**St Raphael's Hospice**

**Meeting of the Clinical Quality & Governance Committee**

**To be held by video call**

**At 10:00am on Friday 12th July 2024 10am-11am**

| | |
|---|---|
| Members: | Dr Carrie Chill – Trustee & Committee member (CC) |
| | Alan Cogbill – Trustee & Committee member (AC) |
| | Bernard Marley – Trustee & Committee member (BM) |
| In attendance: | Nick Stevens – CEO (NS) |
| | Dr Naomi Collins – Consultant (NC) |
| | Rebecca Trower – Clinical Director (BT) |
| | Anna Machin – Governance (AM) |
| Apologies: | Norman McWhinney – Board Chair & Committee member (NM) |
| | Alex Rudkin – Director of Quality and Governance (AR) |

| Item | Time | Description | Purpose | Lead |
|---|---|---|---|---|
| 1. | 10.00 – 10.05 | Welcomes, apologies for absence and declarations of interest | Discussion | Chair |
| 2. | 10.05 – 10.15 | Review of minutes from Clinical Quality & Governance Committee meeting held on 12th July 2024 | Approval | Chair |
| | | Actions List and update on matters arising | Discussion | |
| 3. | 10.15 – 10.40 | Clinical Risk Register | Discussion | RT, NC |
| 4. | 10.25-11.00 | Clinical Quality & Governance Report | Discussion | RT<br>NC |
| 5. | | Evidence of Excellent Practice Register | Information | |
| 6. | | Quality Account 2023/24 | Information | |
| 7. | | Minutes of internal meetings and Audits | Information | |
| 8. | | Safeguarding Report 2023 | Information | |
| 9. | | Any Other Business & Date of next meeting | Discussion | Chair |

**Dates of future meetings:** 10am-12pm Friday 11th October 2024

**St Raphael's Hospice**

**Meeting of the Clinical Quality & Governance Committee**

**Held at St Raphael's, London Road, Cheam, Sutton, SM3 9DX with video call access**

**At 10:00 on Friday 19th April 2024**

| | |
|---|---|
| Members: | Dr Carrie Chill – Trustee & Committee member (CC – Chair for meeting - virtual) |
| | Alan Cogbill – Trustee & Committee member (AC - virtual) |
| | Bernard Marley - Trustee & Committee member (BM - apologies) |
| | Norman McWhinney – Board Chair & Committee member (NM) |
| In attendance: | Nick Stevens – CEO (NS) |
| | Dr Naomi Collins – Consultant (NC) |
| | Alex Rudkin – Director of Quality and Governance (AR - virtual) |
| | Rebecca Trower – Clinical Director (BT) |
| | Anna Machin (Governance – AM - virtual) |

**Actions arising**

| Agenda item | Action | Responsible | Timeline | Ref. |
|---|---|---|---|---|
| 5. Clinical Action Plan | Circulate Quality Account to Committee for comment by correspondence | Alex Rudkin | May/ June | 19.04.24/01 |
| | Place 2023/24 Quality Account on agenda of next meeting | Anna Machin, Alex Rudkin | July meeting | 19.01.24/02 |
| | Place 2023/24 Quality Account on agenda of next meeting | Anna Machin, Alex Rudkin | July meeting | 19.01.24/03 |
| | Look at complaint in further detail, as agreed with Committee | Becca Trower | Update at July meeting | 19.01.24/04 |
| 7. Safeguarding update | Place 2023/24 Safeguarding update on agenda of next meeting | Anna Machin, Alex Rudkin | July meeting | 19.01.24/05 |



1. **Welcome, apologies for absence and declarations of interest**

   Carrie Chill took the Chair and welcomed attendees to the meeting. Apologies were received and accepted from Bernard Marley.

2. **Review of minutes from 19th January 2024 Clinical Quality & Governance Committee meeting, Actions List and update on matters arising**

   The minutes of the previous meeting were approved as an accurate record of proceedings.

The Committee reviewed the actions arising:

- The action relating to use of technology when note-taking would be carried over, and Becca Trower would seek further views from colleagues.
- Becca Trower gave assurance on the continued communications with colleagues on the use of remote worker devices and paired visits for certain parents, and shared the 'buddy notification' system for the Compassionate Neighbours programme which means that the cost of devices is not incurred for these volunteers. This practice is felt to be proportionate to the risks. This action would be closed.
- The PsychoSocial team survey is included in the meeting papers.
- The team took forward more liaison with referral partners on the quality of patient notes used on admission including with the Sutton Hub and Merton End of Life team, and a mini-audit showed that the referrals coming through are more appropriate, and notes are more useful and succinct.
- In reference to the £15k grant application for bereavement support in prisons raised at the last meeting, it was confirmed that the grant had been awarded. A colleague is being recruited one day each week with a meeting with the Lead Chaplain will take place next week.
- The updates to the reporting format had been made.

**3. Evidence of Excellent Practice Register**

The Committee drew out specific examples from the report that evidences the teams in the Hospice working well together, integrating with other services, and reducing calls on the acute sector. This is a source of evidence to the ICB of the ways in which the Hospice relieves pressure on NHS-funded statutory services. The Committee received assurance that Make a Difference Alerts are completed by the Hospice, and it was agreed that a suggestion would be put into the system around ways in which existing services could support patients to move rooms at home when their condition is deteriorating, in order to mitigate the need to call an ambulance.

The data collected also shows that from January to March 2024, the Hospice team gave specialist input in relation to several hundred patients that were not registered, but where the team's advice could be leveraged by other services.

**4. Clinical Risk Register**

The Committee noted that one risk shows as red on the pre-control scores relating to IT system failure, and that this is mitigated down to yellow when the post-control score is calculated.

In relation to staffing quality and levels, the Committee were updated that Becca Wallace, who has been a strong leader within the Hospice, is leaving IPU for a role that presents a promotion in another local Hospice. There was one strong applicant who withdrew for personal reasons. Two Band 6 nurses have been asked to step up, and offered a parallel pay uplift, until the post is filled. This is not expected to decrease the number of beds available on IPU, but staffing levels will be closely monitored. As discussed with the HR Committee, the incident relating to Trustee conduct at a DEI training session has meant that there is reduced capacity in one team in the Hospice whilst an individual is on leave. This has not yet been added to the Clinical risk register as there is cover within the team, but will also be closely monitored. There were no further changes or updates to the risk register to note.

**5. Clinical Quality & Governance Report inc. Clinical Action Plan**

Becca Trower highlighted key points from the report, including fundraising opportunities through Toyota and the Sutton Mayor's Charity of the Year selection for the wellbeing service. More information has been added in to the report on activities of the colleague with social work expertise.

There are new student counsellors, two new nurses, and Band 6 colleagues starting on night shifts. There are no changes in the Medical team, and two Psychiatric registrars starting who will be with the Hospice for 6+ months.

In terms of practices around Covid, lateral flow device (LFD) tests are no longer in use and PCR tests are available should there be a sense that an outbreak has taken place.

The Committee noted the relatively high levels of sickness in some teams and asked for the driving factors. It was confirmed that the Community team have faced a number of personal challenges during this first period of the calendar year, which has contributed to this number. A relatively small number of colleagues are facing mental health challenges, due to factors in their personal rather than professional lives. The Hospice recognises its duty of care to colleagues, and offers the Employee Assistance Programme, engaged support from the HR team in relation to supporting phased returns, clinical supervision, reflection sessions and Schwartz Rounds. Team leaders and managers also hold one-to-one meetings, and SLT members ensure to check in with team leaders who are taking care of the teams. Through the EAP, colleagues can also access the 'Wisdom' app which gives advice on nutrition and exercise.

Alex Rudkin echoed that Becca Wallace would be loss to the Hospice due to her leadership of IPU colleagues, and also her collaborative engagement with the audit programme. Overall, the data is showing a positive picture and relevant information is set out in the report to the Committee, with no concerns to report.

The 2024/25 Clinical Action Plan is being finalised, and key data from last year is being inputted into the 2023/24 Quality Account, which is due for submission in June. This would be added as a substantive item for the next meeting, and the draft report would be circulated to the Committee by correspondence and input in May/ June prior to submission.

In relation to the complaint raised around the perception of the approach to fundraising marketing, Becca Trower gave assurance that the bereavement journey has been developed carefully, so that the only references to fundraising within the first twelve months of bereavement are funeral giving and the 'tree of life'. In relation to this complaint, Becca would liaise with the team to understand the specific trigger/ driver, and report back to the Committee at the next meeting.

**6. Minutes of internal meetings**

The Committee noted the minutes of internal meetings included in the paper pack, and encouraged colleagues to allocate responsibility to a volunteer for seeking feedback on IPU to increase the number of responses. The 2023/24 VOICES report would be presented at the next meeting.

**7. Safeguarding update (standing item)**

There were no concerns to raise with the Committee. Alex Rudkin would present the 2023/24 full-year report at the next meeting.

**8. Annual review of Committee Terms of Reference**

The Committee recommended the changes to the Board for approval.

**9. Any Other Business and Dates of future meetings**

There were no further items of business raised. The Committee thanked the team for the quality of reports provided.

The date of the next meeting was confirmed as Friday 12th July 2024 from 10am-12pm.

*The meeting ended at 11.25am*

Approved……..

Date……..

# Clinical Risk Control Register

| Risk Category | Activity | Top Risk(s) | Initial Likelihood | Initial Severity | Initial Risk Rating | Prevention Controls - reducing likelihood | Mitigation Controls - reducing severity | Final Likelihood | Final Severity | Final Risk Rating | Responsibility? | Last / next review |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | IT PAS System Failure / Cloud Access Down | · Inability to access contemporaneous clinical records or run business continuity reports | 5 | 3 | 15 | · IT System Management Controls | · Contactable team OOH (not formal contract)<br>· Back up resource -outsourced at times of AL<br>· 2 x HSCN routers and lines to support fail over<br>· Hard copy daily print outs to provide basic continuity<br>. EMIS mobile has been rolled out for the IPU, medical team and community team incase of system failure.<br>. Medical team can access our EMIS tenant from Princess Alice Hospice IT system.<br>. In an emergency our neighbouring Hospices would allow us access to our EMIS system from either their sites or through remote access.<br>· 2 x virtual tokens that can be used on the COWs (when tethered with mobile data) to allow remote access from the cloud to IPU NHS data access - should the physical routers or hardware fail. If any site wide issues in gaining access, we can request to visit any of our neighbouring hospices to gain remote access.<br>. 2 x Cisco firewalls configured for high availability. | 4 | 2 | 8 | IT/CD | Jul 24 / Oct 24 |
| 2 | Proposed reduction in clinical workforce / hours | Reduced responsiveness to existing caseloads<br>Management of expectations<br>Lower staff morale<br>Reduce staff retention<br>Reputational damage | 5 | 3 | 15 | Clear messaging to internal and external stakeholders<br>Review of operational guidelines<br>Regular staff meetings / open door policy<br>Timely completion of robust consultation process | Managed staffing levels across a 7 day service<br>Collaborative working with external colleagues to promote efficiency and reduce risk of patient outliers<br>Prioritising on the support that we are responsible for delivering and reducing the amount that we pick up due to a lack of provision within the community. | 4 | 2 | 8 | CD | Jul 24 / Oct 24 |
| 3 | NHS Doctor Strikes | · Impact on outpatient led planned tx<br>· Impact on education and professional activity support<br>· Impact on non-striking medical team ( risk of burn out) | 5 | 2 | 10 | · Government response awaited | · Weekly review of the medical rota to prioritise cover for the IPU<br>· Flexible working pattern across community and inpatient unit<br>· Non-essential non-clinical commitments postponed<br>· Consultant with NHS contract prioritising SRH<br>· Medical capacity added to IPU acuity score | 5 | 1 | 5 | Lead Palliative Medicine Consultant / CD | Jul 24 / Oct 24 |
| 4 | Insufficient Nursing Resource on the Inpatient Unit. | ·Vacant IPU Clinical Lead position<br>Unable to operate IPU safely<br>· IPU has to close<br>· Impact on patients, families and reputation | 3 | 3 | 9 | · Bank and Agency Nurses available<br>· Staff adapting/flexing shifts to cover IPU<br>· Monitoring of staffing capacity monthly/weekly/daily<br>· Alignment with Agenda for Change pay scales implemented<br>· Crisis cover payments in place<br>· Active recruitment ongoing | · IPU admissions can be reduced to meet staffing capacity<br>· Majority of patients are cared for in the community<br>· Nursing Associates are being upskilled<br>· Acuity score being adopted to help guide admissions v staffing levels<br>· All Leave policies amended with improved leave entitlements<br>· Utilisation of 10 hour shifts to provide better cover<br>· Night staff no longer having to rotate onto days | 2 | 3 | 6 | CD/IPU Clinical Lead | Jul 24 / Oct 24 |
| 5 | Breaches of confidentiality involving person identifiable data (PID), including data loss | · Reputational damage<br>· Litigation<br>· Fines from ICO<br>· Service user distress and safety risk | 3 | 3 | 9 | · Protecting Confidential Information Policy<br>· All personnel and volunteers trained on Information Governance on induction and annual mandatory training.<br>· Data User Agreements in place<br>· DPO, ISO, Caldicott Guardian & SIRO in place<br>· Suite of Information Security and Governance policy in place<br>· Test Phishing emails via IT Dept 3rd party contract.<br>· Secure PID communication email channel in place through NHS Net.<br>· Regular organisational sweeps in all departments<br>· Caldicott Guardian attends regular training and presents at associated fora.<br>· Maintenance of shared network drive to ensure file security.<br><br>- IT policy's in place to restrict USB storage devices from being used.<br>- no local workstations store data, all data is accessed on centralised SAN. | · All personnel and volunteers trained on Information Governance on induction and annual mandatory training.<br>· Proactive checking in areas such as photocopier/clear desks.<br>· Established link with Capsticks solicitor who provides ad hoc advice on data access issues<br>· Annual - Information Governance Check list audit / Clinical Record documentation audit | 2 | 2 | 4 | IT/CD | Jul 24 / Oct 24 |

| Risk Category | Activity | Top Risk(s) | Initial Likelihood | Initial Severity | Initial Risk Rating | Prevention Controls - reducing likelihood | Mitigation Controls - reducing severity | Final Likelihood | Final Severity | Final Risk Rating | Responsibility? | Last / next review |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 6 | Infection spread within hospice | · Inability to provide full clinical service impacting on both patients, their families and staff.<br>· May impact on external stakeholders.<br>· May impact reputational damage and potential funding streams | 4 | 2 | 8 | · Attention to and compliance with governmental guidance<br>· Implementation and maintenance of CLIN52 COVID policy<br>· Implementation and maintenance of CLIN08 Infection Control policy<br>· IPC Lead appointed - overseeing the link nurses on the IPU and Community Team and close working with SWL infection control leads. | · Implementation and maintenance of CLIN52 COVID policy<br>· Implementation and maintenance of CLIN08 Infection Control policy<br>· PPE regular supply available<br>· Contingency planning clarified for any identified cases within the Hospice - as per governmental guidance<br>· Single room nursing. Increased telephone contact<br>· FFP3 mask fit testing ongoing<br>· Refresher PPE training and advice and support from PHE<br>· LFD testing for symptomatic staff in clinical situations<br>· Facility for staff to work from home | 3 | 2 | 6 | CD | Jul 24 / Oct 24 |
| 7 | Embedding of clinical administration system EMIS from Crosscare | · Limited Project leadership due to other work pressures<br>· BAU functionality of system (includes reporting)<br>· User proficiency takes time to embed<br>· Incorrect data entry - content & pathway | 3 | 2 | 6 | · EMIS user guide<br>· Reporting testing / Output<br>· Access to Crosscare Archive for 8 years.<br>· More than one project expert<br>Increasing number of EMIS champions | · System User Guides<br>· Induction and training videos<br>· EMIS project team remains active for first year of project<br>· Reporting | 2 | 1 | 2 | EMIS Project Team | Jul 24 / Oct 24 |
| 8 | Lone working | · Staff/volunteers work singularly in the community within referred patients homes.<br>· Risk of accident/incident in a patients home and individual risk to staff member.<br>· Risk in travel to and from home visits | 3 | 2 | 6 | · OP17 Lone worker Policy<br>· Community staff are supplied with a mobile phone for contact with the hospice or other healthcare professionals. ACC informed of access and egress.<br>· Lone worker alert devices in place. | · Lone Worker Policy informing steps to follow if a colleague does not return to base at expected time.<br>· Clarification and supported training on use of safety devices.<br>· EXEC OOH on call in place for contact and advice on further action.<br>· If there is perceived or hx of risk staff work in pairs and alert is added to the EPR. | 2 | 1 | 2 | CD/MDT | Jul 24 / Oct 24 |
| 9 | Extended bed occupancy | · Delay to discharge due to limited availability of CHC funded beds in the community and patient/family reluctance to transfer.<br>· Limits our processing of requests for admission.<br>· Potential effect on reputation, income generation and staff morale.<br>· Does fluctuate but more of an issue in the autumn/winter. | 3 | 2 | 6 | · Maintain relationships with Care Homes/ Sutton and Merton PLACE that have CHC funding.<br>· Provision of information to patient and family | · Staff proficiency in completing fast track.<br>· Screen referrals for potential impact.<br>· Dual planning with Hospital requesting admission.<br>· Consideration of CHC funded IPU beds in future.<br>· Expertise in discussion with patients and family members re discharge planning. | 2 | 2 | 4 | CD/IPU MDT | Jul 24 / Oct 24 |
| 10 | Clinical Incidents | · Serious or moderate harm to patient Safety<br>· Risk of complaints from patients/families<br>· Reputational damage / litigation | 2 | 3 | 6 | · Low threshold to reporting<br>· Culture embraces reporting of all incidents related to clinical care<br>· Hierarchy of investigation<br>· Outputs- Learning informs improved procedures and processes<br>· Report to Clinical Quality & Governance Committee supports transparency | · Continued staff training and awareness of new techniques and products.<br>· Opportunity to participate in refection and sharing learning and outcomes.<br>· Feedback to complainants regarding change in practice.<br>· Encourage an environment of comprehensive reporting to support learning and quality improvement across all departments.<br>· Annual clinical audit /QI / research / data montoring program | 2 | 2 | 4 | CD & Director of QI | Jul 24 / Oct 24 |
| 11 | Clinical Complaints | Local press coverage<br>Potential for public concern<br>Elements of public expecation not being met<br>Loss of confidence in the service<br>Reputational damage | 3 | 2 | 6 | · Organisational policy supporting values, behaviours and practices<br>· Education and training re communication<br>· Adherence to OP05 Feedback and Complaints policy<br>· Reported at Clinical Quality and Governance Committee<br>· All complaints discussed at hospice team meetings for awareness and learning across the organisation | · Reporting culture of any concerns- no blame but responsibility<br>· Use of root cause analysis for significant incidents.<br>· Feedback to complainants regarding change/improvment in practice.<br>· All complaints both verbal and written treated with the same level of scrutiny<br>· Scoping to establish all clinical staff access to communication skills training<br>· Training on care delivery<br>· Information shared re: Duty of Candour and scope of the policy<br>· Complainants (both verbal and written) are offered the opportunity to meet and discuss concerns with Clinical Director, and maybe offered opportunity to join HUG to help with SRH future learning<br>· Complaints documented and register maintained<br>· Annual review by EXEC | 2 | 2 | 4 | CD | Jul 24 / Oct 24 |

Key

The axis for Likelihood should be from 1. Very Low – 2. Low – 3. Medium – 4. High – 5. Very High

The axis for Severity should be from 1. Light – 2. Serious – 3. Major – 4. Catastrophic – 5. Multi Catastrophic

Over 13 = red
8-13 = amber
7 or under = green

# ITEM 04

# Clinical Quality and Governance Report

**Contents**



## Aim

To update the non-executive members of the Clinical Quality and Governance 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

## Clinical Services

**Psychological Support Services**

- The team has been working with 4 full days reduced capacity for the months of April and May due to Steve Molyneux's resignation.
- Diana and Cecilie are now sharing the role of Psychological Leads, increasing their week to 3 ½ days each (covering one of the days lost). They have also recruited one new member, Alison Lutz, who has been volunteering for some time as counsellor for SRH. She will now become a member of staff employed to work 8 hours per week to cover some clinical work. Due to the reduction in resources, the impact of losing 2 days per week from Steve's role means waiting times have increased.
- Patients and family members who require pre-bereavement counselling will continue to be prioritised. The team also aim to ensure that the wait is no longer than 14 days for patients and urgent cases will too be prioritised.
- Bereavement counselling now has a longer wait time which is currently around 6-8 weeks. Ashley Harper – Bereavement administrator is now assisting with the inbound bereavement referrals which this has been immensely helpful.
- Diana is managing the prison project. The project commenced on 1 May providing bereavement counselling at HMP High Down (as per the pre-established project agreement) with an external counsellor under our SRH clinical leadership. The team have been working on building a rapport with HMP High Down staff.
- Cecilie has taken on the main responsibility for the counselling placement service, managing the volunteer/student counsellors, and conducting the Clinical Supervision sessions with Diana stepping in when required. They are recruiting new counsellors for placements with us, and will aim to build closer relationships with local colleges (CCPE in process).
- Despite the pressures, the service is running smoothly.
- **Social Work**
-
- The last 3 months have seen a lot of change to PST – the very sudden departure of a team member – causing significant disruption to our normal working practice, leaving tasks incomplete causing additional work and issues that needed to picked up very quickly to get things in order.
- This has been very unsettling time and a distraction to our already busy workloads, however, we have pulled together to support each other during this time and have good clear communication which as not present before.
- Despite the situation Alison and I have a clear focus to support the wider team, being a active part of the MDT working directly with the IPU and the community teams, (including joint visits when required) to support our patients in their palliative care journey.
- During all this disruption Alison and I have completed all our statutory training.

