10th Meeting of the Clinical Quality and Governance Sub Committee
To be held remotely via Zoom

at 10.00am on 21st August 2020

Agenda

Chair : CC

Item	Description	Purpose[1]	Lead
1.	Apologies for absence	I	AR
2.	Minutes of the last meeting held on 12th June 2020	S	Chair
3.	Action List from previous meetings	I	Chair
4.	Recruitment / Staffing Update	I	GL/RT
5.	Clinical Risk Register	S	GL
6.	Clinical Quality & Governance Report	I	GL/RT/AR
7.	CAP & Management Plan Extract	I	GL/RT/AR
8.	Minutes of Meetings (att) • Clinical HODs Meeting: August 2020 • Prescribers Meeting : July 2020 • Falls Meeting : June2020 • Consultants Meeting : August 2020	I	GL/RT/ AR
9.	Dates of Future meetings in 2020: 10am Friday 30th October 2020	I	Chair

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

SAINT RAPHAEL'S HOSPICE

MINUTES OF THE
9th CLINICAL QUALITY AND GOVERNANCE SUB-COMMITTEE

Held on 12th June 2020
via Zoom

	Non-executive	Executive
Members:	Alan Cogbill (AC) Dr Caroline Chill(CC) Dr Joy Tweed (JT)	Gail Linehan (GL)- Director of Care Alex Rudkin (AR) – Quality Development Manager

Chair: Alan Cogbill (AC)
Minutes Alex Rudkin (AR)
In Attendance: Nil

ITEM 1: Apologies for Absence

Dr Hallstrom and Dr Hoy extended apology.

ITEM 2: Minutes of the last meeting held on 12th March 2020

2.1 Approved

ITEM 3: Action List / Matters Arising

Ref	Action
03/01 (AR)	ToR for CQ&G reviewed and published. Complete.
07/01 (GL)	Submission of the ISR update report to the RCoP is behind schedule. GL will circulate draft to members before sending. GL advised that many of the ISR items don't have relevance now and that the update report will be the last. All agreed.
08/03	PPE supply is fine. Complete.
08/04	Clinical Risk Register item 6 has been downgraded following recent appointment of another specialist palliative care consultant. Complete.
08/07	Records showing active patients have CMC records in place stands at 78.01% as at 28-05/2020. Complete.

ITEM 4: CQC Inspection 11-12 November 2019

4.1 CQC report received and award of 'Good' achieved across all categories – Safe, Caring, Responsive, Effective and Well-led. The only points of critique related to the condition of the IPU carpet and the ease of navigation in the EPR to a requested piece of information demonstrated by a senior nurse on the IPU. GL advised that the Inspector had advised that we were so near to being awarded Outstanding across the criteria. To achieve that, there needs to be evidence of greater external engagement. This endorses the Hospice's Strategy. Comment on our care and interfaces were very positive as too was the inspector's feedback following a community visit. With so many pressures in 2019, the award of Good is acceptable. AR will circulate link to the published report on the Hospice website to all Advisory Committee members. 09/01(AR)

ITEM 5: Clinical Risk Register

5.1 The clinical risk register was reviewed. It was noted that even a positive antibody test to COVID-19 doesn't provide any guarantee over immunity.

GL concerned the potential impact over track and trace and effect on staffing if advised to self-isolate for 14 days. All staff on the IPU have been wearing face masks all the time as routine along with the required PPE in patient rooms. CNSs would step into IPU if required due to staffing crisis. If social distancing isn't deliverable outside the IPU then face masks may be warranted. Key Admin staff will perhaps need to wear face masks.

5.2 GL advised that planning is underway to get feedback on the positives and negatives and lessons learned from the first two months of the pandemic across all departments in order to help prepare for any second wave.

ITEM 6: HR03 Raising Concerns – Freedom to Speak Up Policy

6.1 Points raised at Advisory Committee have been included. There is a responsibility for all professionals to speak up. CC and JT felt that the policy was well written with easy to understand language. It was agreed that the best placed designated Trustee would be a member of the HR Sub-committee.

ITEM 7: CQ&G Report

7.1 The Clinical Quality and Governance Report was reviewed.

7.2 GL's COVID update is a useful aide-memoire for future preparation. All staff have been terrific in their embrace of what's been needed of them. Agency nurses have fitted into the 'one team' approach and support has been put in to upskilling them. Initial reservations from Agency staff because they didn't know what to expect from a Hospice were quickly resolved and their quick adaptation transformed them into

being assets. The agency staff are certainly now better equipped to manage end of life care in other settings and are a potential source of recruitment to our bank in the future. Their feedback has been that they have felt very much part of the Team and is supportive of the efforts in place to achieve the 'one team' approach. The Community Team embraced Whats App consultations and such communications will be retained alongside physical face to face contact and telephone only contact in the future.

7.3 Meetings have been facilitated by Zoom or MS Teams. CC highlighted the value of recorded education and GL confirmed that some educational video has been posted to the website for access by HCPs and that such communications are very much part of the thinking for educational provision going forward. The Communications/Fundraising team are investigating the required equipment that will support developing video presentation.

JT expressed how getting the right balance between physical and virtual contact will be part of the future.

AC remarked how some of the educational activity relates very well to increasing the Hospice's profile. CC commented that tying in video accessibility with freedom to donate is another area for potential development.

CC advised that the SWL Training Hub run educational lunchtime meetings with the most recent topic being on mental health. If SRH hasn't been approached to participate there is perhaps opportunity for SRH to reach out in its offer of educational video. JH has done a GP training webinar on managing SOB. A teaching video on verification of death has also been provided. It was noted that St Christopher's have associated an access charge for such material.

7.4 AC reflected that complaints handling has always looked fairly sound and well-controlled. He reflected on complaint reference 2020/05 for which the review meeting had been pended due to the pandemic. That meeting may well be serviceable remotely if desirable to the complainant. GL will send an email offering a virtual meeting. CC agreed that the longer the complaint remained open then the more exercised the complainant may get. 09/02(GL)

Offer of a video call option for future complaints will be a consideration.

7.5 JT reflected on the Clinical Director role that will close to advert on 1st June 2020. An in depth discussion took place.

7.6 GL reflected on the capacity tracker data and how the calculator used for expected contacts had been flawed in its construct. As endorsed at Advisory Committee, the Hospice's report based on honest, transparent and traceable data remains the accepted approach. GL completes the data returns twice per day. April and May 2020 saw allocation of £220k each month via Hospice UK to SRH and June's income is expected very soon. AC reflected that the political fall out from potential claw back reduces its likelihood.

7.7 GL confirmed that the Hospice's COVID management policy is kept under review as too is its visiting allowances and the information provided to visitors.

7.8 CC reflected that a short paper highlighting performance during the COVID pandemic in terms of headlines and what we have been proud of would be useful. 09/03 (GL/AR)

7.9 Reported incident figures were reflected upon to the end of March 2020.

ITEM 8: Minutes of Meetings

8.1 Minutes of the meetings were accepted:-

- Clinical HODs : June 2020
- Prescribers : March 2020
- Drugs & Therapeutics : February 2020
- Quality Improvement Committee : December 2019
- Consultant Meetings : June 2020

8.2 JT highlighted the joy expressed in having a busier IPU during the COVID period. The extra CCG commissioning of 6 beds is in place to the end of June 2020. GL concurred that a busier unit means for a more diverse and rewarding environment for clinicians.

