	Admission policy updated Verbal referrals from LAS are increasing OOH & weekends from patients home when imminently dying & for NO return to hospital. It was discussed that this is above IPU remit & that CPCT CNS would judge on merit. If appropriate a verbal referral would be taken whilst adhering to COVID plan & referral policy/criteria.	RT/TC RT/TC	Ongoing
Documentation/ Crosscare	Family Information leaflets/website is to be reviewed.	Discuss in leaflet meeting	October 2020
Audit/Research			
Education/Training Reflective Forums	Clinical Supervision training being undertaken by Diana B Ears & Eyes – "Difference in Diversity" training to be carried out CPCT – reflection on case to be carried out Paramedic placements are currently on hold BLS – if Patient COVID + mask to be placed over patient mouth Undertakers – if no COVID diagnosis they are to be given an alert of high risk of infection. If known COVID 19 + funeral directors to be informed	SM SM to liaise with MF/LB TC/Linda M/Nora K MF MF MF/AR to amend COVID & Care after Death policy	Ongoing Ongoing TBA Ongoing Ongoing
Recruitment/ Staffing	Social worker job description to be reviewed	SM/Elisa L	Ongoing

CQC/PIR	.		
AOB			
Well Being Centre	Remodelling to take place with sessions being offered to clients not under our care- Referral criteria & forms to be agreed & devised. Unregistered patients need to be captured NO CLINICAL INPUT to be given	GL/RT/Sheila P RT/JG-IT	Ongoing

Date next meeting: 05.11.2020

Clinical Risk Register Serial No.	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	Culture Change	Reticence of some staff to embrace change to working practice as outlined in Clinical Action Plan (CAP) and current change in leadership.	Proactive leadership to communicate and support change in working practice in line with CAP with Managers and key staff.	3	3	12	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	2	9
2	Workforce: Medical Team Inadequate medical team establishment.	Dependency on agency / locum recruitment increasing cost base and increasing potantial for lack of continuity. Risk of non-allocation of STR from the Deanery due to lack of required education supervision at consultant level. No GP VTS allocated for August - October 2020.	Successful recruitment of 0.6 and 0.8 FTE consultants. 0.8-1FTE position to be recruited to. Utilisation of agency consultant cover reduced to 0.6FTE consultant.	3	3	12	Active recruitment for 0.8-1FTE consultant on-going. Junior Doctors : increased 1 x junior doctor to 0.6 FTE from 0.2 FTE to cover August - October. 1 x Junior Doctor 0.9 FTE remains established. Physician Associate role appointed in August to commence in November 2020 (supports medical team on IPU and Community Team). GP VTS expected in October 2020. Hopeful for STR in January 2021.	3	2	9
4	Workforce: Registered General Nurses Recruitment of appropriately qualified nurses to support the delivery of care on the In-Patient unit.	Night duty cover is problematic . If RGN cover on night duty not sufficient the number of patients that can be safely supported will be affected as safe staffing is across 24hours. Increasing difficulty in recruiting Band 5 nurses for day duty - staff undertaking extra shifts to cover requirement risk burnout. Managing unexpected sick leave can put pressure on the staff cover. Increased risk due to potential need for self-isolation (COVID-19 / Track and Trace).	Current qualified nursing staff levels are adequate to support 6/8 IPU beds on day duty with full current complement of 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. Encouraging Staff flexibility from day duty to night duty is encouraged. Offer of on the job training and mentoring and educational support to obtain required qualifications e.g. Support of the TNA programme for HCAs.	4	3	16	In situations where staffing levels are adversely affected there would be a managed reduction of available beds.Engaging with local and national training schemes to demonstrte the attractiveness of the hospice as an employer. Review sickness policy and maternity leave. Nurse Associate appointed in August 2020.	3	3	12
5	Medication incidents related to controlled drugs	Potential for adverse side effects Complaints from patients relatives	Open culture of reporting of incidents to learn from mistakes/errors Review and monitoring of individal patient to mitigate harm or unsatisfactory symptom relief. Staff actively informing patients/families about medications and rationale for use to ensure understanding and gaining consent.	3	2	9	Continued vigilance Optimum patient monitoring Introduction of Checking CDs twice in 24hrs at 09.00 and 02.00 Spot checks on orders of CDs against invoice and incorporation into CD book Drugs likely to be misused (DLM) recorded in a separate register for monioring against amount ordered and usage. Weekly medication monitoring rounds undertaken by clinical pharmacy.	2	1	4
6	Allergy	Risk of harm to staff member and related impact on staff and patients.	Staff member on night duty with severe nut and pet allergy. Mitigation staff made aware of the allergy- requested not to bring in food containing nuts to TCC and staff room. Patient pets will be risk assessed prior to admission.Staff member to have Epipen on their person at all times and take personal responsibility for their own health as well as relience on staff support. 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.	5	2	15	Staff member has been referred and seen by OH related to the risks and unpredicability of the allergic response. Staff member has transferred to day duty. All current mitigations remiian in place.	2	2	6
7	Staff Well being	Staff sickness Low staff morale. COVID Impact	Staff well being is seen as a priority in the organisation Staff Consultative Group to faciltate staff involvement across the hospice Occupational Health Nurse on site one day a week Regular annual leave encouraged Flexible work patterns to support work life balance Training internal and external Competencies	4	2	12	Clinical Supervision offered to all levels of clinical staff Reflective fora to support staff following difficult cases Mentoring in practice COVID : Staff provided with list of resources to suppport well-being and resilience. Garden tables and chairs provided for outdoor relaxation away from main Hospice building. Staff recognised and thanked through exec team updates in July 2020.	3	2	9
8	Clinical Incidents	Risk of compaints from patients/families Patient safety Requirement to report outside the organsiation to CQC Pre-empt a CQC Inspection Reputational damage	Reporting of all incidents related to clinial care Hierarchy of investigation Outputs- Learning informs improved proceedures and processes Regular review of incidents Report to SMT, Cliniacl 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. Encourage an environment of comprehensive reporting to support learning and quality improvement. Introduction of Datix in December 2020 will support reporting and monitoring.	4	1	8
9	Patient Safety- risk of falls	Patient sustains an injury Patient requires transfer to acute centre for treatment Report to CQC- RIDDOR Negative impact on patients condition Potential for complaint from patient/family	Floor surfaces smooth - non carpeted Movement sensor on each bed Chair sensors accessible (6) for more mobile patients- verbal consent obtained for use from patient/family- documented in EPR Patients discussed and identified as falls risk at the commencement of each shift Patients identified as falls risk on white board Mobility aids provided Clinical teams alacrity to respond to monitors Clinical vigilance Assessment and consent for the appropriate use of cot sides	4	2	12	Frailty of the patient group increases the risk despite mitigation Promoting self determination increases risk Patients right to make unwise decisions where they have capacity increases risk Improve lighting to patient room patio area part of IPU re-fresh project in January 2021.	3	2	9
10	Lone working	Staff members work alone in the community within patient homes. Risk of accident/incident in a patient's home and individual risk to staff member. Risk in travel to and from home visits.	Policy and proceedure in place to support community working. Sign in and out. Supplied with a mobile phone for contact with the hospice or other healthcare professionals. Lone worker alert devices introduced on 11/09/2019.	3	2	9	Lone Worker Policy informing steps to follow if a colleague does not return to base at expected time. Clarification and supported training on newly introduced safety devices. SMT OOH on call in place for contact and advice on further action.	3	1	6