- Our work continues with

    - insuring our patients and families have access to financial benefits they are entitled too, also end of life grants which make a lot of difference for families at this time
    - our memory boxes
    - supporting parent with children and liaising with schools
    - supporting families with the difficult conversations
    - getting their affairs in order re money wills
    - continuing to support families with debt built up whilst unwell

- We have seen a significant increase for support re visas and immigration issues in the past few months.

- Supported a socially complex family – requiring mediation re blended family with and legal implication of this Clear plan now in place.

- A complex social housing of one of our families which has been long standing now sorted with our input.

- Supported a housebound patient in a long term relationship of 29 years ' whom was not the marring kind' I suggested a Civil partnership as an alternative, which he was open to this type of union, to tie the knot in a civil partnership, the wedding part was the issue for him – he was unaware this was an option for him – supported the couple with the process and it was arranged for them within 24 hours – **a very special day** the couple at home with their closest 2 friends as witnesses. This has been a very positive action also giving his long-term partner protection re their assets.

- Continue to Support several patients complex social situation – challenging situations, by unpicking the issues and working with the patients for solutions, working out what would be best for them at this time.

- We continue to see increase in families unable to meet burial costs supporting several families to access grants/benefits to cover funeral costs.

**Wellbeing services**

- Within the weekly programme there have been live music sessions by local bands Vinyl Matters and The Ukele Band as well as a tea dance, IT Virtual Reality sessions, gardening, pampering, nutrition and origami. There have been spiritual wellbeing talks from different faiths as well as external speakers from the Police, CAB, Age UK and Merton & Sutton Uplift. We acknowledged Dying Matters with themed discussions and there were Passover, Eid and Pride Celebrations as well as networking at the Mitcham Carnival. The WBC services are featured in this month's Raphaelite.
-
- Compassionate Neighbours
-
- We have almost reached the 100 referrals mark, from the project launch. This equates to 1 referral every 5.5 days. We currently have 70 trained Compassionate Neighbours (including on hold volunteers) with approx. 5 more in motion. At our most recent training session we recruited a retired Psychotherapist who provides a wealth of communication knowledge to the team.
-
- Comp T
-
- Ana gave a presentation to healthcare staff on self-care and staff wellbeing which was well received. She's been engaging with patients from RMH to increases awareness of our services as well as featuring in this month's Raphaelite. She continues to deliver pamper sessions to the WBC attendees which is popular. A Sleep Well Programme is being planned with the help of the Comms team, to roll out on the ward and in the community, as well as a feedback form to capture impact. Comp T volunteers are successfully being trained on Emis and further recruitment is underway.

**Inpatient Unit**

- The ward has said goodbye to our IPU Clinical Lead Becca Wallis. Becca will be very much missed but has taken on an exciting role at Royal Trinity Hospice, as Head of the Clinical Hub.
- The IPU Clinical Lead post is currently on hold as a ring-fenced role.
- SSN Julie Ford and SSN Penny James are jointly leading the IPU as senior band 6s and have been doing an excellent job.
- We have been supporting a number of nursing students and medical trainees whose interest in palliative care is always encouraging and feedback from them is consistently positive.
- We are using the acuity tool and other measures to look at the numbers of staffing on the IPU each shift – Ward companions (volunteers) continue to support our patients by sitting with them and providing a calm or sociable presence at different times of the day, taking pressure of the nursing staff so they are released to attend to clinical care.
- We have recently had some particularly high dependency patients on the IPU – and some have stayed for longer than would be usual due to their complexities making it difficult for them to be placed elsewhere. On these occasions we have requested extra funding from CHC and have received circa £30K over the last few months.
- We are currently having fire doors replaced on the IPU – two at a time and attempting to keep disruption to a minimum.

**Community Palliative Care Team** (CPCT)

- Naomi Stammers has returned from Maternity, 30 hrs per week as locality lead 3. Kate Weldon excelled within the Locality Lead secondment whilst covering the maternity leave and has now been allocated to Locality 2 and readjusting to the change of role
- Kevin Hobson has returned from compassionate leave
- Referrals are increasingly complex, with the additional challenges of accessing community services in a timely way.
- Triage has been experiencing an increase in calls / tasks / enquiries (often in excess of 30 per day) highlighting the need for two staff to work in this service
- As the only OOH service offering specialist palliative care advice 7 days per week, the weekends continue to be mostly busy supporting both registered and unregistered patients and again, highlighting the need to continue with two CNS/SP on duty

- H@H staffing has been impacted by long term sickness as well as is one vacancy (22.5pw) not currently advertised and HCA Jackie Rickman resigned to retire (leaves July 12$^{Th}$ )
- The H@H service continues to receive outstanding feedback demonstrating the value of their service
- Dr Akhtar and Dr Da Silva have been rotating into the CPCT with SpR Stephanie Ainley also spending a period of time within the CPCT
- PA Jovi continues to work in CPCT on a Tuesday

**Referrals** –There is regular contact between HPOC, MEoLT and SPCCH to discuss referrals and reduce duplicate work and inefficiencies. Planning meeting for July / August with HPOC, MEoLT and SPCCH to discuss referrals to hospice and triggers, in order to encourage timely referrals rather than when in crisis.

**Education/Training**

- Education sessions for SWL care home staff continued on a monthly basis. Really positive feedback was received from those who attended but unfortunately, numbers continued to be low.
- Members of the In-Patient Unit and the Community Team attended their medicines management update, which takes place annually and demonstrates the organisation's commitment to drug safety and governance. Also included were sessions on tracheostomy care, facilitated by Cathy Foster, prescribing in renal failure and the management of terminal agitation, which were kindly supported by the medical team. This session also provides staff with the opportunity to reflect on challenges and refresh their knowledge of medicines management.
- New starters in the nursing teams attended a teaching session on verification of death- this is an extended role for nurses which requires attendance at a theoretical session and the completion of a competency document.
- Several staff members attended Emergency First Aid at Work training in May. This training ensures that we have appropriately trained first aiders in all hospice buildings.
- Equality, diversity and inclusion training was attended by staff from across all hospice departments in February. Basic Life Support training was also attended by clinical staff.
- Mandatory training support was provided for volunteers and housekeeping staff over several days at the end of May. Several staff and volunteers were assisted to begin their Bluestream modules.

- A successful Non-Medical Prescribers update was held in June. Our own staff attended along with 6 external colleagues. The update was facilitated by Maura Flint and Kevin Hobson (NMP Lead) and sessions were provided by Lorraine Jeffreys CNS and Dr Stephanie Ainley. Excellent feedback was received and plans are under way for another update in November 2024.
- The education team are providing ongoing support to two members of staff who are currently completing apprenticeships. This includes attending meetings with personal tutors and supporting their academic and clinical practice.
- Learn@Lunch and MDT Journal Club continued on a monthly basis.
- The team was impacted by long term sickness during this time.

**Medical Team**

**Staffing**

Hospice medical staffing has been stable in the past few months. GP Dr Bushra Omar, Manor Park Practice, has applied to join us for one session per week for the next year, funded by the SPIN fellowship. She started on 10th June.

We continue to host specialist Palliative Medicine Trainees, currently supervising Dr Stephanie Ainley in her final year of training. We await to hear, this month, whether we have a new trainee starting in October 2024. This will be our first experience of trainees on the new dual accreditation curriculum – training in Palliaitve as well as Internal medicine.

**On Call**

On call collaboration with Princess Alice and Kingston Hospital continues, with the consultants across all 3 sites meeting every 3-4 months remotely.

**Audit and Research**

We have almost completed recruitment to the CHELsea 2 hydration at the end of life study, having recruited 18 out of the required 20 patients to date (deadline September 2024).

We continue to recruit for the POST study – Palliative care and Oncology Survey on Terminology – with 5 patients recruited.

We have recently been accepted as a hospice site to host a PhD student at Lancaster University investigating the use of videoconferencing for emotional support in palliative care.

**EMIS**

The EMIS sharing agreement is fully operational with all local GPs. Work to activate the sharing agreement with our local community nursing teams in Sutton and Merton is ongoing.

**Education**

Dr Gaby is the new consultant lead for education.

The medical team continue to meet weekly for journal club/ education/ business meetings as well as joining and contributing to the Monday medical teaching coordinated across Princess Alice and Woking and Sam Beare Hospices.

The medical team continue to provide educational support in the form of presentations for the inpatient unit study days and non-medical prescribing days.

**Supervision**

The consultants continue to be actively involved in educational and clinical supervision of our medical team (rotational specialty registrars and GPVTSs, specialty doctors, and our Physician Associate). We also are responsible for providing medical support for the Locality Caseload reviews for the community team.

**Appraisal**
All three consultants are trained medical appraisers and ensure all of the medical team are supported with their yearly appraisal and revalidation.

# CQC and Organisational Assurance

The CQC last inspected the Hospice in November 2019 and awarded a Good rating. The report is available via the Hospice website.
Much has changed since our last inspection and we are keen to showcase all the developments we have made.
Some Hospices are now being inspected under the new Single Assessment Framework and those with lower ratings or where concerns have been raised, are being inspected first.
A depository for evidence of excellence is included as an Agenda item for the CQ&G Sub.
We expect our KLOE work will support our evidence base to demonstrate compliance and will undertake work this year to make any alignment with the Single Assessment Framework that became effective from April 2023. Achieving an 'Outstanding' rating at our next inspection and maintaining it in the future remains our ambition.

# Governance meetings

The Hospice's 'Governance' meetings feed into the work of all the sub-committees of the Hospice's Board of Trustees. Presently, there are 6 clinically focused forums that currently feed into the CQ&G Committee.
The Health & Safety Committee feeds into the F&R Committee.
The Staff Consultative Group is suspended and the Training & Development Committee feeds into the HR Committee.

| Governance Meetings - Clinical | Date last held | Date of Last Minutes Reviewed at CQ&G Sub | Next meeting |
|---|---|---|---|
| Clinical Audit and Activity Data | Apr'24 | Apr#24 | Jul'24 |
| Clinical HoDs | Jun'24 | Jun'24 | Jun'24 |
| Medical Business | Jan'24 | Jan'24 | Feb'24 |
| Drugs & Therapeutics | Feb'24 | Feb'24 | Jul'24 |
| Outcome Measurement Group | Dec'22 (no min) | May'22 | Pended |
| Infection Control | Jun'24 | Jun'24 | TBA |
| Prescribers | May'24 | May'24 | Sep'24 |

## Incidents / Accidents / Near Misses

- DATIX incident reporting was implemented in November 2021. Each incident is reviewed by the line manager (HoD) and all incidents receive final approval from a member of the Executive team. Clinical review has been incorporated into the business of the Clinical Heads of Department Meeting that meets every 6 weeks. Those that are non-clinical are reviewed at H&S Committee. Representatives are expected to cascade review information back to their teams and an incident feedback facility is programmed into the DATIX report for the reporter. Data is presented later in this report and remains to note how engagement with the system continues to be healthy, from both clinical and non-clinical departments.

- An annual report for incidents has been included as a future planning priority in 2023/24's Quality Account and is part of the Management Plan objectives for 2024/25 to demonstrate the range of incidents / accidents recorded across the Hospice and to provide a useful reference point for the learning taken.

- Quarterly submission to Hospice UK's Quality Metrics project began in July 2017 and are on-going with the latest submission made in April 2024 and next due this month. The submission categories cover pressure sores, patient medication incidents and incidents of patient falls.

# Quality Account

The Hospice published its **Quality Account** for 2023/2024 to its website on 4th July 2024 and URL notification sent to the NHS. It is available here and copy is made available within the Hospice.

# EMIS

Implementation of the new EMIS system commenced in May 2023.
The project team includes Clinical Admin (Kelly & Dawn) who provide users with additional practical support, along with John Groom, Dr Jenny Strawson, Heather Siddall and Alex Rudkin.
EMIS facilitates the data capture that supports the care planned and delivered alongside the data output that feeds into SWLICB activity review meetings.
Design and rollout of EMIS mobile has been effected. This provides both connectivity contingency and facilitate community engagement.
Data sharing was also implemented in December 2023 and shared record access is now in place with all GP practices in Sutton & Merton. Engagement of the community hubs remains ongoing and is proving a challenge but we are hopeful of moving this forward this month (at least for Sutton PCH) with communications with the ESTH IT Manager now established and meeting set with the SWLICB IG team this month.

# Clinical Audit, Quality Improvement, 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. The management of controlled drugs (cds) audit is an annual audit undertaken by the Ashton's Pharmacist and our Clinical Director who is our Accountable Officer for CDs.

Review of progress with the clinical audit program and opportunity to feedback results is provided via the Clinical Audit and Activity Data forum (CAAD). Its next meeting is scheduled for July 2024. A Clinical Audit and Quality Improvement Project Presentation Forum that provides platform for project leads to present results of their project to a wider audience was last held in May 2024 with presentations delivered on mouthcare audit, patient satisfaction on the IPU, IPU Risk Assessment Audit and Safeguarding 2023. The forum usually occupies a lunch-time slot and is open to the clinical teams and those with an interest in topic.

Progress of the Audit/Research Programme 2024/25 - spanning clinical audit, quality improvement, research and data monitoring - is set out from page 12. At the start of 2024/25 we have set out 25 projects for pursuit. New topics in 2024/25 include Abstral prescribing on the IPU, Use of CSCIs and Fast Track patients – a review
Ownership is delegated across the clinical team and Quality office and the medical team projects have Dr Strawson as medical audit and research overseer from April 2024 to the end of September 2025.

# Data Dashboards

The population of clinical data dashboards that inform the service areas of the IPU, Well-being Centre, Community and Psychological Support Services teams is expected to be re-commenced in 2024/25 subject to priorities highlighted at the CAAD meetings. An index of tracked data that has been periodically presented and communicated to the clinical team is held.

| Report Reference | **Title** | **Lead** | **Created** | **Function** | **Primary Aud.** | **Exec / CCG Interest** | **Freq** |
|---|---|---|---|---|---|---|---|
| 20/001 | UCR Monitoring | BG | Jan-20 | To improve UCR data capture | CPCT | Yes | Weekly |
| 20/002 | NoK Details | SM | Jan-20 | To improve NoK data capture | Psy / Qual / Donor Support | No | Monthly |
| 20/003 | Community Team Visit Responsiveness | LB | Jan-20 | To support responsiveness evidence | CPCT | Yes | Quarterly |
| 20/004 | Sharing Information Consent | TC | 2018 | To monitor and improve Sharing Information Consent data capture | CPCT | No | Monthly |
| 20/005 | Safeguarding Monitoring | RW | Feb-20 | To highlight patients with safeguarding concerns and track follow up | CPCT | No | Monthly |
| 20/006 | Referrals Monitoring | JO'G | Mar-20 | To monitor and improve Referrals data capture | CPCT | No | Monthly |
| 20/007 | Referral to RIP Monitoring | JO'G | Mar-20 | To monitor time between referral and death | CPCT | No | Monthly |
| 20/008 | Active Caseloads | NS/ GL | May-20 | To monitor active caseload levels | Exec | Yes | Weekly |
| 20/009 | Daily Activity Data - capacity tracker support | NS/ GL | May-20 | To monitor activity recorded on Crosscare | Exec | Yes | Daily |
| 20/010 | Referrals by Postcode | DN | Jun-20 | To monitor referrals by postcode | Fundraising & Exec | Yes | Monthly |
| 21/001 | PPoD vs Actual PoD Monitoring | RT | Apr21 | To monitor PPoD achievement rates | Exec | Yes | Quarterly |
| 21/002 | IPU Waiting Times / Requests for Admission | RT | Feb-22 | To demonstrate the servicing of admission requests and profile waiting times for admission | Exec | Yes | Quarterly |

# Clinical Quality & Governance Management Plan Objectives 2024/25

## Summary

| DATE | Number | Complete / on-going | Into 25/26 | Pended |
|---|---|---|---|---|
| | | | | |

Review and revision of drafted G&Os for 2024/2025 will be substantively undertaken in September 2024.