8.3 CC advised that if a care home can't accept a patient who doesn't require medical intervention then it is the local authority's responsibility to source suitable accommodation. She will send onto GL copy of the Care Homes' Resource Pack. 09/04(CC)

8.4 Responding to CC's query, GL confirmed that we do canvass for patients that would be better served by our services. Since the extra CCG beds have been commissioned the CCGs have been delighted with how responsive we have been. GL will send a report to the CCGs confirming the positive message associated with a busier unit. GL reflected that we'd be delighted to keep more beds open. The difficulty is in the staffing and whether the CCGs will be willing to continue to pick up the agency staffing costs that allow us to operate at higher capacity. CC reflected that it may be useful to do a business case that supports the continuation of funding especially as it is known that beds have been commissioned in other settings and not used. AC endorsed the idea of a short business case. He reflected that the value of being more involved in a joint campaign in troubled times is something that we may be able to play on. 09/05(GL) 09/06(GL)

ITEM 9: Any Other Business

9.1 Responding to CC's question, GL advised that she wasn't aware of any approach to engage with required training for Care Home staff. We certainly have a willingness but are mindful of not treading on the toes of the EoLC team who've expanded in

Sutton and Merton. Maybe there is conversation to be had about how a collaborative approach may help. GL will discuss the topic further with Tracy Christmas, Community Team Manager. GL expressed how the more we can work with the statutory providers the better. 09/07(GL)

9.2 GL advised that she and NS have sent out a statement this week highlighting the effect COVID-19 pandemic has had on the BEM groups and the recent experience highlighted through the George Floyd killing in the USA and acknowledging the distress that it has caused. Should staff have any concerns then both NS and GL will make themselves available. All the care agency staff have BEM ethnicity.

AC congratulated NS & GL for their proactivity in this regard.

9.3 Responding to CC's question, GL advised that individual risk assessments had not been effected other than for re-induction of furloughed staff or those returning from shielding. GL will explore what RA would be supportive of the BEM workforce now that data has shown the greater impact on that population than others. 09/08(GL)

9.4 CC to chair August's meeting.

ITEM 10: Dates of future meetings

Date	Venue/Time	Chair	Apologies
Friday 21st August 2020	10-12nooon	Dr C Chill	AC (likely)
Friday 30th October 2020	10-12noon	Dr J Tweed	

ITEM 03 ACTION LIST

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

Reference	Lead	Description	Target Date for Completion	Comments
04/01	GL/AR	Performance Management	Oct 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 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.	Sep 2020	Hospital to Hospice Audit led by J O'Grady (HPoC), supported by AR : audit extended to incorporate community admissions in January 2020. Audit period Jan – Jun 2019. Report expected in September 2020.
07/01	GL	ISR Update to RCoP draft to be sent to CQ&G members before sending	Sept 2020	Full report to be compiled. Agreed as the last report to the RCoP.
08/01	GL	Medical Revalidation Policy and Chaperone Policy to construct	Sep 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.	Aug 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.

ITEM 03 ACTION LIST

Reference	Lead	Description	Target Date for Completion	Comments
08/08	GL/AR	To produce draft CQ&G Management Plan for 2020/21 for endorsement by CQ&G Members	Aug2020	Included in August's papers
09/01	AR	Circulate report of November 2019's CQC Inspection	June 2020	Complete.
09/02	GL	Re complaint 2020/05 – offer of remote meeting to close.	June/July 2020	Complete
09/03	GL/AR	Performance during COVID – a short paper to highlight the COVID experience.	Aug 2020	Comprehensive report being drafted by Practice Educators in August 2020.
09/04	CC	Send copy of Care Homes Resource Pack to GL	June 2020	Complete
09/05	GL	Provide report to the CCGs reflecting the positivity of message behind a busier IPU.	July 2020	Complete
09/06	GL	Produce business case for continuation of commissioning of the extra beds and provision of staff to service them.	July 2020	Discussed with CCG/Lucie Waters SWL - Due to spare capacity in acute sector no requirement for continued commissioning. Future commissioning will be considered if there is a need. Complete.
09/07	GL	Discuss with TC – training for Care Home staff and collaborative working with EoLC Team – Sutton & Merton.	July 2020	On-going communication with both Merton and Sutton EoLC teams. No current plans re: education delivery in Care Homes due to current status.
09/08	GL	Explore value of BAME worker COVID-19 RAs	July 2020	BAME risk assessments undertaken and reviewed by OH. Required actions taken to support individuals. Complete.

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.	Active recruitment to 2.2 FTE consultants. Utilisation of agency and locum consultant cover currently servicing 2.4 FTE consultants.	4	3	16	Appointment of 1x 0.6 FTE and 1 x 0.8 FTE (Trust held post). Active recruitment for 0.8 FTE consultant in August 2020. Junior Doctors : increase 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 October 2020 (supports medical team on IPU and Community Team). GP VTS expected in October 2020. Hopeful for STR in January 2021.	4	2	12
3	Workforce: Community Clinical Nurse Specialist Ability to recruit suitably qualified Clinical Nurse Specialists to support the demands of referral for community support	Decrease in service delivery to support the demand in the community. Requirement to review service provision - modify the current offer	Succession Planning- Supporting CNS Development posts Comparible Salaries to NHS AfC Good working Environment Flexible Working Hours Introducing a skill mix of staff into the community service	4	3	16	Advertise for CNS or development posts and over recruit in the short term to reduce risk of not having the required staff. Team are working effectively with recently recruited development CNSs. To ensure service delivery. 2 band 6 CNSs becoming band 7 CNSs. Recruitment of 1 band 7 CNS and 2 band 6 CNS development posts to join team in September/October 2020. Full establishment.	1	1	2
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 appointment in August 2020.	4	2	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 moniroing 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 been advised that transfer to day duty would be a safer working environment for herself/staff collegues and patients. Staff member changed to day duty. All current mitigations remiian in place.	3	2	9
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 October 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 decsions where they have capacity increases risk Improve lighting to patient room patio area	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 Director of Care 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	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	4	20
20	Corona Virus	Change of service delivery model : Suspension of H@H , 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	For discussion	5	2	15	For discussion	5	2	15
23	Corona Virus	2nd wave preparation	Appendix to COVID-19 policy. For discussion							

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

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

Governance Meetings - Clinical	Date last held	Date of Last Minutes Reviewed at CQ&G Sub	Next meeting
Clinical Audit and Activity Data	Jun 20	Jan'20	Aug'20
Clinical HoDs	Augl'20	Aug'20	Sep'20
Drugs & Therapeutics	Jun'20	Feb'20	Oct'20
Falls	Jun'20	Aug'20	Dec'20
Incidents	Mar'20	Mar'19	Sep'20
Infection Control	Jun'20	Nov'19	Dec'20
Prescribers	Jul'20	Aug'20	Sep'20
Quality Improvement	Jun'20	Dec'19	Sep'20

Clinical Update

1. Update on Organisational Response to the Covid 19 Pandemic

The Hospice continues to be vigilant and observe strict infection control measures to mitigate against the spread of Covid 19. Front reception 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. The front desk is manned from 08.00 – 20.00 each day by a team of staff members and volunteers. At the weekend it is supported entirely by volunteers. A splash screen is to be added to the reception desk.
Practice educators will provide refresher sessions for staff on infection control protocols and staff are encouraged to complete the Infection control module on Learningzone as soon as possible

Masks continue to be worn for those entering the IPU. Staff have adapted well, although wearing masks can be very warm and at times uncomfortable. Cohort nursing remains the normal practice to ensure optimum infection control. Staff are reminded to use masks once only and not touch the masks when on as this will reduce their effectiveness.
Due to two recent IPU patients with possible COVID symptoms, all patients admitted to the IPU will be 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 been amended to 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 patients room at any time. Reception is aware of those who have been identified as allowed to visit and a visitors log has now been introduced to ensure that we have details of those visiting – contact details are kept separately for the sake of data protection. PPE continues to be worn by visitors. Footfall onto the IPU is monitored to ensure numbers remain low

The Community Team have been supporting patients remotely as well as visiting service to assess and support patients in their own homes, following a COVID risk assessment. PPE continues to be worn for all visits. Hospice@Home have also reintroduced time limited visits of up to an hour (with some flexibility) to provide support to patients in the last days of life.
CPCT staffing levels are increasing due to shielding /maternity leave staff returning and a number of staff have recently been recruited.