Clinical Risk Register Serial No.	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
11	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 Quality Improvement and Clinical Quality and Governance meetings Complainants (both verbal and written)are offered the opportunity to meet and discuss concerns with the Clinical Director All complaints discussed at hospice team meetings for awareness and learning across the organisation Bi-annual review by SMT Required action taken to address concerns with staff members where individuals have been identified by the complainant File notes kept of discussions by HR	4	2	12	Use of root cause analysis for significant incidents 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
12	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 Policy communicated to whole organsiation Clinical staff have nhs emials (encrypted) Regular organisational sweeps in all departments	3	2	9	IT monitoring and oversight of PID in received and sent emails	3	1	6
13	Brexit - Risk of medication shortages via suppliers	Required medication(opiods, neuropathic agents, anti seizure etc.) not available in in specified dose ranges to support symptom management. Impact on patients.	Liaison with clinical pharmacy Ashton's - Reassurance that adequate supplies in stcck.	2	4	10	Regular updates from clinical pharmacist. Communication with wider CCG pharmacy colleagues.	2	4	10
14	Recruitment of Clinical Director	Insufficient clinical leadership, management and support	6 month secondment post recruited to from 1st July 2020 - January 2021. Use of recruitment agency for substantive post expected.	4	2	12	Close liaison with PAH.	4	2	12
15	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.	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. Barrier (Cohort) Nursing. Face masks being worn on the IPU as routine and where social distancing cannot be supported	4	2	12
16	Corona Virus	Infection spread within hospice	Temperature station set up in main foyer to take the temps of all visitors and staff entering main Hospice building. Set script provided to staff to clarify visitors' health status and recent travel to known infected countries. Air ventilation/circulation reviewed as per guidance.	5	2	15	Introduction of reduced visitor numbers to one per patient per day between 09.00 - 18.00. As of 14-05-20 as per guidance, visitor number increased to two per day per patient (2nd vistor 2pm-5pm). June 2020 - visiting number increased to one all day (9-8), second visitor (10-3pm), third visitor (3-8pm) : one family unit.	3	2	9
17	Corona Virus	Process to reduce infection risk	Staff instructed not to wear uniform into work. Change in work , at beginning and end of shift.	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.	4	2	12
18	Corona Virus	Staff Anxiety re: Covid-19	Interface with Clinical Teams . Regular checks on adequate PPE for assurance.	5	2	15	CPCT supplied with uniforms for community visits. Adequate PPE to undertake duties within safe parameters.	4	2	12
19	Corona Virus	Inadequate supply of PPE	Increased order for PPE and cleaning supplies via usual supply routes	4	4	20	Difficulty in accessing adequate supplies of PPE hightlighted at SWL Covid Meetings. Access via emergency procurement supply route at SHH provided initial supplies. Subsequently weekly supplies via pallet push for Hospices providing PPE (gloves, IIR masks, aprons).Donations of visors and googles from the general public and schools. PPE monitoring implemented on NHS Capacity Tracker.	4	3	16
20	Corona Virus	Change of service delivery model : Suspension of face to face contact - Wellbeing, Hospice Neighbours services. Psycho-social team remote delivery only.	As per government guidance clinical staff that can work from home have been faciltated to do so. Community service provision has changed from face to face to telephone contact or virtual contact via skype.	3	2	9	Reduced face to face visiting dictated by urgency slowly returing to usual practice. Increased telephone contact maintains as too does virtual assessment as neceesary. Well-being service being delivered remotely via Zoom. Normal visiting for CPCT. H@H delivering 1 hour slot max visits once per day. Hospice Neighbours maintaining telephoen contact. Psycho-social continue with remote service provision. 6 student counsellors introduced to support Bereavement Service.	3	2	9
21	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 working from home.	3	2	9	ACC office moved to bigger space (previosuly occupied by HPOC). HPOC team working from home.	3	2	9
22	Corona Virus	NHS Track & Trace	QR Codes in place in St Bedes / Orangery	5	2	15	For discussion	5	2	15
23	Corona Virus	2nd wave preparation	Appendix to COVID-19 policy. Winter Pressures Meeting - Round 1. Wider participation in SWL preparation.	5	2	15	Winter Pressures Meeting - Round 2	5	2	15