## Goals Completed

A listing will appear here after September 2024.

| Ref | Goal |
|---|---|

# Audit / QI /Research 2024/25

## Overview

26 projects scheduled in 2024/2025

**2024/25 Listing**

| Project Ref. | Title | HQIP Prioritisation | Lead | Status |
|---|---|---|---|---|
| 2024/25-01 | IPU & Community - VOICES survey of bereaved next of kin 3-6months post bereavement | • Priority 2 Internal 'must do' audit | Quality Office - J Cope / A Rudkin | Ongoing - Latest Report for Oct 22 – Mar 23 published in March 2024 |
| 2024/25-02 | IPU - Patient Satisfaction | • Priority 2 Internal 'must do' audit | IPU - R Wallis<br>Quality Office - J Cope / A Rudkin | Ongoing - 2023 report published March 2024 |
| 2024/25-03 | IPU – Infection Control : Environment & Hand-washing Audit | Priority 1 External 'must do' audit | IPU - S Leech<br>Community - J Smith<br>Quality Office - J Cope / A Rudkin | Ongoing - Quarterly production of graphical compliance for IPU display across Handwashing, Staff, Environment and Sharps. |
| 2024/25-04 | IPU - Medicines Management Audit | • Priority 2 Internal 'must do' audit | Ashton's Clinical Pharmacist | Ongoing<br>Last published in January 2024 |
| 2024/25-05 | IPU - Re- Audit against Audit NICE Guidance NG31 Care of Dying Adults at the End of Life | Priority 1 External 'must do' audit | Dr Naomi Collins | Last published in Jan 2024. Next audit covering data from March – June 2024. Data collection commences in August 2024. |

| Project Ref. | Title | HQIP Prioritisation | Lead | Status |
|---|---|---|---|---|
| 2024/25-06 | IPU : Patient Handling / Pressure Areas | • Priority 2 Internal 'must do' audit | Rebecca Wallis | Last reported in March 2024 and presented in May 2024 |
| 2024/25-07 | IPU : Mouthcare Audit | • Priority 2 Internal 'must do' audit | Rebecca Wallis | Last reported in January 2024 and presented in May 2024 |
| 2024/25-08 | Controlled Drugs Annual Audit | Priority 1 External 'must do' audit | R Trower | Ongoing<br>Last published in January 2024 |
| 2024/25-09 | Fast Track Patients – a review | • Priority 3 Specialty Priority | Dr A Akhtar/J Giles | TBA in 2024 |
| 2024/25-10 | Project TBA | | Dr B Da Silva | TBA in 2024 |
| 2024/25 – 11 | Prescribing Abstral on the IPU | • Priority 3 Specialty Priority | Dr S Ainley | Project plan in place |
| 2024/25-12 | Outcome measures (Step 2- CSNAT) | • Priority 2 Internal 'must do' audit | Implementation Group<br>Dr NC / TC | CPCT 2024 audit for report in March 2025 |
| 2024/25-13 | Psychological Support Services Questionnaire | • Priority 4 Clinician interest audit | Psychological services<br>SM | Ongoing<br>1st report published in January 2024 |

| Project Ref. | Title | HQIP Prioritisation | Lead | Status |
|---|---|---|---|---|
| 2024/25-14 | Activity Monitoring Data<br>UCR<br>NoK<br>CPCT Responsiveness<br>Sharing Information<br>Safeguarding<br>Referrals<br>Referrals to RIP<br>Active Caseloads<br>Daily Activity Data - capacity tracker<br>Referrals by Postcode<br>PPoD | • Priority 3 Specialty Priority | Quality Office+ CAAD | Ongoing |
| 2024/25-15 | IPU & Community & Psychological Support Services - Activity Data Dashboards Development | • Priority 2 Internal 'must do' audit | Quality Office + CAAD | Ongoing |
| 2024/25-16 | Incidents | • Priority 2 Internal 'must do' audit | Quality Office + CHoDs | Ongoing<br>NEW annual report expected in 2024/2025 |
| 2024/25-17 | Falls | • Priority 2 Internal 'must do' audit | Quality Office + CHoDs Mtg | Ongoing - April 2023 - March 2024 chart last produced in May 2024 |
| 2024/25-18 | Complaints | • Priority 2 Internal 'must do' audit | Quality Office + Exec | Ongoing – 2023/24 complaints reviewed in June 2024 |
| 2024/25-19 | Safeguarding Documentation | • Priority 3 Specialty Priority | Rebecca Wallis | 2023 annual report published in May 2024 |
| 2024/25-20 | Clinical Records Documentation | • Priority 2 Internal 'must do' audit | R Trower | Last Reported in Dec 2022. Re-audit in 2024 |

| Project Ref. | Title | HQIP Prioritisation | Lead | Status |
|---|---|---|---|---|
| 2024/25-21 | Referral to the IPU Re-Audit | • Priority 3 Specialty Priority | Dr J Strawson | Last reported in May 2024 |
| 2024/25-22 | Caldicott - IG Sweep | • Priority 2 Internal 'must do' audit | Dr G Tamura-Rose | Annual Data collection Last undertaken in January 2023. Tool revised for re-audit in 2024. |
| 2024/25 – 23 | Advance Care Planning Re-audit | • Priority 2 Internal 'must do' audit | Dr G Tamura-Rose Tracy Christmas | Data collection underway in July 2024 |
| 2024/25 - 24 | Audit of the use of CSCIs - indication for use, communication, supported via documentation | • Priority 3 Specialty Priority | Dr J Strawson | TBA |
| 2024/25-25 | CHELsea II examining hydration at the end of life - led by Surrey University Clinical Trials Unit : cluster randomised trial til Oct 2024 | • Priority 3 Specialty Priority | Dr N Collins | Data Collection : 18 patients recruited as at 05-07-2024 |
| 2024/25-26 | Patient 'label' research project - the PhD project for a Pall Care SpR in Our Ladies Hospice in Ireland, Dr Any Taylor. Prof Andrew Davies is the overall Principal Investigator and Dr Charlotte Leach, Pall Care Consultant at Royal Surrey County Hospital, is UK lead. | • Priority 3 Specialty Priority | Dr N Collins | Data collection started in November 2023 (whole project nationally to recruit 383 patients across 7 sites). |

# Clinical Risk Management

## Clinical Unexpected Incidents

Overview of incident data for January – May 2024 is shown below:-

| 2024 | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | 2024 | 2023 | 2022 | 2021 | 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Admissions to IPU | 21 | 16 | 18 | 19 | 19 | | | | | | | | 93 | 207 | 207 | 138 | 195 |
| Discharges | 4 | 1 | 4 | 3 | 4 | | | | | | | | 16 | | | | |
| RIPS on IPU | 13 | 13 | 13 | 12 | 17 | | | | | | | | 68 | | | | |
| Beds | 10 | 10 | 10 | 10 | 10 | | | | | | | | | | | | |
| Bed Occupied Days | 237 | 237 | 229 | 238 | 256 | | | | | | | | | | | | |
| Bed Available Days | 310 | 290 | 310 | 300 | 310 | 300 | 310 | 310 | 300 | 310 | 300 | 310 | | | | | |
| Bed Occupancy (variable beds) | 76.45% | 81.72% | 73.87% | 79.33% | 82.58% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | | | | | |
| Bed Occupancy (10 beds) | 76.45% | 81.72% | 73.87% | 79.33% | 82.58% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | | | | | |
| CD Medication Incident | 3 | 0 | 0 | 3 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 10 | 42 | 29 | 35 | 15 |
| CD Medication Near Miss | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 2 | 1 |
| Non-CD Medication Incident | 1 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 22 | 21 | 7 | 4 |
| Non-CD Medication Near Miss | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | | |
| Pressure Sore on Admission | 4 | 4 | 1 | 3 | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 18 | 30 | 22 | 16 | 19 |
| Pressure Sore during Admission | 3 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 16 | 17 | 6 | 4 |
| Moisture Associated Skin Damage ON Admission | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | | |
| Moisture Associated Skin Damage DURING Admission | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | | |
| Sharps/Splash | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 3 | | |
| Infection (Near Miss) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | | |
| Infection | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 3 | 6 | | |
| Unexpected Transfer | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | |
| Near Miss(non-medication & non-IG) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 1 | 1 |
| Staffing | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 9 | | |

| 2024 | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | 2024 | 2023 | 2022 | 2021 | 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Behaviour (staff) : non-complaint | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | | |
| IG | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 15 | 16 | 4 | 3 |
| IG near miss | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 4 | 5 | 1 |
| Manual Handling | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 2 | 1 |
| Slips, trips, falls | 2 | 2 | 3 | 4 | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 16 | 14 | 21 | 19 | 20 |
| Falls near miss | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 6 | | | |
| Verbal Violence (Pt) | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | | | 1 |
| Verbal Violence Rel) | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | | | | |
| Physical Violence (Pt) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 3 | | |
| Bump | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | |
| Burn/Scald | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | | |
| Equipment | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 1 | | |
| Equipment (near miss) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 1 | | |
| Doctor On Call | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | | |
| EXEC Out of Hours Call | 0 | 0 | 1 | 5 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 8 | 5 | 2 | | |
| OTHER - Admin/Property/Documentation/OOH | 2 | 1 | 2 | 1 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 9 | 11 | 12 | 12 | 14 |
| MAD Alerts (re SRH) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | | | |
| * Incidents reported to Community – non-SRH | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 7 | 25 | 2 | 8 |
| * MAD Alerts (incl. in Community:non-SRH) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 12 | | |
| **Total 2024 *excluded** | **16** | **11** | **9** | **18** | **24** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **78** | | | | |
| **Total 2023 *excluded** | 26 | 8 | 31 | 7 | 24 | 12 | 4 | 15 | 20 | 13 | 23 | 9 | | 192 | | | |
| **Total 2022 *excluded** | 8 | 12 | 15 | 10 | 15 | 19 | 18 | 16 | 13 | 24 | 16 | 14 | | | 180 | | |
| **Total 2021 *excluded** | 3 | 2 | 7 | 8 | 21 | 13 | 3 | 1 | 19 | 9 | 11 | 12 | | | | 109 | |
| **Total 2020 *excluded** | 7 | 6 | 7 | 6 | 11 | 15 | 5 | 5 | 4 | 3 | 8 | 8 | | | | | 85 |

## Incident Key

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

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

| *Clinical Significance* | Jan | Feb | Mar | Jan-Mar | Apr | May | Jun | Apr-Jun | Jul | Aug | Sep | Jul-Sep | Oct | Nov | Dec | Oct-Dec | 2024 | 2023 | 2022 | 2021 | 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Admissions to IPU** | **21** | **16** | **18** | 55 | **19** | **19** | **0** | 38 | **0** | **0** | **0** | 0 | **0** | **0** | **0** | 0 | **93** | **207** | **207** | **138** | **193** |
| **Bed Occupied Days** | **237** | **237** | **229** | | **238** | **256** | **0** | | **0** | **0** | **0** | | **0** | **0** | **0** | | | | | | |
| **Bed Available Days** | **310** | **290** | **310** | | **300** | **310** | **300** | | **300** | **310** | **300** | | **310** | **300** | **310** | | | | | | |
| **Bed Occupancy** | **76.45%** | **81.72%** | **73.87%** | | **79.33%** | **82.58%** | **0.00%** | | **0.00%** | **0.00%** | **0.00%** | | **0.00%** | **0.00%** | **0.00%** | | | | | | |
| **Fall No Harm** | 2 | 2 | 3 | 7 | 4 | 5 | | 9 | | | | 0 | | | | 0 | **16** | **11** | **15** | **12** | **14** |
| **Fall Low Harm** | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | | | | 0 | | | | 0 | **0** | **3** | **6** | **7** | **6** |
| **Fall Moderate Harm** | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | | | | 0 | | | | 0 | **0** | **0** | **0** | **0** | **0** |
| **Med Level 0** | 0 | 1 | 0 | 1 | 3 | 3 | | 6 | | | | 0 | | | | 0 | **7** | **32** | **4** | **20** | **9** |
| **Med Level 1** | 4 | 1 | 1 | 6 | 0 | 2 | | 2 | | | | 0 | | | | 0 | **8** | **34** | **49** | **20** | **10** |
| **Med Level 2** | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | | | | 0 | | | | 0 | **0** | **0** | **1** | **0** | **0** |
| **Med Level 3** | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | | | | 0 | | | | 0 | **0** | **0** | **0** | **0** | **0** |
| **Minor (No Harm or Low Harm)** | 3 | 3 | 3 | 9 | 8 | 7 | | 15 | | | | 0 | | | | 0 | **24** | **62** | **65** | **25** | **15** |
| **Moderate (Moderate Harm)** | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | | | | 0 | | | | 0 | **0** | **0** | **0** | **3** | **6** |
| **Serious (serious Harm)** | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | | | | 0 | | | | 0 | **0** | **0** | **0** | **0** | **1** |
| **Pressure Sores** | 7 | 4 | 2 | 13 | 3 | 7 | | 10 | | | | 0 | | | | 0 | **23** | **50** | **40** | **22** | **23** |
| **Totals 2024** | **16** | **11** | **9** | **36** | **18** | **24** | **0** | **42** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **78** | | | | |
| **Totals 2023** | **26** | **8** | **31** | **65** | **7** | **24** | **12** | **43** | **4** | **15** | **20** | **39** | **13** | **23** | **9** | **45** | | **192** | | | |
| **Totals 2022** | **8** | **12** | **15** | **35** | **10** | **15** | **19** | **44** | **18** | **16** | **13** | **47** | **24** | **16** | **14** | **54** | | | **180** | | |
| **Totals 2021** | **3** | **2** | **7** | **12** | **8** | **21** | **13** | **42** | **3** | **1** | **19** | **23** | **9** | **11** | **12** | **32** | | | | **109** | |
| **Totals 2020** | **7** | **6** | **7** | **20** | **6** | **11** | **15** | **32** | **5** | **5** | **4** | **14** | **3** | **8** | **8** | **19** | | | | | **85** |

## Clinical Complaints

- Review of complaints received between 1st April 2023 and 31st March 2024 is planned for a meeting of the Hospice executive in May 2024. Summary will be included in July 2024 papers.
- There have been 0 clinical complaints received in and between April and June 2024.

## Complaints Overview

| 2023 - Complaints | CPCT / H@H Care | CPCT / H@H Comms | IPU Care | IPU Comms | IPU Care & Comms | Bereavement Comms | Reception Comms | Volunteer Services Comms | Fundraising /Shop Comms | HR | Total | Merton | Sutton | Other | UPHELD in Whole or Part |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **January** | | 1 | | | | | | | 1 | | **2** | | **1** | | **2** |
| **February** | | | | | | | | | | | **0** | | | | |
| **March** | | | | | | | | 1 | | | **1** | | | | **1** |
| **April** | | | | | | | | | | | | | | | |
| **May** | | | | | | | | | 2 | | **2** | | | | **2** |
| **June** | | | | | | | | | 2 | | **2** | | | | **2** |
| **July** | | | | | | | | | | | | | | | |
| **August** | | | | | | | | | | | | | | | |
| **September** | | | | | | | | | | | | | | | |
| **October** | | | | | | | | | | | | | | | |
| **November** | | | | | | | | | | | | | | | |
| **December** | | | | | | | | | | | | | | | |
| **2024** | | 1 | | | | | | 1 | 5 | | 7 | | 1 | | 7 |
| 2023 | 1 | 4 | 1 | 4 | 0 | 1 | 1 | 0 | 10 | 0 | 22 | 3 | 9 | 0 | 20 |
| 2022 | 3 | 0 | 2 | 3 | 0 | 0 | | 0 | 0 | 0 | 8 | 1 | 7 | 0 | 6 |
| 2021 | 4 | 5 | 1 | 1 | 1 | 0 | | 1 | 0 | 0 | 13 | 6 | 6 | 0 | 12 |
| 2020 | 4 | 1 | 2 | 3 | 1 | 1 | | 0 | 1 | 2 | 15 | 6 | 6 | 0 | 14 |

## Clinical Complaints: January – March 2024

| ID | FROM | DATE RECEIVED | DETAILS OF COMPLAINT | MAIN CLASS | ACTION TAKEN SUMMARY | UPHELD IN PART OR WHOLE |
|---|---|---|---|---|---|---|
| | | | **None reported between April and June 2024** | | | |

## Records – Access Requests

Between January and June 2024, we have had 1 SAR, 1 access to health records request and 2 sharing requests.

| | DSARs | Access To Health Records | Sharing | Care Cost Summary |
|---|---|---|---|---|
| 2024 | 1 | 1 | 2 | |
| 2023 | 0 | 0 | 3 | 5 |
| 2022 | 0 | 5(*2) | 1 | 3(*2 included) |
| 2021 | 0 | 5 | 4 | |
| 2020 | 0 | 3 | 4 | |
| 2019 | 1 | 4 | 0 | |

## Notifications

Between January and June 2024 there have been 16 serious injury notifications made to the CQC all concerning pressure sores grade 3 or above.

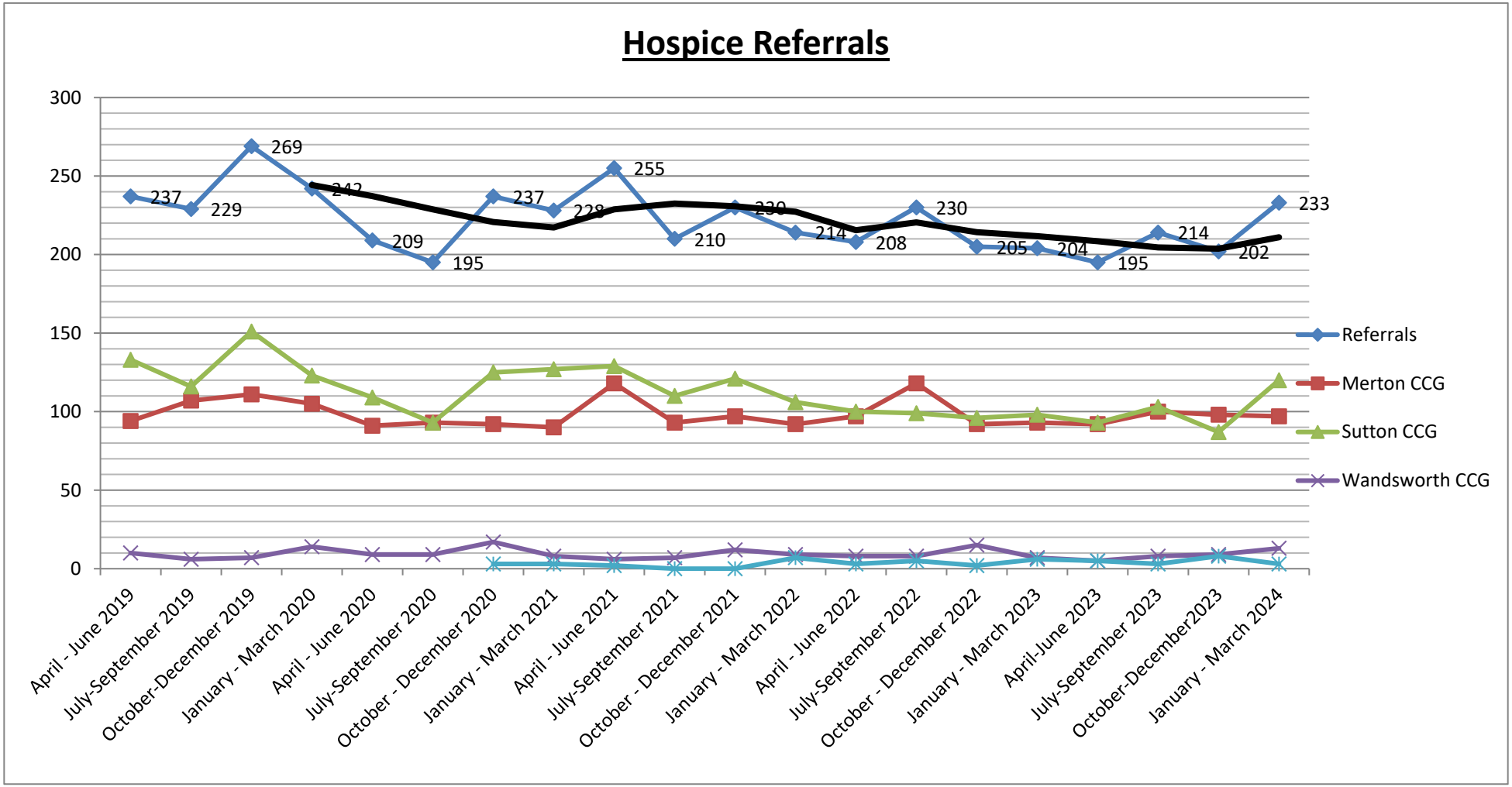
Between January and June 2024 there have been 5 safeguarding notifications made to the CQC: 3 concerning patient self-neglect, 1 concerning financial concern and 1 concerning care provider neglect. All were reported to the local safeguarding teams. Of the 3, 2 have been triggered by report from the Community Team and 1 by the Inpatient Unit Team.

