SAINT RAPHAEL'S HOSPICE

MINUTES OF THE 1st Consultant Meeting

Held on 27.11.109
in St Bede's Conference Centre Room 1

In Attendance:	**Name**	**Role**
	Andrew Hoy	Part-time Consultant
	Martine Meyer	Honorary Consultant
	Rina Patel	Honorary Consultant
	Jan Hallstrom	Locum Consultant
	Sam Raveney	StR SRH
	Ambreen Akhtar	Specialty Dr SRH
	Annelise Mathews	Agency Consultant
	Gail Linehan	Director of Care Services (minutes)

ITEM 1: Apologies for Absence

Laura Cottingham - Part-time Consultant

ITEM 2: Minutes of the Last Meeting

2.1 Nil

ITEM 3:

3.1 AH (Chair) welcomed everyone to the first meeting and clarified that the items on the agenda were approved by the group for discussion.

3.2 **RCP- ISR** recommendation to hold a regular Consultant meeting to discuss practice, therapeutic interventions and any issues.

3.3 Overview of **Consultant establishment** in the hospice. Currently 21 PAs. Consideration of what is the current.

	Mon	Tues	Weds	Thurs	Fri	Sat	Sun
JH	IPU WR/CPCT	IPU WR/CPCT	CPCT On Call	CPCT	SPA/ IPU- pm	As rota	As rota
AM	-	-	IPU	CPCT	CPCT		
AH	On Call				IPU- am On Call	As rota	As rota
MM				IPU WR			
RP				IPU WR			
LC		On Call		On Call		As rota	As rota

3.4 **Non consultant doctors**- AA works Monday – Wednesday on IPU, Thursday in CPCT and half day Friday on IPU. Current StR works in CPCT Monday, Tuesday attendance at SHH to facilitate educational supervision and on the IPU for the remainder.

3.5 GL updated the meeting on the future recruitment of consultants. JDs to be sent to RCP imminently for approval. Recruitment to be active from January 2020.

3.6 **The frequency of Ward Rounds** was raised and a discussion as to whether all patients need to be seen by the consultant. Discussion as to terminology re: MDT. Consultant body discussed that having a concise update on all inpatients was helpful to get an overview of their current status, current interventions and response to same. It was discussed that consultant review should be for patients where status was unstable/deteriorating, or where there was a level of complexity requiring consultation and formulation of a plan. This should be approx.2/3 patients daily. Most patients could be reviewed by the core medical team on the IPU as needed. It was felt that this would be a more productive use of time.

3.7 **Variation in consultant management** had been had been raised by the nursing team. It was discussed that where there is congruent therapeutic philosophy between consultants there is less risk of divergence of opinion – regular meetings of the consultant body should help to support this.

3.8 **Variation in quality of shared information** from nursing team (NT). Would be helpful to have a standard approach . Use of SBAR as an indication of patients requiring consultant review. **Action: GL to discuss with NT**

3.9 Agreement to bring cases to future meetings for discussion re: clinical philosophy.

3.10 It was agreed to hold a **monthly meeting** on a Wednesday with flexibility over the day as required.

3.11 **Crosscare –** The EPR Crosscare was raised an issue related to the length of time it took to input into the record. Difficult to know where to record with all the windows. GL advised that the windows were being reviewed.

ITEM 4:

4.1 AH sought opinion on the 1st/2nd on call rota. All those doing it felt it was OK.

4.2 AH keen to empower the 1st on call to make decisions related to their level of competence. There is not a requirement to run all decisions past the consultant on call.

4.3 National and Local Guidelines: Agreed to use PCF6, Pang and BNF and Microguide. **Action: All**

ITEM 5: Governance and Audit

5.1 Agreed to ask Pharmacist to attend the meting every 6 months to present prescription error log. **Action: GL to request.**

5.2 **Stock medication** list- What is routinely stocked. **Action: GL to source**

5.3 **DTC- Decision from the recent DTC-** Abstral is not 1st line for breakthrough pain.

5.4 **Transfer to acute units** – Discussed that it is very important to establish what a patient wants before sending them to the acute sector. Is the ceiling of care IVs/fluids etc.

5.5 **Antibiotic Stewardship –** Ceiling of care baseline. If a patient has sepsis is treatment being offered for the patient/relative/staff? Hospice would not check Gentamycin/Vancomycin levels. **Action: To return to this topic on a monthly basis.**

ITEM 6:

6.1 **Links with ESHH -** Requirement to improve links with SGH and RMH **re:** prioritisation of patients for admission. AH discussed shared/joint consultant posts and how his experience that this works well. It has not worked so well with nursing staff. The criticism in the ISR was highlighted SRH being isolated.

6.2 Discussion on how to facilitate nurses from IPU rotating into SHH and visa versa. Appreciation of what patients go through.

6.3 Discussed that the hospice may not always have StR or GPVTS. Impact?

6.4 AH discussed that it would be helpful where GPVTSs are prepared to do 1st on call to consider facilitating the GPVTS spending a week in SHH with the hospital palliative care team and their GPVTS attending the hospice.

6.5 Research/education/audit – the meeting discussed that the consultant body should drive it.

ITEM 7: Any Other Business

7.1 None noted

ITEM 8: Future Dates

8.1 Dates of future meetings:

Date	Event	Venue/Time
05/02/2020	Consultant Meeting	St Bede's 15.30

Clinical Audit and Activity Data Committee
Minutes of the 1st meeting held at 2pm on Thursday 3rd October 2019
(GL Office)

Present:

(AR) A Rudkin (Chair, Quality Development Manager)
(GL) G Linehan (Director of Care Services & Strategy Development)
(TC) T Christmas (Community Services Team Manager)
(TY) T Young (Ward Manager)
(JH) Dr J Hallstrom (Consultant)
(MF) M Flint (Practice Development Lead / Clinical Education)
(JO'G) J O'Grady (CNS, HPoC, Community Team)
(JF) Julie Ford (Senior Nurse, IPU)
(JG) J Groom, IT Manager and Head of Data – item 8 only

Apologies

None

	Action
1. Minutes of the last meeting held	
N/A - This was the first meeting.	
2. Matters Arising	
N/A - This was the first meeting.	
3. Terms of Reference	
The draft terms of reference were considered and agreed with the following amendments:- Core membership : 4 members to be quorate, minimum : QDM, DoC/Deputy DoC plus one clinical person for Clinical Audit meetings and to include IT Manager for Activity Data meetings.	AR
4. Meeting Format	
Meetings will alternate between Clinical Audit and Activity Data as main topics. Consequently meetings will be held every 2 months. AR explained how this meeting will feed into the Hospice's Quality Improvement Committee and in turn the Hospice's Clinical Quality and Governance (CQ&G) Sub-Committee. The latter is one of 4 Sub-committees of the Hospice's Advisory Committee that is chaired by and whose membership includes members of the Advisory Committee. Those members are Dr Carrie Chill, Dr Joy Tweed and Mr Alan Cogbill. The Sub-committee meets 5-6 times per year and receives the CQ&G report that, in addition to a number of other topics supporting clinical quality and governance, provides update on the Hospice's Clinical Audit projects.	
5. Policy	
AR explained how audit work hitherto had primarily been driven by the Senior Clinical Team and himself. He felt that that had needed to change in order to improve ownership and participation across the clinical team and the creation of this committee will support that ambition. All agreed that the development of the Hospice's Clinical Audit Policy would support the activity. AR highlighted the Hospice's Clinical Audit Information Leaflet and the existence of the Clinical Audit Project Proposal Form. Whilst completion of the proposal form has not been mandated previously, prior to undertaking projects, it was agreed that it would be here on. It is a supportive document that helps the audit lead in the project's planning and is not designed to take an age in itself to complete.	AR
6. Audit Program & Timetable	
The Hospice's Audit Program and Timetable were reviewed. It was agreed that the program presented a healthy workload and that it may not be all achievable this year (Apr 2019-Mar	

2020). Some rationalisation will be effected. Prioritisation will be given to supporting the ISR required audits. Audit projects without leads were discussed and leads nominated. The updated program is at N:\Clinical\Clinical Governance\Clinical Audit\Audit Program & Timetable\2019-20\2019-20 CLINICAL AUDIT PROJECTS STATUS SUMMARY DRAFT 06 - 20112019.pdf and timeline at N:\Clinical\Clinical Governance\Clinical Audit\Audit Program & Timetable\2019-20\2019-2020 v3 20-11-2019 Clinical Audit & Research Project Progress Timeline.pdf. All present were encouraged to review the timeline to ensure their project is progressing accordingly.	ALL
7. Education	
It was agreed that delivery of an information session / training on clinical audit in 2020 and periodically thereafter would be useful.	MF/AR
8. Activity Data	
It was agreed that at present there was not enough time dedicated to, nor engagement with, the review of the information that the Hospital's PAS system (Crosscare) can generate. Whilst we are data rich, it is the manipulation, analysis and presentation of that data that converts it into information that remains a large body of work to pursue. Part of this group's remit will be to consider the Hospice's information requirements and how its data assures integrity, how it is presented and how it supports the Hospice's services. Beginning with the Hospice's Activity Dataset, this meeting will consider its data. The presentation of clinical data in graphical dashboards will be discussed at the next meeting across all the services.	
9. Any Other Business	
Nil noted	
10. Dates of Future Meetings	
15.30 Wednesday 4th December 2019 Room B St Bedes : Activity Data	

SAINT RAPHAEL'S HOSPICE

MINUTES OF THE
INFECTION CONTROL COMMITTEE

Held on 26th November 2019
St Bede's Conference Centre

Members

(Dr JS) Dr J Stephenson, Consultant Microbiologist -SHH, SSAH - Chair
(PM) P Morris – IPU – I C Lead Nurse
(GL) G Linehan – Director of Care
(MF) M Flint – Education & Practice Development
(SC) S Cresswell – Facilities Manager
(LE) Facilities Team
(TC) T Christmas – Community Team Manager
(AR) A Rudkin – Quality (Minutes)

Apologies

(LI) L Ibrahim – Occupational Health
(TY) Tracey Young – IPU Manager
(JH) Dr J Hallstrom – Consultant
(SD-E) Sue Davies-Evans – Housekeeping Manager

ITEM 1: Welcome

Dr JS extended welcome to all present.

ITEM 2: Apologies for Absence

Apologies had been received from Liz Ibrahim (Occ. Health), Tracey Young (IPU Manager), Sue Davies-Evans (Housekeeping) and Dr Jan Hallstrom (Medical Team)

ITEM 3: Minutes of the last meeting held on 14 May 2019

3.1 These were accepted.

ITEM 4: Matters Arising

4.1 FFP3 Masks – Agreed at the last meeting that access to SSAH stock of FFP3 masks be accommodated as required rather than SRH hold stock. Training remains to be arranged with Matron (SSAH). GL will pursue with SSAH Matron. — GL

4.2 Infection Control Policy and Manual revision is complete and was re-published in October 2019.

ITEM 5: ICC ToR

5.1 ICC ToR was agreed. AR to publish. — AR

ITEM 6: Sharps Injuries & Body Fluids

6.1 Nil to report. AR confirmed that engaging with A&E for Sharps injuries in fulfilment of certain criteria is suitably referenced in the Infection Control Policy and Manual.

JS was provided with hard copy.

ITEM 7: Alert Organisms Surveillance

7.1 Nil to report.

ITEM 8: Water Assessment and testing

8.1 Water Assessment and testing is a routine agenda item at Health & Safety Committee that last met on 13th November.

8.2 Aegis visit identified a high bacteria count in the Orangery Kitchen taps. System flushing was applied. Test results have since returned ok. Acquisition of specific cleaning kit has been effected to target the high bacteria taps. All shower heads, lines and sets will be replaced and a program of deep-cleaning planned for every 3 months. Empty patient rooms have their taps run every day and all rooms as routine Mondays and Thursdays

8.3 A bespoke policy for Water Management is to be written. SC/AR

ITEM 9: Occupational Health Update

9.1 No issues have been made known to the IC from Occupational Health.

9.2 Flu vaccines were organised with a local Pharmacy and uptake has been good..

ITEM 10: CQC

10.1 CQC inspected on 11 & 12 November 2019. No issues were identified..

ITEM 11: Any Other Business

11.1 JS advised that reporting of C-Difficile infection changed in April 2019 whereby if a patient has been an inpatient in the last month with C-diff onset in the community then it is regarded as Hospital acquired.

11.2 JS advised that allergens were an issue for Occupational Health not infection control and that nothing can be done to universally eradicate susceptibility to allergy. Replacement of the flooring on the IPU is not an ICC issue.

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

ITEM 12: Future Dates

12.1 Dates of future meetings:

Date	Event	Venue/Time
Tuesday 5th May 2020	**ICC Meeting**	1pm - St Bedes

SAINT RAPHAEL'S HOSPICE

MINUTES OF THE 2nd Consultant Meeting

Held on 12.02.2020
in St Bede's Conference Centre Room 1

In Attendance:	Name	Role
	Andrew Hoy	Part-time Consultant (Chair)
	Martine Meyer	Honorary Consultant
	Laura Yalley Ogunro	Locum Consultant
	Jan Hallstrom	Locum Consultant
	Sam Raveney	StR SRH
	Ambreen Akhtar	Specialty Dr SRH
	Annelise Mathews	Agency Consultant
	Gail Linehan	Director of Care Services (minutes)

ITEM 1: Apologies for Absence

Rina Patel Honorary Consultant SHH

ITEM 2: Minutes of the Last Meeting

2.1 Agreed

ITEM 3:

3.1 **Consultant Posts** - GL updated on the current position re: FTE post and trying to get a Trust Contract. MM very supportive and taking forward but it is taking longer than expected because of NHS processes. The 2 x 0.6 posts will be advertised next week. It is hoped that in time these posts may become Trust contracts. As yet there has been no applications for FT post. MM updated that the JD is being put into the Trust template. The interview when scheduled will be held at SHH under Trust conditions. GL

3.2 **On Call –** Currently JH FT and AM 3 days week. AM could do 2nd on call Wed/Thurs night if required. AH will discuss remuneration. AH

3.3 **Revalidation –**An update was provided on the NHS England Revalidation Team visit on Feb 14th. The RO Steve Hyer will be attending the meeting. The visit is for assurance that the hospice is meeting its regulatory responsibilities. Currently 4 doctors have been/or are Appraisers – AH, AM, LYO, JH. To inform Steve Hyer at SHH as this may be helpful for the SHH team.

ITEM 4: Therapeutic Philosophy

4.1 Discussion on divergent practice – overall none noted.

4.2 SR discussed his perception that SRH had come a long way since he started. Discussed Lidocaine plasters and the difference in how requests for use are managed in the IPU/Community. At the last DTC it was highlighted that they are no longer an agreed prescription item in the community. They are on the blacklist for prescribing.

4.3 AH discussed the use of mucolytic prescribing – discussion re: benefit. It would be helpful to undertake a review. The use of Glycopyrronium and Carbocisteine in combination was discussed as being counter intuitive- became a trend with MND patients.

4.4 LYO shared that at PAH there had been discussion on an article about the use of Docusate Sodium and the question of whether it actually works. Apparently there is not a robust evidence base for use/efficacy. AM discussed that laxative prescribing at SRH is at variance to where she has worked previously. AH suggested using AMs experience/expertise as a resource to review practice/use. AH/AM

4.5 **National& Local Guidance** – Nothing new noted.

4.6 **EOLC Prescribing across settings** -SR discussed having coherence between CPCT/SHH/SGH EoLC prescribing. At present we can't match both hospitals prescribing regimes. However, if hospitals send patients home with medication we should use what is prescribed rather than order a new range of medications. A Pharmacist has updated that Haloperidol is 1st line for nausea/sedation, in the hospice 1st line is Levomapromazine- however changing this to be in line with both Trusts SGH/SHH. Hyoscine Butylbromide (HB)is 1st line antisecretory. MM discussed that in SHH HB tends to be kept as a PRN. LYO commented that at PAH a Dutch colleague has been surprised at how often HB is used for secretions- for them it is viewed as being part of the dying process not requiring medication intervention.

4.7 The question was asked as to how may Consultants are able to attend the DTC. Would be helpful to have a point by point outline for this meeting.

4.8 **Kardia** – AM discussed that Cathy Foster and TC have been asking for medical input on the 1 lead ECG. It was discussed that an increasing number of medications have an increased QTC interval. Requirement for a pragmatic approach to its use. A pilot will be undertaken on the IPU.. Considerations will be:

- How useful is it?
- Does it change practice?
- Do we ignore risk?
- What to do if QTC prolongation is identified

SR to circulate Kardia document to attendees. AM is working with Pharmacist Margaret Gibbs. SR

ITEM 5: Governance

5.1 The main issue at present is safety in the hospice related to Consultant cover for times of AL/SL. This is impacted by the imminent departure of SR. GL is looking at interim locum Consultant cover to support.

5.2 **Transfer to Acute Units** – What is the escalation process for patients with treatment options? To consider audit of how many patients there are and how often they are transferred. LYO stated that this would be a useful audit, looking at numbers of patients, whether the transfer was appropriate or not and the frequency of occurrence. To look at a **6 month prospective audit**. Ward Clerk Carol Thompson to manage spread sheet with patients data.