Antibody testing for staff across the organisation has been supported by St Helier's Hospital. The testing schedule, which attracted a huge response from staff has been organised by HR and facilitated by our Occupational Health service supported by the GPVTS for taking bloods. The final date for testing was 11th August.

Staff reflective forums across all teams have now been completed and the Practice Education Team (Maura Flint and Laura Briant) will produce a report which incorporates the reflections and makes staff recommendations for practice going forward. The HODS reflections will form a separate part of the report. The Practice Education Team also plan to develop a poster for HUK/conferences next year.

The Psychosocial team continue to work remotely supporting patients/relatives and carers. Both the Social Worker and counsellor have sadly had personal bereavements and so have needed time off for compassionate leave. Steve Molyneux and Tracy Young have met with Becca Trower to look at ways of increasing PS support on the IPU over the coming weeks and months. Six student counsellors/psychotherapists are helping to support carers with less complex needs and are supervised by Steve.

The Wellbeing Centre was closed at the end of March, which was a loss to all the patients who attended. However, telephone contact with patients and carers has been regularly undertaken by the Co-ordinator, Sheila Payne as well as actively supporting and engaging patients via Zoom to deliver sessions. These include coffee and chat/music appreciation/ relaxation and armchair yoga and the men's den. Sessions are supported by volunteers remotely. Numbers participating vary depending on how individuals are feeling on the day but have proved popular. Many patients are keen to revisit when our doors are open again and we are currently thinking about how to reach our community more widely using a blended approach of remote and face to face support.

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.

The support of all our staff has been phenomenal in keeping the hospice safe and functioning.

2. **Recruitment**

Becca Trower, the interim Clinical Director, seconded from Princess Alice Hospice, has now been in post since Monday July 6th. Becca is working across the clinical services, engaging with departments and individuals to provide support and identify opportunities where we can further improve the clinical care that we offer.

The Trust held 0.8 FTE Consultant post has now been successfully appointed to and we look forward to welcoming Dr Gaby Rose in early October. The final 0.8 FTE post will be advertised shortly.

We have also successfully appointed to a number of clinical roles on the IPU and the CPCT including a nursing associate post and a physician associate post. Both these roles are new to the hospice and innovative in their nature. In addition, we are introducing the Care Certificate so that we can appoint HCAs at a level 2 banding, helping to develop those with an early interest in healthcare.

3. Medical Team

Dr Jan Hallstrom, Locum Consultant, has submitted his resignation with effect from September 29th. He is returning to Sweden to work as a palliative care physician. Dr Hallstrom has been with us for two and a half years and has expressed how he has enjoyed his time here working with the clinical teams.

Dr Joe Hawkins, agency locum Consultant will be leaving the hospice in early September, when the new Consultant Dr Jenny Strawson joins the team.

There will be no GPVTS trainee placement from August to October this year as the doctor scheduled to attend the hospice cannot undertake face to face patient care. Dr Busi Da-Silva has agreed to increase her sessions from 2 PAs to 6 PAs and works Wednesday to Friday to support the team. We have also appointed a locum GPVTS, Dr Dan Knights who has a special interest in palliative care and will be joining our 1st on call rota from the end of September.

Unfortunately we have received notification that we have not been allocated a StR for October but are hopeful that we may be successful for the next cohort in Jan 2021.

We continue to monitor medical input as it will be shorter than we would like over the autumn period.

4. Education/Training

The Practice Educators have been supporting training across the hospice including the safe use of PPE by retail volunteers. They have been extremely responsive to the needs of staff including supporting specific and individual requirements such as allergy awareness.

Learning zone has now been introduced and staff are being encouraged to familiarize themselves with the new system and undertake training modules as soon as possible with the infection control module as a priority.

5. Capacity Tracker

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

6. Staff Wellbeing

All teams have continued to work to a very high standard to support all aspects of the hospice service. Staff have been actively encouraged to schedule in annual leave to support rest, relaxation and wellbeing. Initially there was a reluctance to take annual leave as movement was restricted and holidays abroad were not able to be taken. However, at this point it is noticeable that staff are tired and the booking of time off has increased as staff recognise the benefit of time away from work.

Clinical supervision sessions have been resumed for nursing teams.

Staff have been provided with contact details for access to support resources all of which are free of charge.

Kelly Channer, Head of HR, has trained as a Mental Health First Aider. The training helps identify signs of anxiety/distress and also enables the first aider to offer 1st line support and signpost to other services.

7. **Bed Capacity**

Following the de-commissioning of the 6 CCG beds on July 12th and the support of the associated staffing, hospice bed capacity has been reduced to 6-8 beds. This is in the main due to the pressure of staffing to support service delivery.

Staffing levels in the IPU were particularly short in July and staffing remains an issue in August. Staffing numbers will be supported by utilising agency nurses – from the group of staff who have worked with the team over the past three months. Bank staff are not as freely available over periods of school holidays.

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 May 2020. Further submission is expected this month. 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 issued in October 2017 and is under review.

- 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 late Summer/early Autumn although we are back to testing and hope to complete testing in September. Whilst implementation of the new system has been delayed, the established manual reporting system has remained in place. There is renewed energy to get the system 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 dedicated forum (CAAD) established in October 2019 reviews progress with the Hospice's Clinical Audit program and provides opportunity to review Activity Data that will feed into data dashboards. The meeting alternates between review of clinical audit and activity data respectively. It has been 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.

The Audit/Research Programme with timeline is set out on page 9 - Audit/Research 2020/2. The Audit Program was effectively suspended in mid March with the onset of the outbreak. From 18th May participation of the medical team re-commenced. Data collection has completed for 4 projects (2 medical team and 1 community nurse and 1 inpatient nurse-led) and I aim to get these projects written up as a priority in August/September 2020.

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 progress. 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
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

Report Reference	Title	Lead	Created	Function	Primary Aud.	Exec / CCG Interest	Freq.	Resp.	Is Data Presented?	Presentation Tool / Depository
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 from 07-05-2020.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 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 should also be available on the Hospice's website at:- https://www.straphaels.org.uk/quality-accounts

Copy of 2018/19 submission was reviewed at the CQ&G Sub meeting in July 2019.

Deadline for submission of the Quality Account for 2019/2020 has been extended to 15 October 2020. I aim to publish copy in September 2020.

Audit/Research 2020/21

Overview in August 2020

19 projects underway in 2020/2021 : as at 16-08-2020, 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			Aug-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 to progress final report write up.
2020/21-02	Non-pharmacological intervention Audit (ISR Recs 2-5) - prevalence / effectiveness monitoring	Not yet started			Oct-20	
2020/21-03	Community patient follow-up within 48-72 hrs when titrating medications	Analysis/Report / Publication expected - AR			Aug-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			Dec-20	Initial planning meeting held in June 2020. Project plan to be expanded to encompass pain management audit that embraces the LANSS tool. Prospective Audit expected.

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 Sep 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) Respondees 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 have scope for a responsive visit in their working day to increase the responsiveness of the service for those patients rapidly deteriorating.