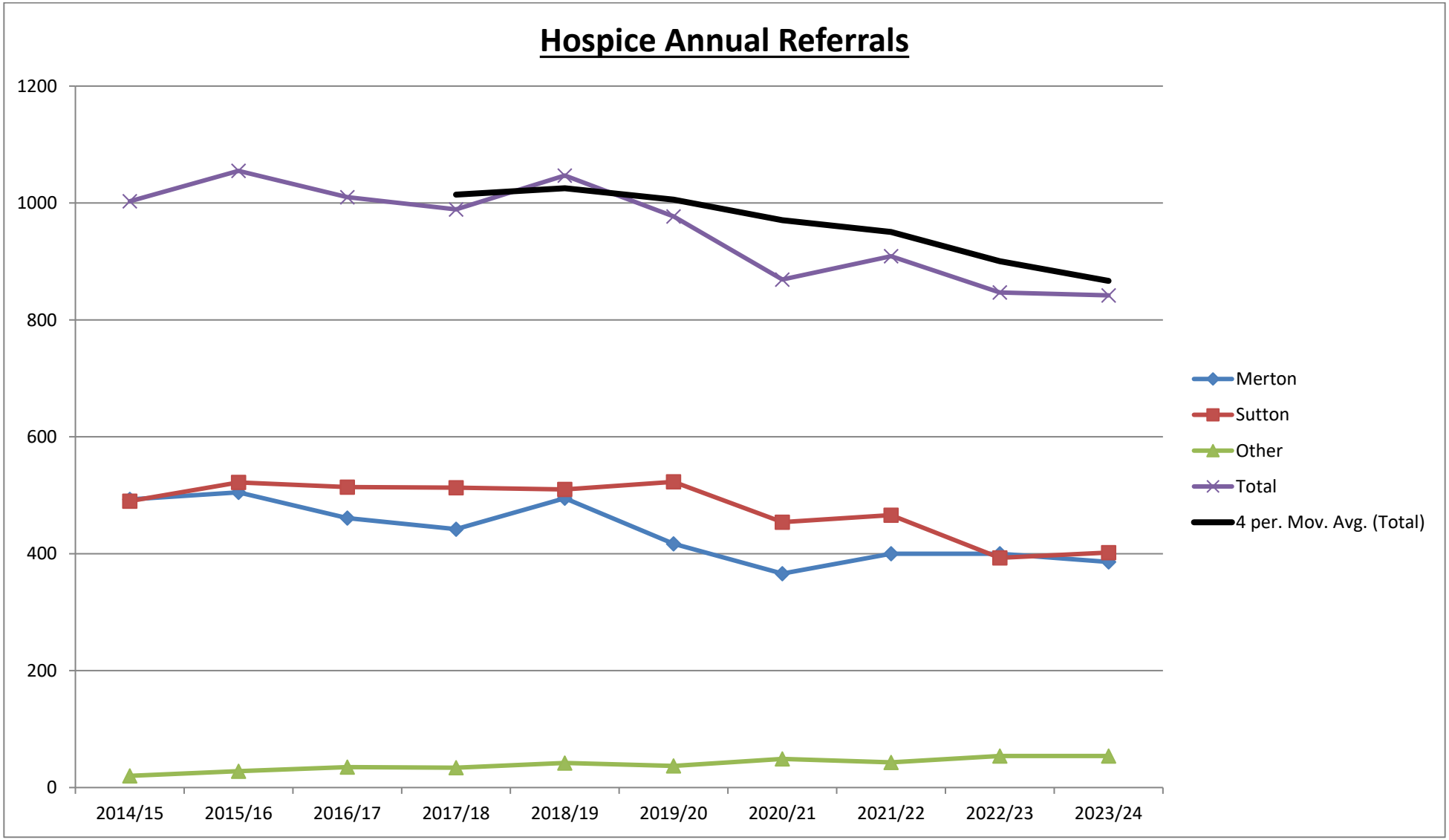
| | Serious Injury | Safeguarding |
|---|---|---|
| 2024 | 16 | 5 |
| 2023 | 21 | 13 |
| 2022 | 9 | 21 |
| 2021 | 10 | 19 |

There have been no safeguarding notification raised against St Raphael's in 2024 to date.

**Clinical Commissioning Group (CCG) Data**

Submission of Activity data for the preceding quarterly period is routinely supplied to the SWL CCG prior to our contract review meetings.




Hospice Annual Referrals
1200
1000
800
600
400
200
0
2014/15
2015/16
2016/17
2017/18
2018/19
2019/20
2020/21
2021/22
2022/23
2023/24
Merton
Sutton
Other
Total
4 per. Mov. Avg. (Total)

The authors of this paper are Mrs R Trower- Clinical Director, Dr N Collins – Lead Palliative Care Consultant and Mr A Rudkin - Director of Quality with inputs from clinical heads.

| Ref No. | Recorded By | Date | EXAMPLES OF EXCELLENT PRACTICE - Description |
|---|---|---|---|
| 2024/17 | | 19/04/2024 | To everyone at St Raphael's, Thank you so much for the kindness you showed not only to our brother/uncle during his last few hours, but also to us as a family. Although he was only with you a few hours he was always clear it was where he wanted to be at the end. Special thanks to the ladies who sat with him until we arrived. |
| 2024/18 | TC/AR | 22/04/2024 | My thanks and appreciation to all of you at St Raphaels Hospice. Thank you for the care and attention that you gave my husband. Also thank you for supporting me during this difficult time. Your invaluable advice helped me a lot to cope with everything. |
| 2024/19 | BT | May-24 | I just wanted to feed back about how brilliant Kate Weldon has been leading Locality 3 while Naomi has been on maternity leave.<br>She is always so approachable, good humoured, willing to listen and help, extremely perceptive and great fun to work with. She clearly demonstrates a natural gift for leadership both as a team leader and on triage, and manages the MDM and caseload reviews efficiently and with great humour and is very skilled at getting the best out of everyone and is very respected and trusted.<br>I have also had the pleasure of doing many joint visits with Kate to some very complicated patients. She has a very warm and easy manner and builds rapport with patients and families very easy and always puts the patient first. She is extremely compassionate and empathetic, has amazing emotional intelligence and is a very instinctive practitioner and I feel she is an exceptional nurse.<br>I went on a joint visit with Kate to a young patient who was struggling with the knowledge she was dying and in severe emotional distress (NSP 1284). Kate had already met NSP a few times previously so had established a relationship and it was clear that both the patient and her husband had great faith in her. When we arrived at the house, NSP was very distressed and wailing and appeared inconsolable. Kate was amazing. She said very little, but simply sat beside her and held her for around 20 minutes until she calmed a little. She created a safe space for her to simply cry as much as she needed to and gave the impression that she had all the time in the world to be there. She was patient and gentle and knew when to challenge and when to sit and be and it was a real privilege to watch her manage the situation so expertly.<br>I will really miss her as our locality lead as she has been wonderful<br>Lorraine |
| 2024/20 | | 07/06/2024 | Deborah Thaxter H@H visited patient 1450 The patient was actively dying and unsettled. His wife was distressed and socially isolated, with no family or friends to turn to for support.<br>Debbie stayed with the patient and his wife all day.<br>Deborah Thaxter H@H visited patient 1450 on 07/06/24 The patient was actively dying and unsettled. His wife was distressed and socially isolated, with no family or friends to turn to for support.<br>Debbie stayed with the patient and his wife all day.<br>The patient died at 1650. Debbie stayed beyond her scheduled finished time to support the patients wife and liaise with his other community services for onward coordination of care |
| 2024/21 | AR | 13/06/2024 | Annual review of individual complaints received between 1st April 2023 and 31st March 2024 highlighted a variety of practice changes / learning that have been exacted/effected that included: -<br><br>1. On the job procedural training re retail sales etiquette, customer service and responding to queries over price.<br>2. The value of documenting patients' wishes in the EPR was re-enforced.<br>3. Consideration to the contacting of DN teams following a patient death on the IPU.<br>4. A recognition that individual behaviours are not always deliberate and that there may be underlying reasons that, when understood, improve acceptance thresholds.<br>5. The value of appropriate and timely communication with those important to patients, customers in the retail environments and volunteers.<br>6. A recognition that behaviour can affect perception and that we should all be self-aware. |
| 2024/22 | TC | Jun-24 | Rapidly deteriorating patient with severe agitation and family distressed . Michelle visited for over 3 hours supporting with s/c EOLC medication and supporting DNs in the home . 5pm joint visit required with Katie and Michelle as patient again very agitated and gap in DN service for shift change |
| 2024/23 | RT/AR | 27/06/2024 | Community member feedback at review summarised relationship with compassionate neighbour (CN) and value of the service offered. My CN is fantastic. We are great friends and have so much fun. We are both flexible and have weekly calls, vists and days out. I wouldn't know what I woudl do if i didn't have her as my CN. Don't you dare separate us or I would be straight down to have words with the manager. All my friends now ask after my CN and want to pinch her and I have to remind her that she is my friend (said in a very fun and jokey way). |

St Raphael's
Your Local Hospice

# QUALITY ACCOUNT
# 2023-2024

"Very caring, individualised and personal care tailored to the patient's and our family's needs"
"Everybody was most helpful. Always had time to answer my questions".
"Compassionate staff, professional at all times. Lovely doctors and nurses and volunteers."

(2023 VOICES SURVEY)

# Contents

# Part 1

## What is a Quality Account?

The Quality Account for St Raphael's Hospice covers the period from 1 April 2023 to 31 March 2024 and is a record of the cycle of continuous quality improvement as we strive to deliver excellent specialist palliative care. It provides an opportunity for us to share best practice and is driven by the experiences of both those providing and receiving our services. It allows us to demonstrate our commitment to engage with evidence-based quality improvement and to outline our progress to the public. We hope that our Quality Account will facilitate an opportunity for review, debate and reflection as well as provide the public, our regulator and commissioners, assurance that we are routinely evaluating our services and focusing on improvement that will enhance and support the delivery of expert specialist palliative and end of life care to the people who use our services.

## St Raphael's Hospice

St Raphael's is an independent registered charity (charity number 1182636, company number 11732567) providing specialist palliative and end of life care services to our community.

Since 1987, St Raphael's has offered hospice care to those facing life-limiting illness living in the boroughs of Merton and Sutton. The service is free of charge to all who use it and provides high quality, expert medical and nursing care delivered in patients' own homes or in our in-patient unit, which has 12 en-suite single rooms and one larger, family suite. We also provide wellbeing services and psychological support services, including social work and bereavement support, to patients and those who are important to them.

Hospice care is holistic and tailored, as far as is practicable, to an individuals' needs. Our expert team are skilled in supporting patients and enabling them to maintain the best quality of life within the constraints of their condition. Our Services included:

- **Specialist clinical care provided by doctors and nurses in our in-patient unit.**
- **Specialist clinical care provided by doctors, nurses and specialist practitioners in patients' homes.**
- **Hospice at Home service offering respite and support to carers.**
- **A Wellbeing Centre providing social and creative opportunities together with practical information and complementary therapies.**
- **Pastoral care and spiritual support.**
- **Psychological support for patients, counselling and bereavement support for those who are important to the patient (including children).**
- **Expert advice and specialist education and information for patients, carers and other professionals.**

It costs around £6.5 million every year to run the Hospice and support the services we provide. We receive a contribution of around 25% of these costs from the NHS, but, we are reliant on the generosity of our local community through charity fundraising, donations and legacies, our lottery and charity shops, to raise the remaining 75% which allows us to continue providing high quality care without charge to everyone receiving our services.

## Statement from the Chief Executive

St Raphael's Hospice provides specialist palliative and end of life care to one in every four people who die in the boroughs of Merton and Sutton. Ultimately, that means that the Hospice will support one in four of all of us, and as the other three are family, friends and neighbours, the work impacts everyone in our community at the deepest level.

As an independent charity which was originally part of the Congregation of the Daughters of the Cross of Liege, our values arise from the Christian teaching to "love our neighbour as ourselves". At its heart, this means to care for everyone, from any and every background, regardless of who they are or what they can do in return, and to do this with the same tenderness and compassion that we might reserve for our closest family or indeed, hope for ourselves. This is our aspiration and I am often heartened to hear how our team has brought a sense of relief to the patients we support and to their families and to others who love and care about them.

As a local charity which is only 25% funded by the NHS we rely on the generosity of our community to raise the money that enables us to be here for all who need us, free of charge. Our strategy of "EVE" is to focus first on "excellence" as this is the foundation from which all else follows; we then aim to raise our "visibility" in the community so that people can be reassured to know who we are and what we do and, crucially, that we aim to do it as well as possible; we then look to "engage" with the whole diversity of our community in order to learn from them and also to provide opportunities for them to connect with us. In this way, we believe that our community will respond and support us by volunteering, by donating and leaving legacies, by playing our lottery or spending in our shops. That is what will enable us to continue to be serving Merton and Sutton long into the future.

This Quality Report outlines some important plans we have for the future and provides some feedback on plans from last year. It also evidences some of the ways that we are able to check ourselves and seek to improve and learn from our shortcomings as well as celebrate things that go well. I am very grateful to our Director of Quality and Governance, Alex Rudkin, who, together with the wider team, has written the report and, as a member of many key committees, helps to hold us all to account in the delivery of these vital services.

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

Nick Stevens
Chief Executive

## Part 2

# Priorities for improvement 2023 – 2024

St Raphael's Hospice is fully compliant with the Fundamental Standards of Quality and Safety that support the section 20 regulations of the Health and Social Care Act 2008 and its subsequent amendments. Consequently, there were no areas of shortfall to include in its priorities for improvement in 2023-2024.

Effective from 1st April 2015, has been our responsibility to meet two groups of regulations:

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

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

Our planning priorities ultimately depend on the resources available to St Raphael's from the NHS's contribution and the very generous support of our donors, supporters, and the communities we serve. The substantial financial challenges we face will affect what we can deliver in the coming year.

Our mission remains to provide a safe and efficient clinical service within the boroughs of Merton and Sutton and parts of Wandsworth, maintaining our IPU facility and specialist care outside, alongside the wellbeing, counselling and bereavement support we can provide to patients, those important to them, and community members.

Our staff and volunteers are at the heart of this, and our wish to support them through necessary organisational change in 2024/25 will be an underpinning factor.

The Board of Trustees and/or its committees have endorsed the Management Plan for 2024/25 and considers that its top three quality improvement priorities are:

## Future planning priority 1:

### An improvement project to develop the Bereavement Pathway

**Standard:** To develop the bereavement pathway project

**Measures:**

- Step by step process spanning pre-death to one-year post death
- Collateral (communication leaflets and letters that support the bereaved that includes fundraising/in memory giving pleas) produced for each step
- Tree of life sculpture
- Book of Remembrance
- Virtual Book of Remembrance & Memory Wall
- Refurbished reflective space
- Closer working between clinical and non-clinical

**Review:** Clinical Heads of Department & Clinical Quality & Governance Committee

## Future planning priority 2:

### An improvement project to expand Provision of Bereavement Support Work to High Down Prison as well as specialist palliative care psychotherapy to residents at end of life

**Standard:** Expand Provision of Bereavement Support Work to High down Prison as well as specialist palliative care psychotherapy to residents at end of life.

**Measures:**

- Grant to fund the project (Linden Foundation) deployed.
- Specialist psychotherapist recruited.
- Project evaluation infrastructure for funding organisation

**Review:** Clinical Heads of Department & Clinical Quality & Governance Committee

## Future planning priority 3:

An improvement priority to embrace the NHS Patient Safety Incident Response Framework (PSIRF), maintain robust infection prevention and control and produce annual report for all accidents and incidents

**Standard:** To build upon the foundation of an open and supportive learning culture through demonstrable embrace of the NHS PSIRF, maintenance of a robust approach to Infection Control across clinical and non-clinical services and production of an annual review report for accidents and incidents that showcases assurance and learning.

**Measures:**

- Incorporation of the PSIRF actions into policy and development of a patient safety plan.
- Accessing of additional training to ensure compliance with PSIRF requirements.
- Production of an annual report for all accidents and incidents.
- Production of an Infection Control annual report.
- Continuation of quarterly graphical presentations of audit results
- Maintenance of access to expert infection control advice and up to date policy.

**Review:** Clinical Heads of Department & Clinical Quality & Governance Committee

# Statements of Assurance from the Hospice Board of Trustees

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

## 2.1 Review of Services

During 2023/2024, St Raphael's Hospice provided 6 NHS partially funded services:

- In-Patient Unit
- Wellbeing Centre
- Outpatients
- Hospice @ Home
- Community Clinical Nurse Specialist/Specialist Practitioner Service
- Psychological Support Services

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

The whole of the income provided by the NHS in 2023-24 was spent directly on the provision of the services listed above that same year.

### What this means

St Raphael's Hospice is partially funded via a standard NHS contract and we need to fundraise in order to balance the books. The income provided by the NHS represents approximately 25% of the overall running costs of the Hospice. We aim to cover the remaining costs through legacies, the profits from our hospice shops and lottery and through donations, grants and fundraising activities from our generous.

## 2.2 Participation in national clinical audits and confidential enquiries

During 2023/2024, no national clinical audits and no confidential enquiries covered NHS services provided by St Raphael's Hospice.

### What this means

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

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

## 2.3 Participation in local clinical audits

The undertaking of clinical audits at a local level feeds into the management planning round for St Raphael's Hospice. Details of projects undertaken in 2023/2024 can be found at section 3.2.1.

## 2.4. Participation in clinical research

Participation in clinical research includes:-

CHELsea II research study examining hydration at the end of life - led by Surrey University Clinical Trials Unit: cluster randomised trial

Palliative care and Oncology Survey on Terminology (POST) Study - led by Our Ladies Hospice in Ireland in liaison with Royal Surrey County Hospital: a patient survey.

## 2.5 Goals agreed with commissioners

The NHS contribution towards St Raphael's Hospice's income in 2023/2024 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework.

## 2.6 What others say about us

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

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

The last Direct Monitoring Review was undertaken by the Care Quality Commission via virtual interview on 19th December 2022. No further regulatory activity was indicated.

The Care Quality Commission has not taken enforcement action against St Raphael's Hospice during 2023/2024.

The hospice has not participated in any special reviews or investigations by the CQC during the reporting period.

## 2.7 Data quality

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

- Data integrity checks to service production of activity data
- System design enhancements to facilitate inputs and useful outputs
- Data cleansing
- Data monitoring

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

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

St Raphael's Hospice submitted its self assessment to service compliance with the NHS Digital Data Security and Protection Toolkit (DSPT) in June 2024.