5.3 SR acknowledged the active support of AM of a patient transferred from the RMH to the SRH.

5.4 **IV Interventions –** There was a discussion about IV therapies and how to support these. LYO informed that PAH do not tend provide IV antibiotics. Discussion on competence of nurses and doctors to undertake this intervention. Difficult to assure ongoing competence because of the infrequent use. There would need to consideration of frequency of administration – would once a day antibiotic suffice? All agreed that transferring a patient to the acute sector could be problematic, but at present this is the only option if appropriate. There ensued a discussion on the sub cutaneous fluids versus IV fluids and their effectiveness. It was suggested that an audit of patients with hypercalcaemia be undertaken looking at how many patients are diagnosed with this. Look across SRH and SHH. Also potential for closer links with SHH for training re: IV competence. **Plan:** Undertake 6 month audit looking at: 1. Incidence of transfer to acute sector for IV treatment 2. How many S/C fluid interventions undertaken. Bring information back to the meeting.

5.5 Consider antibiotic stewardship audit – who will action?

ITEM 6: Any Other Business

6.1 None noted

ITEM 7: Future Dates

Date	Event	Venue/Time
08/04/2020	Consultant Meeting	St Bede's 15.30

St. Raphael's Hospice

Minutes of Prescriber's Meeting

15th January 2020

Present - Kevin Hobson - CNS / NMP
Tracy Christmas – CNS / NMP
Jill Smith - CNS / NMP
Bernie Griffin - CNS / NMP
Dr. John Hallstrom – Palliative Care Consutant
Dr. Ambreen Akhtar – Hospice Dr.
Margaret Gibbs - Hospice pharmacist

Apologies for absence – Dr. Annelise Mathews, Dr. Sam Raveney

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

Patient leaflets and advice

- TC will recruit volunteers in coming weeks to set up group to look into producing info sheets. Margaret will bring info leaflets already provided by other palliative care centres that we could possible adapt for St. Raphael's.

1 Lead ECG's

- Group acknowledged that other hospices have not introduced this policy and it is likely to be small population of our patients that would need ECG. However we could still pursue / look into feasibility of introducing to the hospice. TC will catch up with Kathy F on inpt. unit to see how far she has got with policy.

Item 2 : **Review of Anticipatory Meds**

Group reviewed sub-cut meds given by our colleagues in local hospitals.
We have agreed that our guidelines could be changed to be in line with PCF and our palliative care colleagues at St. Helier and St. Georges.
Main changes agreed –

- Oxycodone prn s/c to be started at 1mg to 2mg

- Haloperidol as 1st line anti-emetic followed by Levomepromazine and other listed anti-emetics
- Glycopyrronium as 1st line anti-secretory followed by Hyoscine Butylbromide

KH will rewrite Guidance on Injectable Medications for Symptom Control Management at End of Life (with help from Alex!). Will share with all prescribers for agreement before bringing to DTC meeting.

Item 3 : **Furosemide CSCI guidelines**

TC has met with Heart Failure nurse and EOLC lead in community (see email sent 10.1.20)
They will take lead re pt's on or in need of Furosemide infusions.
Heart Failure team will liaise with Maura and arrange to come to a future education day to teach. It was agreed that this would be open to DN's (as they often call hospice for advice at weekends).
It was agreed that there will be monthly MDT meetings to discuss shared patients with Furosemide CSCI.
They are meeting in February to discuss new guidelines. TC will feedback at our next meeting.

Item 4 : **Competency Framework for NMP's and Supervisors.**
The document kindly forwarded by Alex is more relevant to supervisors of NMP's.
While we have a Non medical Prescriber's Scope of Practice in place, we don't have a competency framework.

- Margaret will look in to what is used at St.Christopher's that we could possibly adapt for St. Raphael's

Item 5 : **Medicines Alerts**
Recent alerts highlighted.
Although some alerts not relevant to our practice team grateful for Alex for sending them on.

AOB :

- JS - List of Pharmacy's supplying EOL drugs needs updating - (Kevin / Margaret will contact community pharmacists for update list)
- MG – highlighted some hospices starting to use Levetiracetam in Syringe Drivers to control seizures rather than Midazolam.
- MG – recent guidelines recommend Cyclizine dose should be halved when given s/c

Next meeting - Wed 26th Feb 2020 (St. Bede's room 1)

Clinical Audit and Activity Data Committee
Minutes of the 2nd meeting held at 13.30pm on Tuesday 28th January 2020
(St Bedes Room B)

Present:
(AR) A Rudkin (Chair, Quality Development Manager)
(GL) G Linehan (Director of Care Services & Strategy Development)
(TC) T Christmas (Community Services Team Manager)
(TY) T Young (Ward Manager)
(JH) Dr J Hallstrom (Consultant)
(AA) Dr A Akhtar (Speciality Doctor)
(MF) M Flint (Practice Development Lead / Clinical Education)
(JO'G) J O'Grady (CNS, HPoC, Community Team)

Apologies

None

	Action
1. Minutes of the last meeting held	
Minutes of the meeting held on 3rd October 2019 were accepted.	
2. Matters Arising	
ToR – published to the Manual on 28th November 2019	
Clinical Audit Policy – remains an action for AR	AR
Clinical Audit Leaflet – for review post Clinical Audit training in February 2020	AR
Clinical Audit Project Proposal Form - for review post Clinical Audit training in February 2020	AR
Clinical Audit training day with external facilitation delivered on site set for 4th February 2020.	
3. Audit Program & Timetable	
Program and timeline were considered:- 2019-20 DRAFT 08 - CLINICAL AUDIT PROJECTS STATUS SUMMARY DRAFT 08 - 27-01-2020.pdf 2020-01-24 2019-2020 v5 Clinical Audit & Research Project Progress Timeline.pdf 3 projects complete; 8 on target schedule ; 5 behind target schedule ; 3 associated with activity data dashboard production behind target schedule. Agreed – priority audits are those servicing the ISR. **Actions** 1. Project 1 – ISR Medications Audit Recs 2-5 : JH to meet with AR to move project along and complete before end of March 2020. 2. Project 2 – ISR Non-pharmacological Audit Recs 2-5 : TC & TY to meet with AR to move project along and complete before end of March 2020. 3. Project 4 – AA to meet with AR to set out audit. 4. Project 6 – AR to discuss with JO'G who will lead after completion of Project 13 (Admissions Audit) 5. Project 7 – JH to lead post completion of Project 1. 6. Project 11 – TY volunteered to take over as project lead from GL & JH. She will arrange planning meeting with AR.	

4. Completed Project Review	
• The latest VOICES report has been circulated for key staff member comment. Very positive report. Awaiting final input from TY before cascade to teams.	TY
• AA presented audit results for the Audit of Discharge Letters that she undertook. Small sample size. Simple audit for re-audit in 2021. Further required field highlighted for the mail merged discharge letter produced from the Crosscare system. AA to liaise with Pascale Evans to effect required changes. Audit highlighted gap in induction to Crosscare of medical staff. GL to adjust local induction for medical team.	AA GL
• The IPU Satisfaction survey was revised and re-implemented with new methodology in Summer 2019. Results are very positive and have endorsed approach for using ward companions conducting the patient/carer interviews. Training of ward companions to be delivered in February / March 2020.	TY
5. Education	
AR to review Information Session on Clinical Audit presentation post Clinical Audit training in February 2020.	AR
6. Any Other Business	
Nil noted	
7. Dates of Future Meetings	
13.30 Friday 28th February Room B St Bedes : Activity Data	

8th Meeting of the Clinical Quality and Governance Sub Committee
To be held in Gail Linehan's Office, building 759

at 10.00pm on 12th March 2020

Agenda

Chair : JT

Item	Description	Purpose[1]	Lead
1.	Apologies for absence	I	AR
2.	Minutes of the last meeting held on 22nd November 2019	S	Chair
3.	Action List from previous meetings	I	Chair
4.	CQC Inspection 11-12 November 2019	I	GL
5.	CQ&G Terms of Reference (att)	S	Chair
6.	Clinical Risk Register • Corona Virus RA (att)	I	GL
7.	Clinical Quality & Governance Report • Review report (att)	I	GL/AR
8.	CQ&G extract from Management Plan (att)	I	GL/AR
9.	Minutes of Meetings (att) • Clinical HODs : February 2020 • Prescribers : January 2020 • Drugs & Therapeutics : October 2019 • Quality Improvement Committee : December 2019 • Clinical Audit and Activity Data Committee : October 2019 & January 2020 • Infection Control : November 2019 • Falls Meeting : December 2019 • Consultant Meetings : November 2019 & February 2020	I	AR/GL
10.	Dates of Future meetings in 2020: 10am Friday 17th April 2020 10am Friday 26th June 2020 10am Friday 21st August 2020 10am Friday 30th October 2020	I	Chair

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

SAINT RAPHAEL'S HOSPICE

MINUTES OF THE 7th
CLINICAL QUALITY AND GOVERNANCE SUB-COMMITTEE

Held on 22nd November 2019
in GL's office, 759

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

Chair: Mr Alan Cogbill (AC)
Minutes Alex Rudkin (AR)
In Attendance: Dr Jan Hallstrom

ITEM 1: Apologies for Absence

Alan Cogbill (AC)

ITEM 2: Minutes of the last meeting held on 27th September 2019

2.1 Approved

ITEM 3: Action List / Matters Arising

Ref	Action	
03/01 (AR)	Application of required universal statements for all the Terms of Reference for the sub-committees and Advisory Committee is being undertaken by the CEO. Once applied, the ToR for this committee will be reviewed again. GL will check upon status and send out to members.	GL
03/06 (GL)	Exploration into how medical team appraisal can be better supported through collaboration with another Hospital/Hospice remains of interest but will be explored further with the appointment of a Clinical Director. Dr S Hyer has replaced Martin Stockwell as the Responsible Officer for SHH and is the Hospice's RO. He is also agreed to be the re-validation officer for Dr Hallstrom. The appraisal process is currently adequate. All medical team appraisals have been undertaken. A visit form the Medical Appraisal Revalidation Team remains expected in February 2020. Keep on the action list as on-going.	GL
03/07 (GL/JT)	Submission of the working model for the community team for submission to a UK journal by November 2019 has been overtaken by events and is removed	

	from the action list.	
04/01	Copy of the Hospice's new People Performance Management Policy will be provided to members.	AR
04/08	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. Report is expected in November 2019.	AR
06/01	Summary of required ISR actions and progress toward them remains to be produced. It was acknowledged that action items were included in the clinical action plan and management plan accordingly.	GL/AR
06/02	Medical supply (Brexit) has been added to the clinical risk register. CC stated that MMS drug tracker may be a useful resource. GL confirmed that Ashtons have confirmed there are no expected difficulties with medication supply. AC ventured that he understood there may be difficulties over supply of specific epilepsy control drugs but had no such awareness for palliative care drugs.	

ITEM 4: Matters Arising

4.1 **External engagement :** GL highlighted engagement with the Sutton Health Care Board and that presentation to them on 9th October by GL , Dr Martine Meyer and Clare O'Sullivan went well. She reflected that the meeting had been a little too 'acute care' focused but discussion afterwards acknowledged the Hospice's role in preventing Hospital admissions and how keen SRH is to have discussion on the Hospice's representation on the Provider board. The presentation had focused on the Sutton End of Life Care Hub which was again a bit frustrating and missed the opportunity to specifically shine light on the Hospice and its role. Brendan Hudson did acknowledge that SRH wasn't represented on the Board and encouraged a formal approach from the CEO and Advisory Committee Chair. CC cautioned that there may well be tension between St Helier's Palliative Care needs and those of the Hospice.

Considering senior medical team staffing, there may be potential for SHH to host the consultants. CC stated that details are very important and cautioned that being part of a Provider Board needs to be fully understood in exactly what that means or entails.

4.2 GL advised that Sutton's End of Life Coordination Centre is being created under the project leadership of Amanda Allen who is known to the Hospice through her volunteering at the Hospice on reception and the IPU. The Hub has been assured of social enterprise funding and plans are for its call centre to remain at SHH 8am-8pm with DNs to pick up calls OOH. Staffing will consist of 3 RGNs – bands 8a, 7 and 6. Facility to base themselves at SRH is being explored. GL feels that there is potential benefit in consolidating relationships particularly with the DNs. JT felt that this

presented as a positive step toward improved integration. GL expressed how the Hospice receives a lot of 'late' referrals and hopefully the Coordination Centre will help facilitate an earlier 'feed in'. JH expressed how he felt that integrated working with other providers is part of the way forward.

ISR : GL highlighted Psycho-social team integration and responsiveness and how this would be an improvement project for the new team leader to effect once in post in the New Year. Some applicants for the position had commented on what they felt were a low number of visits by the team. JH advised that referral to the Psycho-social service is constrained by its capacity and advocated for a more responsive and integrated service. CC stated that the new recruitment opportunity will be opportunity to better address the needs of both patients and staff. GL stated that with it may come further opportunity for student placement to support the psycho-social service. She explained that the new role will be about service development and will bring with it opportunity to evaluate and do things differently – potentially even looking at volunteers and how their skillsets can be harnessed in this support service.

GL advised that training and upskilling nurses' psycho-social skills will be part of 2020/21's objectives. AR reflected and GL endorsed how tasks and medication needs have overtaken time that is a finite resource in not only its own 'giving' but also its connectivity to therapeutic intervention. CC agreed that that is an experience realised across other sectors.

The ISR acknowledged the up-skilling of HCAs in wound care, catherisation and in support of IV therapies; GL is examining the 'Nurse Associate' role and path for HCAs to develop into that role.

AC highlighted the ISR's focus on prescribing practice and how collaborative working would be support to the then Matron. JH stated that he appreciated the ISR as there were things going on led by the Medical Director that he felt were not commonly practised in palliative care. He felt things were a bit odd. From a medical point of view – practise had become isolated and old-fashioned over the years. Medical practitioners had become very scared of opioid toxicity and had increased poly-pharmacy which had led to difficulty in isolating causative factors in interactions and side effects. He was happy that the report was written and identified that which he expected. He stated that things have changed with the medical team working more or less in the same way but with a firm underpinning from national guidance and the latest version of the Palliative Care Formulary. Individual bespoke medication guidance documentation had been removed. He expressed how regular consultant team meetings are scheduled to start next week, that integration had improved and the problem of IPU discharge practice being sometimes disconnected from Community Team support and skillset had been relieved. Rotating staff across teams has resolved a lot of problems and whilst consultants may always have differing opinions, discussions are now more creative rather than combative.

GL advised that the H@H integration into the Community Team has gone very well. She will be meeting with Tracey Young, IPU Manager, very soon to discuss the

rotation of night staff on day shifts. She stated that whilst it won't be before March 2020, it is planned for IPU RGNs to spend a month in the Community Team. She is not sure if there needed to be reciprocation by the CNSs undertaking shifts on the IPU due to pressure on Community Team provision. CC remarked that it may be a future ambition when staffing is in a better place or indeed an induction consideration.

AC welcomed any update report for submission to the RCoP be seen by this Committee. It was understood that original timeline was for further progress update to be submitted in January 2020 but this has since been revised to March 2020. 07/01 GL

GL stated that lack of consistency of consultant cover on the IPU has been fed back which can affect prescribing practices. However, our patient record supports the documentation of rationale that supports decision-making. Both GL and JH asserted that the regular doctor meetings have been more open and straight-forward and facilitate creative discussion.

[JH left the meeting]

4.3 GL stated that Christmas medical cover was in place with 1st and 2nd on-call Drs.

4.4 GL advised that staff had showed their robustness despite the departures of both Dr Joseph and Caroline Betts.

ITEM 5: CQ&G Report

5.1 The Clinical Quality and Governance Report and the Clinical Update report was reviewed.

5.2 CC was pleased to see that the audit project listing had been rationalised and tailored to need. GL reflected how staff are appreciating the need for their engagement with the program and a Clinical Audit Education Day is being facilitated in February 2020.

5.3 Incident data entry is complete to the end of September 2019 and data shows a reduced incidence comparatively to the previous 2 years particularly from April 2019: reported clinical incidents have reduced in the 9 months of 2019 quite significantly to 67 (c.f. 116 in 2018, 101 in 2017 and 112 in 2016) – a 42% reduction on 2018. The number of admissions to IPU are comparable with 2018. Medication incidents are notably reduced as too are pressure sores, information governance incidents, manual handling incidents, slips, trips and falls.

5.4 Administrator training for Datix has been delivered to a small group of Hospice staff. User Testing has been delayed owing to technical issues at Datix's end and our testing will commence w/e 18th November 2019. We are hopeful that we can go live with the incident reporting from 1st January 2020. It was agreed that getting the system right before it is implemented should be the main objective and that there is not an over-bearing deadline given the adequacy of the existing reporting system.

5.5 Regular meetings of the Hospice's PAS system (Crosscare) implementation group have been re-convened in 2019 following a small hiatus. The meeting supports the system's design and the users usage and welcomes the IPU Manager, the Community Services Team Manager and the Practice Development lead to its membership. A number of design enhancements have been effected in 2019 and further enhancement is required. This is primarily resourced through clinical leads running through design needs with our IT Manager.

5.6 Complaints were reviewed; all adequately handled and none considered to be clinically significant. Like incidents, complaint numbers too are down on the past 2 years.

5.7 **GL's clinical update report:** CC highlighted how if T&Cs are less favourable than the NHS then successful recruitment may be compromised. It was agreed that the full time medical consultant position needs to be a 'specialist'.

5.8 GL explained that the deputy Practice Development Lead Nurse (Maura Flint) has stepped up into the main role following resignation of the incumbent (Katherine Gogarty)due to family reasons. Recruitment for her deputy will be progressed.

ITEM 6: CQC Inspection 11-12 November 2019

6.1 As reflected at Advisory Committee on 20th November. GL advised that the feedback she had received was that all teams conducted themselves in preparation and during the inspection admirably. It is expected that the report will be a positive one and will be received by the start of February 2020. An inspector spent time with Sr Pauline Morris on the IPU in the absence of the IPU Manager but didn't visit the Jubilee Centre at all.