Project Ref.	Title	Status	Report Date	Re-Audit	Report Due Date	Results
2020/21-06	Community – Referrals Audit – timeline from request to admission (by source)	Report / Publication expected August 2020 - AR			Aug-20	
2020/21-07	IPU - Audit against Audit NICE Guidance NG31 Care of Dying Adults at the End of Life	IPU - Data Collected & Report to be written - August 2020; Community - Audit standards agreed July 2020			Sep-20	
2020/21-08	IPU & Community - VOICES survey of bereaved next of kin 3-6months post bereavement	Reported/ Ongoing	Aug-19	Yes	Aug-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 2020's IPU re-fresh project.
2020/21-10	IPU - Medicines Management Audit	Reported/ Ongoing	Jan-20	Yes	Sep-20	Reminder for all queries/interventions to be duly acknowledged via Liveview.
2019/20-11	IPU - Audit of Medication recording on Discharge from IPU : EPR 'Medication Module' vs Discharge Letter	Data Collection Period			Nov-20	
2020/21-12	IPU - Audit of medication charts to review the number of PRNs given in a 12hour period.	Report / Publication expected - AR			Aug-20	
2020/	IPU – Hospital to Hospice Admissions Audit	Analysis			Aug-20	

Project Ref.	Title	Status	Report Date	Re-Audit	Report Due Date	Results
21-13						
2020/21-14	IPU & Community & Psycho-social - Activty Data Dashboards Development to include:-	Ongoing	n/a	n/a	n/a	Index as at 18-03-2020 includes topics: 1. CMC, 2. NoK, 3. Community Team Responsiveness, 4. Consent to Sharing Information, 5. Safeguarding, 6. Referrals, 7. Referrals to RIP
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	Sep-20	Following SIGN discharge document template well. Actions: Discharge letter template to be changed: 1. Add section/heading in the discharge letter on the Action required by the GP; 2. Add section on Advanced Care Planning when discussing resuscitation/CMC; 3. Medication Changes section should be divided into two further headings: Started and Stopped.
2020/21-19	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 - October 2020

Clinical Risk Management

Clinical Unexpected Incidents

Overview of incident data for January – June 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							120	212	211	214	236
Bed Occupied Days	213	188	195	219	353	292											
Bed Available Days	248 (8)	232 (8)	248 (8)	420(14)	434 (14)	420(14)											
Bed Occupancy	85.89%	81.03%	78.63%	52.14%	81.34%	69.52%											
CD Medication Incident	1	2	1	1	4	1	0	0	0	0	0	0	10	23	27	18	110
CD Medication Near Miss	0	0	0	0	0	1	0	0	0	0	0	0	1	1	3	7	
Adverse Reaction (Opioid Toxicity)	0	0	0	0	0	0	0	0	0	0	0	0	0	1	10	8	1
Adverse Reaction	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2	1
Non-CD Medication Incident	0	1	0	1	0	0	0	0	0	0	0	0	2	12	22	27	24
Non-CD Medication Near Miss	0	0	0	0	0	0	0	0	0	0	0	0	0	1	5	12	
Pressure Sore on Admission	1	2	2	1	1	3	0	0	0	0	0	0	10	16	20	23	20
Pressure Sore during Admission	0	0	2	0	0	0	0	0	0	0	0	0	2	3	8	4	12
Sharps	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0
Infection	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Readm <7days	0	0	0	0	0	0	0	0	0	0	0	0	0	1	4	1	
Unexpected Transfer	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2		
Near Miss(non-medication & non-IG)	0	0	0	0	0	1	0	0	0	0	0	0	1	1	2	1	1
PE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	4	

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2020	2019	2018	2017	2016
Staffing	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1		
IG	0	0	1	0	1	3	0	0	0	0	0	0	5	0	7	12	19
IG near miss	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	4	
Manual Handling	0	0	0	0	1	0	0	0	0	0	0	0	1	5	10	2	
Slips, trips, falls	2	0	0	2	1	6	0	0	0	0	0	0	11	21	29	18	
Verbal Violence	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	
Bump	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	
Other - Admin/property/Documentation/Clinical	2	1	1	1	3	0	0	0	0	0	0	0	8	12	18	15	14
* Incidents reported to Community – non-SRH	2	0	0	1	2	0	0	0	0	0	0	0	5	12	25	24	
Total 2020 *excluded	7	6	7	6	11	15	0	0	0	0	0	0	52				
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 June 2020 are reduced comparatively to previous years but in keeping with the decrease in reported numbers seen in 2019. The number of admissions to IPU in January – June are slightly higher than most recent years.

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				0				0	120	212	211	214	236
Bed Occupied Days	213	188	195		219	353	292														
Bed Available Days	248 (8)	232 (8)	248 (8)		420 (14)	434 (14)	420 (14)														
Bed Occupancy	85.89%	81.03%	78.63%		52.14%	81.34%	69.52%														
Fall No Harm				0	2	1	3	6				0				0	6	15	21		
Fall Low Harm	2			2			3	3				0				0	5	6	10		
Fall Moderate Harm				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				0				0	6	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				0				0	12	19	38		
Moderate			1	1	1	1		2				0				0	3	2	21		
Serious				0		1***		1				0				0	1	1	3		
Pressure Sores	1	2	4	7	1	1	3	5				0				0	12	19	27		
Totals 2020	7	6	7	20	6	11	15	32				0				0	52				
Total 2019	1	14	13	28	7	8	7	22	6	6	5	17	16	10	6	32		99			
Total 2018	21	14	11	46	10	18	24	52	15	8	13	36	16	17	9	42			176		
Total 2017	13	11	19	43	15	15	17	47	12	2	16	30	16	15	12	43				163	
Total 2016	14	28	11	53	18(5)	12(5)	9(1)	39(11)	14(2)	6	10(3)	30(5)	17(2)	15(3)	23(3)	55(8)					177(24)

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

***The clinical incident reported and classified as Serious from May 2020 concerned the Community Team and the system for follow-up telephone calls. The incident led to 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 2 access to health record requests in 2020 (July & August) from solicitors
- There has been one sharing request from a GP Practice in 2020 (June)

	DSARs	Access To Health Records	Other
2020	0	2	1
2019	1	4	0

Clinical Complaints

- There have been 3 clinical complaints received since last report. Details are below.

ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASSIFICATION	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE	STATUS
2020/07	SURVEY	Wife	09/07/2020	VOICES survey returned by wife of patient who died in December 2019 expressing a lack of support. Investigation by Community Services Team Manager and Psychosocial Support Team Manager	Support	Investigated by Community Services Team Manager who reported that from the record the patient had complex pain that appeared challenging to control and obviously very distressing for the patient and family . Contrary to the wife's report that he received no input from a CNS he had a comprehensive 1 st assessment by a CNS and several follow up review calls by her providing some continuity. There was a couple of out of hours calls and calls to triage regarding pain control , all of these were followed up appropriately and he was discussed in MDT for admission but there was no availability. Hospice Consultant did a response visit to the patient on the 4th of December when the patient and family declined to go to A&E and the GP was unable to visit. Unfortunately the planned visit by our CNS on the 9 th of December didn't go ahead as the patient had been admitted to SHH and died on the 12th Dec. Hospice Consultant kindly did a bereavement call to wife on the 17th wife and she reported he had been in a lot of pain despite the HPCT being involved in his care . Hospice Consultant invited her to call back anytime if she	Upheld	Clsoed

ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASSIFICATION	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE	STATUS
						wished to have further discussion. Recognised the patient had complex pain and didn't die in his PPD , however he received prompt advice and support both face to face and telephone from CPCT . However we obviously didn't meet their expectation as his PPD to die at the hospice wasn't achieved. Complaint highlighted bereavement follow-up gap in month of December 2019. Investigated by Psycho-social Head - acknowledged omission in service provision (n.b. happened before he took over the role) . Recognition that the historic cut off death for next of kin letters hadn't been a hand over item (no handover). All next of kin who were missed in December 2019 will be written to and due apology relayed and bereavement support extended and individual letter to complainant extending apology and support available to her. Complainant telephoned on 20-07-2020 by Clinical Director and followed up with her own letter and enclosing the PS letter. Condolences and apology extended in acknowledgement of complainant's feelings of being unsupported and the bereavement support omission. Offer of bereavement support was declined on telephone but offer that should she wish to change her mind then she may do so at any time.		
2020/08	SURVEY	Daughter	06/08/2020	VOICES survey returned by daughter of patient who died in April 2018 expressing lack of support at home and in particular regarding pain relief.	Support / Pain Relief	RT handling		

ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASSIFICATION	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE	STATUS
2020/09	ORAL	Paramedic	28/07/2020	Paramedic attended MND patient at home due to SOB c7pm on a Tuesday evening. Wanted a Hospice Dr to attend patient and administer injectable medications. SATS were 70. Patient didn't want to go to A&E. D/N present at the patient's home. Paramedic completed LAS Datix owing to perceived lack of response from Hospice.	Responsiveness	1st on-call contacted by IPU (no answer - message left). 2nd on-call contacted. 2nd on-call (Consultant) called Paramedic. Patient by this time had agreed to go to Hospital. Patient admitted to SGH General ITU. Patient died from respiratory failure in SGH 4 days post admission. E-mail request from LAS Macmillan Nurse Consultant & EoLC requesting our review in particular to :- • What does it mean about SRH's Dr only doing 111 OOH referrals? I'm not sure I understand that system? • Had community seen the patient recently to update the CMC Plan? • Is there anything else that could have been done to avoid this patient going to ED? Concerns investigated and e-mail response provided by Clinical Director: - MND patient had been under the care of SRH since May 2019 and was initially referred as an introduction to the hospice as well as respite sits to allow his wife a break, and access to the Jubilee Centre for gentle exercise. He was also well supported by the respiratory team at SGH and the MND specialist CNS and was last visited on 15 June 2020 when the MND specialist CNS assessed his condition to be stable. He had been declining visits from the St Raphael's hospice community team for some time and so following SRH MDT discussion to debate discharging him from our service, the decision was made to transfer him on to our open access caseload whereby patients are contacted at 3 monthly intervals to support them during the stable phase. SRH had not had any in depth conversations about end of life and how patient symptoms might manifest, mainly because patient didn't feel ready to discuss these and had been declining visits. Therefore there were no anticipatory medications in the house. Timing of these conversations and ordering of medications can	Not Upheld	Closed

ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASSIFICATION	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE	STATUS
						be difficult to judge when patients potentially have a longer prognosis and particularly when they are reluctant to engage. SRH medical team provide an on call service out of hours which is purely for advice to healthcare professionals – community patients remains under the care of their GP service and 111 OOH. Although SRH does not have the capacity to be able to offer a visiting service to its community patients OOH, support and advice to other HCPS in the main works well. SRH's CPCT also don't visit patients OOH after 5pm on weekends and telephone calls are then handed over to the staff on our IPU who again, will offer support and advice. SRH has reflected on this situation to consider whether it could have done anything differently to change the outcome in terms of symptom management and PPD for patient. Clinical Director advised that in this situation she is not sure that SRH could have done anything differently but extended welcome to any further thoughts from the LAS Nurse Consultant or a further discussion that may offer a more positive outcome in a similar situation.		

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	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
September															**0**
October															**0**
November															**0**
December															**0**
2020	**2**	**1**	**0**	**0**	**0**	**0**	**1**	**3**	**0**	**0**	**1**	**0**	**1**	**0**	**9**
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

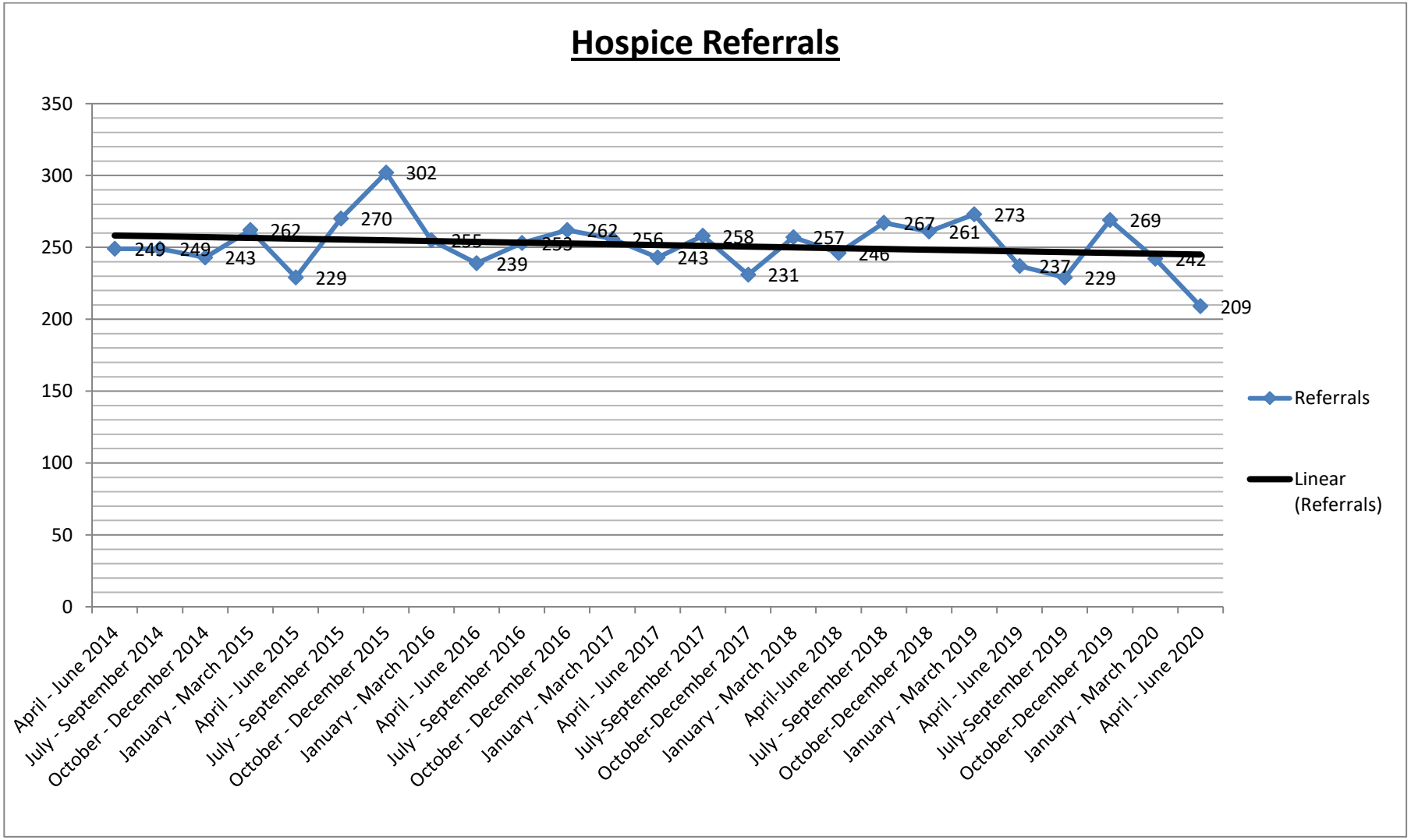
There were 4 serious injury notifications made to the CQC between January and July 2020 all concerning pressure sores grade 3 or above.