MINUTES OF THE
DRUGS & THERAPEUTICS COMMITTEE

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

Attending

(AH) Dr Andrew Hoy – Consultant in Palliative Care / Chair
(JH) Dr Joe Hawkins, Hospice Consultant
(HH) Heather Howell - Advisory Committee Member
(TC) Tracy Christmas – Community Services Manager NMP
(AM) Dr Annelise Matthews - Hospice Consultant
(AR) Alex Rudkin – Head of Quality and Improvement / Mins
(MG) M Gibbs - Ashton's Pharmacist
(CF) Cathy Foster – IPU Senior Nurse
(GL) Gail Linehan – Joint CEO
(AA) Dr Ambreen Akhtar - Hospice Doctor
(HT) Hai To - Sutton CCG Care Home Pharmacist

ITEM 1: Welcome

1.1 AH extended welcome

ITEM 2: Apologies for Absence

(JH) Dr Jan Hallstrom- Hospice Consultant, (BDS) Dr Busi Da Silva – Hospice Doctor, (TY) Tracey Young - IPU Manager, (BG) Bernadette Griffin -CNS, NMP, (PH) Philomena Hutchinson- Night Team Leader, (MF) Maura Flint – Practice Development, (KH) Kevin Hobson - CNS NMP

ITEM 3: Minutes of the Last Meeting

Minutes of the last meeting held on 6th February 2020 were agreed, noting that item 4(i) in review of the Harrogate policy on PRN administration in the community is an action for TC alone and 'Michelle Philpott' referenced at 14.3 is the Medicines Optimisation Dietitian and not a nurse.

ITEM 4: Matters Arising

a) AM's review of the IPU medication stock list and liaison with MG & TY to agree required stock and levels is on-going. TC advised that the oromorph provided in the community packs that was close to expiry will go into ward stock. MG has shared the PAH stock list and AM felt that it too had the same need as ours for review. AH commented that the main concern is to ensure enough stock of emergency medications. Stock lists need to reflect must have medications. AM will complete the review and circulate for comment. MG expressed how she was happy to run through cost implications in the stock list construct. AM/TY/MG

GL advised that where there is therapeutic benefit from use of methadone then such use won't be prohibited. JH queried if there was a protocol in place for methadone/ketamine use. Previously, protocol had existed but had been removed from our Manual in keeping with Hospice practice following PCF guidance. The Hospice's own CLIN28 Ketamine - Monitoring Guidelines for Palliative Care Patients

is in place.

b) Use of Abstral is an item for discussion at the Prescribers' meeting. Abstral use peaked in June 2019 and is barely used on the IPU which reduces its prevalence in the Community. GL agreed to sharing our data with other units. MG stated that there was variable use of Abstral in other units. MG will research any useful information on its efficacy. KH MG

c) PRN administration in the community by carers was a subject that TC had began considering pre-Covid but has since been put on hold. She 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. TC

d) It was agreed that any further work or consideration of the potential research and project development required in respect of a recommendation from the RCP's ISR in January 2019 to undertake ECGs for QTC prolongation is pended. It was felt that the topic may be picked up again as a research topic.

Lengthy discussion acknowledged the work that had been undertaken to date by CF and TC alongside grateful appreciation of inputs from both JH and AM. Its origins were considered and it was again recognised that no other Hospice was doing this. TC advised that no further work had been put into the project since the pandemic began and remarked how the project had become more complicated as it had progressed. Having reached out to the ISR Doctor who had made the recommendation for policy guidance, he had advised that he didn't have one. Our own policy construction had begun but a number of ethical issues had arisen not least amongst which was potentially subjecting patients to a test that then won't affect their care options. AH queried whether the topic was in danger of being over-thought through and felt that the project should be an academic one for a research centre rather than an individual Hospice. He felt that we may be at risk of taking on something that could burden our patients and not bring benefit. JH stated that none of his palliative care colleagues in Scandinavia had come across this topic in Palliative Medicine.