ITEM 7: Minutes of Meetings

7.1 Minutes of the meetings were accepted:-

- Clinical HODs : Nov-2019
- Prescribers : Nov 2019

ITEM 8: Clinical Risk Register

8.1 GL will re-circulate copy of the clinical risk register following review of the risk scoring and then share with January 2020's Advisory Committee. 07/02 GL

ITEM 9: Any Other Business

9.1 Management Plan will be reviewed at the next meeting to inform new or carry over items for 2020/21's plan. 07/03 GL/AR

9.2 Draft copy of the Freedom to Speak Up policy was briefly reviewed. CC expressed how she had been put off by reference to malpractice in the first sentence and felt that its language needed to be more accessible. She circulated copy of a Hospital

policy that she preferred. AC felt that that had better feel, look and language about it than the Hospice's draft. CC also felt that the policy should embrace volunteers. The policy will be brought back to the next meeting.

07/04 GL/AR

9.3 Discussion about a Board Guardian for Speaking Up led to reflection on the training and required skill set for Board members. Members advocated for Board member Development training recognising their accountabilities and responsibilities in moving to become Board members.

9.4 GL advised that arranging a Provider Visit from members would be best coordinated through herself. Community MDT meetings are routinely 9-10am each morning.

ITEM 10: Dates of future meetings

Date	Venue/Time	Chair	Apologies
Friday 14th February 2020	10-12noon	Dr J Tweed	AC
Friday 17th April 2020	10-12noon	Dr C Chill	
Friday 26th June 2020	10-12noon	Mr A Cogbill	
Friday 21st August 2020	10-12nooon	Dr J Tweed	AC (likely)
Friday 30th October 2020	10-12noon	Dr C Chill	

ITEM 03 ACTION LIST

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

Reference	Lead	Description	Target Date for Completion	Comments
03/01	MJR	Universal references to be applied to all sub-committee ToRs and CQ&G ToR to be reviewed again at CQ&G.	Nov 2019	Revised ToRs are with respective Subs for sign off. ToR for C&F Sub for sign off at March 2020 meeting
03/06	GL	Exploration into collaborative working re medical appraisal with another Hospice or Hospital.	On-going	Exploration into how medical team appraisal can be better supported through collaboration with another Hospital/Hospice remains of interest but will be explored further with the appointment of a Clinical Director . Dr S Hyer has replaced Martin Stockwell as the Responsible Officer for SHH and has accepted our approach to be the RO for the Hospice. The appraisal process is currently adequate. A visit form the Medical Appraisal Revalidation Team is expected in February 2020. Keep on the action list as on-going.
04/01	GL/AR	Performance Management	Dec-2019	Development of a universal tool / policy for performance management throughout the Hospice that builds on the nursing tool that is already in place is being led by HR and MJR. Policy was published in December 2019 and has been included in papers for March 2020 meeting.

ITEM 03 ACTION LIST

Reference	Lead	Description	Target Date for Completion	Comments
04/08	JG/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.	Apr 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 April 2020.
06/01	GL/AR	A summary of ISR required actions and progress against them will be created for review	Dec 2019	Action items included in the clinical action plan and, in turn, the management plan.
07/01	GL	ISR update report to RPoC	Mar 2020	
07/02	GL	Clinical Risk Register to incorporate risk scoring update, re-circulate and share at January's Advisory Committee.	Jan 2020	Deferred to March's Advisory Committee
07/03	GL/AR	Review Management Plan to feed into 2020/21 plan	Mar 2020	March 2020 CQ&G meeting

Clinical Quality and Governance Committee Terms of Reference

Title	**Saint Raphael's Hospice - Clinical Quality and Governance Committee**
Purpose of the committee	The Clinical Quality and Governance Committee (CQGC) is a Committee of the Saint Raphael's Hospice Board of Trustees. The overall purpose of the CQGC is to provide assurance to the Hospice Board that the organisation has a robust framework for clinical governance that supports the delivery of safe and effective care and the management of clinical systems and processes. To achieve this, the Committee will ensure that: • Quality is integral to the work of the Hospice and the systems and services that support that work. • There is a robust programme that supports the monitoring of clinical performance across all clinical services. The Clinical Quality and Governance sub Committee will: • Assure the quality and safety of any service development or re-design. • Assure the delivery of a work programme on an annual basis in accordance with hospice strategic objectives and the annual plan. • Have delegated authority to review progress and take decisions within a framework approved by the Advisory Board and linked to the annual business cycle.

Responsibility	Specifically, the CQGC is responsible for: Providing assurance that the key critical clinical systems and processes are robust, safe and effective. These systems will include, but are not limited to: • Clinical Leadership • Clinical Staffing • Clinical Competence • Clinical Activity • Clinical Learning/Education • Clinical Incident Management • Clinical Complaints • Clinical Audit • Clinical Effectiveness • Patient and Service User Experience • Compliance with the CQC Fundamental standards of quality and safety; • The Electronic Patient Record (EPR) • Research and Development; • Medicines Management. The Committee will: Provide assurance that safe and effective person-centred care is being delivered and will do this by: • Assuring clinical quality across the Hospice • Providing assurance that mechanisms are identified to enable all clinical teams to review performance in line with national bench marking and evidence based practice and review/agree subsequent action plans. • Providing assurance that that new clinical systems are implemented within a framework of robust clinical governance, improve patient care and experience. • Supporting the clinical governance infrastructure through update from SMT and periodic receipt and review of minutes from the Hospice's clinical committees • To liaise with committees both internal and external to the Hospice as is necessary to achieve the objectives of the committee. To be mindful of how the hospice contributes and is part of the wider health and care system.

Comment [C1]: This may need some clarification. The list of responsibilities suggests we need to do much more than support the clinical governance infrastructure

Comment [C2]: Maybe not just committees. I'm not sure about external as we are a committee of the board.

Objectives	The Committee shall agree annual objectives with the Board and the Committee Chair shall report progress on these as required.
Resources	The Committee does not hold a budget but may request funds to support their work as part of the annual planning process to the Director of Finance and Resources.
Confidentiality	Whilst the Committee is not a forum for the resolution or discussion of individual cases, there may be occasions when issues of a confidential or personal nature have to be discussed. Unless clearly with the explicit consent of the individual concerned, the Committee is to ensure that no discussion is held with outside attendees present in which any individual is able to be identified, that all notes/minutes are anonymised and that, as a general principle, confidentiality is respected and maintained at all times.
Composition and co-option	The Committee comprises: • At least three Board members of whom one should be proposed to the Chair of Trustees to serve as Chair of the CQGC and at least one should have a clinical background. Should the Chair be unable to attend the meeting then he/she should nominate another Board member to act as Chair for that meeting. The Committee, as required and at its discretion, may invite other people to attend. ~~to represent the views of users and carers.~~ Staff in regular attendance: • CEO or Director of Care Services and Strategy Development • Clinical Director • ~~Head of Clinical Governance~~Deputy to the Clinical Director • Quality Development Manager (Secretary) • ~~Others as required by invitiation~~ •
Meetings	**Agenda:** Either the Chair or Secretary will circulate an agenda before each meeting, normally seven days in advance of the meeting. Any member of the Committee may propose agenda items. **Minutes:**

Comment [C3]: Should we say at each meeting. I would be concerned if the board did not want a clinical quality report at each meeting

Comment [C4]: This is hard to understand and I think the wording should be simplified. In a small organisation it can be hard to anonymise and we also all have a duty of candour.

Comment [C5]: I wonder if we also need to say that at least one member needs to be from a clinical background. I would be concerned I there were no clinicians in a clinical governance committee – Yes done

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	The Secretary, or other person nominated by the Chair, will take a note of each meeting recording the action/decision agreed and any critical discussion necessary to explain the basis of decision taken. Approved minutes will be issued, normally within 10 working days of the meeting and will list the topics discussed, actions agreed, and all individuals responsible for undertaking these actions. Once agreed, the minutes will made available to staff and volunteers. The Committee may, at its discretion, record confidential aspects of its business in "Part 2 Minutes" which will remain confidential to those present, the Board, the Senior Management Team and other persons with whom the Committee agrees it is necessary to share those matters. **Quorum:** A meeting will be quorate with at least four members, at least one of whom must be a Hospice Board member who will chair the meeting and another must be either the Director of Care Services and Strategy Development or the Clinical Director. **Voting:** Should a vote be required a decision will be determined by a simple majority. Each member will have one vote with the Chair having an additional casting vote, if required. **Frequency:** Meetings will normally be held at least four times a year. Additional meetings may be held by mutual agreement or at the direct request of the Committee Chair and may be virtual i.e. some or all of the participants may be on audio or video links.
Committee Reports	The Committee will receive and review: • A clinical report from the Clinical Director and Director of Care Services that amalgamates inputs from all clinical areas and the minutes of all hospice clinical forums as necessary. • A Clinical Governance report from the Head of Clinical Governance and the Quality Development Manager. The Committee has specific responsibility for receiving, advising on, and communicating to the Board key points relating to certain documents and publications, including: • Provider Information Return • Clinical Risk register

Comment [C6]: Agreed by whom? I do not think they should be available until approved by a meeting and they may need to have been approved by the board. For discussion

Comment [C7]: I thought we were providing assurance that this had been done by the hospice committees. We may need to think about wording

	• Clinical Action Plan progress reports • Clinical KPIs • Clinical Complaints • Other related clinical reports or publications as agreed In addition to any regular reporting, the CQGC will submit a summary annual report on its work to the Board. **Evaluation Report:** The CQGC will evaluate its own performance at least annually so as to provide assurance to the Board that it continues to operate at maximum effectiveness. This will include a review of the membership and any proposed changes will be recommended to the Board.
Review	These Terms of Reference will be reviewed at least annually. Any changes that are considered necessary will be recommended to the Board for approval.

Comment [C8]: Good idea. Will there be a standard format for all the committees of the board?

St Raphael's Hospice Clinical Risk Register

Serial	Cause of Risk	Description of Principle Risk to Charity	Current Controls to prevent occurance	Current Impact	Current Probability	Raw Score	Additional Controls	Residual Impact	Residual Probability	Residual Score
1	Culture Change	Reticience of some staff to embrace change to working practice as outlined in Clinical Action Plan (CAP) and current change in leadership.	Proactive leadeship 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: 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.	4	2	12
3.	Workforce: Registered General Nurses Recruitment of appropriately qualified nurses to support the delivery of care on the In-Patient unit.	Night duty cover can be problematic . If RGN cover on night duty not suffcient the number of patients that can be safely supported will be affected as safe staffing is across 24hours. Increasing difficulty in recruiting Band 5 nurses for day duty - staff undertaking extra shifts to cover requirement risk burnout. Managing unexpectd sick leave can put pressure on the staff cover.	Current qualified nursing staff levels are adequate to support 8/10 IPU beds on day duty with full current complement of staff. 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 educatuional 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 avialablel beds.Engaging with local and national training schemes to demonstrte the attractiveness of the hospice as an employer. Review sickness policy and maternity leave	4	2	12
4	Medication incidents related to controlled drugs	Potential for adverse side effects Complaints from patients relatives	Open culture of reporting of incidents to learn from mistakes/errors Review and monitoring of individal patient to mitigate harm or unsatisfactory symptom relief. Staff actively informing patients/families about medications and rationale for use to ensure understanding and gaining consent.	3	2	9	Continued vigilance Optimum patient monitoring Introduction of Checking CDs twice in 24hrs at 09.00 and 02.00 Spot checks on orders of CDs against invoice and incorporation into CD book Drugs likely to be misused (DLM) recorded in a separate register for monioring against amount ordered and usage.	5	1	10
5.	Allergy	isk of harm to staff member and related impact on staff and patient	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.	5	1	10
6.	Inadequate Senior Clinician Cover	Resignation of the MD- impact on medical cover across departments. Imapct on 2nd on call cover to support 1st on call doctors. Impact on admissions to the IPU.	6 month Locum Consulatnt cover in place 3 days per week- continuing informally into 2020. Ongoing contract has been put in place to support Consultant 2nd on call cover 2 nights per week and 1 weekend a month.	4	4	20	Active review of senior medical cover across hospice - completed. JDs for 1 x FTE Specialist Palliative Medicine Consultant and 2 x 0.6 FTEs Specialsit Palliative Medicine Consultant approval from RCP for all posts. Out to advert Feb 2020. Deanery informed of upcoming posts to alert potential applicants. Locum Consulant post extended for 1yr to March 2021. Currently seeking another Locum FTE Consultant role to support across recruitment process and to mitigate loss of StR in April to October.	2	2	6
7	Staff Well being	Staff sickness Low staff morale	Staff well being is seen as a priority in the organisation Staff Consultative Group to facilitate 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 Under review is space to facilitate staff having ability to take time out during the working day to destress.	4	1	8
8.	Clinical Incidents	Risk of compaints from patients/families Patient safety Requirement to report outside the organsiation to CQC Prempt a CQC Inspection Reputational damage	Reporting of all incidents related to clinial care Heiracrchy 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 June/July2020 will support reporting and monitoring.	4	1	8
9.	Patient Safety- risk of falls	Patient sustaines 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	4	1	8

Serial	Cause of Risk	Description of Principle Risk to Charity	Current Controls to prevent occurance	Current Impact	Current Probability	Raw Score	Additional Controls	Residual Impact	Residual Probability	Residual Score
10	Lone working	Staff members work singularly in the community within referred patients homes. Risk of accident/incident in a patients home and individual risk to staff member. Risk in travel to and from home visits	Policy and proceedure in place to support community working. Sign in and out. Supplied with a mobile phone for conatct with the hospice or other healthcare professionals. Lone worker alert devices introduced on 11/09/2019.	4	2	12	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 tfor contact and advice on further action.	4	1	8
11.	Inadequate Senior Nursing Clinician Cover	Loss of Operational Lead across clinical settings due to resignation of Matron. Resulting in loss of support for direct reports.	Director of Care and Strategy to fulfill role requirement in the interim. New Community Services manager role in place alongside IPU Mangaer. Clinical Action Plan for service development agreed and being progressed. Job Specification has been constructed for a new Clinical Lead Nurse role with responsibilty for Clinical Govenance to incorporate Matron and MD responsibilities Pended until recruitment of Clinical Director.	4	2	12	Director of Care Services (DCS) to manage all clinical teams including Medical team in interim. JD underview- Plan to go out to advert October 2019. Awareness this role may take some time to fill. Impact on work load. Clear lines of delegation to be implemented and monitored to ensure it is actively engaged with in order to prevent work oveoad on DCS.	4	1	8
12.	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 File notes kept of discussions by HR	4	2	12	Use of root cause analysis for significant incidents Scoping to establish all clinical staffs access to communication skills training Training on care delivery Information shared re: Duty of Candour and scope of the policy Reporting of any concerns- no blame but responsibility	3	1	6
13	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
14	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 shtone - Reassurance that adequate supplies in stcck.	2	4	10	Regular updates from clinical pharmaist. Communication with wider CCG pharmacy colleagues.	2	4	10
15	Recruitment of Clinical Director	Insufficient clinical leadership, management and support	Role out to advert with closing date 9th March 2020.	5	5	30	Role currently being provided by Director of Care Services.	4	4	20
16	Corona Virus	Service provision compromised through staffing shortfall	All staff emails alert. Signage directing vistors to use of hand-gels and hand-washing on entering and leaving the ward / rooms and staff to adhere to control of infection policy.	5	2	15	PPE supplies checked. Contingency planning set out for any identfied case within the Hospice.	5	2	15

ITEM 07
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 Meeting - Clinical	Date last held	Date of Last Minutes Reviewed at CQ&G Sub	Next meeting
Clinical Audit and Activity Data	Jan 20	Jan'20	Mar'20
Clinical HoDs	Mar'20	Feb'20	Apr'20
Drugs & Therapeutics	Feb'20	Oct'19	Jun'20
Falls	Dec'19	Dec'19	Jun'20
Incidents	Feb'19	Mar'19	Mar'20
Infection Control	Nov19	Nov'19	May'20
Prescribers	Mar'20	Jan'20	May'20
Quality Improvement	Dec'19	Dec'19	Mar'20

Clinical Update

1. Organisational

The Hospice continues to deliver all services within capacity and safety parameters. There has been a lot of activity in the clinical sphere over the past few months keeping everyone busy.

2. Recruitment

Recruitment remains a high agenda item for senior posts. The Clinical Director position is out to advert with a closing date of March 9th. Interviews scheduled for the mornings of 18/19 March.

The Consultant posts have been approved by the RCP and are all out to advert. There has been interest in all positions, with visits supported for the 0.6 posts, and telephone enquiries for the full time post. Interestingly two of the Consultants who expressed interest stated their preferred option would be for 0.8 FTE. This may be a consideration providing it does not impact on the proposed Trust support of the contract for the 1 FTE post. This will have to be discussed and explored further.

The Epsom and St Helier Trust continue to progress the process for holding the contract for the FTE post. The process is actively supported by Dr M Meyer and the Executive Director for Integration Thirza Sawtell. At a recent meeting (Jan 2020), there was a positive discussion about the Trust being willing to hold all three Consultant post contracts. This would make the posts more attractive to potential applicants. However, at present only the FTE position is being progressed as this is a new initiative for the Trust.

As part of the process the Trust requested an undertaking from the hospice via our FD that all financial risk would be absorbed by the Hospice. Nick Stevens (NS) constructed the letter which has been furnished to Dr Meyer for presentation to the Trust. A meeting is due to be arranged between NS and the Hospital Divisional Financial Director, Helen Cullen DTBC.