## Part 3

# Quality Review

### 3.1 Review of quality performance in 2023/2024

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

## Past planning priority 1:

### An improvement project to broaden the offer from the Psychological Support Services Team

**Standard:** To maintain student placements at 8 with the potential to expand should additional environments be secured. To expand the provision of bereavement support work through continuation of the quarterly structured and facilitated bereavement support group and establishment of drop-in groups in partnership with the Wellbeing Centre and North Cheam Church. To increase the delivery of Trauma Specific work (EMDR). To increase the reach of Social Work support and intervention

**Measure:** Maintained or increased student counselling numbers; increased environment provision of counselling rooms; exploration of satellite venues; reduced need for counselling by the Psychological Support Services Clinical Lead; shorter waiting lists; referral and activity data monitoring; increased and /or more responsive Social Work contacts through addition of a part-time Social Work Asst.

**Review:** Student placement numbers have maintained in 2023/24 and bereavement counsellors continue to make a highly valued contribution to the individuals who are either preparing for or are handling a bereavement. Plans for drop-in groups at the North Cheam Church required changing whilst a drop-in group on our site led by our pastoral Sister has flourished. Our Wellbeing Centre and complementary therapies have also been accessed by the bereaved. A Psychological Support Services hub has been established on the Hospice site with designated counselling offices re-furbished and equipped to provide suitable environments for counsellors to use. Planned access to bereavement counselling out of hours was accommodated by the team and provided within the Hospice main building. Social work support was complemented by the addition of a part-time social work assistant and continues to meet the challenges faced by our

patients and their families amidst increased complexity owing to shortage in social housing, cost of living increases and ensuring wishes are in place. Trauma specific work (EMDR) remains a well utilised and comprehensive psychotherapy and in 2023 we were the only UK Hospice delivering this type of treatment. Implementation of a psychological support services client feedback survey that are provided to all once their counselling has ended was implemented in June 2023 and continues to provide excellent assurance that the service meets the needs of its clients.

## Past planning priority 2:

- An improvement project to grow the Compassionate Neighbours Program with community engagement and integration in local health pathways
-
- **Standard:** To grow the number of volunteer Compassionate Neighbours and target funding opportunity to support service growth.
-
- **Measure:** Compassionate Neighbour referral activity data, volunteer numbers, retention and recruitment rates.
-
- **Review:** The number of volunteer Compassionate Neighbours (CN) reached a high of 77 in 2023/24 with 33 being active, 20 on hold and 24 in progress. The average number of visits per month was 125. Recruitment is steady and administrative support was increased in line with the growing numbers. CN support takes the form of weekly visits or telephone calls and is flexible and varied. Some CNs bring their community members to our Wellbeing Centre, others might provide support and company at home to those who are less mobile – this also provides respite for carers. Demand is infinite and challenge is meeting that demand. £10K has just been awarded by the Wimbledon Foundation Community Fund.

## Past planning priority 3:

- An improvement priority to support the design, implementation, training, use, integrity and output of the EMIS (electronic patient record) system
-
- **Standard:** To review membership of the EMIS implementation project team, to highlight user champions within services, to continue with the EMIS issues log review meetings, to plan best use of EMIS professional support, to establish EMIS induction for new starters, to plan staff training that is directed by service, to implement data sharing across GP providers in Merton and Sutton, to evaluate the integrity of data output and feed into user training/communications and develop reporting output that supports the production of organisational activity data.
-
- **Measure:** EMIS project team feedback
-

**Review:** EMIS replaced Crosscare as the Hospice's electronic patient record system in May 2023. Its project team was led by the Director of IT and Estates and the system's configuration was heavily supported by one of the Hospice's consultants in palliative medicine and one of the Hospice's clinical nurse specialists. The project team also comprised the Director of Quality and Improvement and the lead administrator. Following retirement of the lead administrator, the project team was complemented by the addition of the clinical administration lead – a role shared by two members of staff who have provided practical support to users alongside other members of the project team. A program of training that spanned 4 weeks was facilitated by EMIS and was attended by Hospice team members. The system's implementation and usage has been a success and user feedback has been positive. An issues' log that is available to all users provides a depository of required questions, issues and actions. The log is reviewed and actions effected by the consultant in palliative medicine and Director of IT on a routine basis and wider discussion items are included in the agenda of the project team meetings that are held as required. Induction and training on the system is delivered by team members with support from the clinical administration lead, the IT department and other members of the project team. Once the required information governance assurances were

established, implementation of data sharing across all GP providers in Merton and Sutton began in November 2023 and this has been completed with efforts continuing to activate the sharing agreement with our local community nursing teams. System reporting has serviced the delivery of activity data to the Hospice's commissioners – SWLICB and continues to provide assurance over data integrity.

## 3.2 Quality Management

**Clinical Quality and Governance Committee**

The Hospice's Clinical Quality and Governance Committee takes responsibility for providing assurance to the Hospice Board that the organisation has a robust framework for clinical governance that supports the delivery of safe and effective care and the management of clinical systems and processes. To achieve this, the Committee ensures that quality is integral to the work of the Hospice and the systems and services that support that work, and that there is a robust programme that supports the monitoring of clinical performance across all clinical services. Committee members contribute expertise, human resource capacity, and their professional perspectives to the development and successful operation of the Hospice's clinical governance activities. Chaired by a member of the Hospice Board of Trustees, it meets every 3 months. Its membership includes Trustee Members, the CEO, the Clinical Director, the Lead Palliative Medicine Consultant and the Director of Quality and Governance. Standing items for this Committee include Evidence of Excellent Practice, the Clinical Risk Register, Clinical Quality and Governance Objectives, the Clinical Quality and Governance Report (Clinical Developments, Clinical Risk Management, Clinical Audit, Clinical Effectiveness including Policy Development, Information Material, Practice Development, Patient/User Feedback, Organisational and Regulatory Assurance, Infection Prevention and Control and Clinical Complaints).

**Training & Development Committee**

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

## Drugs & Therapeutics Committee

The Hospice's Drugs & Therapeutics Committee steers the Hospice's approach to drug and therapeutic governance. Chaired by a Hospice Palliative Medicine Consultant, it meets every 4 months. Its membership includes the Consultants in Palliative Medicine, medical prescribers, non-medical prescribers, the Inpatient Unit Nursing Lead, the Community Services Team Manager, Practice Education, the Clinical Pharmacist, the Chief Pharmacists for Sutton and Merton areas of the SWLICB (or designated representative), the Clinical Director and the Director of Quality and Governance. Standing items for this Committee include Safe CD prescribing & administration, Guideline/Policy updates, Therapeutic Governance including cost trending, Medication Incident Review, Non-medical Prescribing and MHRA Drug & Device Alerts.

## Health & Safety Committee

The Hospice's Health & Safety Committee steers the Hospice's approach to health and safety and supports the communications of 'Works' updates for the site. Chaired by the Director of Quality and Governance, it meets every 2-3 months. Its membership includes the Facilities Manager, the CEO, the Clinical Director, the Director of IT and Estates, the IPU Nursing Lead, the Community Services Team link nurse, the Housekeeping Manager, the Commercial Director (or rep), and both clinical and non-clinical link staff for Health & Safety. Standing items for this Committee include Health & Safety Management Update regarding H&S legislation/practice development, Compliance with Audit Recommendations, Policies & Risk Management, Water Quality and Management. Non-clinical Accident & Incident Review, Works Update, Health & Safety matters affecting staff, volunteers, systems and the environment.

## Infection Prevention & Control Committee

The Hospice's Infection Control Committee steers the Hospice's approach to infection prevention and control. Chaired by a Consultant Microbiologist from the local acute Trust, it meets between two and four times per year. Its membership includes the Clinical Director, the Hospice Lead for Infection Prevention and Control, a Palliative Medicine Consultant, the IPU Nursing Lead, the IPU IC link nurse, Practice Education, the Facilities Manager, the Director of Quality and Governance and the Housekeeping Manager. Standing items for the Committee include Infection Control Issues, Sharps Injury & Body Fluid Exposure, Alert Organisms Surveillance, Water Management, Occupational Health Update and Regulatory/Best Practice Requirements.

### 3.2.1 Clinical Audit

During 2023/2024, the Hospice undertook a number of clinical audit projects, amongst which were:

| Project | Results/Actions/Comments |
|---|---|
| Prescription Chart Documentation Audit | Weekly audit by the Hospice's Clinical Pharmacist shows 316 charts assessed in 2023/24 (c.f. 340 charts in 2022/23) comprising 5709 prescription items (c.f. 5722 in 2022/23) and a respective evident prescription writing error rate of 0.8% and administration error rate of 0.8% (c.f. 0.7% and 0.5% in 2022/23). |
| Inpatient Unit Satisfaction Survey | 2023 results show that overall satisfaction returns at 98% c.f. 99% in 2022. Feedback around care and treatment has been excellent. Particularly complimentary responses surround being treated with dignity and respect, hygiene, nursing care and privacy. Further effort has been highlighted to improve participation with the survey alongside access to OOH vending. |
| Safeguarding Documentation Audit | All safeguarding events raised to the LA were raised with the CQC – 100% compliance. |
| Care of Dying Adults in the last days of life – IPU & Community Re-audit | Report published in 2023 showed the good documentation of the assessment of needs across all symptoms and including pressure areas, mouth care, hygiene, bladder and bowel function (100% achieved). This is testament to the diligence of medical and nursing teams work and documentation.<br>There was good documentation of other needs- anxiety, psychological support, social and practical needs (100%). This was slightly less for spiritual, religious and cultural needs (86%).<br>There was documentation confirming that 100% of patients had their nutrition and hydration assessed daily and that all patients were supported to eat and drink as long as they were able to and wished to.<br>100% of patients who were able (due to conscious levels and capacity) and 100% of next of kin had a discussion regarding resuscitation.<br>100% of patients had a treatment escalation plan documented.<br>Additional actions include review of the elements that comprise the "individualised end of life care plan", usage of the EOLC template when the patient is entering the dying phase, raising the profile of spiritual care and production of new information literature on eating and drinking at the end of life. |
| Mouthcare Audit | 2023's audit showed an improvement in mouthcare risk assessments being completed on admission, however, the target of 100% was only reached twice on any audit month with the average completion across the 8 months of audit reaching 89%. Frequency of reassessment being every 3 days improved during the audit period with 5 of the latest audit months achieving either the 80% median or higher with a peak at 92%. Undertaking mouthcare three times a day was a new objective and whilst compliance initially was low, this improved to the latter four months data showing 69% compliance. |

| Project | Results/Actions/Comments |
|---|---|
| IPU Risk Assessments Audit | 2023's report showed that 97% (c.f. 83% in 2022) of admissions had their pressure area risk assessment (RA) undertaken on admission, 97% (c.f. 95% in 2022) their handling and falls risk assessment undertaken within 4 hours of admission. 92% of pressure area risk assessments (c.f. 90% in 2022) and 92% of handling and falls risk assessment (c.f. 89%) hold evidence of review within 3 days. 88% of Cat 2 (or above) pressure ulcers (c.f. 64% in 2022) were reported in the risk management incident system. 100% of patients (c.f. 100% in 2022) identified as falls risk had care plans written. 100% of falls were reported in the risk management incident system (c.f. 100% in 2022). 100% of falls had their RAs updated (c.f. 50^ in 2022). 100% of falls were reported to a Doctor (c.f. 100% in 2022). 100% of falls had the falls protocol followed (c.f. 88% in 2022). Compliance for completing risk assessments for pressure ulcers and falls on admission and after 72 hours has improved since the last audit which is positive. Auditing whether risk assessments continued to be reviewed every 72 hours was new for the latest audit and showed less compliance. On over half of the cases where a risk assessment was completed on day 4 rather than day 3 this was between the end of one month and beginning of the next.<br>There were no instances where one risk assessment had been completed without the other, for example falls being completed without pressure ulcer care. Compliance with falls reporting and following protocol has improved from 2022. |
| Use of Language Line QI project | Results in 2023 showed that 29% of patients were non-native English speakers and, of these, 77% of these patients were fluent in English and did not require an interpreter. 16% were not fluent in English, 5% did not have their fluency recorded and 2% were fluent but had other communication difficulties. Language line was offered to 33% of those who were not fluent with/without communication difficulties. Use of relatives were the main interpreters during consultations. The offer of interpreter can be multi-faceted owing to patient preference, perceptions of interpreters, precedents already set by hospital to not use an interpreter owing to patients attending appointments with a carer, friend or family member.<br>Recommended actions included:<br>1. To identify at first point of contact whether or not the patient speaks English fluently/ well enough to engage in a first assessment without a need for an interpreter. If this is not the case then to recommend/offer the use of an interpreter, and document clearly this discussion/decision and outcome.<br>2. First language and fluency status should be documented for all non-native English speakers, and the nature of communication difficulties should be specified. Where interpreters are offered this should be documented, including the informed consent process if the offer of an interpreter is declined.<br>3. To ensure every patient on our caseload has a confirmed ethnicity recorded and checked with them. |
| Hospice @ Home Carer/Relative Satisfaction Survey | 2023 results show that 100% of respondents would recommend St Raphael's Hospice @ Home service with, again, an increase in how 'very' helpful the service had been across a range of criteria that includes comfort measures, emotional support, face to face advice, telephone advice during the day and night, respite sits, enabling the patient to stay at home and dealing with a crisis. The survey affirms the value and skill of the service and staff involved. |

| Project | Results/Actions/Comments |
|---|---|
| IPU Referrals QI project | 2023/24's review period showed that 91% of patients referred to the IPU were able to be admitted to the hospice compared to 84% and 54% in the previous periods. The data demonstrates that remaining open to 10 beds with required occupancy flexibility based on patient dependency and staffing levels allowed almost all patients referred to be admitted to the IPU during this review period.<br>The number of admissions achieving the urgency time frame standard during this review period was 90% versus 57% and 43% during the previous periods. This is a significant improvement and reflects the responsiveness of the IPU to admission requests during this time period. The afternoon admissions meeting becoming embedded may have contributed to this responsiveness. Examining the source of referrals, this has evened out with 48% from home and hospital respectively and one admission from prison. Clarification of the process for OOA requests within local policy documents has increased team confidence in this area, including the process for OOA NHS CC funding for symptom control admissions.<br>The number of IPU referrals was slightly higher than the previous review period with a rate of 0.7 referrals a day compared to 0.6, but still lower than the peak of 0.9 referrals a day during the initial review period (Feb/March 22). This may reflect the return to normal community services following a period of instability around the COVID pandemic allowing more people to remain at home.<br><br>Looking at AKPS this review period showed that the majority (95%) of patients had a score of 40% (in bed more than 50% of the time) or lower with only one patient with a score above this of 70%. This supports the ongoing nursing numbers required to safely manage our inpatients, who require extensive nursing care. Looking at POI, the majority of patients were rated as deteriorating on admission to the hospice.<br><br>Admission Score sheet completion showed some improvement during this review period with 87% of patients referred having a scoresheet completed compared with 83% and 79% during the previous audit periods.<br><br>This review period showed continued improvement in the IPU responsiveness to admission requests during January 2024 with 96% of patients being offered a bed following referral to the IPU. The urgency of the referral was met for 90% of referrals. This supports our current model of working with an occupancy of 10 IPU beds, with daily review of staffing levels and patient dependency guiding the number of admissions each day. |
| Phase of Illness & AKPS Audit | 2023's report showed 100% patients had POI & AKPS completed on admission which is the same as in the initial 2021 audit. 100% patients had POI & AKPS completed on discharge – the 2021 data showed 60% had AKPS completed, so re-audit has shown improvement in this aspect although the sample size is lower. POI/AKPS is a useful, more objective way to monitor a patient's condition during admissions at the hospice. On the IPU, admission scores were completed 100%, and there was an improvement to 100% of recording POI/AKPS on discharge. The recognition of last days of life is always nuanced & difficult to assess, however our team have demonstrated the ability to recognise deterioration & dying, reflected in POI scores which were selected appropriately around 67 – 100% of the time. It is likely deteriorating and the possibility of dying were communicated to families even if the dying POI was not selected. From experience, the team only feel able to select the dying phase when they recognise 'active' dying. |

| Project | Results/Actions/Comments |
|---|---|
| Psychological Support Services (PSS) Survey | 2023 saw the introduction of a feedback questionnaire for the clients receiving a psychological support service from St Raphael's Hospice i.e. counselling/psychotherapy or social work support. Overall satisfaction with the service across 10 criteria achieved 98% compliance with 100% of participants recommending the services to others. The survey supports the maintenance and development of the counselling services offered to patients and those important tto them |
| VOICES Survey | The National Survey of Bereaved People (VOICES, Views of Informal Carers – Evaluation of Services) collects information on bereaved people's views on the quality of care provided to a friend or relative in the last 3 months of life. The survey was commissioned by the Department of Health in the NHS in 2011. Nationally, VOICES data provides information to inform policy requirements, including the End of Life Care Strategy, that promote high quality care for all adults at the end of life<br>The information given in response to the survey supports us to improve people's experiences of care at the end of life. Results in 2023:-<br>Responses to the questions on the care and environment provided in the inpatient ward (IPU) are overwhelmingly positive, with all respondents agreeing that help with personal care and nursing care met their requirements and all but one agreeing that the environment respected the patients' privacy.<br>Definite assertion of the adequacy of emotional support decreased slightly to 89% from 90%.<br>Definite assertion that symptoms other than pain in the IPU had been definitely or to some extent relieved has decreased to 94% from 100%.<br>Pain relief in the IPU, reported to have been relieved completely either, 'all of the time' or 'some of the time', has decreased slightly to 94% from 95%..<br>Keeping family members always informed of the patient's condition was considered met for 84% from 82%.<br>Always treating patients with respect and dignity was considered highly for both doctors and nurses at 100% from 95% for nurses and at 100% from 95% for doctors.<br>A larger proportion of respondents regarded that being able to stay overnight in the Hospice was important – 75% from 55%.<br>A decrease in the numbers that considered they had definitely received enough emotional support as an inpatient – 75% from 86%.<br>Respondents were asked to rate care given to the patients by doctors and nurses on admission to the IPU. Taking 'exceptional' and 'excellent' together there is maintenance at 95% from 95% for doctors and nursing staff.<br>Regarding the food provided on the IPU, 'exceptional' and 'excellent' ratings combined decreased to 80% from 82%.<br>95% of respondents rated the patient bedroom as 'Excellent' from 91%.<br>Overall, care provided by the Community Palliative Care Team was considered as either 'Exceptional', 'Excellent' or 'Good' by 100% from 88% in the previous bi-annual report.<br>The proportion of respondents that considered contact from the bereavement team was either definitely helpful or helpful to some degree has increased to 82% from 76%.<br>Responding to the Friends & Family question, 98% rated the Hospice as either 'Very Good' or 'Good' (c.f.94%), 2% 'Neither Good Nor Poor' (c.f. 3%) and 0% rated it as either 'Poor' or 'Very Poor' (c.f. 3%). |

### 3.2.2 Risk Management

| Project | Actions |
|---|---|
| Non-patient Accidents & Incidents | 100% of reported non-patient accidents or incidents showed evidence of action taken consequential to occurrence. The number of reported non-patient incidents/accidents has maintained a reporting level of within 2.6% of 2022's figures owing to continued embrace of the electronic reporting system, a low threshold reporting culture and the value associated with our potential to learn. Number of injurious accidents were 50% lower than 2022's figures. There were no non-clinical incidents nor accidents that required report to the CQC in 2023. |
| Clinical Incidents & Near Misses | A 6.7% increase in reported incidents in 2023 overall maintains the embrace and use of of the electronic incident reporting system alongside a low threshold reporting culture and the value associated with our potential to learn.<br>In 2023, medication incidents constituted 34% of all clinical incidents (c.f. 30% in 2022).<br>In 2023, pressure ulcers on admission constituted 16% of all clinical incidents (c.f. 12% in 2022).<br>The patient fall rate in 2023/24 per 1000 bed days is 6.81 (c.f. 8.26 in 2022/23 and injurious falls in 2023/24 is 1.02 (c.f. 2.41 per 1000 occupied bed days in 2022/23). |
| CQC notifications | In 2023/2024, there were 27 serious injury notifications all relating to pressure ulcers of which 21 were identified upon admission and 12 safeguarding notifications made. |
| Continuous Improvement Log | In compliance with information governance requirements to log information incidents, 23 incidents were recorded in our information governance continuous improvement log in 2023/2024. |
| Subject Access Requests under the Data Protection Act 2018 or Requests made under the Access to Health Record Act 1990 | In 2023/2024, there was 1 access request received under the Access to Health Record Act 1990. |

### 3.2.3 Clinical Effectiveness

## Clinical policy and guidelines

Clinical policy and guidelines are incorporated into the central system of policy document management. As with all policy, review lead ownership is attributed to individual members of the multi-disciplinary team.