GL explained that the origination of the recommendation was particular to the review that the Hospice had commissioned and she will update the RCP how the topic has been explored but the Hospice has decided that it doesn't have the resources to take it forward. AH suggested we also include our enthusiasm for the topic to be pursued as part of a multi-centre study.

AH remarked that sometimes palliative physicians forget about cardiac arrhythmia and so access to ECG testing does make sense. He expressed his support for purchase of an ECG machine. JH felt that if methadone or ketamine is to be used on the IPU then access to ECG testing would be ideal. AH suggested the topic be kept on the back burner. TC confirmed there would be no poster presentation.

e) AM is still to review the Hospice's Diabetic Guidelines last reviewed in November 2018 to reflect desired changes. She will do so in due course and let AR know once complete. AM

f) HT reported that the new stock list of EoLC medicines remains under review by NHS England.

g) The education visit by Michelle Philpott was postponed due to the pandemic. HT will draft guidance on supplement prescribing and circulate. HT

ITEM 5: Pharmacy Update

5.1 MG stated that she received update from the visiting Pharmacist whilst she had been shielding and that there had been no issues raised. The quarterly audit results were again good with only minor points raised and no concerns over CDs. 72 charts assessed, 1186 prescribed items and 18 prescribing errors : all minor. Excellent result. Intervention rate compares very favourably across Hospice providers. No supply issues during the height of the pandemic and nil untoward over prescribing / spending practice.

ITEM 6: Prescribing in the Community

6.1 HT advised that a new stock list for community pharmacists that stock anticipatory medicines remains to be published very soon for all SWL CCGs. Current stock list remains.

ITEM 7: IV Therapies

7.1 Initial discussion focussed on how best to approach the Hospice's provision of IV support for its inpatients. Roles and responsibilities of doctors and nurses across the clinical team alongside required training and competency assurance all need to be agreed within the clinical team. GL & Medical Team

ITEM 8: End of Life Prescribing

8.1 CLIN29 Preparing and Administering Injectable Medications Guidelines has been signed off by the clinical team. Appendix 1 Community Guidance remains to be signed off by the local MMC. Until the Appendix 1 has been approved by the MMC it is not for circulation within the community. GL

ITEM 9: Anti-microbial Stewardship

9.1 AM will discuss with the medical team and report back. AM

ITEM 10: Update on Medication Policy review

10.1 There have been 6 published updates to medication policy / guidance since the last meeting between February and June 2020.

CLIN29 Preparing and Administering Injectable Medication Guidelines N:\Policy Manual\CLIN\CLIN29 Preparing and Administering Injectable Medication Guidelines.pdf v3.0 revised and published to the Manual on 23-03-2020 (changes to Appendix 1 that remains in draft and not for community distribution until MMC approved)
CLIN26 Generic Drugs Policy N:\Policy Manual\CLIN\CLIN26 Generic Drugs Policy.pdf v1.5 revised and published to the Manual on 09-04-2020 (inclusion of section on COVID Pandemic Response)
CLIN25 Controlled Drug Policy N:\Policy Manual\CLIN\CLIN25 Controlled Drug Policy.pdf v1.7 revised and published to the Manual on 09-04-2020 (inclusion of section on COVID Pandemic Response)
CLINSOP03 Inpatient Unit Medication Round N:\Policy Manual\CLINSOP\CLINSOP03 Inpatient Unit Medication Round.pdf (re-published in new format only)
CLIN26 Generic Drugs Policy N:\Policy Manual\CLIN\CLIN26 Generic Drugs Policy.pdf v1.6 revised and published to the Manual on 21-04-2020 (inclusion within section on COVID Pandemic Response reference to process for issue of EoLC Oral Medication Packs to patients known to the Hospice and replacement of references to 'Director of Care' with 'Acting Clinical Director')
CLIN25 Controlled Drug Policy N:\Policy Manual\CLIN\CLIN25 Controlled Drug Policy.pdf v1.8 revised and published to the Manual on 21-04-2020 (inclusion within section on COVID Pandemic Response reference to process for issue of EoLC Oral Medication Packs to patients known to the Hospice and replacement of references to 'Director of Care' with 'Acting Clinical Director')

10.2 Medication policy / guidance that is overdue for review as at 11th June is:-

CLIN27 IV Administration Guidelines AA

ITEM 11: Serious Medication Incidents

11.1 Nil to report.

ITEM 12: Update on CAS/MHRA Alerts

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

12.2 There have been 7 alerts relevant as listed.

Reference	Title	Date	Action
EL (20)A/09	Diamorphine Hydrochloride BP 100 mg Lyophilisate-17-2-2020	17/02/2020	Diamorphine is very rarely if ever used in the community however it is useful for staff to be aware of the potential problem
SDA/2020/003	Diamorphine Hydrochloride powder for reconstitution and injection 5mg & 10mg ampoules - supply disruption alert 26-2-2020	26/02/2020	Information printed and put on the ward to ensure staff are aware
CEM/CMO/2020/006	Coronavirus - 5-3-2020	05/03/2020	Hospice Risk Assessment for COVID-19
CEM/CMO/2020/009	Coronavirus - 13 March - Community Swabbing Services	13/03/2020	Coronavirus 13th March staff responses
SDA/2020/003(U)	Diamorphine Hydrochloride powder for reconstitution and injection 5mg & 10mg ampoules 25-3-2020	25/03/2020	IPU aware
EL (20)A/20	Emerade 300 micrograms solution for injection in pre-filled syringe 7-4-2020	07/04/2020	IPU aware as device in anaphylaxis kit. Dealt with in liaison with Ashton's
CEM/CMO/2020/017	Ibuprofen and coronavirus (COVID-19) - 14-4-2020	14/04/2020	Note taken of the below resource suggesting that with a lack of evidence that NSAID's alter disease related issues in COVID19 positive patients we should advise as normal on NSAID use in these patients.