Dates for the Consultant interviews have not been decided as the depending on Trust adoption of the FTE, the interview will need to be undertaken at the Trust under NHS process and for the hospice only contracts an RCP rep and panel will have to be organised.

We are actively engaged in the recruitment of a Locum Consultant to commence at the end of March to support the departure of Dr Sam Raveney (StR), who leaves on April 9th to take up his first

Consultant post at St Bartholomew's Hospital. There will not be a replacement for the months April to October which does impact on medical cover across the hospice. We have been informed that we will get an StR from October. In the meantime the recruitment of a Locum Consultant will support safe cover and enable annual leave to be facilitated across the Consultant Team, which otherwise will be very difficult to support.

We have been informed that we should be allocated an StR from October, but we will need to ensure that we have a Consultant who is an educational supervisor to support.

Two Clinical Nurse Specialist left the team in mid February. We have been fortunate in recruiting replacement CNSs both substantive and Bank. There are still 2 CNS posts vacant which are advertised.

Band 5 nurse roles continue to be advertised as there is difficulty recruiting to this grade at present.

Recruitment of Healthcare assistants has been positive and current vacancies are filled.

Recruitment to the Physiotherapy role to be the clinical lead in the Wellbeing Centre remains active. We have received two applications and interviews are being arranged for mid March.

The role of Education Facilitator has been recruited to internally. Laura Brian a CNS from the community Team has taken this role to work collaboratively with Maura Flint. She will take up her new post at the beginning of May. They will make a really good team.

The Band 8B (Lead Nurse/Clinical Governance role) has been pended pending the recruitment of the Clinical Director who can have active participation in recruitment to the role.

Steve Molyneux was appointed as Lead for the Psychosocial Team and commenced work with the hospice on January 6th 2020. He is enjoying his new role and is actively working to increase the service delivery via trainee counsellors from academic institutions ad training more Bereavement Volunteers.

Education/Training.

Two HCAs have applied to train as Nurse Associates at Kingston and St Georges in September. The cost of this training will be supported by the Apprenticeship Levy. We will hopefully get the £7,200 allocation of funding for the two years, attached to each trainee role which can be used to support backfill etc.

The Mandatory Training IT provider is being changed from Skills for Health to the Princess Alice Mandatory Training platform which is focused on the Hospice sector. The new system should be ready to go live in July.

The Education committee continues to support application for external courses to support staff development.

Wellbeing Centre

The move to the new Wellbeing Centre took place on January 7th. The team of Sheila Payne(including Sheila's husband Tony) and Lucy Moore, prepared and organised the centre for its opening in early January. Our sincere thanks are extended to them for all their hard work. So far so

good. The patients and carers appear to be delighted with the new space. All sessions are adapting well to the new environment.

The Art Therapy sessions on a Tuesday are now progressing well. The adjustment to a therapy focused approach took a little adjustment but are being positively engaged with. The Contract for the Art Therapist has been extend for a 12 month period.

Visit by NHS REVALIDATION-LONDON (NHS ENGLAND & NHS IMPROVEMENT

On February 11th a visit by the Higher London Revalidation Officer took place in accordance with the Framework of Quality Assurance and the Quality review process. The meeting was attend by three representatives from the London Team, Dr Steve Hyer, RO for SHH and the Hospice and Laura Neal Revalidation Officer at SHH. Hospice representatives were Gail Linehan and Jacky Crawley SRH HR. The team were happy with the supporting paper work they had been provided with and prior to the report being sent recommendations are that we require a Medical Revalidation Policy and a Chaperone Policy, both of which are under construction.

Royal College Physicians Invited Service Review

The RCP have requested the next report against recommendations to be furnished by April 3rd.

CQC Inspection

We await the CQC report from the November Inspection. With awareness of the change in Provider status, it seems likely that the hospice will have an unannounced inspection towards the end of March beginning April. Teams have been advised that this may happen and to be continue to work to the same high standards as is usual practice.

Corona Virus

The hospice has taken steps to prepare for any suspected infection. Warning signs advising visitors not to enter the Hospice if they have visited the list of 11 countries known to be at risk have been posted on the main Hospice door, Reception and on the door leading to the IPU. Stocks of aprons, masks and gloves have been checked in the event of reverse barrier nursing being required. The Infection Control Consultant Dr Stevens has been contacted for any advice/action that the hospice should be taking to protect the vulnerable patient population should a case be detected. Signs have been posted around the unit advising staff and visitors to adhere to rigorous hand washing and use of antibacterial gels on entering and leaving rooms and the IPU. Clinical Staff have been emailed to remind them to adhere to our infection control processes.

'Boris' Non recurrent Funding for Hospice and Palliative Care

From the 25 million gifted by the Prime Minister to support Hospice sustainability and palliative care, Merton received £85, 000 from this fund and asked for bids to deliver projects which were in line with the 5 year SWL plan. We submitted two bids 1. For training staff in care homes utilising the SRH APP and some face to face training 2. Pilot project to train Volunteers to undertake conversations about Advanced Care Planning . We attracted £50,000 funding to deliver these two projects, which were noted as being innovative in approach. Now that we have the money we will have to carefully consider the feasibility of delivery as set out in bid.

Sutton were very slow to inform us about what funding they received. As it turns out the £86,000 they received has been put towards the construct of their End of Life Care Co-ordination Hub. I have communicated my disappointment to both Deputy Director Michelle Rahmin and Director of Sutton CCG Lucy Waters. No reply or acknowledgment has been received.

Community Team

The team continue to actively support patients in their own homes. Crosscare windows to support ease of documentation have been modified by Tracy Christmas (TC) and John Groom. The new windows which significantly reduce the time component of engaging with input have been well received.

TC is reviewing caseload management in an effort to ensure that only patient who require ongoing support remain on active caseloads. The telephone caseload is also being reviewed as it is questionable if patients in receipt of 3 or 6 monthly telephone calls should be discharged until more active intervention is required.

The management of patients on case loads has been an active topic since the beginning of the year across all services and a group from consisting of representatives from CPCT, H@H, Wellbeing Centre and the Hospice Neighbours have met to discuss the pathways for referral and exit strategies.

In Patient Unit

The IPU continues to run with capacity of 6-8 beds. Recruitment of Band 5 Staff Nurses remains problematic.

Psychosocial Team

The new team Leader is settling in well and has had taken a proactive approach to managing referrals and response times which has reduced the waiting list and supported a reduction I team anxiety.

The monthly Mortality and Morbidity review facilitated by Diane which was started in June continues to be well attended and reviewed.

Hospice@Home

The team are successfully integrating into the wider CPCT

Professional Coaching

Continues with all involved staff. All participants report how helpful it is, and its benefit is reflected in the approach of participants.

Clinical Action Plan (CAP)

We continue to review the CAP and work towards an integrated flexible workforce and efficient effective service delivery. The report submitted to the RCP outlined hospice progress against the 0-3 month achievement – all attained or in progress. Next report due in April 0-6 month update. The CAP objectives have been integrated and cross matched with the Management Plan.

Plans to introduce one day shift per month for night staff for assurance of update of clinical practice and competency assessment by December 2019 has been pushed back until after independence in April and TUPE has happened. A consultation with staff will then be taken forward.

With reduced senior staff capacity it is difficult to keep fully abreast and apace with all requirements of the CAP.

Appraisal

Continuing as routine across all teams.

All medical team members have now had their organisational appraisal. All doctors have completed their annual clinical appraisal.

TUPE

Discussions progressing well.

Pool Car

We have been donated a Pool Car by a local Company DCL Insurance Brokers. Andy Hussey, Managing Director has been very supportive of the Hospice and its mission to support people at the end of life in their own home. Two years fully comprehensive insurance was also provided. The car carries the Hospice Logo and the logo of DCL. It is hoped that using the car will raise awareness of the hospice across the area and help brand recognition.

Incidents / Accidents / Near Misses

- All incidents are reviewed at the Hospice's Incident Review Meeting (AR, GL, JH, MF, TY). 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 February 2020. The submission categories cover pressure sores, patient medication incidents and incidents of patient falls.

- Nothing has been heard of the plans for Hospice UK to develop a new performance indicator dataset that will replace the MDS that up to April 2017 had been a data collection exercise orchestrated solely by the National Council for Specialist Palliative Care Services. Since April 2017 the National Council has merged with Hospice UK who is now collecting a mini-MDS dataset from participating Hospices; 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 December 2019 and its next meeting is scheduled for June 2020. The Falls Policy was last reviewed in October 2017.

- 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 has been delivered to a small group of Hospice staff. User Testing was delayed owing initially to technical issues with Datix and latterly due to competing demand on IT resources. Our testing will be underway again in March 2020 with hope for system roll-out in June 2020. Whilst implementation of the new system has been delayed, it has not been considered an issue owing to the acceptability of the long established manual reporting system.

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.

October 2019 saw the first meeting of a dedicated forum (CAAD) to keep under review progress with the Hospice's Clinical Audit program and provide opportunity to review Activity Data that will feed into data dashboards. The meeting is held every 2 months and alternates between review of clinical audit and activity data respectively. It has been well-received by the MDT and has made 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 9Audit/Research 2019/20.

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.

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.

Submission of the Quality Account for 2019/2020 is required before 30th June 2020.

Audit/Research 2019/20

Overview

19 projects underway in 2019/2020 : as at 06-03-2020, 4 have been complete, 9 remain on target, and 6 have fallen behind schedule. Of the 9 that are on target, report is expected for 3 (Ref 1,12 &13) by the end of March 2020; 3 are rolling projects (Ref 8,9 &10) ; 2 (Ref 14 & 16) that involve data extraction, manipulation and presentation are being progressed and 1 (Ref 2) is likely to fall behind schedule.

Engagement with the audit process has been encouraging and there is a positivity in undertaking audit and taking it 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 this year 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	Lead	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Progress	Project Status
1	**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**	On target	Dr JH								Audit Planning / Design	Audit Planning / Design	Data Collection Period	Data Collection Period	Analysis/Report / Publication expected				On target	Audit Planning / Design
2	**Non-pharmacological intervention Audit (ISR Recs 2-5) - prevalence / effectiveness monitoring**	On target	TC/TY										Audit Planning /	Data Collection	Data Collection				Behind Schedule	Data Collection

Project Ref.	Title	Status	Lead	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Progress	Project Status
3	**Community patient follow-up within 48-72 hrs when titrating medications**	Behind Schedule	TC								Audit Planning / Design	Data Collection Period	Data Collection Period	Analysis/Report / Publication					Complete	Analysis
4	**LANSS tool audit - use**	Behind Schedule	Dr AA								Audit Planning / Design	Data Collection	Analysis/Report /							Report / Publication
5	**Community - Carer & relative questionnaires for the Hospice @ Home Service**	Complete	AR	Data Collection	Data Collection Period	Analysis	Report / Publication	Data Collection Period	Report Published	Data Collection Period	Data Collection Period	Data Collection Period	Data Collection Period	Data Collection Period	Data Collection Period	Data Collection Period	Analysis	Report / Publication			
6	**Community – Referrals Audit – timeline from request to admission (by source)**	Behind Schedule	JO'G/ AR								Audit Planning / Design	Data Collection Period	Analysis	Report / Publication						
7	**IPU - Audit against Audit NICE Guidance NG31 Care of Dying Adults at the End of Life**	Rolled into 2020/21	Dr JH							Audit Planning / Design	Audit Planning / Design	Audit Planning / Design	Data Collection Period	Data Collection Period	Analysis	Report / Publication	Report / Publication			

Project Ref.	Title	Status	Lead	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Progress	Project Status
8	IPU & Community - VOICES survey of bereaved next of kin 3-6months post bereavement	On target	AR	Data Collection	Data Collection Period	Analysis	Report / Publication expected	2018 Report Part 1 published	Data Collection Period	2018 Report Part 2 expected	Data Collection Period	Data Collection Period	2018 report drafted for comments	Data Collection Period	Analysis	2019 Part 1 Report / Publication expected	Data Collection Period	Data Collection Period		
9	IPU – Infection Control : Environment & Hand-washing Audit	On target	PM	Data Collection	Data Collection Period	Analysis	Report / Publication	Data Collection Period	Data Collection Period	Data Collection Period	Data Collection Period	Data Collection Period	Data Collection Period	Data Collection Period	Data Collection Period	Data Collection Period	Analysis	Report / Publication		
10	IPU - Medicines Management Audit	On target	Ashton's MG	Data Collection	Data Collection Period	Data Collection Period	Report / Publication	Data Collection Period	Data Collection Period	Data Collection Period	Report / Publication	Data Collection Period	Data Collection Period	Data Collection Period	Report / Publication	Data Collection Period	Data Collection Period	Data Collection Period		
11	IPU - Audit of Medication recording : EPR vs Prescription Charts	Behind Schedule	GL/JH : lead change to TY in Feb 2020								Data Collection	Analysis	Report / Publication							
12	IPU - Audit of medication charts to review the number of PRNs given in a 12hour period.	On target	TY								Audit Planning /	Data Collection	Report / Publication	Report / Publication						

Project Ref.	Title	Status	Lead	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Progress	Project Status
13	IPU – Hospital to Hospice Admissions Audit	On target	JO'G				Audit Planning / Design	Data Collection Period	Data Collection Period	Analysis	Analysis	Data Collection Period	Data Collection Period	Analysis	Report / Publication					
14a	IPU & Community - Data Dashboards Development to include:-	On target	AR	Data	Data Collection	Data Collection	Analysis	Report / Publication	Data Collection	Analysis	Report / Publication	Data Collection	Analysis	Report / Publication	Data Collection	Analysis	Report / Publication	Data Collection		
15	-OACC measures (iPOS, Phase of Illness, Karnofsky performance status)	Behind Schedule	AR	Data	Data Collection	Data Collection	Analysis	Report / Publicatio	Data Collection	Analysis	Report / Publicatio	Data Collection	Analysis	Report / Publicatio	Data Collection	Analysis	Report / Publicatio	Data Collection		
16	- Activity Data	On target	AR	Data	Data Collectio	Data Collectio	Analysis	Report / Publicati	Data Collectio	Analysis	Report / Publicati	Data Collectio	Analysis	Report / Publicati	Data Collectio	Analysis	Report / Publicati	Data Collectio		
17	• IPU – Research Study of Opioid Induced Constipation (STOIC)	Complete	Dr SP	Data	Data Collection	Data Collection	Data Collection	Data Collection												
18	IPU - Audit of Discharge Documentation	Complete	Dr AA							Data Collectio	Analysis	Report / Publicati								
19	IPU - Patient Satisfaction	Complete	TY/GL /Vol AA/AR					Data Collection	Data Collection	Analysis	Analysis	Report / Publicatio	Report / Publicatio							

Clinical Risk Management

Clinical Unexpected Incidents

Overview of incident data for January – December 2019 is shown below.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2019	2018	2017	2016	2015	2014
Admissions to IPU	**24**	**17**	**21**	**16**	**16**	**10**	**20**	**19**	**17**	**18**	**15**	**19**	**212**	**211**	**214**	**236**	**335**	**350**
Bed Occupied Days	**210**	**283**	**257**	**187**	**204**	**213**	**221**	**192**	**230**	**232**	**235**	**246**						
Bed Available Days	**248**	**310**	**310**	**210**	**248**	**240**	**248**	**248**	**270**	**279**	**270**	**310**						
Bed Occupancy	**84.7%**	**91.3%**	**82.90%**	**89.1%**	**82.3%**	**88.75%**	**89.1%**	**77.4%**	**85.2%**	**83.2%**	**87.0%**	**79.4%**						
CD Medication Incident	0	1	4	1	1	3	1	0	1	7	2	2	**23**	**27**	**18**	**110**	**74**	**31**
CD Medication Near Miss	0	0	0	0	0	0	0	0	0	0	1	0	**1**	**3**	**7**			
Adverse Reaction (Opioid Toxicity)	0	0	0	1	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**	**1**	**2**	**1**		
Non-CD Medication Incident	0	3	2	0	5	0	1	0	0	0	1	0	**12**	**22**	**27**	**24**		
Non-CD Medication Near Miss	0	0	0	0	0	0	0	0	0	1	0	0	**1**	**5**	**12**			
Pressure Sore on Admission	1	2	2	1	1	0	0	1	2	2	2	2	**16**	**20**	**23**	**20**	**19**	**15**
Pressure Sore during Admission	0	1	0	0	0	0	0	0	1	0	0	1	**3**	**8**	**4**	**12**	**9**	**6**
Sharps	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**	**2**	**0**	**2**	**2**
Readm <7days	0	0	0	0	1	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**	**2**				

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2019	2018	2017	2016	2015	2014
Near Miss(non-medication & non-IG)	0	0	0	1	0	0	0	0	0	0	0	0	**1**	**2**	**1**	**1**	**1**	**0**
PE	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**3**	**4**			
Staffing	0	0	0	0	0	0	0	1	0	0	0	0	**1**	**1**				
IG	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**7**	**12**	**19**	**0**	**0**
IG near miss	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**1**	**4**			
Manual Handling	0	0	1	1	0	1	1	0	0	1	0	0	**5**	**10**	**2**			
Slips, trips, falls	0	4	3	1	0	1	1	4	0	2	4	1	**21**	**29**	**18**			
Verbal Violence	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**1**			
Bump	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**2**			
Other - Admin/property/Documentation	0	3	0	1	0	2	2	0	1	3	0	0	**12**	**18**	**15**	**14**	**11**	**4**
*** Incidents reported to Community – non-SRH**	1	0	1	0	3	1	0	1	0	4	1	0	**12**	**25**	**24**			
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)**		
Total 2015	**15**	**12**	**14**	**8**	**6**	**14**	**9**	**4**	**7**	**12**	**13**	**2**					**116**	
Total 2014	**5**	**2**	**6**	**4**	**8**	**6**	**1**	**2**	**6**	**7**	**6**	**5**						**58**

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

() Near Misses included in Totals for 2016

Reported clinical incidents have reduced in 2019 quite significantly to 99 (c.f. 176 in 2018, 163 in 2017 and 177 in 2016) – a 44% reduction on 2018. The number of admissions to IPU are comparable with 2018. Medication incidents are notably reduced as too are pressure sores, information governance incidents, manual handling incidents, slips, trips and falls.