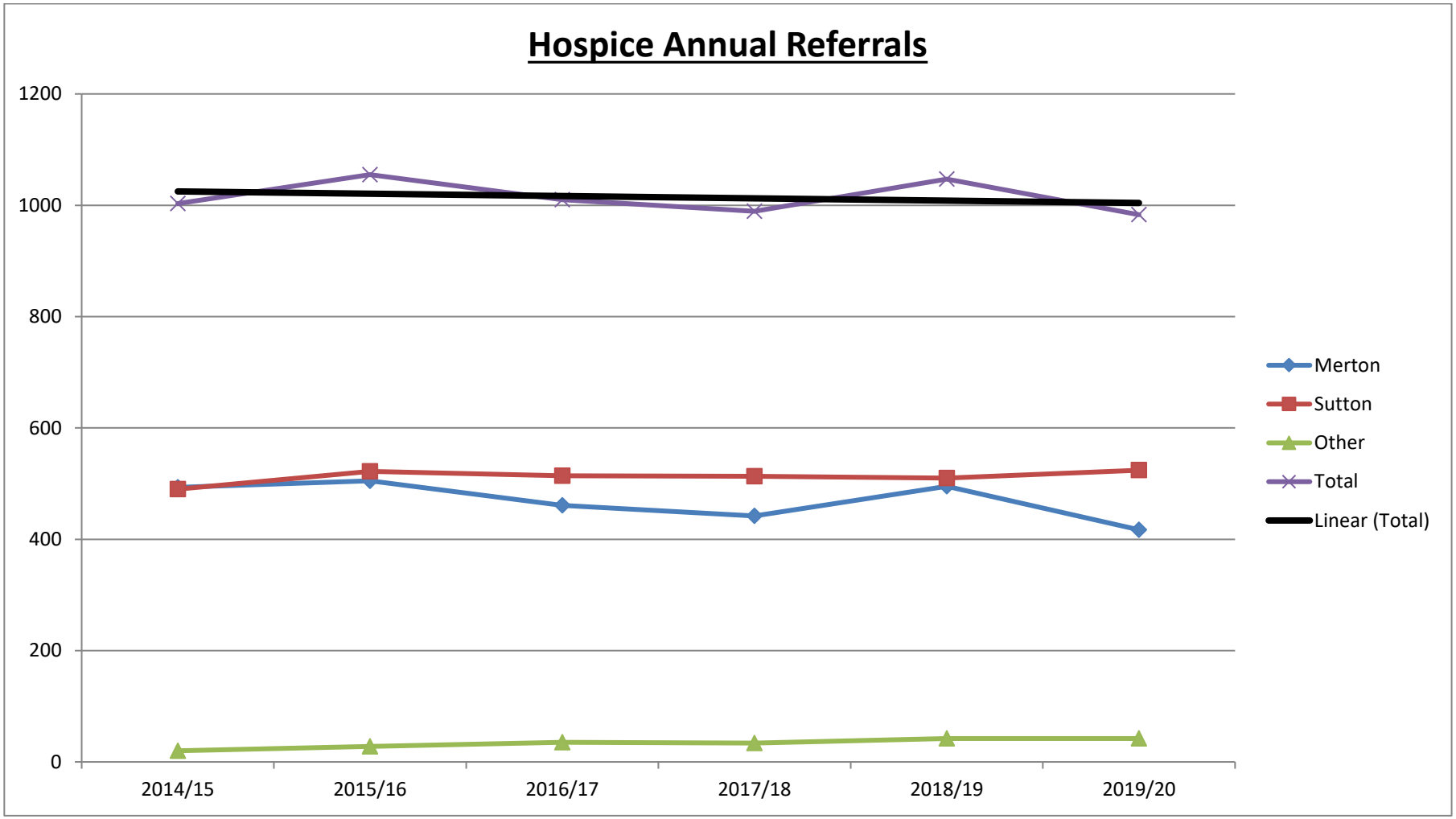
There have been 6 safeguarding notifications made to the CQC between January and July 2020: 4 concerning individuals and 2 care agencies. All 6 were reported to the local safeguarding teams.

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 Q1 (April – June 2020) was submitted on 15th July 2020. A selection of graphical representations for some of the data items will be incorporated into routine report.

Hospice Referrals





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

Clinical Action Plan 2020-2021

Introduction

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

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

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

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

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

OVERVIEW

DATE	COMPLETE	PROGRESSING	YET TO START
12-AUGUST-2020	5	11	5

Clinical Action Plan

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	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	Currently advertised. July 2020 – 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 October 2020	

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	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 in September 2020 Implementation October 2020.	
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 October 2020.	

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Status
CAP05	**Rotation of IPU staff across 24 hours** **Provide adequate competent staffing across days and nights**	**T**o ensure consistency of approach and delivery to service provision across 24 hours. Assurance of clinical competence via night staff coming on to days for 1 week every 4 months and accessing education, development and competency assessment. To break down cultural barriers between day and night teams. All newly recruited staff will have internal rotation across days and nights built into contract. To support the one team approach. To ensure that staff across all shifts are accessing education and associated competencies. To ensure all staff are being developed and feel part of the wider team. Provide opportunity to rotate to Community Team for further development, .	Consultation time for existing staff across day and nights with HR and Clinical Director Employment contract updates	Staff will not engage with the process. Staff will leave. Potential for variability in skills and abilities across days and nights. Staff retention / recruitment	Current Staff Costs Possible requirement for identified external training	Effective Caring Well-led Responsive Safe	Consultation process dates September – December 2020. Implementation January 2021. Aim to rotate nursing staff from the IPU into community 'for experience' from dtbc. Incorporated into new recruitment contracts	

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	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 and patients/families) • The Psychology of Death & Dying (to enable Level 1 Psychosocial skills across the teams) To be incorporated into education program / timeline 20/21	

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Status
							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	
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.	

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Status
CAP09	**CNS Development posts**	For succession planning. To ensure we have replacements for future retirees or those leaving through natural attrition. To ensure the service can operate in the future. To ensure competencies and training allows for development nurses to progress to CNS level and work within all departments	HR Recruitment	Cost to organisation in terms of care delivery if not planned. This could be mitigated by Trust application funding.	Salary costs	Safe Effective Responsive Well-led	July 2020 – successful recruitment to 3 positions : band 7 & 2 band 6s..	
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.	

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Status
CAP11	**Re-implementation, training and embedding of Outcome Assessment and Complexity Collaborative (OACC)**	To measure outcomes and gain feedback and consider KPIs through its use. Some departments using iPOS. All departments using the Australian-modified Karnofsky Performance Status scale & phase of illness. To integrate all aspects of the suite of measures into all documentation, training and audit.	Time Audit Multi-disciplinary education Collaboration with clinical teams to embed and integrate into daily practice	Becoming target driven in our care delivery – must remain mindful of patients and interrogate outcomes accordingly.	OACC education courses – facilitating key staff comprehension and practical application. Project management – team time	Safe Effective Responsive Caring Well- led	Key staff attendance at OACC training in February 2020 (TC,TY&JF). Project re-implementation 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	
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	

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Status
CAP13	**Implementation of Datix to manage Incident/complaint/complements**	To facilitate ongoing review of Incident/complaint/complement	Time – (project leads for Datix implementation) HoDs – Testing and Training Time – Training on new system	None – adequate manual reporting system in place.	Cost of implementation of Datix Time/resource	Safe Effective Responsive	Testing: July – September Training: October 2020 Full implementation – Nov/Dec 2020 See 3.13 of CQ&G section of Management Plan	
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	October 2020	

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Status
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	
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 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	September 2020 for all Band 6 & 7 staff to be assessed as competent.	
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.	