There were 56 clinical policy/guideline reviews in 2023/24:-

| CLINICAL | TITLE | ISSUE DATE |
|---|---|---|
| CLIN01 | Admissions Policy | 11/09/2023 |
| CLIN02 | Care after Death | 02/08/2023<br>23/08/2023<br>25/10/2023 |
| CLIN05 | Consent Policy | 30/08/2023 |
| CLIN07 | Discharge Policy | 03/08/2023 |

| CLINICAL | TITLE | ISSUE DATE |
|---|---|---|
| CLIN08 | Infection Control | 31/08/2023<br>16/11/2023<br>06/02/2024 |
| CLIN09 | Referral to Hospice Services | 05/10/2023 |
| CLIN12 | Safeguarding Children | 07/06/2023<br>16/10/2023<br>19/02/2024 |
| CLIN13 | Suicide Policy | 13/02/2024 |
| CLIN14 | Safeguarding Adults | 07/06/2023<br>16/10/2023<br>19/02/2024 |
| CLIN15 | Deprivation of Liberty Guidelines | 30/06/2023 |
| CLIN16 | Mental Capacity Act – Guidelines | 22/03/2024 |
| CLIN17 | Management of Patients with Enteral Catheters and Feeding Systems | 22/12/2023 |
| CLIN24 | Diabetic Management | 06/10/2023 |
| CLIN25 | Controlled Drugs | 22/12/2023 |
| CLIN25a | Safety and storage of patients' own CDs in the Community | 19/03/2024 |
| CLIN26 | Generic Drugs | 09/08/2023 |
| CLIN31 | Mouthcare Guidelines | 23/05/2023 |
| CLIN32 | Naloxone administration in the palliative care setting | 07/02/2024 |
| CLIN32a | Naloxone flowchart | 07/02/2024 |
| CLIN33 | Non-medical Prescribers' Policy | 07/06/2023 |
| CLIN39 | Pressure Ulcer Prevention and Management Guidelines | 20/12/2023 |
| CLIN44 | Venous Thromboembolism Prophylaxis Guidelines | 15/05/2023 |
| CLIN48 | Community Services' Operational Policy | 07/09/2023 |
| CLIN52 | Managing Covid 19 | 25/05/2023<br>16/11/2023<br>18/01/2024<br>19/02/2024 |
| CLIN53 | Implantable Cardiac Defibrillator Guidance | 25/03/2024 |
| CLIN57 | Community Guidance on Injectable Medications for Symptom Control at the End of Life | 19/12/2023 |
| CLIN58 | Use of the MAAR Chart for subcutaneous and intramuscular medication in the community | 08/03/2024 |
| CLIN60 | Subcutaneous Administration of Levetiracetam (Keppra) | 22/12/2023 |
| CLIN67 | Treating patients and those important to them with dignity, privacy and respect | 04/01/2024 |
| CLINSOP02 | Medical Team On-call (PAH, SRH, Kingston Acute Trust) | 25/03/2024 |
| CLINSOP04 | Inpatient Unit Shift Coordinator | 03/08/2023 |
| CLINSOP05 | Inpatient Unit Weekend or Bank Holiday Coordinator | 30/06/2023 |
| CLINSOP08 | Using Phase of Illness and the Australian Karnofsky Performance Scale Index – integrating OACC step 1 | 12/12/2023 |
| CLINSOP11 | Aerosol Generated Procedures – Visiting Patients in the Community | 09/05/2023 |
| CLINSOP20 | Safe Handling and Management of SHARPS injury / occupational exposure to blood borne viruses | 28/04/2023 |
| CLINSOP22 | Re-purposing medication that is no longer required by inpatients | 13/11/2023<br>22/12/2023 |
| CLINSOP24 | Transport of medication | 08/03/2024 |
| CLINSOP24a | Returning unused CDs or medication to a community pharmacy from the patient home | 19/03/2024 |

| CLINICAL | TITLE | ISSUE DATE |
|---|---|---|
| CLINSOP25 | Supporting a mesothelioma and/or private health insurance claim | 07/06/2023<br>28/11/2023 |
| CLINSOP27 | Visiting Guidance | 30/06/2023 |
| CLINSOP28 | Care and maintenance of a PICC (Peripherally Inserted Central Catheter) | 09/11/2023 |
| CLINSOP29 | Transfer of IPU Patients | 31/10/2023 |
| CLINSOP30 | Palliative care support for patients who are substance misusers | 19/02/2024 |

## Education

Education is an on-going activity and is vitally significant to the care delivered at St Raphael's. There is a considerable amount of formal and informal clinical education usually delivered across all service areas. Provision of education was impacted by an ongoing period of sickness from November 2023. Mandatory training remained a priority in 2023/2024. Training is delivered by the Education Team, SRH staff, external trainers and via Bluestream Academy. Whilst not an exhaustive list, the clinical training delivered in 2023/2024 included:

## Non-clinical team training

- Equality, diversity and inclusion
- Industrial Manual Handling
- Food Hygiene
- First Aid at Work

## Clinical team training:

- Manual Handling
- PPE training
- Fit testing
- Equality, diversity & inclusion
- Sage & Thyme communication training
- Conflict Resolution
- First Aid at Work
- EMIS

## Nursing Team Training

- Registered Nurse Verification of Adult Expected Death
- Tracheostomy care
- Safeguarding
- HCA second checker of controlled drugs
- Competencies
- Medicines management IPU and CPCT
- Catheterisation training
- Preceptorship programme- supporting newly qualified nurses in their new role
- Non-Medical Prescribing Update
- Advanced Communications Skills Training
- HCA Study Day
- IPU Study Day (incl. 'Agitation')
- Fast Track Training
- EMIS

## Training for external healthcare professionals

- Palliative care 'Masterclass'- facilitated by the Medical Team. Attended by 16 GPs from the local area.
- Non–Medical Prescribing Update - facilitated by the Education Team and the Medical Team. Attended by internal non -medical prescribers and external non -medical prescribers
- Advanced Communication Skills Training- facilitated by the Education Team. Attended by internal and 6 external healthcare professionals.
- The Education Team gave a presentation on Palliative Care to third year nursing students at the University of Roehampton.
- End of Life: Sensitive conversations and planning ahead- monthly sessions for care home staff in Sutton and Merton, to facilitate advance care planning. Facilitated by the Education Team.

- Invitation to speak at Merton GP training afternoon delivered by palliative medicine consultants alongside Merton EOL team lead CNS Smith.
- The Hospice supports placement requests from the wider healthcare community including District Nurses, Paramedics, Clinical Nurse Specialists and GPs.

## Medical team Journal Clubs

- Fatigue in cancer patients in palliative care – a review on pharmacological interventions
- MDU – introduction to confidentiality
- Dealing with cultural diversity in palliative care
- Psychogenic non epileptic seizure: an empathetic, practical approach
- Ignorance is bliss? With attention to ethical theories, discuss the role of truth-telling within good palliative care
- Finding meaning in the hidden curriculum – the use of the hermeneutic window in medical education
- Iatrogenic suffering at the end of life: an ethnographic study
- Epilepsy and brain tumours
- Cultural competence in pain and palliative care
- Ethics of sedation for existential suffering
- AI-based clinical decision making systems in palliative medicine ethical challenges
- Redefining palliative care – a new consensus-based definition
- Propantheline for excess respiratory secretions in MND
- Differences in trends in discharge location in a cohort of hospitalised patients with cancer and non-cancer diagnoses receiving specialist palliative care: a retrospective cohort study
- Podcast – people I (mostly) admire – drawing from life (and death)
- Palliative care for people with a pre-existing diagnosis of mental health – Hospice Webinar
- A good death: non-negotiable personal conditions for clinicians, healthcare administrators and support staff
- Effect of chair placement on physicians' behaviour and patients' satisfaction: randomised deception trial
- Workload and the mysterious law of karma
- Efficacy of cola ingestion for oeseophageal food bolus impaction: open label, multicentre, RCT

## Schwartz Rounds

| | |
|---|---|
| April 2023 – ‘An unusual request’ | June 2023 – ‘When you feel you can’t go back’ |
| July 2023 – ‘Why I work here’ | September 2023 – ‘A patient I’ll never forget’ |
| December 2023 – ‘This time of year’ | January 2024 – ‘Feeling on the outside’ |
| March 2024 - ‘Kindness’ | |

## 3.2.4 Mandatory Training

Whist the importance attached to clinical education is particularly high, all staff at St Raphael’s and volunteers undertaking specific roles are required to undertake mandatory training. E-learning across the required mandatory training is complemented by ‘hands-on’ training as the topic requires. Bluestream Academy was introduced as our new e-learning provider in February 2024. The new system provides a wide range of modules and enhances our reporting. Training effected in 2023/2024 included the following topics:

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

**Planned training for 2024**

- Palliative Care Masterclass
- Advanced Communication Skills Training
- Non -Medical Prescribing Update
- Medicines Management for nursing teams

- HCA Second Checker Controlled Drugs MDT Journal Club meets on a monthly basis and is open to all clinical staff
- Learn@Lunch is open to all staff with different presentations each month.
- The EducationTeam support nursing staff with their revalidation process.

### 3.2.5 Clinical Research : See 2.4. Participation in clinical research.

### 3.2.6 Complaints Management

In 2023/24, there were 18 complaints received: 7 clinical and 11 non-clinical. All have been investigated by a member of the Executive and reviewed by the Hospice Board of Trustees. All complaints received in 2023/24 have been closed.

### 3.2.7 User Feedback

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

- Inpatient Satisfaction Survey
- Bereaved Carer/Relative Survey (VOICES)
- Hospice@Home Service Carer/Relative Survey
- Psychological Support Services Survey

Feedback on the services provided and experienced is regarded highly at St Raphael's. User feedback is embraced as a spoke of the continuous quality improvement that the Hospice seeks to achieve. Actions arising from feedback either through survey or other route continue to inform plans amongst which are service re-design, development of literature, policy and stewardship arrangements alongside improved forms of communication and engagement.
The Hospice User Group (HUG) was initiated in January 2024 and is already contributing to the content of the Hospice's patient and carer information. Its usefulness will be developed over the coming year.

### 3.2.8 Information Governance

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

### 3.2.10 Organisational Development

St Raphael's Hospice seeks to be a learning organisation that is evolving and expects to continue to evolve to meet the changing demands for palliative and end of life care effectively. Within the constraints of our charitable funding we aim to provide the highest quality service that we can and to aspire to excellence in all that we do, whether clinically or in our fundraising and retail activities. We recognise that our external facing reputation is an important reflection of our internal realities and as such we seek to reflect upon and learn from feedback in all its guises.

As an independent charity we are governed by a Board of Trustees who are unremunerated volunteers and freely provide their expertise, and are ultimately responsible for the operation of the Hospice. With support from the Executive team, who create the annual management plan and budgets, the Board approve the plan and monitor progress on a quarterly basis through the Committee structure which reports to the main Board. The Board are also responsible for the longer term strategy and vision of the charity and each year aims to progress towards that sustainable future where St Raphael's is known as a reassuring presence at the heart of the communities of Merton and Sutton.

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

The Quality Account was compiled by the Director of Quality and Governance.
Extensive consultation with managers constitutes the annual management planning process that feeds into the Quality Account.
The Quality Account has been derived from the management planning process and the business of the Hospice's governance committees.

**MINUTES OF THE**
**INFECTION CONTROL COMMITTEE**

**Held at 1pm on 11th June 2024**
**at St Bede's Conference Centre and via Zoom**

**Attendance**

(Dr JS) Dr J Stephenson, Consultant Microbiologist -ESTH, SSAH (Chair)
(AR) A Rudkin – Director of Quality and Improvement
(JC) J Cope – Quality Support (Minutes)
(RT) R Trower – Clinical Director
(SM) Sara Mosalam – Infection Control Lead

**Apologies**

(PD-P) P Di-Palma – Housekeeping
(AD) A Durrant – IPU rep
(SL) S Leech – IPU IC Link HCA
(MP) M Prior – Clinical Nurse Specialist
(NC) Dr N Collins – Palliative Care Consultant
(TC) T Christmas – Community Team Manager
(CF) C Foster - IPU IC Link RN
(MS) M Sorrell – Community rep
(SC) S Cresswell – Facilities
(MF) M Flint – Palliative Care Educator
(JF) J Ford – Staff Nurse

**ITEM 1: Welcome**

**Action**

Dr JS extended welcome to all present. AR welcomed SM to the meeting. The contract with the Epson and St Helier Infection Control Team has ended and SM is the Infection Control Lead at the Hospice

**ITEM 2: Apologies**

Apologies as listed above

## ITEM 3: Minutes of the last meeting held on 20 February 2024

3.1 These were accepted.

## ITEM 4: Matters Arising

4.1 **Removal of hand washing basin plugs (8.1).** This has been carried out.

4.2 **ICC on-line courses (12.1).** The ICC online courses were completed. SM advised that the module took the form of questionnaires, but there has been no feedback as yet. The questionnaires were sent by Debbie Calver through South West London Health Protection Unit.

## ITEM 5: COVID-19 Update

5.1 **Staffing:** Currently minimal impact

5.2 **Testing :** SM advised that the testing guidelines have been updated. LFT testing is only used if symptomatic. The definition of an outbreak has been updated in the policy. There is still a stock of LFT tests for patients who are eligible for treatment. AR pointed out that COVID testing is on the meeting's agenda through being a legacy item and asked Dr JS whether COVID is still an item on St Helier's agenda. DR JS replied that hospital acquired COVID is still an item at St Helier.

5.3 **PPE :** Dr JS told the meeting that in the Epsom and St Helier trust, all clinical staff do Fit testing. SM informed the meeting that Fit testing was performed by 65 staff members (90% of staff) over the past 6 months. Fit testing is to be reviewed once every 2 years for each staff member.

5.4 **POLICY :** SM has updated CLIN52 Managing COVID to include the route of availability and FTP testing. AR informed the meeting that, unsurprisingly, the COVID policy has been the most frequently updated policy.

## ITEM 6: IPC training/ education

6.1 SM informed the meeting that some sessions have already been conducted with IPU staff. There is a board in the staffroom with updates for staff.

## ITEM 7: IPC Incidents / Sharps Injuries / Body Fluid Exposures / Audit

7.1 There have been no new incidents. AR commended staff for their diligence. RT informed the meeting that the hospice uses needles with safety caps now. SM added that the monthly IC audits provide assurance and support aspects for improvement. Quarterly graphical reporting produced by JC reflects the data. Dr JS suggested that there be a written summary included in the minutes and delivered at this meeting. Set out below are the figures for the 4th quarter (January-March 2024) of 2023/24 with available figures for the 3rd quarter 2023 (October – December) 2023/24 also included. This is followed by a written summary specifically for the 4th quarter of 2023/24. **SM/JC**

| IPC Criterion | Jan-Mar 2024 | Oct – Dec 2023 |
|---|---|---|
| Staff Hand Hygiene | **80%** | **95%** |
| St Bede's Environmental | **99%** | **NA** |
| Wellbeing Centre Environmental | **92%** | **NA** |
| Men's Den Environmental | **100%** | **NA** |
| IPU Environmental | **90%** | **86%** |
| IPU Staff Spot Check | **98%** | **100%** |
| Sharps | **89%** | **88%** |
| Urinary Catheter Insertion | **92%** | **97%** |
| Waste Management | **50%** | **80%** |

7.2.1 Overall compliance for staff hand hygiene is 80%. Overall compliance is reduced due to lower compliance related to the availability of alcohol gel –15% compliance.

7.2.2 The St Bede's Environmental Audit shows 99% compliance. The only instance of non-compliance was unused items in reception not being stored correctly. The Wellbeing Centre Environmental audit showed a 92% compliance. The area of lowest compliance was the Wellbeing main room with 77% compliance. The Men's Den Environmental Audit showed 100% compliance across all criteria

7.2.3 The Sharps Audit showed 89% compliance overall. Areas for improvement include keeping sharps' trays clean and tidy and making sure that sharps bins are not missing and do not contain items other than sharps.

7.2.4 IPU staff spot checks showed a 98% compliance. The only instances of non-compliance were single instances of staff members not being compliant regarding being bare below elbows, keeping nails short and free of polish, and not wearing jewelry.

7.2.5 The IPU Environmental Audit showed an overall compliance of 90%. The areas which brought down the overall compliance were: unused items being stored away, soft furnishings being clean and in good working order, and desks and surfaces being clean and free of dust. These 3 criteria achieved 50% compliance, whereas the other 12 criteria all achieved 100% compliance.

7.2.6 Waste Management showed 50% overall compliance. Areas where compliance was not achieved were the bin area being secure from public access, the bins not being overfilled, the bins being labelled correctly and the bins being labelled and tied correctly.

7.2.7 The Urinary Catheter Insertion audit shows overall compliance of 92%. The one criterion that reduces overall compliance is the standard that the draining bag be dated and changed by day 8. This has achieved 60% compliance whereas the other criteria show perfect compliance.

## ITEM 8 : Alert Organisms Surveillance

8.1 RT informed the meeting that pathology services from SSAH will require review alongside evaluation of potential service from Epsom and St Helier. The current contract with Spire Healthcare is expensive. SSAH provide paper reports rather than electronically linking into EMIS – the Hospice EPR system. RT will liaise with Princess Alice Hospice in Esher to check what their contract with Epsom and St Helier entails and what the cost is. There will be the additional considerations of storage and delivery should another provider be viable.

## ITEM 9 : Water Assessment and testing update

9.1 AR informed the meeting that there has been a refurbishment of the kitchen area with fitments replaced and a more robust flushing routine implemented by Facilities. There have been no new outbreaks of Legionella in the water. Dr JS asked whether there was a separate water safety group and AR replied that there is not, but water safety is a standing item at the H&S Committee.

## ITEM 10 : Any Other Business

10.1 SM informed the meeting that in the event of a COVID outbreak the Hospice must inform the South West Team. SM has queried if the team would then send PCR tests, but received no reply. Dr JS advised that, in the event of outbreak, they would set up communications to ensure that measures are put in place and that there are testing and isolation routines. If a hospital patient develops an infection then other patients in the same hospital bay are tested. If more patients in that hospital bay are infected then that constitutes an outbreak. Such an outbreak mandates an outbreak meeting. An outbreak is two or more cases in the same hospital bay. Similarly, when there have been just two cases of Listeria in sandwiches that can be linked to the same food supplier, that constitutes an outbreak as well – the criteria are two or more cases linked to the same supplier.