Clinical Significance	Jan	Feb	Mar	Jan-Mar	Apr	May	Jun	Apr-Jun	Jul	Aug	Sep	Jul-Sep	Oct	Nov	Dec	Oct-Dec	2019	2018	2017	2016	2015	2014
Admissions to IPU	**24**	**17**	**21**	62	**16**	**16**	**10**	42	**20**	**19**	**17**	56	**18**	**15**	**19**	52	**212**	**211**	**214**	**236**	**335**	**350**
Bed Occupied Days	**210**	**283**	**257**		**187**	**204**	**213**		**221**	**192**	**230**		**232**	**235**	**246**							
Bed Available Days	**248**	**310**	**310**		**210**	**248**	**240**		**248**	**248**	**270**		**279**	**270**	**310**							
Bed Occupancy	**84.7%**	**91.3%**	**82.9%**		**89.1%**	**82.3%**	**88.8%**		**89.1%**	**77.4%**	**85.2%**		**83.2%**	**87.0%**	**79.4%**							
Fall No Harm	0	1	3	4	1	0	1	2	0	3	0	3	2	3	1	6	**15**	**21**				
Fall Low Harm	0	3	0	3	0	0	0	0	1	1	0	2	0	1	0	1	**6**	**10**				
Fall Moderate Harm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**1**				
Med Level 0	0	0	4	4	0	3	1	4	1	0	0	1	2	2	0	4	**13**	**6**				
Med Level 1	0	3	0	3	1	3	2	6	1	0	1	2	6	2	2	10	**21**	**37**				
Med Level 2	0	0	2	2	1	0	0	1	0	0	0	0	0	0	0	0	**3**	**10**				
Med Level 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**3**				
Minor	0	4	2	6	3	0	2	5	2	1	1	4	4	0	0	4	**19**	**38**				
Moderate	0	0	0	0	0	1	1	2	0	0	0	0	0	0	0	0	**2**	**21**				
Serious	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	**1**	**3**				
Unavoidable Pressure Sore	1	3	2	6	1	1	0	2	0	1	3	4	2	2	3	7	**19**	**27**				
Not Reviewed	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**47**				
Total 2019	**1**	**14**	**13**	**22**	**7**	**8**	**7**	**22**	**6**	**6**	**5**	**17**	**16**	**10**	**6**	**32**	**99**					
Total 2018	**21**	**14**	**11**	**28**	**10**	**18**	**24**	**52**	**15**	**8**	**13**	**36**	**16**	**17**	**9**	**42**		**176**				
Total 2017	**13**	**11**	**19**	**24**	**15**	**15**	**17**	**47**	**12**	**2**	**16**	**30**	**16**	**15**	**12**	**43**			**163**			
Total 2016	**14**	**28**	**11**	**43**	**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 serious incident in July 2019 concerned staff communication following the correct procedure for family viewing of their deceased relative. Care of the Deceased Guidelines have been revised accordingly.

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 Complaints

- There have been 4 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
2019/13	ORAL	Daughter	18/11/2019	Patient's daughter advised that she feels badly let down by the services (not specific to SRH) other than her calling the Hospice continuously for seven minutes last week with no answer. She said that she wasn't complaining and didn't wish to pursue a complaint.	SRH Comms	Apology extended and home visit offered for when the patient returned to Surrey from her daughter's in Sussex. Re-affirmed contact numbers and availability. Safety netting advice given if patient becomes unwell again. Reviewed by CEO in GL's absence : • In respect of the call for help and hands-on care, it is, again, a misunderstanding as to what we do and do not do, and what we can and cannot do. All things considered, CEO feels it was handled as well as it could have been. • In respect of the apparently unanswered call CEO shares CNS surprise that the daughter says that the phone just rang and rang without being answered. The FPOC does not have a DDI so during working hours the call will have gone through ACC. If a call that ACC have placed does not get answered, it stays on their display and they pick it back up. The only alternative is that it came in before ACC started up and therefore went through the silent-hours process, which could mean that it went to Reception and/or the Ward and was not picked up.	Upheld	Closed

ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASSIFICATION	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE	STATUS
2019/14	ORAL	Patient	27/09/2019	Patient verbally complained that agency nurse had left her in the bathroom without a call bell and later had not asked another nurse to attend to her when asked to.	IPU Care	Patient did not wish to discuss her complaints any further and preferred to forget about them. Nurse receiving complaint advised patient that the nurse would be spoken to. Patient did not want to receive an apology from the agency nurse concerned just didn't want to be cared for by her. Agency nurse spoken to and reflection accounted for. Acknowledged that she had forgotten to both provide call bell and alert another nurse following the patient's separate request.	Upheld in Whole	CLOSED
2020/01	ORAL	Daughters	03/02/2020	Daughters had felt pressured into finding a suitable care home for mother. Accentuated by CHC phone call to daughters alluding to imminent discharge from SRH.	IPU Comms	IPU Manager apologised that the family felt the way they did and would speak with the team to ensure improved communication around discharge. Patient had been reviewed by the Medical Team and discharge decision deferred until patient's condition stabilised. CHC had made premature contact with the family which had accentuated the discharge situation.	Upheld	Closed

ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASSIFICATION	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE	STATUS
2020/02	ORAL	Patient	03/02/2020	Patient expressed being asked the question as to whether she or a family member had smoked cannabis in the Hospice had made her feel judged. She remarked that she was not aware that the same question had been asked of other patients. She did not want the matter escalated but she felt that the bout of SOB had been exacerbated by the upset caused by the question.	IPU Comms	Ward Manager discussed the matter with patient who did not wish to name the staff member that had asked the question. Patient advises that she and family understand Smoking policy and that they adhere to it. Patient smokes on the patio and family in the smoking shelter. Patient feels judged owing to her previously being a cannabis smoker. Reflection requested from HCP who asked the question. Email circulated regarding communication and smoking policy.	Upheld	Closed

Complaints Overview

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

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

Notifications

There were 5 serious injury notifications made to the CQC between January and December 2019 all concerning pressure sores grade 3 or above.

There have been 0 (zero) serious injury notifications made to the CQC between January and February 2020.

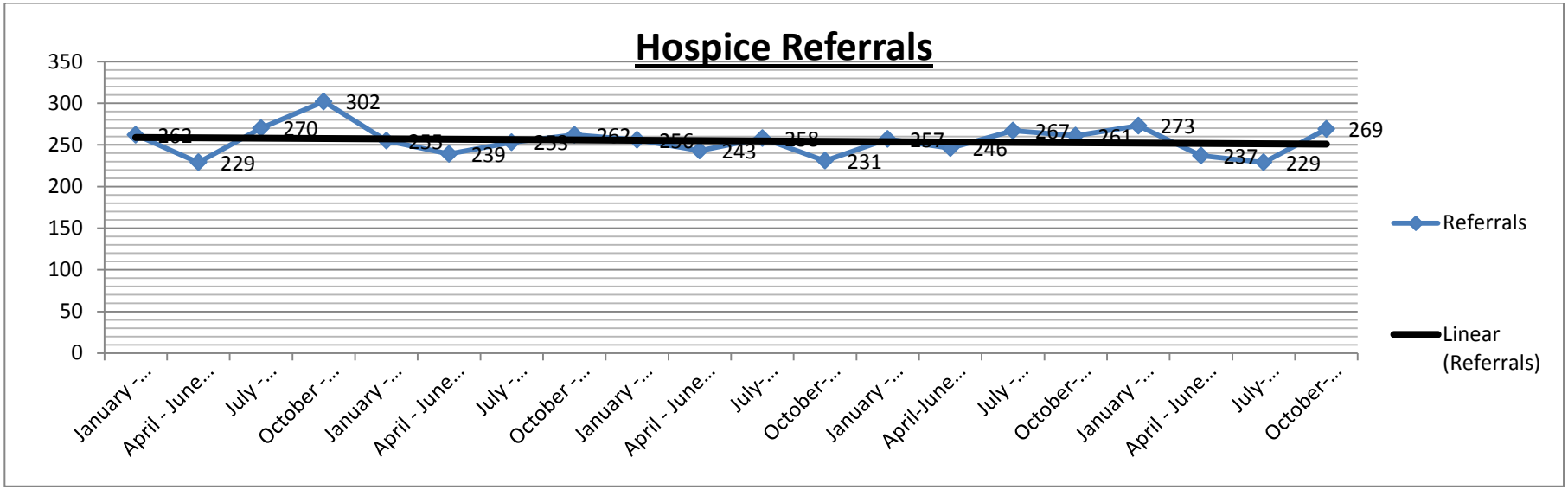
There were 7 safeguarding notifications made to the CQC between January and December 2019: 5 concerning individuals and 2 concerning Care Homes. All 7 were reported to the local safeguarding teams.

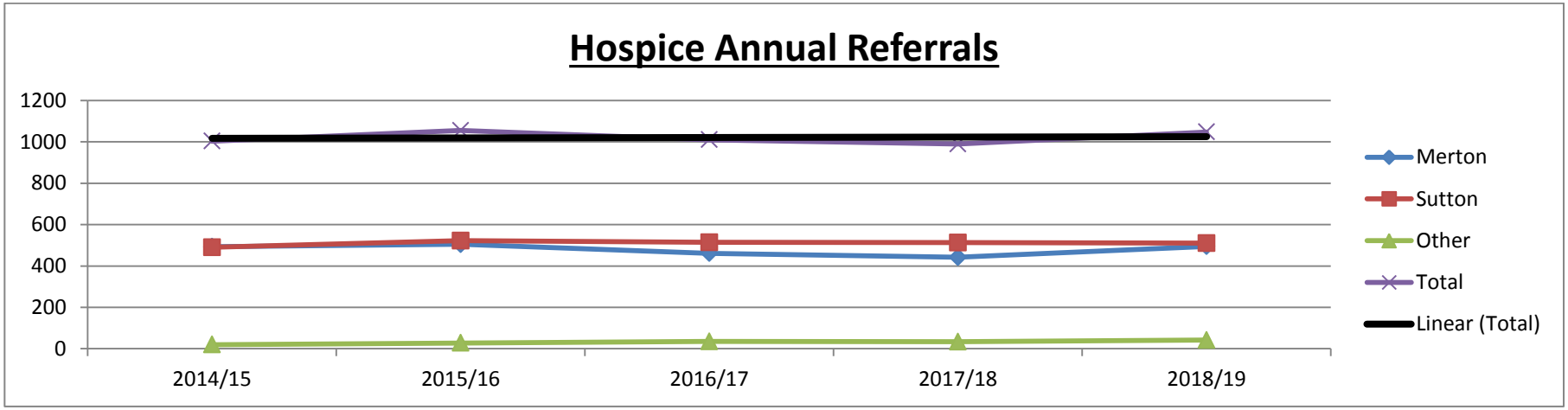
There have been 3 safeguarding notifications made to the CQC between January and February 2020: 2 concerning individuals and 1 care agency. All 3 were reported to the local safeguarding teams.

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. July - September 2019 (Q2) data was supplied in January 2020.

Hospice Referrals





Annual figures for Hospice activity are shown on the following pages.

Hospice Activity Data

St Raphael's Hospice												
	2016/2017				2017/2018				2018/19			
	April - March			2016/2017	April - March			2017/2018	April - March			2018/2019
	Merton	Sutton	Other	Total	Merton	Sutton	Other	Total	Merton	Sutton	Other	Total
HOMECARE SERVICE												
First Point of Contact (Crosscare)												
Number of Referrals Overall	461	514	35	1010	442	513	34	989	495	510	42	1047
Number of Referrals Cancer	288	383	26	697	305	368	17	690	343	359	31	733
Cancer Referrals %	62%	75%	74%	69%	69%	72%	50%	70%	69%	70%	74%	70%
Number of Referrals Non-Cancer	173	131	9	313	137	145	17	299	152	151	11	314
Non-cancer Referrals %	38%	25%	26%	31%	31%	28%	50%	30%	31%	30%	26%	30%
Gender Female n=	244	280	14	538	247	271	17	535	269	272	21	562
Gender Female %	53%	54%	40%	53%	56%	53%	50%	54%	54%	53%	50%	54%
Gender Male n=	217	234	21	472	195	242	17	454	226	238	21	485
Gender Male %	47%	46%	60%	47%	44%	47%	50%	46%	46%	47%	50%	46%
Ethnicity Split of Referrals (Crosscare)												
White British	277	374	17	668	269	389	17	675	301	375	16	692
White Irish	13	14	3	30	12	12	1	25	14	8	1	23
Any Other White	29	19	2	50	23	10	1	34	32	15	3	50
Black Caribbean	18	8	2	28	20	7	3	30	22	4	6	32
Other Asian	19	15	1	35	14	9	2	25	26	8	3	37
Black African	10	7	0	17	11	4	1	16	10	6	3	19
Not Stated	66	52	5	123	54	57	5	116	55	69	6	130
Far Eastern	0	0	0	0	0	0	0	0	0	0	0	0
Chinese	0	2	0	2	3	2	0	5	7	2	0	9
Indian	7	9	0	16	4	9	0	13	3	6	0	9
Pakistani	3	3	2	8	6	3	3	12	3	4	1	8
White Asian	0	1	0	1	2	1	0	3	2	0	0	2
Mixed White/Black African	0	0	1	1	0	0	0	0	1	0	0	1
Mixed White/Black Caribbean	1	1	0	2	0	0	0	0	1	3	0	4
Bangladeshi	0	0	0	0	3	0	0	3	1	0	0	1
Black Other	2	4	3	9	1	2	1	4	8	2	2	12
Mixed Other	3	0	0	3	3	3	0	6	0	3	0	3
Other	9	4	1	14	13	5	0	18	9	5	1	15
	457	513	37	1007	438	513	34	985	495	510	42	1047
Advanced Care Planning Offered (Crosscare)												
Based on patient deaths					82.82%	92.86%	100.00%	88.53%	88.97%	90.15%	94.74%	89.78%

Coordinate My Care (CMC)												
Based on patient deaths									**29.38%**	**40.64%**	**26.09%**	**35.12%**
	2016/2017			**2016/2017**	**2017/2018**			**2017/2018**	**2018/2019**			**2018/2019**
Community Palliative Care Team including FPoC (Crosscare)	**April - March**			**Total**	**April - March**			**Total**	**April - March**			**Total**
	Merton	**Sutton**	**Other**		**Merton**	**Sutton**	**Other**		**Merton**	**Sutton**	**Other**	
1st Assessments (Visits)	**234**	**289**	**12**	**535**	**231**	**268**	**17**	**516**	**249**	**302**	**20**	**571**
1st Assessments Cancer	**181**	**249**	**10**	**440**	**186**	**232**	**11**	**429**	**205**	**260**	**16**	**481**
1st Assessments Non-cancer	**53**	**40**	**2**	**95**	**45**	**36**	**6**	**87**	**44**	**42**	**4**	**90**
Number of patients receiving Follow Up Visits	**305**	**379**	**18**	**702**					**295**	**370**	**27**	**692**
Follow Up Visits (Face to face encounters with patients minus 1st Assessments)	**1528**	**2065**	**81**	**3674**	**1411**	**1791**	**66**	**3268**	**984**	**1397**	**99**	**2480**
FU Visits by CPCT/FPoC CNS	**1221**	**1477**	**71**	**2769**	**1159**	**1270**	**63**	**2492**	**686**	**934**	**87**	**1707**
Face to Face Visits by Medical	**71**	**129**	**3**	**203**	**47**	**64**	**1**	**112**	**118**	**136**	**7**	**261**
Face to Face Visits by Other (Hospice Neighbours et al)	**236**	**449**	**7**	**692**	**205**	**457**	**2**	**664**	**180**	**327**	**5**	**512**
Number of Patients - Telephone Contact Patient	**241**	**334**	**17**	**592**					**318**	**391**	**28**	**737**
Telephone Contacts Patients Overall	**1363**	**2146**	**108**	**3617**	**1749**	**2503**	**111**	**4363**	**2186**	**2813**	**246**	**5245**
Telephone Contacts Patients with CPCT/FPoC CNS/RGN	**1200**	**1832**	**92**	**3124**	**1564**	**2257**	**105**	**3926**	**2058**	**2653**	**237**	**4948**
Telephone Contacts Patients with Medical	**21**	**32**	**3**	**56**	**4**	**3**	**0**	**7**	**22**	**20**	**2**	**44**
Telephone Contacts Patients with Other(Psycho-social, OT,Hospice Neighbours et al)	**142**	**282**	**13**	**437**	**181**	**243**	**6**	**430**	**106**	**140**	**7**	**253**
Number of Patients - Telephone Contact Family/Carer	**337**	**425**	**22**	**784**					**396**	**481**	**28**	**905**
Telephone Contacts Family / Carers Overall	**2154**	**2977**	**115**	**5246**	**2571**	**3277**	**136**	**5984**	**3007**	**3642**	**294**	**6943**
Telephone Contacts Family / Carers with CPCT/FPoC CNS (includes Community Admin from April 2018)	**1920**	**2654**	**102**	**4676**	**2378**	**2980**	**126**	**5484**	**2789**	**3359**	**277**	**6425**
Telephone Contacts Family / Carers with Medical	**21**	**33**	**3**	**57**	**5**	**8**	**0**	**13**	**15**	**8**	**0**	**23**
Telephone Contacts Family / Carers with Other (Psycho-social, OT,Hospice Neighbours et al)	**213**	**290**	**10**	**513**	**188**	**289**	**10**	**487**	**203**	**275**	**17**	**495**
Number of Patients - Telephone Contact Healthcare Professional	**474**	**551**	**37**	**1062**					**547**	**611**	**42**	**1200**
Telephone Contacts Healthcare Professionals Overall	**2705**	**3624**	**195**	**6524**	**4000**	**4528**	**181**	**8709**	**4121**	**4405**	**398**	**8924**
Telephone Contacts Healthcare Professionals with CPCT/FPoC CNS (includes Community Admin from April 2018)	**2605**	**3445**	**192**	**6242**	**3649**	**4064**	**169**	**7882**	**4025**	**4260**	**377**	**8662**
Telephone Contacts Healthcare Professionals with Medical	**44**	**59**	**2**	**105**	**14**	**18**	**0**	**32**	**15**	**35**	**4**	**54**
Telephone Contacts Healthcare Professionals with Other (Psycho-social, OT,Hospice Neighbours et al)	**52**	**120**	**1**	**173**	**317**	**446**	**12**	**775**	**81**	**110**	**17**	**208**