ITEM 13: Any other business

13.1 The bladder u/s on the ward is now working

13.2 JH will explore value of re-introducing local guidance for methadone / ketamine as distinct from PCF reliance to assist standardisation of approach.. JH

ITEM 14: Future Dates

14.1 Dates of future meetings in 2020:

Date	Event	Venue/Time
15th October 2020	Drugs and Therapeutic Committee	St Bede's 14.30

Minutes of Meeting

Meeting: Prescribers Meeting			
Date: Wed 21st October 2020			Time: 16:00
Chair: Kevin Hobson **Minutes:** Lynn Jackson			
Present: Kevin Hobson (KH), Tracy Christmas (TC), Bernadette Griffin (BG), Dr Annalise Matthews (AM), Dr Gabby Tamura-Rose (GTR)			
Apologies; Jill Smith			
Agenda item		**Actions & by whom**	**Anticipated date for completion**
Topic			
Prescribing Data	KH circulated the Sutton PAT data April-June 2020 to group. There has been a reduced usage of prescriptions by prescribers this may be due to various factors including GP usage, COVID restrictions & the nature in which prescribing has changed especially during COVID lockdown. Prescription pads to possibly be changed by CCG to SWL in the future, this would make sense for Sutton and Merton	KH to acquire the Merton PAT data	November 2020
Prescribing competencies	KH & TC have adapted & completed the Royal Pharmaceutical Society competency form for use by St Raphael's Hospice (SRH) prescribers.	KH & TC have completed their competency. JS, BG, NS, TG to complete their competency	December 2020
St.Christopher's Education	Non-medical prescribers to undertake St Christopher's training. This will be via 10 virtual sessions approx. 1 ½ hrs long, from November 2020 until December 2021	All relevant staff	December 2021

Minutes of Meeting

Community s/c guidelines	Although agreed these are still in draft form Crosscare PRN medication letter that is generated needs to be reviewed & medication in dropdown box to be changed.	KH to contact Alex Rudkin to get these active. Then to cc to Gail L & Tebecca T KH to liaise with Pascale E to change as necessary	December 2020 December 2020
Writing prescriptions for Controlled Drugs	JS wanted to discuss this issue but in her absence this is to be discussed at the next meeting, however if any urgent concerns GTR willing to advise as 2nd on call.	JS next meeting	Next meeting
AOB	Non-Medical Prescribers policy is now complete	KH to email to group.	ASAP

Date next meeting:

Quality Improvement Committee
Minutes of the meeting held at 1.30pm on Thursday 25th June 2020

Present:
(AR) A Rudkin (Chair, Quality Development Manager)
(GL) G Linehan (Joint CEO, Interim Clinical Director)
(NS) Nick Stevens (Joint CEO)
(JH) Dr Joseph Hawkins (Head of Medical Team)
(LB) L Briant (Education Team)
(TC) T Christmas (Community Services Team Manager
(JC) J Cope (Audit Support & Minutes)

Apologies
(JHall) J Hallstrom (Palliative Care Consultant), (TY) T Young (IPU Manager), (MF) M Flint (Clinical Education)

1. Minutes of the last meeting held in December 2019	
These were accepted as a true and accurate record	
2. Matters Arising	
OACC Carer Survey : Use of the OACC Carer Survey remains still to be assessed. This will be an objective for 2020/2021. OACC measures including iPOS, Phase of Illness and the Karnofsky scoring were incorporated into the EPR and plan is to re-educate and re-implement. Training will need to be rolled out. The Karnofsky scoring system is not the Australian model, so will need to be changed and training delivered. TC added that a lot of training will be needed for staff regarding iPOS and how it should be integrated into practice. JH stated that changing the Karnofsky definition and scoring to reflect the Australian model and the roll out of Karnofsky training should wait for the IPU and Community Aram audits of NG31 have reported in order to feed in any requirements. JH told the meeting that he has talked to ward staff regarding the OACC suite. Staff need to see and understand the practical applications. AR agreed that aspects of the OACC suite over the years had not had the required education and support required practical integration and demonstration of the functional benefits on a daily basis. Plan is to make headway with implementation this year with a Clinical Director and substantive medical team in place.	Clin Dir / Med Team / TY / TC / AR
Prescribers' Meeting ToR : NS entered the meeting at this point. The Prescribers' Meeting allows for multi-disciplinary discussion and review. The minutes also feed into the CQ&G sub-committee. Its ToR has been discussed with one or two amendments agreed at the last meeting.	
Clinical Objective review – Management Plan : The Clinical Objectives are included in the Management Plan that is available at N:\Plans and Budgets\Plan 2019-20\2019-20 SRH Management Plan Version 2.1.docm. AR told the meeting that the Clinical Objectives complement and are referred to within the CQ&G section of the Management Plan as the Clinical Acton Plan. Their construct is not an arbitrary process and promotes the input of the clinical Head and their teams in the construct. Draft will be circulated for inputs. It is ideally not a construct for mid year but this has been an exceptional year and future intent is for its construct to align with financial planning as too should all other objective setting across the piste.	AR/JH/GL/TY/ MF/TC/SM