## ITEM 11 : Date of next ICC meeting

| Date | Event | Venue/Time |
|---|---|---|
| TBA | **ICC Meeting** | |

**April 2023 – March 2024**

**COMPLAINTS REVIEW**

**June 2024**

**Invited : The Executive**

**Attended :**
**Nick Stevens**, CEO
**Sara-Jane Woods**, Commercial Director
**Dr Naomi Collins**, Lead Consultant
**Barry Angel**, Head of HR
**Becca Trower**, Clinical Director
**Kate Billingham-Wilson**, Director of Fundraising & Communications
**Alex Rudkin**, Director of Quality & Improvement

**Apologies**
**John Groom**, Director of IT and Estates

**Introduction**
To inform the annual review of complaints received by the Hospice between 1st April 2023 and 31st March 2024

**Aims**
1. To identify underlying themes and points of learning
2. To review responsiveness to complaints

**Actions from 2022/23' review**

| Action | Lead |
|---|---|
| Feedback was cascaded back to the clinical team Heads for their robust and attentive approach to complaints / feedback received. | RT |
| Practice changes / learning following complaints review was included in the Excellence Register and CQ&G report. | AR |
| Extrapolation of any feedback suggestive of improvement reported via DATIX feedback in 2023/24 will be administratively cumbersome. There are a number of suggestions that are received via the Hospice's portfolio of reported surveys. Individual reports pick up on elements of development or change undertaken. A Hospice User Group was established in January 2024 and feeds its reflections on material presented for its review into the clinical teams. | AR |

**Complaints Summary**

The complaints' summary document found at Complaints Register extract of April 2023 - March 2024 data was reviewed alongside a quantitative graphical comparative overview 2019-2024 Complaints Annual Overview 2019-2024 Graphic and calendar year overviews Jan - Dec 2023 Complaints Quantitative Overview & Jan - Mar 2024 Complaints Quantitative Overview

There were 18 complaints received between 1st April 2023 and 31st March 2024, 100% of which are closed. It was noted that:-

- There were 7 clinical and 11 non-clinical complaints.
- Reported numbers are proportionally at variance to previous years that have all been dominated by clinical complaints in proportion to non-clinical - 2022/23 (12), 2021/22 (12), 2020/21(14), 2019/20 (14). This is largely down to the re-energised engagement of

Retail in the reporting of complaints. Non-clinical complaints are substantively generated from Retail.
- Clinical complaints (7) are notably fewer in number than previous years and significantly less than the numbers reported between 2017-2019 (22 each year).
- Overall, complaint numbers are generally very low.

The number of complaints that have been upheld in full or part following investigation have increased on last year yielding an 89% rate (c.f. 80% in 2022/23, 92% in 2021/22 & 93% in 2020/21).

This should again be seen in a positive manner that continues to support the Hospice's receptiveness to exploring opportunities to learn and develop.

It is noted that there had been a maintained reduction in the clinical complaints founded in the Community (22% in 2023/24; 20% in 2022/23, c.f. 83% in 2021/22 and 57% in 2020/21), a significant decrease in those founded in the IPU (17% in 2023/24, 40% in 2022/23, c.f. 8% in 2021/22 and 29% in 2020/21) and, as mentioned an increase in those complaints founded in retail/fundraising (56% in 2023/24, c.f. 20% in 2022/23, 0% in 2021/22 and 14% in 2020/21). Communication, as distinct from care, presents as the dominant theme underlying the complaints received.

It was noted that the significance/severity of complaint remain low which is encouraging and re-enforces the Hospice's low threshold to report.

Responsiveness to complaints is maintained and compliant with policy.

Policy in place was last reviewed on 24/11/2022 and supports the DATIX Feedback module that provides an electronic route for reporting complaints and feedback.

Review of individual complaints highlighted a variety of practice changes / learning that have been exacted/effected that included: -

1. On the job procedural training re retail sales etiquette, customer service and responding to queries over price.
2. The value of documenting patients' wishes in the EPR was re-enforced.
3. Consideration to the contacting of DN teams following a patient death on the IPU.
4. A recognition that individual behaviours are not always deliberate and that there may be underlying reasons that, when understood, improve acceptance thresholds.
5. The value of appropriate and timely communication with those important to patients, customers in the retail environments and volunteers.
6. A recognition that behaviour can affect perception and that we should all be self-aware.

Communication remains a consistent area for improvement and development and efforts to support effective delivery in 2024/25 will include maintenance of information leaflet review and customer service training. Maintaining and managing staff morale will be increasingly challenging in 2024/25. Well supported initiatives such as EAS and Schwartz rounds will continue to play a valuable role in supporting staff. Other initiatives in 2024/25 may include the offer of free massage to staff in St Bedes, the Staff E-Newsletter and introduction of employee of the month awards.

It was agreed that the Hospice's culture maintains its embrace of the value of feedback and attention was again afforded to the robust and responsive management of complaints from our Clinical Director and Commercial Director in 2023/2024.

It was agreed that given the low number of complaints review will remain as annual.

| **Action** | **Lead** |
|---|---|
| Maintenance of information literature review | RT |
| Maintenance of customer training | S-JW |
| Availability and publishing of access to the Employee Assistance Scheme | BA |
| Maintenance of Schwartz rounds | Dr JS |
| Maintenance of a staff e-newsletter | KB-W |

| | | | |
|---|---|---|---|
| Meeting: **Clinical HODs Meeting** | | | |
| Date: 17.06.24 | | Time: 13.30 | |
| Chair : Rebecca Trower | | Minutes: Lynn Jackson | |
| Present: R Trower, Dr J Strawson, Dr N Collins, A Rudkin (1.30-3pm), T Christmas, M Flint, J Ford, L Jackson<br>Joined at 3pm by: D Bromboszcz, J O'Grady | | | |
| **Apologies:** Dr G Tamura-Rose, P James, S Mosalam, K Cook | | | |
| **Agenda item** | **Discussion** | **Actions & by whom** | **Anticipated date for completion** |
| **Review of previous minutes** | | | |
| **Matters Arising** | | | |
| **Topic** | | | |
| Infection Prevention | The COVID policy has been updated.<br>2 issues of the Infection Control newsletter have been shared with Staff.<br>Sara is on AL in July & will also be working from home during July – dates TBC<br><br>RT thanked Sam Leech who is leaving for her support & hard work whilst being IPU staff link for Infection Control & manual Handling.<br><br>Infection Control Link staff are now<br>• Cathy & Dosia – IPU<br>• Marnie & Katie W - CPCT | | |
| Medical Devices | Ceiling hoist & bariatric equipment– training started & will continue when room is unoccupied.<br><br>Virtual headset –This has been used in the Wellbeing Centre & by some IPU staff. The appropriate videos are to be chosen & posters are to made with regards the usage guidance, benefits & side effects of the headset. CHODS also discussed the implementation of a questionnaire with regards the usage of the headset & its benefits. | Education/IPU staff<br><br>IT/Dr GTR | Ongoing<br><br>Ongoing |

| | | | |
|---|---|---|---|
| Medicine Management | CPCT are to dedicate 1 MDT meeting per month to Education<br><br>NMP training to be re-run at the end of the year & offered to external agencies<br><br>Buscopan has been implemented in IPU as a 1st line instead of glycopyrronium due to cost and supply issues . Dr JS has discussed with Mario at Ashtons re cost implications.<br>At the next Drugs & Therapeutics meeting a flowchart is to be discussed & compiled for staff use. | TC/Education/ CPCT staff<br><br>Education<br><br>RT/IPU staff/Dr JS | Ongoing<br><br>Ongoing<br><br>Ongoing |
| Incidents & Accidents/RCA's | Pressure ulcers on admission (n=9), patient falls (n=9), CD medication incidents (n=8) and ooh access/network disruption (n= 7) constitute 79% of reported clinical incident numbers in April and May of 2024 (n=42).<br>Of the 9 patient falls, there were 6 attributed to one patient.<br>Of the 9 PUs on admission,<br>Of the 8 CD incidents, 2 were associated with community patients and 6 IPU patients, of which 4 were nursing (omission, incorrect dose admin, destruction of meds and medication count) and 2 medical (both chart documentation errors).<br>There were no incidents associated with medium or severe harm.<br><br>Review of patient falls is at Patient Falls Chart Apr 18 - Mar 24.<br>In summary,<br>**2023/24 Review Patient falls** (20) are within historical range - noting reduction in the number of falls on 2022/23 (24) but an increase in the number of patients who fell - 16 in 2023/24 c.f 14 in 2022/23.IPU fall rate (6.81) is the lowest it has been since 2019/20 (5.48) and injurious fall rate (1.02) is the lowest in the past 6 years. Reporting of falls via DATIX began in November 2021 and staff are commended for their attention to reporting and embrace of development and learning consequential to reported events. Patient fall events in 2023/24 led to investigations into sensor mat trigger operating effectively, increased frequency of monitoring, one to one monitoring, reiterations of use of call bell. Injurious falls were low harm and included bump to back of head, cut and bruise to head.<br><br>There has been a need to call to the Executive on Call recently with regards IT issues – the issues been resolved. | | |

| | | | |
|---|---|---|---|
| Complaints & Compliments | AR reported that the yearly review of complaints has taken place & the learning outcomes have been implemented where appropriate.<br><br>All compliments have been & are requested to be logged on the Excellence Register.<br><br>Complaints regarding the retail sector have been responded to & learning outcomes implemented.<br><br>The group discussed the recent complex/aggitated visitor & the subsequent DATIX. RT to follow up various outcomes including call bells, code warning, procedures & Police advice. Facilities & Ginny to lead on reception desk area/safety | All staff<br><br>RT/AR/TC/ Facilities | Ongoing<br><br>Ongoing |
| Health & Safety | Next H&S Committee scheduled for Thursday 20th June at 1.30 in St Bedes. IPU representation encouraged. | | |
| New Policies/ Guidelines | Clinical policy publications in May 2024 to date include:-<br><br>**CLIN34 Nutrition and Hydration Guidelines** N:\Policy Manual\CLIN\CLIN34 Nutrition and Hydration Guidelines.pdf v3.0 issued 28/05/2024 **(multiple changes throughout)**<br>**CLINSOP08 Using Phase of Illness and the Australian Karnofsky Performance Scale Index - integrating OACC step 1 N:\Policy Manual\CLINSOP\CLINSOP08 Using Phase of Illness and the Australian Karnofsky Performance Scale Index - integrating OACC step 1.pdf** v1.5 issued 10/06/2024 **(section 5 subsection Community Recording of PoI 'after discussion in MDT if a change in the POI is identified' and under 6.2 'after discussion in MDT if a change in AKPS ids identified')**<br>**CLIN02 Care After Death Guideline** N:\Policy Manual\CLIN\CLIN02 Care After Death Guidelines.pdf v6.0 issued 14/05/2024 **(7.3 added re VOED and competency; 10.6 removal of ref. to cremation form; 10.10 added re learning disability / autism notification; 16.3 Rapid burial procedure added; 18.2 telephone number added; 24.3 and 24.4 added re LeDer notification and CQC notification for community deaths at which a Hospice HCP is in attendance at the time of death; Appendix 1 amended)**<br>**CLIN04 Clinical Governance Strategy** N:\Policy Manual\CLIN\CLIN04 Clinical Governance Strategy.pdf v issued 23/05/2024 **(minor adjustments throughout)**<br>**CLIN08 Infection Control Policy** N:\Policy Manual\CLIN\CLIN08 Infection Control Policy.pdf v6.1 issued 22/05/2024 **(Refs. to IPU Sister amended to IPU Clinical Lead)**<br>**CLIN26 Generic Drugs Policy** N:\Policy Manual\CLIN\CLIN26 Generic Drugs Policy.pdf v 3.4 issued 14/05/2024 **(ref. to** | | |

| | | | |
|---|---|---|---|
| | **CLINSOP24a re returning unused CDs/medication to a community pharmacy from the patient home; Appendix 4 bullet point 7 amended)**<br>**CLIN53 Implantable Cardiac Defibrillator Guidance** N:\Policy Manual\CLIN\CLIN53 Implantable Cardiac Defibrillator Guidance.pdf v3.0 issued 28/05/2024 – **(Insertion of Consent form at Appendix 4 and updated patient leaflet link on pg 8)**<br>**CLIN15 Deprivation of Liberty Guidelines** N:\Policy Manual\CLIN\CLIN15 Deprivation of Liberty Guidelines.pdf v1.8 issued 07/05/2024 **(minor textual amends at 1.1 and 1.2 noting the delay to implementation of Liberty Protection Safeguard until after the current parliament; 3.1 the DOLs authorisation must be obtained from the borough the person normally resides in**)<br>**HR17 Training & Development Policy** N:\Policy Manual\HR\HR17 Training & Development Policy.pdf v3.2 issued 14/05/2024 **(Appendix 1& 2 amalgamated into Application for Study Leave and Learning Contract; 4.1 updated re keeping mandatory training up tod ate and reporting facility via Education Team; 4.3 inserted re. no reimbursement unless a signed Study Leave and Learning Contract is in place prior to the event; 5.2 adjustments made to leaving periods)**<br>**CLIN52 Managing COVID-19** N:\Policy Manual\CLIN\CLIN52 Managing COVID-19.pdf v39 issued 22/05/2024 **(Refs. to IPU Sister amended to IPU Clinical Lead; 8.6 removed re staff completion of individual COVID-19 workplace RAs; section 9 'Staff with COVID-19 Symptoms' replaces 'Staff with a confirmed positive result'; section 10 'Patient with COVID-19 symptoms on the IPU' inserted; 15.2 amended to 'visitors with COVID-19 symptoms must wear PPE'; 15.3 removal of bullet point re 'unlimited visitors for COVID negative patients and wearing of FRSMs is optional'; 16.3 re-written to include cessation of routine LFD testing for asymptomatic individuals prior to discharge from hospital into hospices; 17.7 FFP3 mask changed to FRSM; section 21 'Masks and Respirators' re-written; 25.17 added re Appendix 5; section points28.3-28.6 re-written re management of COVID-19 outbreak; 28.10 re-written re symptomatic visitors being required to wear PPE; insertion at Appendix 1 of PPE Requirement When Caring for a Person with Suspected or Confirmed Cases of Acute Respiratory Infection; Appendix 4 inserted re COVID 19 Antiviral Medications Request; Appendix 5 COVID pathway guidance removed; Appendix 6 Visitor guidance re-written; Appendix 7 Guidelines for reporting and testing COVID-19 added)**<br>**CLIN68 Cannabis based medicinal products policy** N:\Policy Manual\CLIN\CLIN68 Cannabis based medicinal products policy.pdf v1.0 issued 17/04/2024 **(NEW)** | | |

| | | | |
|---|---|---|---|
| | **CLINSOP14 Admitting patients from prison to the IPU** N:\Policy Manual\CLINSOP\CLINSOP14 Admitting patients from prison to the IPU.pdf v2.0 issued 28/03/2024 **(multiple amendments made throughout)**<br>**ToR15 Clinical Audit, QI, Research & Activity Data Committee Terms of Reference** N:\Policy Manual\ToR\ToR15 Clinical Audit,QI, Research & Activity Data Committee Terms of Reference.pdf v4.0 issued 16/03/2024 **(multiple amendments made throughout)** | | |
| Documentation/ EMIS | Wimbledon Village Surgery has now joined EMIS<br><br>The sharing agreement for District Nurse teams is near completion. Dr Jenny is in discussion with the appropriate teams. | Dr JS | Ongoing |
| Audit/Research | Latest Audit presentation forum on 9th May 2024 covered 'Mouthcare Audit', Patient Satisfaction', 'IPU RA' and 'Safeguarding' all presented by R Wallis, IPU Sister.<br>**2024/25 program**<br>17 recruited to CHELSea 2 study (3 to go)<br>POST ongoing<br>Michele Wood researcher coming to meet team Tuesday 18th re emotional support via virtual platform PhD research<br>SRH involved in Research Governance project KSS, community of practice (Shannon Milne PAH)<br><br>Med teaming aiming for one audit each per year:<br>GTR and TC ACP re-audit<br>JS CSCI audit<br>NC EOL care audit<br>JG/AA: Fastrack audit<br>BDS ? OACC and follow up audit<br>SA-Abstral audit<br>VOICES Survey<br>Psychological support services survey<br>IPU Satisfaction Survey<br>H@H Survey<br>LIveview Medicines Management Audit<br>IPU nursing led audits TBA | | |

| | | | |
|---|---|---|---|
| Education/Training Reflective Forums | NMP Update- 6 external candidate and 4 internal. Great feedback. Kevin, Lorraine & Steph provided sessions.<br>Work on Palliative Masterclass in progress<br>SWL Sensitive conversations finishing 18.6- potential for funding to continue programme- TBC<br>First Aid training 21.5- every 3 years<br>EDI June- next session October<br>ECEPC- Bev- Martina in Autumn<br>Refresher MH training – Maura & Helen. Train the Trainer – Paula B<br>65% of clinical staff have completed their Bluestream training | | |
| Recruitment/ Staffing | Interviews for the IPU Clinical lead post has been rescheduled until July.<br>IPU HCA Sam Leech is leaving due to moving out of area<br>IPU HCA Denise Manning will be leaving in July<br>CPCT – H@H Jackie Rickman is retiring in July<br>Psychosocial - Cecilie & Diana have agreed to increase their hours & 1 day per week counsellor role has been advertised. Interviews to take place shortly. | | |
| CQC/PIR | No news update. KLOE update meetings scheduled. Safe section – update complete. | | |
| **AOB** | | | |
| | Syed Miah – Clinical Psychologist from Maggie's Centre will be at our meeting from 1.30-2pm to talk about their services.<br><br>Complex referral case was discussed by the group | | |

**Date next meeting:** **Jul 29, 2024 1:30 PM**

**Sep 9, 2024 1:30 PM**

**Oct 21, 2024 1:30 PM**

**Dec 2, 2024 1:30 PM**

**Jan 13, 2025 1:30 PM**

**Meeting ID: 856 3859 2795**

**Passcode: 976968**

# An audit looking at referrals to the Hospice Inpatient Unit

## 1.0 Introduction

This is a re-audit looking at all referrals made to the inpatient unit from 1st January 2024 to 31st January 2024. During this period of time the IPU remained at a maximum occupancy of 10 inpatient unit beds, with daily flexibility in occupancy, in keeping with patient dependency scores and staffing levels, experience and skill mix. This matches the available bed occupancy during the previous audit period from 13th April to 14th June 2022. A change since the previous audit period in 2022, was the formal introduction of an IPU acuityscore being taken into consideration alongside staffing levels with the aim of ensuring safe decision-making regarding bed occupancy and number of admissions accepted each day. The twice daily admissions' meetings at 9am and 3pm continued during this audit period, with pre-booking patients and ambulance transport in advance where feasible.

## 2.0 Aim of the Audit

To audit the number of referrals to the IPU and the number of patients accepted and cared for on the IPU from 1st January 2024 to 31st January 2024 and to compare this data to the previous audit periods 13th April to 14th June 2022 and February/March 2022. To audit where referrals are coming from (community versus hospital) and to review waiting times in relation to the referrer's triaging of urgency (emergency within 24 hours, urgent within 48 hours, routine within 5 days), including those patients that died whilst awaiting a bed or those that became too unwell to transfer. To audit the use of the admissions' score sheet. Additional factors to be reviewed include transport method into the IPU, time of medical clerking, AKPS and POI on admission, length of stay and outcome of the referral.