INPATIENT SERVICE	2016/2017			2016/2017	2017/2018			2017/2018	2018/2019			2018/2019
Inpatient Unit (Crosscare)	April - March			Total	April - March			Total	April - March			Total
	Merton	Sutton	Other		Merton	Sutton	Other		Merton	Sutton	Other	
Total Admissions	80	131	5	216	77	120	6	203	85	131	9	225
Cancer Admissions	69	125	5	199	64	110	4	178	72	120	8	200
Non-cancer Admissions	11	6	0	17	13	10	2	25	13	11	1	25
Total No. of Distinct Patients Admitted	75	117	4	196	73	102	5	180	76	119	8	203
Total Deaths	64	90	4	158	53	80	5	138	57	99	8	164
Cancer Deaths	54	84	4	142	47	74	3	124	47	92	7	146
Non-Cancer Deaths	10	6	0	16	6	6	2	14	10	7	1	18
Total Discharges	14	39	1	54	22	39	2	63	25	35	1	61
Cancer Discharges	13	38	1	52	16	36	2	54	22	31	1	54
Non-Cancer Discharges	1	1	0	2	6	3	0	9	3	4	0	7
Cancer Death Total Length of Stay	640	845	41	1526	458	938	11	1407	438	950	101	1489
Cancer Deaths Avg LoS									9	10	14	10
Non-Cancer Death Total Length of Stay	55	30	0	85	22	69	3	94	105	59	4	168
Non-Cancer Deaths Avg LoS									11	8	4	9
Cancer Discharges Total Length Of Stay	251	491	30	772	214	559	20	793	451	382	29	862
Cancer Discharges Avg LoS									21	12	29	16
Non-Cancer Discharges Total Length of Stay	1	39	0	40	97	21	0	118	89	46	0	135
Non-Cancer Discharges Avg LoS									30	12	0	19
Cancer Deaths/Discharges	67	122	5	194	63	110	0	173	69	123	7	199
Non-cancer Deaths/Discharges	11	7	0	18	12	9	0	21	13	11	0	24
Cancer Deaths/Discharges Avg LoS									13	11	19	12
Non-Cancer Deaths/Discharges Avg LoS									2	2	0	1
Deaths/Discharges Total Length of Stay	947	1405	71	2423	791	1587	34	2412	1083	1437	134	2654
Death/Discharges Average LoS	12	11	14		10.55	13.34	4.86	12.00	13	11	15	12
Deaths Average LoS	11	10	10		9	13	3		10	10	13	10
Discharges Average LoS	18	14	30		14	15	10		22	12	29	16
Occupancy	82.51%				78.47%				84.23%			
Throughput (Death & Discharges / Available Beds)	1.96				1.78				2.30			
Beds Available	108				113				105			
Occupied Days	2699				2693				2969			
Available Days	3271				3432				3525			

	2016/2017			2016/2017	2017/2018			2017/2018	2018/2019			2018/2019
Hospice @ Home (Crosscare)	**April - March**			**Total**	**April - March**			**Total**	**April - March**			**Total**
	Merton	**Sutton**	**Other**		**Merton**	**Sutton**	**Other**		**Merton**	**Sutton**	**Other**	
Windows - Clinical Hx General Encounter data												
Referrals	**153**	**204**	**11**	**368**	**128**	**196**	**6**	**330**	**115**	**174**	**7**	**296**
Cancer Referrals	**98**	**143**	**5**	**246**	**84**	**129**	**3**	**216**	**73**	**115**	**4**	**192**
Non-cancer Referrals	**55**	**61**	**6**	**122**	**44**	**67**	**3**	**114**	**42**	**59**	**3**	**104**
First Assessment Visits (Not an accurate fig as 1st	**54**	**74**	**5**	**133**	**32**	**69**	**1**	**102**	**30**	**40**	**2**	**72**
Face to face encounters with Patients	**881**	**1254**	**43**	**2178**	**787**	**1491**	**22**	**2300**	**867**	**1202**	**95**	**2164**
Number of Individual Patients - Follow Up Visits	**121**	**160**	**5**	**286**					**116**	**164**	**8**	**288**
Follow Up Visits Total (Face to face encounters with	**827**	**1180**	**38**	**2045**	**755**	**1422**	**21**	**2198**	**837**	**1162**	**93**	**2092**
Average Number of Follow Up Visits per patient	**6.83**	**7.38**	**7.60**	**7.15**	**#DIV/0!**	**#DIV/0!**	**0.00**	**0.00**	**7.22**	**7.09**	**11.63**	**7.26**
Follow Up Visits - CNS	**34**	**39**	**1**	**74**	**0**	**1**	**0**	**1**	**0**	**0**	**0**	**0**
Follow Up Visits - RGN/Assoc CNS	**88**	**121**	**6**	**215**	**90**	**175**	**4**	**269**	**74**	**94**	**4**	**172**
Follow Up Visits - HCA	**709**	**1025**	**32**	**1766**	**665**	**1246**	**17**	**1928**	**763**	**1067**	**89**	**1919**
Number of Individual Patients - Telephone Contacts	**19**	**32**	**2**	**53**					**24**	**41**	**2**	**67**
Telephone Contacts Patient Total	**37**	**62**	**2**	**101**	**67**	**59**	**0**	**126**	**39**	**74**	**9**	**122**
Telephone Contacts Patients - CNS	**11**	**13**	**1**	**25**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**1**
Telephone Contacts Patients - RGN/Assoc CNS	**9**	**20**	**0**	**29**	**23**	**20**	**0**	**43**	**13**	**20**	**0**	**33**
Telephone Contacts Patients - HCA	**17**	**29**	**1**	**47**	**44**	**39**	**0**	**83**	**25**	**54**	**9**	**88**
Number of Individual Patients -Telephone Contacts	**135**	**180**	**6**	**321**					**132**	**192**	**10**	**334**
Telephone Contacts Family / Carers Total	**711**	**1022**	**34**	**1767**	**610**	**1104**	**32**	**1746**	**842**	**1105**	**68**	**2015**
Telephone Contacts Family/Carerss - CNS	**226**	**271**	**7**	**504**	**0**	**0**	**1**	**1**	**0**	**1**	**0**	**1**
Telephone Contacts Family/Carers - RGN/Assoc	**187**	**271**	**13**	**471**	**253**	**573**	**13**	**839**	**269**	**333**	**19**	**621**
Telephone Contacts Family/Carers - HCA	**297**	**480**	**14**	**791**	**356**	**551**	**18**	**925**	**573**	**771**	**49**	**1393**
Telephone Contacts Family/Carers - Medical	**2**	**1**	**0**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Number of Individual Patients - Telephone Contacts	**83**	**115**	**6**	**204**					**49**	**58**	**5**	**112**
Telephone Contacts HCPs Total	**266**	**363**	**41**	**670**	**155**	**425**	**3**	**583**	**95**	**104**	**8**	**207**
Telephone Contacts HCPs - CNS	**180**	**230**	**24**	**434**	**1**	**1**	**1**	**3**	**0**	**2**	**0**	**2**
Telephone Contacts HCPs - RGN/Assoc CNS	**68**	**98**	**14**	**180**	**106**	**347**	**2**	**455**	**71**	**77**	**7**	**155**
Telephone Contacts HCPs - HCA	**17**	**33**	**3**	**53**	**48**	**77**	**0**	**125**	**22**	**25**	**1**	**48**
Telephone Contacts HCPs - Medical	**1**	**2**	**0**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Telephone Contacts HCPs - Community Admin									**2**	**0**	**0**	**2**

DAYCARE SERVICE	2016/2017			2016/2017	2017/2018			2017/2018	2018/2019			2018/2019
Jubilee Centre (Crosscare)	**April - March**			**Total**	**April - March**			**Total**	**April - March**			**Total**
	Merton	**Sutton**	**Other**		**Merton**	**Sutton**	**Other**		**Merton**	**Sutton**	**Other**	
No of distinct patients (for attended)	**59**	**116**	**0**	**175**				**175**	**111**	**148**	**4**	**263**
No of actual attendances (for attended)	**342**	**1015**	**0**	**1357**	**433**	**770**	**2**	**1205**	**591**	**1341**	**9**	**1941**
BEREAVEMENT SERVICE	**2016/2017**			**2016/2017**	**2017/2018**			**2017/2018**	**2018/2019**			**2018/2019**
Bereavement Service (Crosscare)	**April - March**			**Total**	**April - March**			**Total**	**April - March**			**Total**
	Merton	**Sutton**	**Other**		**Merton**	**Sutton**	**Other**		**Merton**	**Sutton**	**Other**	
No of distinct family members receiving face to face encounter					**32**	**61**	**5**	**98**	**51**	**72**	**73**	**196**
Face to face encounters with family members					**145**	**327**	**5**	**477**	**182**	**308**	**331**	**821**
No of distinct family members receiving telephone contact					**123**	**191**	**6**	**320**	**166**	**195**	**203**	**564**
Telephone contacts with family members					**213**	**294**	**17**	**524**	**290**	**340**	**351**	**981**
OUTPATIENT SERVICE	**2016/2017**			**2016/2017**	**2017/2018**			**2017/2018**	**2018/2019**			**2018/2019**
Outpatient Service (Crosscare)	**April - March**			**Total**	**April - March**			**Total**	**April - March**			**Total**
	Merton	**Sutton**	**Other**		**Merton**	**Sutton**	**Other**		**Merton**	**Sutton**	**Other**	
No of outpatients receiving face to face encounter					**49**	**63**	**2**	**114**	**47**	**67**	**1**	**115**
Face to face encounters with outpatients					**75**	**83**	**2**	**160**	**53**	**78**	**1**	**132**
No of distinct outpatients receiving telephone contact					**4**	**10**	**1**	**15**	**8**	**14**	**0**	**22**
Telephone contacts with outpatients					**6**	**13**	**1**	**20**	**10**	**14**	**0**	**24**

The authors of this paper are Mrs G Linehan, Director of Care and Strategy Development and Mr A Rudkin, Quality Development Manager/ISO.

Clinical Quality & Governance – CQ&G Sub

	Area of Development	What will we do?	How will we know?	Lead(s)	Target Date	KLOE	RAG	Notes
3.1.	Clinical Audit	Produce and maintain an audit/monitoring/research project schedule 2019/20	• CQ & G Sub Minutes • QIC Minutes	AR	Apr 20 ongoing	Well-led Effective Safe Caring Responsive	G	N:\Clinical\Clinical Governance\Clinical Audit\Audit & Monitoring Projects Schedule\2019-20 CLINICAL AUDIT PROJECTS STATUS SUMMARY DRAFT 04 - 21062019.pdf N:\Clinical\Clinical Governance\Clinical Audit\Audit & Monitoring Projects Schedule\Clinical Audit & Research Project Progress Timeline 2019-2020.xlsx
3.2.	Education and training	• Ensure training database captures ALL training across ALL staff	• Training & Development Committee Minutes	PE/AR/GL	Jun 19	Well-led Effective Safe	A	Clinical training db maintained by PE. Non-clinical training db maintained by HC (HR)

	Area of Development	What will we do?	How will we know?	Lead(s)	Target Date	KLOE	RAG	Notes
3.3.	Education and training	• Production of patient leaflets re. standard medications and interventions in Hospice	• Training & Development Committee Minutes	GL/MF	Sep 19	Well-led Effective Safe	A	Clinical Action Plan v6
3.4.	Education and training	• Delivery of Advanced Communication training	• Training & Development Committee Minutes	GL/MF	May 19	Well-led Effective Safe	G	Clinical Action Plan v6 Courses delivered in February and April 2019 Further courses for 2020.
3.5.	Education and training	• Implement appropriate DNACPR completion in the community by SRH	Clinical Action Plan Update • Minutes of CQ&G Sub	GL/TC	Dec 19	Well-led Effective Safe	A	Clinical Action Plan v6
3.6.	Education and Training	• New competencies for all qualified staff & HCAs to replace existing ones	QIC Minutes	GL/MF	Jun 19	Well-led Effective Safe	G	Clinical Action Plan v6
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	GL/MF	Sep 19	Well-led Effective Safe Caring	A	Clinical Action Plan v6

	Area of Development	What will we do?	How will we know?	Lead(s)	Target Date	KLOE	RAG	Notes
3.8.	Education and Training	• Completion of Healthcare Professional Resource Pack (HCRP)	• HCP Resource Pack	GL/MF	Aug-19	Well-led Effective Safe	A	Clinical Action Plan v6
3.9.	Education and Training	• Completion of patient and family resource pack (PFRP)	• PFRP Resource Pack	GL/MF	Aug-19	Well-led Effective Safe	A	Clinical Action Plan v6
3.10.	Organisation	Ensure ToR for CQ&G Sub-committee is complete	Minutes	AR	Mar-20	Well-led	A	Nov/Dec 2020 : MJR consolidating Sub-committee ToRs with universal references. Target date re-set to March 2020
3.11.	Organisation	Document a Clinical Audit Policy	CQ&G Minutes Policy Manual	AR	Mar 20	Well-led	R	Target date re-set to March 2020 from July 2019
3.12.	Organisation	IPU Psychotherapist to facilitate informal reflection/drop in clinics for all clinical staff and so provide a safe forum to express feelings.	Reflection/drop in clinics	GL/ED	Mar 20	Well-led Effective Caring	A	Post consultation Clinical Action Plan v6 Objective amended to explore Wellbeing options to support staff resilience and self-expression.

	Area of Development	What will we do?	How will we know?	Lead(s)	Target Date	KLOE	RAG	Notes
3.13.	Organisation	Review current psycho-social model and referral system	Current system barriers broken down Increased referral response times	GL/ED	Dec 19	Well-led Effective Caring	R	Clinical Action Plan v6 New Psychosocial lead appointment – Jan 2020. Service review consequential.
3.14.	Organisation	Restructure the clinical team's leadership to consider new role requirements.	Clinical Action Plan Update Minutes of CQ&G Sub	GL	Dec 19	Well-led Effective Responsive	G	Clinical Action Plan v6
3.15.	Organisation	Effect model of performance support and management in place for nursing team across the whole Hospice.	Clinical Action Plan Update Minutes of CQ&G Sub	CB/GL	Jun 19	Well-led Effective Responsive Safe	A	Clinical Action Plan v6 People Performance Policy to be finalised in December 2019.
3.16.	Organisation	Establish a Clinical Audit and Activity Data Committee	QIC Minute	AR	Jul 2019	Well-led Effective	G	1st meeting held in October 2019.
3.17.	Patient administration system - Crosscare	Implement substantive 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/TC/TY/GL/AR	Dec 19	Well-led Effective Caring Responsive Safe	A	Clinical Action Plan v6 Substantive revision to EPR windows effected on 11-Mar 2019. Further revision / re-write effected in December 2019

	Area of Development	What will we do?	How will we know?	Lead(s)	Target Date	KLOE	RAG	Notes
3.18.	Patient administration system - Cross Care	Provide training surgeries	Crosscare Project team meeting minutes.	CB/JG/KG/AR Project Team	Jun -20	Well-led Effective Responsive Safe	A	Training / User update to be implemented following latest revision work. Likely mid 2020.
3.19.	Patient administration system - CrossCare	Develop reporting to feed dashboards	Crosscare Project team meeting minutes.	AR/JG	Dec 19	Well-led Effective Responsive Safe	A	Part of Clinical Audit and Activity Data Meeting remit.
3.20.	Patient administration system - CrossCare	Develop Crosscare configuration to service the palliative care and MDS datasets	Crosscare Project team meeting minutes.	AR/JG	Mar 20	Well-led	G	IG Committee reviewed objective and agreed to mothball. Servicing the Hospice Uk Mini-Dataset is currently managed.
3.21.	Policy	Publish a SOP for the daily IPU MDT meeting	SOP in place	CB	Apr 19	Well-led Effective Safe	G	**Clinical Action Plan v6**
3.22.	Policy	Produce index of required SOPs across the clinical teams and produce plan for effecting their documentation in 2019/20	Clinical Action Plan Update Minutes of CQ&G Sub	GL/AR	Sep 19	Well-led Effective Safe	A	**Clinical Action Plan v6**