3.	**Covid Disruption**	
	Survey/ Reflection forums: AR introduced conversation he had had recently with LB and MF regarding feedback and learning (strengths and weaknesses) from the COVID experience March – May 2020. LB said that she and MF were wondering about a debrief for an education opportunity. TC said that Hospice UK had circulated a survey called Bluebird and is designed as a COVID well-being survey. AR felt it would be a useful means with which to benchmark the Hospice with similar organisations. AR highlighted that reflection forums are needed to facilitate feedback to managers from their teams and extract learning points. It is necessary to extract learning in this way, and this will be cathartic for clinical teams. LB added that it would be useful for all staff and a way of helping them understand the pandemic better. GL told the meeting that a reflection forum includes a quick presentation of issues. TC said that all staff, including housekeeping, admin and retail get to give their feedback in reflection forums. JH advised that such a forum should not be overcomplicated, as this would be off-putting to some personnel. AR said that group facilitation is a great structure for ordering thoughts and a facilitative tool for teaching. He added that he had no experience of the Schwartz round, but recommended that staff have a simple, structured questionnaire to feed into the learning experience of the first 3 months of the pandemic. GL recommended facilitating what goes into the Schwarz round with feedback from different departmental team meetings. NS asked whether there was a contact to facilitate the various team meetings and collate the feedback. LB said that she and MF would do that. GL suggested arranging meetings of ten minutes per team. JH agreed that smaller meetings that allow introspection are a positive idea. GL suggested that the team leader of each meeting be given a short (1/2 side of A4) list of bullet points covering the important points the staff need to know. Responding to AR, LB replied that she and MF had capacity to deliver the feedback the sessions and report. It will be more productive to speak to teams separately e.g. speaking directly to housekeepers would be advantageous as they might not feel comfortable voicing their concerns in front of nursing staff. NS pointed out that arranging different meetings for all teams would take time. GL said that it would feed into the Hospice preparations for the second wave of COVID. JH said that the question of social visits and whether they continue to be of use would need to be addressed. LB considered the time frame for the meetings and said that business related to Princess Alice's e-training preparations is scheduled for July and that MF is off during the last three weeks of August. TC said that it would have to be scheduled before August. JH and TC can facilitate their teams' feedback if felt helpful. **Communications/Practice:** AR brought the attention of the meeting to the topic of COVID communications and whether the Hospice's communications are good enough. TC speculated that there had been an information overload. She herself had passed on one email a week. LB added that there had been an enormous number of emails to pass on and that this was symptomatic of an information overload at a national macro level. AR asked whether enough information had been communicated to patients and relatives and JH replied that this has not been perfect. There has in fact been a lot of upset to staff and other relatives surrounding communication and the changing rules. There have also been problems stemming from certain key staff members having a lock on certain types of information, which is then not available when they are absent or go on leave. AR asked specifically about communication with the medical team and JH replied that this had gone smoothly. The medical team is small and holds weekly meetings. The doctors are accustomed to discussing future decisions with one another, whereas the nursing team on the ward have had issues that have been ongoing since the beginning of the pandemic which highlight training needs. LB asked about the training needs and JH replied that there had been a patient who could not make decisions for herself and whose daughter is in Spain. The daughter has had issues with other organisations in the past and certain papers were sent to Continuing Healthcare	LB/MF