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Status
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 under construction – July 2020. Audit scheduled for August – September 2020.	

Clinical Quality & Governance – CQ&G Sub – section 3 extract from Draft Management Plan 2021/21

	Area of Development	What will we do?	How will we know?	Lead(s)	Target Date	KLOE	RAG	Notes
3.1.	Clinical Action Plan	• Progress and fulfil the annual Clinical Action Plan	• Review at CQ&G • CQ& Report	GL/RT/AR	As set out in CAP	Well-led Effective Safe Caring Responsive	A	2020-2021 Clinical action plan version 4
3.2.	Clinical Audit	• Produce and maintain an audit/monitoring/research project schedule 2020/21	• CQ & G Sub Minutes • QIC Minutes	AR	June 2020 ongoing	Well-led Effective Safe Caring Responsive	G	2020-08-12 2020-2021 v3 Clinical Audit & Research Project Progress Timeline.xlsx
3.3.	Education and training	• Replace Skills for Health with Learning Zone module for delivery of mandatory e-learning	• CQ&G Sub Mins • T&D Mins	MF/LB/PE	August 2020	Well-led Effective Safe Responsive	G	Complete

	Area of Development	What will we do?	How will we know?	Lead(s)	Target Date	KLOE	RAG	Notes
3.4.	Education and training	• To produce regular report in to the T&DC that provides assurance that the training databases capture ALL training across ALL staff	• Training & Development Committee Minutes	PE/JC	Dec 2020	Well-led Effective Safe	A	Clinical training db maintained by PE. Non-clinical training db maintained by JC (HR)
3.5.	Education and training	• Produce and maintain an education delivery programme that is routinely reviewed at T&DC	• Training & Development Committee Minutes	MF/LB	Sep 20	Well-led Effective	A	
3.6.	Education and training	• To monitor the interface with accessing Hospice educational videos that support HCPs in the community	• Develop user feedback questionnaire • Website clicks	MF/LB	Nov 20	Well-led Effective Responsive	A	

	Area of Development	What will we do?	How will we know?	Lead(s)	Target Date	KLOE	RAG	Notes
3.7.	Education and Training	• Training for clinical staff in identifying need and measuring QTC interval and in understanding bloods and when to request them (both are required)	Clinical Action Plan Update CQ&G Report	AM/CF/TC/MF/LB	Mar 21	Well-led Effective Safe Caring	A	Pended – for consideration as part of a wider Research Project. To be discussed at 21-08-2020 CQ&G Sub.
3.8.	Organisation	• To establish a forum and system for the co-ordination compilation and review of clinical information material that supports , patients, their families and carers and other HCPs is communicated effectively. • Facilitate access to information material via the website and other agreed media that educate and inform patients, families and other healthcare professionals.	• Feed into QIC • CQ&G Report • Website Accessibility	Exec Team	Dec 2020	Well-led Effective Caring Responsive Safe	A	• Forum established July 2020
3.9.	Organisation	Document a Clinical Audit Policy	CQ&G Minutes Policy Manual	AR	Oct 20	Well-led	R	

	Area of Development	What will we do?	How will we know?	Lead(s)	Target Date	KLOE	RAG	Notes
3.10.	Patient administration system - Crosscare	Implement revision to the windows of the EPR in order to improve care planning and completeness of documentation	EPR Peer Review EPR report reviews EPR bespoke review meetings	JG/TY	Nov 20	Well-led Effective Caring Responsive Safe	A	Substantive revision to EPR windows effected for the Community Team in November 2019 Revision / re-write of windows for the IPU remains outstanding
3.11.	Patient administration system - CrossCare reporting	Develop reporting to feed dashboards	Crosscare Project team meeting minutes.	AR/JG	Dec 20 On-going	Well-led Effective Responsive Safe	A	Data Dashboards Part of Clinical Audit and Activity Data Meeting remit. Incorporated into 2020-08-12 2020-2021 v3 Clinical Audit & Research Project Progress Timeline.xlsx
3.12.	Policy	Identify required clinical standard operating procedures that will support care delivery and practice and agree leads and timetable for effecting their documentation in 2020/21	Clinical Action Plan Update Minutes of CQ&G Sub	TC/TY/SM/RT/AR & Med Team	Sep-20	Well-led Effective Safe	A	CAP-15 - 2020-2021 Clinical action plan version 4

	Area of Development	What will we do?	How will we know?	Lead(s)	Target Date	KLOE	RAG	Notes
3.13.	Quality assurance / monitoring	Embed the OACC assessment measures in to clinical training and development, clinical practice and the clinical record to include Phase Of Illness, Karnofsky (AUS) Performance Status and IPOS.	Clinical Audit CQ&G Report	Med Team RB/TY/TC/MF/LB/AR	Mar 21	Well-led Effective Care	A	CAP11 - 2020-2021 Clinical action plan version 4 Overall 18-24 month project.
3.14.	Risk management	Implement Datix incident reporting	• QIC Minutes	AR/JG	Sep 20	Well-led Effective Responsive Safe Caring	A	CAP13 - 2020-2021 Clinical action plan version 4 Testing: July – September Training: October 2020 Full implementation – Nov/Dec 2020

SAINT RAPHAEL'S HOSPICE

MINUTES OF THE CONSULTANTS MEETING

Held on 5.8.2020
in St Bede's Conference Centre Room B

In Attendance:	**Name**	**Role**
	Ambreen Akhtar	Specialty Doctor
	Andrew Hoy	Consultant and Chair
	Annelise Matthews	Locum Consultant
	Becca Trower	Clinical Director
	Busi Da Silva	Specialty Doctor
	Jan Hallstrom	Locum Consultant
	Rina Patel	Consultant (St Helier)
	Pascale Evans	Secretary (minutes)

ITEM 1: Apologies for Absence

Laura Yalley-Ogunro; Martine Meyer

ITEM 2: Minutes of the Last Meeting

2.1 Minutes approved with revision on dates: Jan Hallstrom will leave on 25th September and Jenny Strawson will start on 7th September.

ITEM 3: Rota/staffing changes

3.1 Becca and Pascale have discussed induction for the new consultants and a welcome pack will be put together.

3.2 Dan Knights GPVTS has agreed to cover 1 weekday (Wednesday) and 1 weekend on call from 27th September. He will spend an afternoon with Ambreen on the IPU before his first shift.

3.3 A physician associate has been recruited and will join early November. This is a new role for St Raphael's and for hospices in general. He will cover both IPU and Community. Becca and Andrew will discuss the role in more details.

ITEM 4: Clinical challenges

4.1 Joe introduced the following presentation on Integrating Care
SWL recovery Integrated Care workstream v4 (LuWa).pptx
The presentation highlights the programme work stream to integrate care and what we should be focussing on.

4.2 The care home issue was discussed. Care homes have been squeezed out of proper care planning and in some cases have been neglected. We need to learn how to take them under our wing.

4.3 The task force is very migratory which makes it difficult for us to keep up with training and addressing issues.

4.4 When a patient moves into a care home is when the discussion about care planning should take place as life expectancy is on average 1 year after moving in.

4.5 St Raphael's video on nose swabbing is still being viewed and has helped increase the number of usable swabs.

4.6 Reflected on how many patients did not need ventilators as was previously thought. We are better prepared for a potential 2nd wave as we have learned many lessons over the past 6 months.