	Area of Development	What will we do?	How will we know?	Lead(s)	Target Date	KLOE	RAG	Notes
3.23.	Quality assurance / monitoring	Embed the OACC assessment measures to include Phase Of Illness, Karnofsky Performance Status and IPOS and produce routine data reports/dashboards to feed into clinical/assurance fora.	Clinical Action Plan Update Minutes of CQ&G Sub	AR/GL/TY/TC	Dec 20	Well-led Effective Care	A	Clinical Action Plan v6 Objective to roll into 2020/21
3.24.	Risk management	Produce annual report on incidents for 2018.	• Annual reports	AR/JC	Sep 19	Well-led Effective Safe Caring	R	Need for report reviewed. Agreed present information produced service organisational review needs.
3.25.	Risk management	Implement Datix incident reporting	• QIC Minutes	AR/CB/JG	Mar 20	Well-led Effective Responsive Safe Caring	A	April 19 – Datix system design phase – coding August 19 – Admin training Dec 19 - Testing
3.26.	Risk management	Utilise Risk Assessment module in Datix	• H&S Minutes • IG&S Minutes	AR/NS	Sep 19	Well-led Effective Safe Caring	A	
3.27.	Risk Management	• Monthly Incident review meeting to interact with Datix and review extending membership	CQ&G Report	GL/AR	Dec 19	Well-led Effective Safe	A	Clinical Action Plan v6

	Area of Development	What will we do?	How will we know?	Lead(s)	Target Date	KLOE	RAG	Notes
3.28.	Staffing	Undertake staff consultation to support staff development, team integration and rotation	Staff consultation	GL	Sep 19	Well-led Effective Caring	R	Clinical Action Plan v6 Revised date January 2020
3.29.	Staffing	Introduce a structured development programme supported by competency assessment for bands 5 and 6 nurses to rotate between departments.	Development programme	GL	Sep 19	Well-led Effective Caring Responsive	R	Post consultation Clinical Action Plan v6 Revised date January 2020
3.30.	Staffing	Increase establishment of band 5 and band 6 nurses in development roles that will service rotation between departments	Clinical Action Plan Update Minutes of CQ&G Sub	GL	Mar 20	Well-led Effective Caring Responsive	R	Clinical Action Plan v6
3.31.	Staffing	To utilise volunteer support in the administrative duties undertaken by the CNSs	Clinical Action Plan Update Minutes of CQ&G Sub	GL	Mar 20	Well-led Effective Responsive	R	Clinical Action Plan v6
3.32.	Staffing	To introduce 4 CNS development posts - Business case to CCGs for half funding of trainee costs	Clinical Action Plan Update Minutes of CQ&G Sub	GL	Sep 19	Safe Effective Responsive	G	Clinical Action Plan v6

	Area of Development	What will we do?	How will we know?	Lead(s)	Target Date	KLOE	RAG	Notes
3.33.	Staffing	To integrate staff rotas across clinical teams	Clinical Action Plan Update Minutes of CQ&G Sub	GL/TY/TC	Sep 19	Well-led Effective Responsive Safe	R	Post consultation Clinical Action Plan v6 Revised date April 2020

Meeting: **Clinical Heads of Department**			
Date: 7th Feb 2020		Time: 11.00am	
Present: Gail Linehan (GL) Tracey Young (TY) Tracy Christmas(TC) Maura Flint (MF) Steve Molineux (SM) Jon Hallstrom(JH)			
Apologies:			
Agenda item	**Discussion**	**Actions & by whom**	**Anticipated date for completion**
Review of previous minutes	agreed		
Matters Arising	**HODS** **Fund raising –** NEW Staff several - new co prorate fundraiser – Emma Raised £31,000 so far Nepal Trip Light up a life £56,000 . Lots of money raised from other events Team of 10 for London Marathon **Retail** Shop refits continue 10 vacancies filled **House keeping** Volunteers day Quiz day 6th March – 5 to 7 people on a team 1 member of staff on sick leave **Finance** 1 member of staff leaving **IT** CCTv in main hospice and WBC NO faxes now NHS email account – IT now can fully mange It systems upgrade **Ipu** Vacancies continue Long-term sick Mat leave **PST** Steve welcomed 15 referrals a week – high for hospice population Steve reviewing the waiting list and aim to reduce significantly using a systematic approach Patient contract review as none in place previously and patient seen for long periods Plan - Bereavement 12 sessions, Pre bereavement 6 sessions , patients 6 sessions then review a further 6 can be offered		

	2 new volunteers= 1000 hours per year. Steve is working closely with Sister Anne who has vast bereavement experience . Steve is planning training for staff to acquire "soft skills " to support patients / families / carers Psychosocial need **Estates** Steve Cresswell – hedge / boundary work will begin hospice :covenant New CPCT office in progress Creating more storage space within organisation **Hospice Volunteers** A Volunteers Award day this month **Medical Team** New GP trainee 2nd consultant meeting next week **Gail** Pool car with sponsorship- brand awareness Full time consultant post advertised- possibly NHS contract – in negation 2 part time consultants Clinical Director post – Guardian on line / NHS jobs / websites HCA Lisa and Paula accepted to do Nurse Associate training(TNA) **HODS Clinical** Agreed minutes and chair should rotate Minutes checked Good practice example – action -TC to display how medication is request -standardised - Leaflet group – Gail has spoken to Dymond: GL Date to be arranged and to invite as many staff as possible HODS – Gail updated meeting Long conversation regarding reactiveness within the community service / management of case loads / discharging patients and lack of continuity / SOPS. Action -TC and GL –meeting next week with Hospice Volunteer co coordinator CUI – Incidents that occur externally discussed challenges addressing these. Important to follow up as maybe future implications. MF and TY have recent CUI training on Education Day TC reported that a OOH message was left on ward with no contact . Poorly taken message. TY has had a meeting with volunteers regarding how to take messages to ward. Ginny has been updated.		

	Discussed strategies how we can address gaps of volunteer knowledge. MF is happy to address message taking at volunteer induction TY fed back on complaints received regarding IPU. Discussion regarding LOS and families expectation of stay .How to manage expectation from admission request in CPCT to ward admission. Staff attitudes and values discussed and Steve fed back his observations. Meeting agreed that workshop required Steve fed back his complaint received MF – advised that continuing care is coming to give an update on. ICD policy update given Becky Lucas has been working on Spires have agreed to provide service for IPU and £175 per patient- GL to negotiate IPU will be refurbished - the whole unit will be closed GL will negotiate with Spire if we could have bed PST - referring a relative – pre bereavement support is a psychosocial referral not bereavement Audit -positive feed back from the training Education – PAH e learning for MT. Laura B joining the team. Tender won by GL (Boris money) for education Merton NH Sharing of Education App to NH (Merton). Training of volunteers to deliver communication skills to Recruitment – as HODs 8b pended until Clinical Director Commences		
Topic			
Infection Prevention	No issues		
Medical Devices	• IPU – all equipment needs to be uploaded to log by April 1st 2020. • Life span of equipment identified with a view for planning replacements.	TY/SC	
Medicine Management	• Kardia being reviewed at DTC with a view for involvement form medical team and then to roll out and publish with some actions for training needed. Cathy Foster and Tracy Christmas leading.	TC/CF	
Incidents & Accidents/RCA's	• JH advised he had not received any incident forms recently – appears all had gone to GL! In future all to go to Jon. • RCA sent to CQC re category 6 PU – no further		

	correspondence received.		
Complaints	•Family made oral complaint regarding feeling pressurised into picking a nursing home for mother. •Patient made complaint regarding a discussion over smoking cannabis.		
Health & Safety	• Water testing – all clear form Aegis • IPU safe moved • For reps from IPU/facilities and SMT to meet 18th Feb to discuss refurb of IPU. Have been donated flooring form company who did well being centre for free but cost price to fit. Possibly to be completed in next 6 months. GL will negotiate with Spire if we could have bed • Small glasses being trialled in galley kitchen • Microwave moved form galley kitchen due to risk of scalds form hot food when being transported to IPU • CCTV updated across main Hospice and IPU		
New Policies/ Guidelines			
Documentation/ Crosscare	• Cross care is going through some changes over the last few weeks with a view to adapting the windows to be more user friendly but continue to collate data for reports and audits. Individual review training will happen following completion and senior nurses will be monitoring use from HCP on IPU.		
Audit/Research	• Audit Sister Morris continues to do monthly hand washing/environment audit • TY ahs completed audit for PRNS given in 12 and 24 hour period – awaiting report • Clinical audit training day completed by staff on 4 Feb. – this means they will be more involved in audits in the Hospice		
Education/Training Reflective Forums	• Laura Briant will be working alongside Maura Flint in the Education department across the Hospice form April 2020. • Away days will be every quarter for band 5 and HCA. • Band 6 will have monthly support • RGN Clinical supervision dates have been sent to staff on IPU • HCA clinical supervision will be on the away days		
Recruitment/ Staffing	• Karise Berry HCA 30 hours week starting form 2 March – she will have induction programme and be super numery for approx. 4-6 weeks.		
CQC/PIR	. • NO report received yet form CQC – please note an local organisation where in a similar position to us and had an unannounced visit form inspectors 2 month post original visit. Please ensure you are following best practice at all times.		
AOB			

	• Minute taking to be rotated amongst Clinical HoDs • Chairing of meeting to be rotated amongst Clinical HoDs		

Date next meeting:

Falls' Meeting

Date: 11/12/2019

Present: Gwyn Hawden(GH-Chair), Tracey Young(TY), Maura Flint(MF), Ginny Toubal(GT), Lesley Elden(LE), Gail Linehan(GL), Sue Davies-Evans (SD-E), Alex Rudkin(AR - Mins)

Apologies : Sheila Payne(SP),

Agenda item	Discussion	Actions & by whom	Anticipated date for completion
Review of previous minutes	Meeting held 9th June 2019 – Minutes Agreed		
Matters Arising			
Topic			
Case Study	GH to organise a case study for the next meeting.	GH	June 2020
Patients falls statistics	AR presented data to the end of Q2 2019 (September 2019) which showed a decrease in the number of falls sustained over the past 2 quarters compared with the prior year. Current IPU Fall rate per 1000 occupied bed days 2019/20 (Apr-Sep 2019) : 4.81 IPU Fall rate per 1000 occupied bed days 2018/2019: 7.82 IPU Fall rate per 1000 occupied bed days 2017/2018: 5.20 IPU Fall rate per 1000 occupied bed days 2016/2017: 8.52 AR confirmed corroboration between Crosscare data and Incident data. All 7 fall incidents were reviewed (Incident Reference Numbers 506, 532, 472, 538, 546, 551, 550). Ref No. 506: Chapel courtyard step will be reviewed by LE. Informed there is not enough space to ramp the step. Signage to be considered. Ref No. 538: System of checking sensor attachment in place. Family disconnecting sensor happened between checks. The most common cause of fall is patient independence. Seasonal issue of donated goods accumulating in volunteer locker room will be alleviated by calling LE who will arrange for driver collection.	All IPU staff LE TY/GT/S-DE	Ongoing February 2020 Ongoing
Feedback from Teams	• Well-being Centre: Nil • Volunteers: Nil • OT: Nil • Facilities: Nil • IPU: Purchasing of inflatable cushion has been pended due to balance between cost and need: keep under review.	TY/MF	Ongoing
Training & staff development	• Manual Handling training is on-going. Plan in place to alter Induction to ensure capture of volunteers	MF	February 2020

	for all mandatory training by February 2020. Feedback on the mandatory training delivery is very positive.		
Falls Policy	• AR raised use of bed rails and assessment guidance that may be usefully included in the Falls Policy. Agreed. AR to incorporate and circulate policy for finalisation of its review.	AR	February 2020
AOB	Nil		
Next Meeting	TBA	AR	

MINUTES OF THE
DRUGS & THERAPEUTICS COMMITTEE

Held on 31st October 2019
in St Bede's Conference Centre

Attending

(GL) Gail Linehan – Chair & Director of Care
(HH) Heather Howell - Advisory Committee Member
(TC) Tracy Christmas – Community Services Manager NMP
(AM) Dr Annelise Matthews - Hospice Consultant
(MF) Maura Flint – Practice Development
(AR) Alex Rudkin - Quality & Mins
(MG) M Gibbs - Ashton's Pharmacist
(KH) Kevin Hobson - CNS NMP
(TY) Tracey Young - IPU Manager
(AA) Dr Ambreen Akhtar - Hospice Doctor
(SR) Dr Sam Raveney - Hospice Registrar
(HT) Hai To - Sutton CCG Care Home Pharmacist

ITEM 1: Welcome

1.1 GL extended welcome and introductions were made.

ITEM 2: Apologies for Absence

(JS) Jill Smith - CNS NMP , (BG) Bernadette Griffin -CNS, NMP, P,(PH) Philomena Hutchinson- Night Team Leader, (JH) Dr Jan Hallstrom- Hospice Consultant, (PM) Pauline Morris – IPU Sister, (BDS) Dr Busi Da Silva – Hospice Doctor

ITEM 3: Minutes of the Last Meeting

Minutes of the last meeting held on 13th June 2019 were agreed.

ITEM 4: Matters Arising

a) Anti-microbial stewardship : Guidelines for the Hospice on Anti-microbial prescribing have been removed from the Hospice's Manual advocating reference to BNF, PCF and NICE guidance as routine. AM expressed how Hospice Doctors are not particularly aware of anti-microbial prescribing best practice. MG suggested that accessing local Hospital guidance that is aligned to national guidance may be helpful.

b) Speed of communicating discharge information to GPs. TY advised that discharge letters are securely emailed to GPs on the day of discharge and followed up by the Hospice Doctor if felt required. This would be particularly the case in regards to complex medication regimes. Responding to MG's question, both TY and SR confirmed that TTO details are included on the discharge letter. Nursing Homes should also now be copied into discharge communications to GPs. It was agreed that an audit of discharge letter content to pick up on copying to Nursing Homes should be undertaken. AA

c) AM felt that communications between IPU and Community team has improved since there has been increased medical team integrated working with the Community Team over recent weeks. Assurance was given on systematic assessment and review of patients.

d) Recording of medication start date on the prescription was believed to be an issue more so to do with its transcribing from one chart to another. Transcribing the Start date to the new medication chart is a point of reminder for the medical team. All Med Team

e) GL will review reference to a 20 point prescribing plan that had been written by Dr Joseph. This 'plan' document has not been passed into Hospice policy. The threshold for when a new chart needs to be re-written following crossing outs will be reflected upon by the medical team. GL / All Med Team

f) Review of current practice for the documenting of indicators for use for each drug is required. It was considered particularly appropriate for PRN drugs but not so for regular prescribed drugs. All Med Team

g) TC will investigate if there is any supportive reference for "8.1 - Gabapentoids should not be used with Tricyclic antidepressants as the QTC interval is affected which can negatively impact". TC

ITEM 5: Pharmacy Update

5.1 MG stated that she had no concerns to raise and congratulated the team for very low error rates : 1168 item checks produced 1 prescribing and 1 dosing error.

5.2 CD auditing is all fine.

5.3 It was agreed that having the Pharmacist checking if PRN doses are correct provides useful assurance evidence.

5.4 Labelling PRNs for oral TTOs – Ashton's can produce blanket label regarding frequency and maximum dose.

5.5 Spending on medication is just under £5k pcm and compares quite favourably with other Hospices.

5.6 Question was raised as to why prescribe oxycodone 50mg rather than morphine and levetiracetam (oral keppra) vs midazolam. Discussion to be held at prescribers meeting. KH

5.7 MG confirmed that the IPU stock list is available and advised AM to review it. AM

5.8 MG advised that they were on the ball with the DoH and NHS Supplies Chain for Brexit's impact on medication supply. Advised to order early and keep a bit extra stock. She felt that supply issues are a little more prevalent than previously.

ITEM 6: Prescribing in the Community

6.1 All non-medical prescribers have their own FP10 prescription pads bespoke to either Sutton or Merton CCG. Hospice Doctors who make community visits also have FP10s available to them so should prescribe as required for palliative care rather than refer to the patient's GP.

ITEM 7: CSCI Furosemide

7.1 The Guidance for the Prescribing and administration of Subcutaneous Furosemide that was developed by SGH and CLCH in liaison with Dr Joseph (previously the Medical Director at SRH) in May 2018 has not been approved by the D&TC and has had no consultation with any of the Hospice's clinical team. It does not have a consensus of support. A review meeting with Dr Anderson (Heart Failure Consultant) at SGH and Kim Smith (EoL CNS, Merton CLCH) will be arranged by AM supported by TC. GL will circulate draft Furosemide guidelines written by Dr Cottingham (Palliative Care Consultant) that have never been approved but may be useful for AM & TC in their meeting. TC stated that further education for the Community Team must be a consideration on this topic. It was agreed that the title of any guidance on this topic must include reference to End of Life. AM

ITEM 8: IV Therapies

8.1 The Hospice does not offer a blood transfusion service. The provision of IV therapies has been a topic under discussion, balancing the logistics of competency against demand and the overwhelming imperative of respecting patient safety. Work is underway in increasing the RGN competency for IV administration on the IPU and there will be some value in discussing outside the meeting the role the medical team can play in IV therapy delivery and maintenance. GL

8.2 TC questioned whether the provision of IV therapies will have impact on the Hospice's admissions. Will demand for admission increase as patients that previously wouldn't have been accepted will be? It was agreed that decision to accept an admission will always be an individual decision made within and supported by the Hospice's policy. SR suggested that competency may be maintained through increased working with NHS partners.