without the daughter's consent. GL has fortunately resolved this issue and the daughter has been satisfied with apologies. TC suggested that staff need to be confident about their ability to make decisions and JH once again pointed out the problem of overreliance on key staff. There is a need for strategic staffing that takes into account the number of admissions each day compared to staff availability. Other hospices have a system whereby the leadership is aware of these statistics each day. AR thanked JH for his points and reiterated the need for a COVID survey and Reflection forum. LB asked whether the Hospice will use Bluebird and added that she had not seen it. AR said that he would discuss it with her outside the meeting and LB said that the survey and the reflection forum could be implemented with individual teams at the start of August.	
4. Practice Development	
LB informed the meeting that the Princess Alice hosted training goes on live at the start of August and that there will be a dedicated training room for the staff who have restricted access to computers. The modules are only likely to take 20 or 30 minutes. There will be a need to complement mandatory e-learning with some physical sessions. LB said that they would need a third date from John Hynes and said that Housekeeping would require face to face training since they do not have computer access. She added that MF had a list of dates for when individual staff are due their updates and that a meeting would be held to check in advance that staff are satisfied. TC added that all but two staff have completed their competencies. AR asked JH about the Mortality/ Morbidity meeting led by the psychosocial team counsellor DB. JH said that it was best practice to have every IPU death documented and to have an MDT to hold daily meetings to compile data on each IPU death and store this information where it is regularly accessible. The MDT meetings should include filling out questionnaires on safeguards, coroner feedback and disease, which will then serve as evidence for the CQC. AR asked whether nutrition and hydration should be a standing item for reflection. JH said that they could be. Another item would be documenting how the patient's family is comforted. TC said that she and John Groom would assign an MDT window for the Mortality/ Morbidity meeting.	JH TC
5. Education, Training and Development Committee	
The scheduled start date for the E-Learning is 3rd August and that there is a communications course planned for 2020/2021. GL told the meeting about Sage and Time Level One – a course in the basics of communications which had a list of phrases with which to address distressed people. Previously all volunteers did this course. GL suggested buying it from St Helier. 30 people would be able to take it. It is £600 for a course for 30 people. An advanced communications course would be a kin to the one we hosted (Dr A Hoy) a couple of years ago. This was expensive. TC announced that she had taken an advanced communication skills course at St Peter's. JH said that he had done a communications course specifically for consultants. He said he would pass on the structure of that particular course. GL recommended a course which makes it possible for the participants to learn by viewing the body language they themselves are accustomed to use when they are communicating, allowing them to self-critique as it were. This course had once been run every four years. NS suggested that a course could be run every two years. GL said that MF and LB can manage the education program and buy Sage and Time from St Helier. NS stated that it is not necessary to wait until the budgeting program in September to schedule required training. Merits should be considered now.	MF/LB
6. Clinical Structure	
GL informed the meeting that the Hospice would be bringing in an interim Clinical Director on 6th July for a period of six months. In September and October 2020 respectively, two 0.8 consultants will be appointed to support the clinical structure across the Hospice. The Clinical Director will manage all the Clinical Heads. NS and GL agreed that the Clinical Director would provide a fresh pair of eyes for empowering the team and supporting a collaborative approach. AR emphasised the importance of accountability and	GL

responsibility, especially regarding times without designated managers. An MDT approach does not reduce responsibility of leaders in those times.	
7. Invited Service Review	
GL told the meeting that she was addressing the 18 points raised in the Invited Service Review report. She is halfway through the report and this is the final report that includes reflection on the two audits undertaken in January 2020. The report will be given to the Advisory Board before it is sent off.	GL
8. Clinical Quality & Governance Sub-Committee	
AR reflected upon recent business that had seen some focus on Raising Concerns – Freedom to Speak Up Policy which is revised and is based on the NHS model. It highlights the responsibility of staff to raise concerns and issues outside normal communications in a structured format. AR is the "freedom to speak up" guardian for the Hospice and will seek out the appropriate training for the role. AR reminded the meeting that communication is key. Staff must support it as much as possible, so individuals and line managers must support a structure by which criticism is effective. The Advisory Committee has a nominated member as outlet to support the freedom to speak up function and the HR Manager is also an additional conduit. The creation of the freedom to speak role does not remove the importance nor significance of effective communication between staff and managers which is the life-blood of the organisation.	
9. Policy review	
AR reported that percentage compliance in policy review fluctuates as per table below and at May 2020 rested at 85%. The Hospice has a robust policy/procedure publication and document control structure in place. They reflect the services the Hospice provides and support the delivery, staff and volunteers in so doing. Each policy has a review lead. Ensuring policies are read and understood is a managerial responsibility. The Policy Manual Index can be found here: N:\Policy Manual\INDEX OF POLICIES.	

	Nov-17	Jan-18	Mar-18	May-18	Jul-18	Sep-18	Nov 18	Jan 19	Mar 19	May 19	Jul 19	Sep 19	Nov 19	Jan 20	Mar 20
Up to date	94%	91%	90%	86%	90%	87%	84%	77%	67%	61%	70%	69%	88%	91%	87%
	May 20														
Up to date	85%														

10. Infection Control	
GL will discuss with TY who will be lead for IC on the IPU in light of PM's intended retirement. TY. AR announced that Jim Stevenson, the consultant Microbiologist, will hold a remote meeting on Infection Control on Tuesday 30th June. LB said that the updates to the policy are due in August 2020 and that there is nothing major to change.	GL/TY
11. Care Quality Commission	
AR told the meeting that the last report in March 2020 shows a fair representation with rating awarded as Good across all domains – Safe, Effective, Responsive, Caring and Well-led. There are only a couple of areas for improvement cited. One is the functionality of Crosscare and the other relates to IPU décor, particularly the carpets. This will be actioned this year. NS said that the Ward refurbishment project has been pushed back to the end of Autumn.	
12. Audit/ Monitoring/ Research Projects	
a) Clinical Audit and Activity Data Meeting: AR informed the meeting that the ISR's comments last year following the January 2019 review had said that the Hospice embraces incident reporting – maybe to excess by reporting minor incidents. That poses the question, what is the definitive medium?	AR