ITEM 5: Infection control:

5.1 no new cases on the IPU of COVID-19

ITEM 6: Achievements

6.1 Flexibility of the team is to be lauded given notable shortages amongst the medical team.

ITEM 7: Education:

7.1 ReSPECT updates over the next month-JoeH

7.2 PAH system for our mandatory training now updated with St. Raph's specific documents,

7.3 BLS mandatory training module requires review- JoeH to do in August.

ITEM 8: Audit and governance

8.1 Waiting for recently completed audits to be released by Alex R. These will tie in to on-going work on OACC.

ITEM 9: Any other business

9.1 Next Consultants meeting will take place on Wednesday 2nd September at 1pm.

Minutes of Meeting

Meeting: Clinical HODS meeting			
Date: 06/08/2020 Time: 11.30-1pm			
Present: Rebecca Trower, Tracy Christmas, Dr Joe Hawkins, Tracey Young, Maura Flint, Laura Briant, Alex Rudkin (remote)			
Apologies: Steve Molyneux			
Agenda item	**Discussion**	**Actions & by whom**	**Anticipated date for completion**
Review of previous minutes	Minutes of 02/07/2020 – accurate and actions complete		
Topic			
Infection prevention	Covid protocols continue to be followed – risk assessments awaiting review so staff can transition back to place of work	Awaiting OH guidance	
Medical devices	Nil		
Medicine management	'Pill Box' medication module to be audited to check maintained and up to date (responsibility of IPU nurses on discharge) PCF online is costly at £2005 per annum – CHODS felt not value for money as not used frequently and hard copies are available. Therefore not to renew this year and can review in 2 months	AR to add to audit list and audit to be allocated MF to feedback to CEOs	
Incidents & Accidents/RCA's	TC has updated community SOP in light of previous incidents and actions decided from reflection		
Complaints	None discussed although TC mentioned there has been a slight increase over the past few weeks (? As COVID lifts, people feel more ready to engage in complaining)		
Health & safety	RT updated re equipment store – 759 garage to be cleared to allow storage of 'dirty' equipment returned from the community. OOH returns of equipment to be placed on floor in chaplaincy store and then transferred to 759 garage when facilities staff are back on duty	RT to check set up	
New policies/guidelines	Nil discussed		
Documentation/CrossCare	TC highlighted that during admissions meeting, score sheet not used consistently. TC/TY established that when a patient is being admitted from hospital, FPOC should confirm with		

	the hospital and liaise with the HPCT. HPCT then to call IPU to handover. Discussed referrals to Psychosocial team not always fully complete and difficult to 'pull' from the system. JG to amend so that Psychosocial review topic will pull data from both "Patient Assessment & Care Planning" and "Community Assessment" windows.	JG to amend	
Audit/research	AR /RT – brief discussion re OACC and embedding across the system. IPOS will be helpful when introducing Nurse-led clerking. OACC is part of the audit programme and Clinical Action Plan	AR	Ongoing
Education/Training Reflective forums	LB/MF have now completed all the COVID reflections with staff – positives were that some new relationships have been created/ negatives were that social distancing was sometimes felt not to be effective. Will be writing up with staff recommendations to be put into a report (HODS reflection to be separated out) and also produce as a poster for HUK /conferences 2021 E-learning commenced on 3 August and so far running smoothly BLS and Manual Handling dates to be disseminated TC reported that CPCT will recommence clinical supervision with Barbara Bradbury and are aware that this needs to constructive	MF/LB MF	
Recruitment	CPCT have recruited to 3 posts – 1x band 7 and 2 x band 6 IPU have recruited to 3 posts – 1 x band 2, 1 x band 3 and 1 x bank band 5 Physician Associate appointed (band 7) - to commence in Oct/Nov and work across clinical services		
CQC/PIR Updates	RT highlighted value of collating examples of outstanding evidence for CQC as a continuous process – AR explained that Datix will help to enable this through logging of incidents/complaints etc and the reflective cycle		
AOB	RT mentioned Wellbeing model and that it is being reviewed to appeal to a wider audience. TC discussed the difficulties with staff attending GSF meetings due to the sheer number that are held in the two districts and that there needs to be a way around, due to the time commitment attendance		

	would take.		

Date next meeting: 3 September 11.30-1pm

St Raphael's
Your Local Hospice

Meeting: Falls Meeting			
Date: 11/06/2020		Time:	
Present: Alex Rudkin (AR- Chair),Gail Linehan (GL), Steve Cresswell(SC), Ginny Toubal(GT), Pauline Morris(PM), Maura Flint(MF)			
Apologies: Gwynne Hawden (GH), Laura Briant (LB)			
Agenda item	**Discussion**	**Actions & by whom**	**Anticipated date for completion**
Review of previous minutes	Meeting held 11/12/2019- agreed. Removal of Chapel courtyard step will be part of reception refurbishment.		
Matters Arising			
Topic			
Patients Falls Statistics	AR presented the Fall stats for review. Falls rate is within acceptable range and the number of injurious falls is decreasing. Patient independence continues to be a common cause. SC to address a falls incident in a shop and will investigate.	IPU Staff SC	
Feedback from teams	• Wellbeing centre – nil • Volunteers- Some volunteers are returning to staff reception. Nil other • OT- nil • Facilities- the facilities department is now more involved with retail and will deal with reported incidents/hazards • IPU- PM reports that the use of the sensor mattresses have made a big difference to the number of falls. Patients continue to be supplied with non slip socks. Staff continue to use risk assessments on every patient.	SC	
Training and staff development	Manual Handling training is ongoing. The induction day has been changed to include face to face manual handling training for volunteers	MF/LB	
Falls Policy	AR is meeting with Tracey Young to raise the use of bed rails on the IPU	AR	
AOB	Nil Raised		

Date next meeting: TBA

St. Raphael's Hospice

Prescribers Meeting

Present –

Kevin Hobson CNS / NMP
Tracy Christmas CNS / NMP
Jill Smith CNS / NMP
Bernie Griffin CNS / NMP
Dr. John Hallstrom – Palliative Care consultant
Dr. Annelise Mathews – Locum Palliative Care consultant
Margaret Gibbs – Pharmacist

Apologies – Dr. Hawkins, Dr. Ambreen Ahktar, Dr. Busi Da Silva

Item 1 : **Minutes of last meeting**
Discussed and agreed

- Patient advice leaflets

A number of leaflets have been produced already. Annelise and Tracy will meet up to review what has been done / needs to be done.
Margaret reminded group that Ashtons on line info (Mapps – Palliative care resources) have a number of info leaflets we could access / adapt for hospice

- 1 Lead ECG's

Group updated re policy – now put on abeyance. Inpatient unit looking into getting ECG machine

Item 2 : **Prescribing Competency Framework**
RCN and NMC have adopted framework from The Royal Pharmaceutical Society as guide to formatting competency frameworks for organisations.
Kevin, Tray and Annelise will book time to go through competencies together and how we can take this forward for hospice prescribers.

Item 3 **: Terms of Reference for Precribers meetings**
The team considered the terms of reference for the Prescribers meeting and made a few minor changes –

- A minimum of 4 members of staff are required to be in attendance to make the committee quorate. Should include representation from medical and non-medical prescriber team.
- We will aim to hold meetings bi-monthly (every two months) / realistically 5 times a year.
- Community Services Administrator (Lynn Jackson) has agreed to attend meetings and take minutes.

Item 4 : **Non Medical / Independent Nurse Prescribers update**
The team have coped well with recent challenges of Coronavirus restrictions and have been kept up to date with the many changes along the way.

Nik Sanderson and Teleri Gulvin recently joined to CPCT – both prescribers with many years of experience! We are in the process of organising their prescription pads.

St. Christopher's Hospice are holding an annual Non Medical Prescribers update day on 15th Sept – Kevin and Bernie will attend.
Tracy and Jill will look at attending alternative update day.

Next meeting date to be confirmed.