8.3 MG stated that there were some bi-phosphonates that can be administered s/c.

ITEM 9: End of Life Prescribing

9.1 An extract at Appendix 1 of CLIN29 Preparing and Administering Injectable Medication Guidelines was previously created at the request of DNs and GPs who were seeking advice on injectable medications at the end of life. It was agreed that a working party consisting of AM, SR, KH, MG, GL and TC shall review content and agree required changes prior to GL's presentation to the MMG who will ratify its use AM,SR,KH,TC,MG, GL

and adoption in the Community.

ITEM 10: Update on Medication Policy review

10.1 The following medication policies were removed from the Hospice's Policy Manual in September 2019:

CLIN20 Analgesic Guidelines
CLIN30 Intravenous Biphosphonate Infusion Clinical Guideline
CLIN19 Midazolam – Use in Palliative Care
CLIN22 Antimicrobial Therapy Guidelines
CLIN37 Use of Phenobarbital in the Management of Terminal Agitation and Status Epilepticus Guideline
CLIN41 Steroid Therapy

and in November 2019:-
CLIN32 Naloxone Administration

10.2 The following medication policies were revised in the Hospice's Policy Manual in September 2019:-

CLIN33 Non-medical Prescribers' Policy

10.3 The following medication policies were revised in the Hospice's Policy Manual in October 2019:-

CLIN29 Preparing and Administering Injectable Medication Guidelines
CLIN26 Generic Drugs Policy
CLIN25 Controlled Drug Policy
CLIN28 Ketamine – Monitoring Guidelines for Palliative Care Patients

10.4 The following medication policies were NEW in the Hospice's Policy Manual in November 2019:-

CLIN50 Administration of Subcutaneous Fluids in Palliative Care Guidelines

ITEM 11: Abstral use – protocol and evidence

11.1 AM stated that the Hospice prescribes a lot of Abstral – more than has been her experience in other Hospices. She referenced evidence that she had from evidence published in Scotland that It is not a front-line medication. She felt that it was not being prescribed inline with NICE guidance, rather as a front-line drug. She advocated that clinicians should consider morphine sulphate as the front-line. This will be further picked up at the Prescribers Meeting. AM/KH

ITEM 12: Administration of PRN injectable medication by a family member on the community

12.1 TC raised the question as to whether family members can administer sub-cut medications in the community. She referenced St Barnabas Hospice that has a robust policy that supports the practice and input from informal carers. MG felt that such practice should not be encouraged but it should be a MDT decision especially with regard to frequency of PRN administrations and communications with Palliative Care Teams involved.

12.2 AM expressed her experience of 2 patients for whom it worked well.

12.3 TC will circulate the St Barnabas policy for review and discussion at the Prescribers Meeting. TC

ITEM 13: Serious Medication Incidents

13.1 Nil to report.

ITEM 14: Update on CAS/MHRA Alerts

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

14.2 There have been 7 alerts relevant as listed.

MDA/2019/030	T34 Ambulatory Syringe Pumps Alert 18-9-2019	Updated cleaning schedule for syringe pumps now in place
EL (19)A/23	Emerade 150 micrograms solution for injection in pre-filled pen defect 3-10-2019	The pre filled syringes in the Anaphylaxis kit have been checked and re ordered from Ashtons pharmacy
EL (19)A/24	GlaxoSmithKline is recalling all unexpired stock of the above products from pharmacies	Ashtons Pharmacy collected affected stock.
SDA/2019/005	Ranitidine - all oral formulations – Supply Disruption Alert 15-10-2019	Ward staff made aware Alternative medication already in stock
EL (19)A/27	Teva UK Limited trading as ratiopharm GmbH is recalling all unexpired stock 17-10-2019	Not a stock item. Community staff to be vigilant.
EL (19)A/29	Rosemont Pharmaceuticals Limited (part of the Perrigo group) 25-10-2019	Not a stock item. Community staff to be vigilant.
EL (19)A/30	Zantac 75 Relief Tablets 25-10-2019	Not a stock item. Community and ward staff to be vigilant.

ITEM 15: Any other business

15.1 Highlighted by SR, TY will implement the locking of the CSCI boxes in use. TY

15.2 TY requested Keppra be considered for a Stock drug. AM to review stock list for suitability. AM

15.3 Following the RCP review, Cathy Foster is working with TY in constructing the Hospice policy document for undertaking ECGs for QT prolongation that will be discussed at the Prescribers Meeting and circulated fro comment. It was remarked that there was a lot of work involved in this that will be ultimately be suitable for a very small cohort of patients. TY

15.4 AM highlighted practice whereby diabetic patients that are admitted on NOVORAPID are switched to ACTRAPID. Why is NOVORAPID not simply ordered in? AR will send AM copy of the Hospice's Diabetes Management Guidelines for review. AR

15.5 The next Prescribers Meeting is scheduled for 13-Nov-2019.

ITEM 16: Future Dates

16.1 Dates of future meetings in 2020:

Date	Event	Venue/Time
6th February 2020	Drugs and Therapeutic Committee	St Bede's 14.30
11th June 2020	Drugs and Therapeutic Committee	St Bede's 14.30
15th October 2020	Drugs and Therapeutic Committee	St Bede's 14.30

Quality Improvement Committee
Minutes of the meeting held at 2pm on Wednesday 11th December 2019

Present:
(AR) A Rudkin (Chair, Quality Development Manager)
(MJR) M Roycroft (Chief Executive)
(JH) J Hallstrom (Palliative Care Consultant)
(GL) G Linehan (Director of Care Services & Strategy Development)
(TY) T Young (IPU Manager)
(MF) M Flint (Clinical Education)
(JC) J Cope (Audit Support & Minutes)

Apologies
(TC) T Christmas (Community Services Team Manager)

1. Minutes of the last meeting held in July 2019	
These were accepted as a true and accurate record	
2. Matters Arising	
OACC Carer Survey : Use of the OACC Carer Survey remains still to be assessed. This will be an objective for 2020/2021. OACC measures including iPOS, Phase of Illness and the Karnofsky scoring have been incorporated into the EPR but there remains a good deal of work to effect the OACC reporting tool built into Crosscare which may offset its value. TY said that she and Caroline Betts did organise changes in Crosscare that were effected earlier in 2019 with the production of the larger Care Assessment and Planning window and that she and John Groom were currently effecting further design changes to improve flow and increase data capture for the IPU. Aspects such as the phase of illness and Karnofsky performance status should also be discussed. AR said that the OACC suite of measures need to be practically useful in the delivery of care and fundamentally support the assessment of outcome. The tools are integrated into the EPR but further work is required to utilise their information more effectively. The value of iPOS in a controlled environment has a different significance than in the uncontrolled environment of the Community. Review should highlight how effective we are at capturing the data and AR questioned how we capture the data at the bedside and transfer that to the EPR. JH welcomed further discussion on iPOS and its use.	
Prescribers' Meeting ToR : The Prescribers' Meeting allows for multi-disciplinary discussion and review. The minutes also feed into the CQ&G sub-committee. AR will draft ToR for its meeting for it to sign off against.	AR/JH/GL/TY/ MF/TC
Clinical Objective review – Management Plan : Nine months have elapsed of the year. The Clinical Objectives are included in the Management Plan that is available at N:\Plans and Budgets\Plan 2019-20\2019-20 SRH Management Plan Version 2.1.docm. GL and AR will review the clinical quality and governance section of the Plan in December and begin consideration of the objectives for the 2020/2021 year that will be signed off by the CQ&G Sub-committee. MJR told the meeting that there must be realism applied to the Management Plan about priorities and what is achievable – otherwise it can become aspirational without accountability. Aspiration does have merit none the less. There will be carry over of some objectives from 2019/20 to 2020/21.	AR GL/AR
3. Practice Development	
AR highlighted the staffing changes that have occurred this year and commended MF for stepping up and into fulfilling a really valuable role. Further support to her role will be recruited in 2020. Building on the good work that Katherine Gogarty (retired)	GL/TY/MF

undertook, MF advised that intent is now to up-skill the Hospice HCAs. Clinical Skills Days will be booked for them. There have been issues with some District Nurses having unrealistically high expectations of our HCAs, so up-skilling is much needed. HCAs (Band 3) can be upskilled so as to become Band 4 Associate Nurses. Government funding for 'up-skilling' through localised training delivery lasts until March 2020. It remains to be seen whether the new government will extend the funding. One of our HCAs is definitely interested in upskilling. Two more are possibly interested. There are certain entry level requirements. The Hospice has recruited skilled Band 3 staff from both Spire St Anthony's Hospital and St Helier Hospital. They can carry out certain duties which until now the Hospice Band 5 nurses have been doing. In the Hospice, there are some Band 3 duties at the lower end that could be taken over by volunteers if the volunteers were given basic training. MF said that not to lose any staff due to their role not being sufficiently challenging for them was an important consideration.	MF GL
On the subject of E-Learning, MF said that she and Pascale Evans had visited Princes Alice Hospice to see their E-Learning system and found that it is comprehensive and user-friendly. The Hospice will have a month's free trial, starting 6th January 2020, and cost to the Hospice will be the same price as the Hospice's current E-Learning software. MJR informed the meeting that the Princess Alice product uses the Moodle platform. MF told the meeting that the Early Warning System (NEWS 2) will be in place for the end of January 2020 and IV Therapies for March 2020. The cardiac testing that was recommended by the RCoP will need a standard operating procedure set up. Cathy Foster is the link on the ward. JH enquired as to where the cardiac reference info can be found and MF said that the Royal Marsden manual is online for anyone to use as a template for a standard operating procedure. JH said that the medical team use the PCF6 app on a daily basis.	MF/TY/AR
MF told the meeting that non clinical staff had requested training for advanced communication skills. Doctor Hoy can provide this training on an informal basis. The previous course for formal training delivered last year on this topic was expensive and lasted two days. AR asked if there are any courses provided by either St Helier Hospital or St George's Hospital that could be accessed by SRH and potentially save us money. MJR replied that there have been efforts made to develop links with other Hospices. MF said that TC has suggested setting up a South London network of Hospice Practice Developers. AR suggested that MF should start one if one doesn't exist. GL told the meeting that a lot of groups that service South London have disbanded since the inception of STPs. She has made enquiries as to whether there is an executive level South London Hospice group, but it turns out there is not. MJR informed the meeting that there is a network for Hospice Directors for the whole of London. AR suggested that people may be motivated to attend meetings of a South London network whether that be for Community Team, IPU or Practice Development. There is a Quality and Service Improvement Network Group (Members are PAH, Royal Trinity Hospice, SRH, Phyllis Tuckwell Hospice, St Catherine's Hospice (Crawley), St Christopher's Hospice (Sydenham), Sam Beare and Woking Hospice, St Michael's Hospice (Basingstoke), St Peter and St James Hospice (Sussex)) that supports staff that work in quality and clinical governance in South London hosted out of Princess Alice Hospice.	MF

4. Clinical Structure	
GL informed the meeting that there are lots of changes afoot. The Hospice has advertised for the post of Lead Nurse with Clinical Governance as part of the role. The recruitment process is underway. The job description and personal specification for the Clinical Director role is prepared and will go out in January 2020. Interviews for the Physio and Wellbeing lead will take place next week. The specifications for the consultant roles have been submitted to the Royal College of Physicians for approval. They will hopefully be returned by Christmas. Dr Matthews has agreed to stay on, even though her contract was only for six months. The Hospice is advertising online for CNS vacancies. For Band 5 nurses, there is a rolling advert, but as yet there has not been much success in attracting applicants. There has been greater success following the HCA advertisements and interviews have been scheduled. GL reiterated that the Hospice is also advertising for someone to work with MF. She informed the meeting that the vision for the Hospice is that we will be the first Multi-Disciplinary Hospice – no longer hierarchical. AR enquired about the position in charge of supporting psychological care on the ward. There had been a dedicated nurse for this purpose. GL replied that teams should be trained to undertake the level of support required and appropriate referral made to the Psycho-social team. The IPU nurse that had provided psycho-social support on the IPU had had a unique skillset, but there had been limitations given her hours of work had been 9am to 3pm. The training related to the skills required to support psycho-social provision on the IPU will be arranged for the inpatient and community teams. The more skilled volunteers may be given the training they require to be able to provide further support to patients and their families.	AR GL/MF
5. Invited Service Review	
MJR told the meeting that in the July QIC meeting he had announced that the action plan had to be submitted after six months. On 19th September the Hospice sent feedback in the form of two letters, one giving our reaction to the ISR, and the other a side letter about the way the review was done – the ISR did not adequately distinguish between opinion and fact, nor take into account that St Raphael's is the first Hospice they have reviewed. The ISR recommendations have been incorporated into the Clinical Action Plan and, in turn, the CQ&G section of the Management Plan.	
6. Clinical Quality and Governance Sub-Committee	
The Sub-committee's function is to provide assurance to the Advisory Committee on clinical quality and clinical governance. The Sub-committee explores, critiques and supports the executive in the fulfilment of its objectives. AR announced that the Sub-committee's last meeting re-enforced the Hospice approach and support for staff to raise concerns (speaking up). MJR added that the Hospice has adopted the NHS model in revising and re-drafting its organisational policy.	
7. Policy review	
AR reported that percentage compliance in policy review has risen as per table below. There are over 120 documents and only a small number are now overdue for review – the majority of which are on the clinical side, which the designated staff are now working on. The number of bespoke medication guidance documents have been reduced by 8. The policy sign off is a logistical undertaking for managers. Individual managers remain responsible for managing their own staff sign off and have a degree of flexibility in deciding upon those relevant to specific staff. Jason in IT has created an Excel spreadsheet to capture staff signoff and Heads of Departments will be able to use this to monitor and manage sign off in their departments. Roll out will be in 2020 following some testing. The Policy Manual Index can be found here: N:\Policy Manual\INDEX OF POLICIES.	AR

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

8.	**Infection Control**	
	(a) **Sharps audit:** The last Sharps audit was undertaken in March 2019 with 96% compliance. It was led by Spire St Anthony's Infection Control Lead. (b) **IC meeting:** The last meeting was held on 26th November 2019. Jim Stevenson (St Helier Consultant Micro-Biologist) has agreed to continue to chair it. There are a couple of areas he requested reassurance over: water checks (minuted at H&S Committee) and ultimate action in response to Sharps injuries - involvement of A&E as required - as should be referenced in policy. AR confirmed that that was covered in policy and provided JS with hard copy. JH added that when the IV competency is introduced, it will be necessary to address the question of which anti-biotic is used.	
9.	**Education, Training and Development Committee**	
	Covered in Agenda Item 3 above. There is now an HR training agreement in place for applicants to sign in order to support training.	
10.	**Care Quality Commission**	
	Report following the last inspection in November 2019 is awaited but not expected before February 2020.	
11.	**Audit/ Monitoring/ Research Projects**	
	a) Clinical Audit and Activity Data Meeting: AR told the meeting that the first meeting had been held on 3rd October 2019 whereupon its TOR was agreed to include that meetings would alternate between topic - Clinical Audit and Activity Data. AR advised that we are, generally speaking, rich in data but there is much opportunity to develop its conversion to information. It is time that we made in-roads into improving and developing this area from both proactive practical usage and assurance perspectives. Our data and its transition into information should be of interest to multiple forums internally as well as our CCGs (as it is presently). Clinical Audit now has a timeline associated to each project and engagement across the teams is improving. Policy is under construction and use of the pre-existing Project Plan template now mandated. A Clinical Audit training day is planned for February 2020. b) **Audit/ monitoring report**: The monitoring report for projects underway in 20-19/20 was reviewed. It is a standing item at the CAAD Clinical Audit meeting that will next be held in January 2020.	AR
12.	**Clinical Risk Management**	
	(a) Datix will replace the paper-based incident reporting system currently in use. Currently the Hospice is behind the self-imposed schedule, originally because of Datix's technical issues and lately because the testing phase of the Datix Software is still underway. Implementation will follow adequate testing and training. There is no imperative and it is competing amongst a number of other IT projects that are more of a priority. Implementation is expected in the first half of 2020. Heads of Departments will need specialist training but for the majority of users training/instruction will be minima due to the intuitive system design. (b) Clinical Risk management stats 2015-2019: Reported Incidents are lower in numbers than in previous two years. (c) UI&NM Clinical Significance Rating has been introduced this year to track significance of incident to compare against numbers of Incidents. There have been a number of changes this year. In 2019, other than 5 incidents of grade 3+ pressure sores for patients either on admission (2) or during their admission (3) there have been no other incidents reported under the 'serious injury' notification. All were	AR/JG

investigated accordingly. AR thanked everyone for engaging with the system.	
13. Complaints	
(a) AR informed the meeting that the number of complaints for the 2019/20 period is 5 – significantly lower than in the previous two years. Communication is the dominant theme. This will be relevant to the informal training on advanced communications that Dr Hoy will provide.	
14. NICE Standards & NPSA Safety Alerts/ MHRA Alerts/ CAS Notifications	
CAS notification feedback is an ongoing process, with nothing new of note to report recently. Medication alerts are summarised at D&TC. A CAS excel database is accessible to all at N:\Governance\Central Alerting System\Register of Alerts\CAS Register.xlsx, is maintained by JC and AR and engagement and communication with the clinical team is good.	
15. Forum Feedback	
Given the well-established and minuted business of the Hospice committees and meetings – this item will be removed.	
16. Any Other Business	
MJR commented that the screen in St Bede's will ensure that its projection fills the entire screen and that that font shall show large enough to be legible, and be bright enough to still be visible on sunny days. He pointed out that St Bede's requires blinds as well. GL agreed and suggested IKEA which does a great deal on reasonably priced black out blinds.	
17. Dates of 2020 Meetings	
12th March 2020 TBA	