	b) **Audit/ monitoring report**: The monitoring report for projects underway was reviewed	
13.	**Clinical Risk Management**	
	(a) Datix will replace the paper-based incident reporting system currently in use. Currently the Hospice is behind the self-imposed schedule, originally because of Datix's technical issues and the project being pended due to the pandemic. The testing phase is to get underway again and the project team meeting expanded. Implementation will follow adequate testing and training. The desire is to get the system right, in and functioning with users adequately trained in their interactions and it is competing amongst a number of other IT projects. Heads of Departments will need specialist training but for the majority of users training/instruction will be minimal due to the intuitive system design.	
	(b) Clinical Risk management data 2015-2019: Reported clinical incidents reduced in 2019 quite significantly to 99 (c.f. 176 in 2018, 163 in 2017 and 177 in 2016) – a 44% reduction on 2018. The number of admissions to IPU are comparable with 2018. Medication incidents including those related to opioid toxicity are notably reduced as too are pressure sores both on and during admission, information governance incidents, manual handling incidents, slips, trips and falls.	AR
	(c) NS highlighted the available bed days figure. AR explained that the figure was not fixed according to any given month other than the number of days in that month. The beds available figure was not calculated each day rather each month based on the bed occupancy in that month e.g. a month of 31 days with a beds occupancy of 255 days would usually lead to an occupancy being calculated on either 9 or10 beds dependent on usage of those beds as distinct from 8 beds whose maximum occupancy can only be 248 for that month. The availability of beds is underpinned by staffing and to have a fixed figure of 10 / 12 or 14 beds available for example may show the Hospice being more unoccupied than you'd expect if the staffing were actually available to service the 10 / 12 / 14 beds. It was agreed that NS and GL would deliberate on this figure outside the meeting given a fluctuating beds available figure may falsely show occupancy as distinct from a rigid figure even if the staffing isn't in place to service it. GL said that available beds normally number between 8 and 10, depending on staff availability. NS said that staff availability should be factored in. It would certainly impact the bed occupancy percentage figure. AR advised that in 2019 monthly occupancy was based on 1 month having 11 beds available, 3 months having 10 beds available, 2 months having 9 beds available, 5 months having 8 beds available and 1 month 7 beds. JH said that the Hospice should simply close beds if there are not enough staff and not include them in the figure of available beds for that day, which would definitely make the percentage figures for bed occupancy give a more accurate picture.	NS/GL
	(d) UI&NM Clinical Significance Rating monitoring was introduced last year to track significance of incidents. 2019's data shows a large proportional decrease in incidents classified as moderate alongside medication incidents classified at level 2 or 3.	
	(e) Clinical Risk Management Stats 2015-2020. Incidents reported from January – March 2020 continue the lower reporting trend from 2019. NS observed that these show far fewer drug incidents in 2020. AR pointed out that the Hospice once reported far higher drug related incidents and IG related Incidents. In previous years, the greater numbers reported were symptomatic of increased prevalence and reporting. The fact that there are fewer despite a continued and more proactive	

approach to reporting them is, all in all, an encouraging trend. Pressure sores on admission are up on last year.	
14. Complaints	
(a) The number of complaints reported in January - May 2020 is 6 : 5 clinical and 1 non-clinical and lower than last year. IPU complaint numbers were higher peaking between 2017 and 2019.	

2020 - Complaints	CPCT Care	CPCT Comms	CPCT Care & Comms	H@H Comms	Jubilee Comms	IPU Discharge	IPU Care	IPU Comms	IPU Care & Comms	OPD Comms	Bereavement Comms	External- Provider Care /	Fundraising /Shop Comms	HR	Total
January	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
February	0	0	0	0	0	0	1	2	0	0	0	0	1	0	**4**
March	0	0	0	0	0	0	0	1	0	0	0	0	0	**0**	**1**
April	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
May	0	1	0	0	0	0	0	0	0	0	0	0	0	**0**	**1**
2020	**0**	**1**	**0**	**0**	**0**	**0**	**1**	**3**	**0**	**0**	**0**	**0**	**1**	**0**	**6**
2019	0	0	0	1	1	0	3	3	0	0	1	1	2	2	14
2018	2	5	1	0	0	1	10	4	1	1	0	1	1	0	27

	Comms				Dignity	Clin. Tx / Care	Other	Policy			Fundraising / Shops		
2017	12				0	5	1	2			2		22
2016	6				2	5	0	0			0		13

15. NICE Standards & NPSA Safety Alerts/ MHRA Alerts/ CAS Notifications	
CAS notification feedback is an ongoing process, with nothing new of note to report recently. Medication alerts are summarised at D&TC. A CAS excel database is accessible to all at N:\Governance\Central Alerting System\Register of Alerts\CAS Register.xlsx, is maintained by JC and AR and engagement and communication with the clinical team is good. AR appreciates the feedback from the clinical staff.	
16. Forum Feedback	
- Regarding matters for the Health and Safety Committee, AR announced that he would be arranging a fire risk assessment re-do with Hettle our Risk Management Consultancy. Plan is to complement the audit work externally with inspection internally. - Drugs & Therapeutics – AR said that the feedback from the Ashton's Audit was that the Hospice stands fairly well among other hospices. GL said that the number of errors on the Hospice's prescription charts are relatively low which is definitely encouraging. - The QSING meeting (local Hospice's Quality & Improvement forum) has been historically held at Princess Alice. The next meeting will be hosted by ourselves via Zoom in a couple of weeks time. Staff are able to constructively share information in this forum.	

-TC announced that the Prescriber's Meeting remains useful. Kevin is looking at developing a competency for all prescribers.	
17. Any Other Business	
None	
18. Dates of 2020 Meetings	
18th September 2020 11th December 2020	