## 3.0 Methodology

Retrospective collection of data from the EMIS EPR using EMIS's reporting function.

## 4.0 Standards

The hospice aims to admit patients in line with the standards set out in the hospice admissions policy. Referrers use the admission score sheet to set out details of the referral to the IPU, with the urgency of the referral stated (emergency same day, urgent within 48

hours, routine within 5 days). Triaging of multiple admission requests on the same day takes into account the admission score calculated by the referrer. See admissions policy for more details.

## 5.0 RESULTS

NB previous audit data is in purple and blue to allow comparison

**Number of admission requests and urgency of referral:**

**Jan 1-31st 2024: 23 admission requests (31day total = 0.7 referrals a day, 5.1 a week, 23 a month)**

**12 urgent referrals, 6 routine, 4 emergency, 1 unknown.**

**Symptom control (SC) requests:7(30%); Terminal Care(TC) requests:14 (61%); SC/TC= 2 (9%)**

**Primary diagnosis: Cancer: 16 (70%); Non-cancer: 7 (30%)**

**Female=12; Male= 11 Age range: 39 to 98**

**April/Jun 2022: 37 admission requests between 13th April and 14th June (63 days total, 0.6 referrals a day, 4.1 a week, 18.5 per month)**

**26 referrals marked as urgent, 10 marked as routine, 1 marked as an emergency**

**Feb/March 2022: Compared with 28 admission requests to IPU between 2nd Feb and 4th of March 2022. (31 days, 0.9 referrals a day, 6.3 a week, 28 per month)**

**Place of care at time of referral:**

**Home = 11/23 (48%) Hospital = 11/23 (48%) (SGH=6, SHH=3, Kings =1, Leeds hospital=1) Prison=1/23 (4%)**

**Home=21/37 (57%) (20 patients own home, one Nursing Home) Hospital 16/37 (43%) - SGH: 8/16, SHH: 8/16**

Home = 13/28 (46%) Hospital 15= 54% (SGH 7/15, SHH 5/15, Croydon 1/15, Springfield 1/15, William Harvey hospital Kent 1/15)

**Number of referrals versus number admitted to SRH IPU**

**Number of patients admitted to SRH IPU= 21/23 = 91%**

**Home: 11/21=52%  Hospital: 9/21=43%  Prison= 1/21=5% (total 48%)**

**Number of patients admitted to SRH IPU** =31/37=84%,

Home/NH:18/31(58%) Hospital: 13/31 (42%)

**Number of patients admitted to SRH IPU =15/28=54%**

Home: 11 (73%)  Hospital: 4 (27%)

**Number of patients not admitted to SRH=2/23= 9%**

- 1 patient died before bed available SGH – referred Friday pm 1650, Routine referral (within 5 days) patient died 2 days later.
- 1 patient offered a bed but the referrer cancelled due to clinical improvement.
- **Revised figure could be argued 22/23 offered a bed (96%) not offered= 1/23 (4%)**

**Number of patients not admitted to SRH= 6/37=16%**

**Number of patients not admitted to SRH= 13/28=46%**

**Urgency of referral met for those admitted:**

Yes= 19/21 (90%)

No =2/21 (10%) (1 emergency request was admitted after 2 days and died at the hospice the following day, 1 urgent request was admitted after 5 days, occupancy was at 8 due to staffing shortages).

**April/Jun 2022:** 57% achieved this standard
**Feb/March 2022:** 43% achieved this standard

**Number of scoresheets completed and average score**

The admission score is made up of three areas, physical symptoms, psychological/spiritual symptoms and social needs, each with 3 points available (3=severe, 2= moderate, 1= mild). The highest score available is 9 and would represent the most symptomatic, social and psychological complexity.

**Number of score sheets completed:20/23= 87%  3 not completed were for community patients at home**

**Average score = 7.3 average (Home=8.25, Hospital=6.7  Prison =8)**

**Number of score sheets completed:31/37=83%**

**Not completed : 6/37** (2 community referrals, 4 hospital referrals)

**Average score patients at home: 6.7**

**Average score patients in hospital: 6.3**

**Number of score sheets completed:22/28 =79%**

**Not completed : 6/28** (3 community referrals, 3 hospital referrals)

**Average score patients at home: 6.5**, h**ospital: 7**

**AKPS and POI on admission to the IPU (n=21):**

Comatose or barely rousable **AKPS 10% =4**

Totally bedfast and requiring extensive nursing care by professionals and/or family **AKPS 20%=5**

Almost completely bedfast **AKPS 30%= 7**

In bed more than 50% of the time **AKPS 40%=4**

Cares for self; unable to carry on normal activity or to do active work **AKPS 70%= 1**

**POI on admission: Unstable= 4 (19%)  Deteriorating = 12 (57%)  Dying= 4 (19%)  Stable= 1(5%)**

**Bed occupancy:** Occupancy recorded via EMIS ranged from 5 inpatients to 10, reasons stated for reduced occupancy (i.e. lower than 10) included staffing issues, a broken bed and high dependency score for one patient (tracheostomy care).

**Transport to IPU and time of medical clerking:**

Own transport:1 (relative's car) Ambulance: 20

Pre-booked ambulance = 1 (OOA Leeds)

**Time of medical clerking on IPU 19/21:**

before midday= 1 12pm to 13.59pm= 3 2pm to 3.59= 11

4pm to 4.59pm= 1 5 pm and later=3

**Clerked at home = 2/21** clerked at home 1530 -ambulance arrived at hospice 1730, clerked at home 1500- ambulance arrived at hospice=1820

**Outcome of admission:**

4 patients discharged to NH (19%) (2 admitted for SC, 2 admitted for TC)

2 of these patients subsequently died in their NH : 13 days later, the other patients are still alive as of 30.4.24.

17 patients died (81%)

Length of IPU stay 217 days/21 : average length of stay 10 days

range= 1 day to 22 days. 1 day=4 2 to 5 days = 3 6 to 14 days= 7 15 day to 22 days= 7

**SEE RESULTS TABLE in Appendix**

## 6.0 Discussion :

This audit period shows that 91% of patients referred to the IPU were able to be admitted to the hospice compared to 84% and 54% in the previous audit periods. 2 patients died before they were able to be admitted to the IPU from SGH hospital, one referred routinely and one was offered a bed but then declined admission due to clinical improvement (a fentanyl patch was applied when opioid naïve and caused sedation which was reversed on removing the patch). Given this, a revised figure shows that 96% of patients were offered an IPU bed following IPU admission referral. This audit demonstrates that remaining open to 10 beds with required occupancy flexibility based on patient dependency and staffing levels allowed almost all patients referred to be admitted to the IPU during this audit period. Bed occupancy flexed from 5 to 10 inpatients to allow for staff shortages, a broken bed and a high dependency tracheostomy patient. I note that the referral from hospital where the patient died before admission was received late in the afternoon on a Friday, given our current practice for only admitting emergency admissions from the community over the weekend except in exceptional circumstances, this trend is likely to continue for those patients referred to us from hospital on a Friday afternoon. I also note that the hospital treating team triaged the patient as routine.

In terms of the triaging of urgency of referral by the referrer there were 12 urgent referrals, 6 routine, 4 emergency, 1 not recorded. The number of admissions achieving the urgency time frame standard during this audit period was 90% versus 57% and 43% during the previous audit periods. This is a significant improvement and reflects the responsiveness of the IPU to admission requests during this time period. The afternoon admissions meeting becoming embedded may have contributed to this responsiveness. Examining the source of referrals, this has evened out with 48% from home and hospital respectively and one admission from prison. There were more referrals from SGH during this period compared to SHH and 2 OOA requests. Clarification of the process for OOA requests within local policy documents has increased team confidence in this area, including the process for OOA NHS CC funding for symptom control admissions.

We were pleased to be able to facilitate an OOH emergency admission from the prison sector during this audit period, with the associated complexity inherent in these admissions. The policy and SOP around admitting prisoners has been subsequently reviewed and shared with our on-call partner hospice to ensure awareness around the SOP and the risk assessment required.

The number of IPU referrals was slightly higher than the previous audit period with a rate of 0.7 referrals a day compared to 0.6, but still lower than the peak of 0.9 referrals a day during the initial audit period (Feb/March 22). This may reflect the return to normal

community services following a period of instability around the COVID pandemic allowing more people to remain at home. The majority of patients were transported to the IPU by ambulance (20/21, 95%) with one arriving in a relative's car and with 1 documented pre-booking of an ambulance for an OOA patient being repatriated from Leeds.

In terms of time of medical clerking, 4 of 19 (21%) patients arrived after 4pm , which while less common, often means the admitting doctor stays late to complete the patient review and paperwork. It is interesting to note 2 patients were clerked from home to avoid late hospice admissions, while generally felt to be a pragmatic solution to ambulance waiting times, there remains some concern from the IPU nursing team around nursing admission of patients without medical team presence on the ward, which requires ongoing review, especially for very complex or agitated patients.

Looking at AKPS this audit showed that the majority (95%) of patients had a score of 40% (in bed more than 50% of the time) or lower with only one patient with a score above this of 70%, this supports the ongoing nursing numbers required to safely manage our inpatients, who require extensive nursing care. Looking at POI, the majority of patients were rated as deteriorating on admission to the hospice which normally refers to a care plan being in place which requires periodic review, one could argue that moving to a hospice is an urgent change in the care plan, so further discussion around use of POI on admission may be warranted to ensure consistency across the team.

Admission Score sheet completion showed some improvement during this audit period with 87% of patients referred having a scoresheet completed compared with 83% and 79% during the previous audit periods. The three patients without scoresheets were referred by our own community team and were emergency and urgent referrals admitted on the same day as the referral. The absence of scoresheets may reflect the predominantly verbal communication around internal emergency referrals. This process has recently been revised and updated within our admissions policy. The average score for patients referred during this period was 7.3; slightly higher than the previous audit periods with average scores of 6.5 and 6.75, the significance of this, if any is unclear. We know that while we hope the score adds some objectivity, that the scoring remains subjective to the individual scorer and specific to the time the score is calculated.

This audit also looked at the outcome of admissions to the IPU, with 17 (81%) patients dying on the ward and 4 being discharged to Nursing Homes. The average length of stay was 10 days with a range of 1 to 22 days. It is interesting to note that there were no discharges home during this period, given the low AKPS of patients this may reflect their 24-hour care needs and requirements for NH care on discharge, alongside the significant limitations of accessing 24-hour care at home with current health and social care provision. It is worth noting that of the 4 patients discharged to NHs 2 are still alive 4 months post discharge, but that the other 2 patients died 13 days following discharge. While this is a short time for someone to move to a new place of care, given the limited

IPU resource, we must consider the number of patients that may have been able to access the IPU as a result of their discharges. A brief review of their notes revealed peaceful deaths with no concerns from NH staff or family.

## 7.0 Conclusions

7.1 This audit demonstrates continued improvement in the IPU responsiveness to admission requests during January 2024 with 96% of patients being offered a bed following referral to the IPU. The urgency of the referral was met for 90% of referrals. This supports our current model of working with an occupancy of 10 IPU beds, with daily review of staffing levels and patient dependency guiding the number of admissions each day. It is worth noting that IPU nursing staffing was significantly better during this audit period than it was before with 4 on at night, a new night RN and another band 6 in the team.

## 8.0 Recommended Actions:

8.1 We have identified as a team that since we have started the extra admissions' meeting at 3pm, that we have not formally informed our hospital colleagues of this. Knowing tThis may change the time they prioritise sending their referrals to us, if they know they will be seen and discussed with the potential for a pre-booked admission the following day.

8.2 Continuing to try to pre-book admissions as much as possible may help to reduce the number of admissions arriving after 4pm, allowing the medical team to avoid clerking beyond their working hours and to reduce pressure on the nursing late shift. This may also reduce the need to clerk patients at home which comes with some limitation and challenge.

8.3 Medical team discussion may be helpful around the POI on admission to the hospice i.e. do we feel the move to the hospice represents a significant acute change in the care plan which may fit more with an unstable phase or does the deteriorating phase feel appropriate.

8.4 Continue to reflect on and review the current weekend on call admissions policy which currently limits the admission of patients in hospital to the hospice IPU over the weekend to exceptional cases.

8.5 Bed occupancy was reduced to 9 for a period of time due to a broken bed, considering ways to replace/fix broken beds more quickly should be considered.

## 9.0 Appendix 1: Results table

Pt was admitted within referrer triaged time frame i.e. emergency within 24 hours, urgent within 48 hours, routine within 5 days
Pt was admitted but not within referrer's triaged time frame
Pt died before bed available
Pt offered a bed, then admission declined due to clinical improvement

| EMIS no, age sex | Date on IPU waiting list | Urgency of admission request | Time on waiting list | Ward beds open | Date admitted, or reason not admitted | Place of care prior to admission | Admission score | Admission request TC/SC | Primary diagnosis, POI/AKPS on admission | Transport to IPU, time of medical clerking | Length of stay | Outcome of admission |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 14, age 39, F | 29/1(Mon) | Urgent | 0 days | 9(1 bed broken) | 29/1(Mon) | Home | 9 | SC | Breast Cancer POI=unstable AKPS=40% | Ambulance 1820, clerked at home 1500 | 11 days | Died 8/2 |
| 3665, F | 3/1 | Urgent | 5 days | 8 (staff sickness) | 8/1 | SHH | 7 | SC | Lung cancer Deterioratin g 30% | Ambulance Clerked 1530 | 6 days | Died 14/1 |
| 5277, F | 15/1 | Urgent | 1 day | 9 (1 bed broken) | 16/1 | Home | 9 | SC/TC | Breast cancer Unstable 20% | Ambulance 1540 | 9 days | Died 25/1 |
| 23898, F | 29/1(Mon) | Urgent | 1 | 9(1 bed broken) | 30/1(Tues) | Home | 6 | TC | Non-cancer: CVA, frailty POI: unstable AKPS:30% | Ambulance, 1440 | 17 days | Died 16/2 |
| 34272, F | 22/1(Mon) | ? | 0 | 9(1 bed broken) | 22/1(Mon) | Home | ? | TC | Lung cancer | Ambulance, 1500 | 16 days | Died 6/2 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | Deterioratin g, 30% | | | |
| 346 , 59, M | 27/1 (Sat) | Emerge ncy | 0 | 9(1 bed broken) | 27/1 (Sat) | HMP | 8 | TC | Neuroendo crine bowel Deterioratin g 30% | Ambulance 1750 | 8 days | Died 3/2 |
| 378 66, M | 3/1 | Routine | 1 day | 7 (staffing issues) | 4/1 | Hospital Leeds | 7 | SC | Prostate cancer Deterioratin g 70% | Pre-book: Ambulance from Leeds 1550 | 18 days | D/C to NH 22/1 Still alive |
| 641 66, M | 12/1 | Urgent | 0 days | ? 8 | 12/1 | RMHS | 7 | SC | Pancreatic cancer Deterioratin g 40% | Ambulance 1400 | 13 | Died 25/1 |
| 872 66 F | 15/1 4pm | Emerge ncy | 2 | 7 beds ,staffing | 17/1 | Home | 9 | TC | Ovarian cancer Dying 10% | Ambulance 1300 | 1 | Died 18/1 |
| 888 51, M | 22/1 | Urgent | 0 | 9 beds | 22/1 | SGH | 6 | SC | Lung cancer Stable 20% | Ambulance 1500 | 17 | D/C NH 7/2 Died 20/2 |
| 940 70, F | 15/1 | Routine | 2 | 9 beds | 17/1 | SGH | 8 | SC | Lung cancer Deterioratin g 30% | Ambulance 1700 | 22 | Died 5/2 |
| 952 | 23/1 | Urgent | 2 | 9 beds | 25/1 | Home | 8 | TC | Cholangioc a | Ambulance 1250 | 14 | Died 5/2 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 73, M | | | | | | | | | Deterioratin g 40% | | | |
| 1048, 53, F | 11/1 (thurs) | Routine | 4 | 9 beds | 15/1 | Home | 9 | SC/TC | Breast ca Unstable 40% | Own car 1530 Clerking 1700 | 3 | Died 18/1 |
| 1161 51 M | 12/1 (Fri) | Urgent | 3 | 9 beds | 15/1 | Home | 9 | SC | Pseudomix oma peritonei Deterioratin g 30% | Ambulance 1600 | 1 | Died 16/1 |
| 1238 M | 29/1 | Routine | 5 | 5 beds, staffing, high depende ncy | 3/1 | Kings college OOA request | 8 | TC | Fungal arachnoiditi s Deterioratin g 20% | Ambulance 1500 | 14 | Died 17/1 |
| 1248 F | 1/1 | Emerge ncy | 0 | ? | 1/1 | Home | ? | TC | Heart failure Dying 10% | Ambulance 1530 | 1 | Died 2/1/24 |
| 1267 M | 2/1 | Urgent | 0 | ? | 2/1 | Home | ? | TC | Multiple myeloma 10% Dying | Ambulance 1400 | 2 | Died 4/1 |
| 1289 86, M | 8/1 | Urgent | 1 | 7 beds open | 9/1 | SGH | 6 | TC | Sepsis, organ failure eGfr 9 10% Dying | Ambulance 1450 | 16 | D/C NH 25/1 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1307 58 M | 12/1(fri, 1650) | Routine | 2 | 9 beds | Died 14/1 | SGH | 5 | TC | Alcoholic liver disease | N/A | N/A | Died before admission |
| 1315 91F | 18/1 | Urgent | 1 | 8 beds | 19/1 | SHH | 5 | TC | non-Hodgkin's lymphoma deterioratin g 20% | Ambulance 1200 | 5 | Died 24/1 |
| 1321 88 F | 19/1 | Emerge ncy | 3 22/1 bed offere d | 8 beds | N/A | SGH | 8 | TC | Aortic dissection | N/A | Improv ed over weeke nd once off fentan yl patch | Admissi on cancelle d |
| 1328 63, F | 23/1 | Urgent | 0 | 9 beds | 23/1 | SHH | 7 | TC | Lung cancer Deterioratin g 30% | Ambulance 11:50 | 1 | Died 24/1 |
| 1360 M,93 | 29/1 | Routine | 3 | 10 beds | 1/2 | Home | 7 | TC | Frailty Deterioratin g 20% | Ambulance Arrived 1730 Clerked at home 1530 | 22 | DC NH 19/2 Died 3/3 |

| DRAFT Minutes Medical Business Meeting<br>5th June 2024 | | | |
|---|---|---|---|
| **In attendance** | Chris Roughly | Specialty Dr | CR |
| | Ambreen Akhtar | Specialty Dr | AA |
| | Jovy Giles | PA | JG |
| | Naomi Collins | Consultant | NC |
| | Stephanie Ainley | SpR | SA |
| | Busi Da Silva | Speciality Dr | BDS |
| | | | |
| **Apologies** | Jenny Strawson | Consultant | JS |
| | Gaby Tamura-Rose | Consultant | GTR |
| | Bavan Sasi | GP VTS | BS |
| | Saskia Bridge | Psychiatry SpR | SB |
| | | | |
| **Minutes of the last meeting (8/5/24)** | Reviewed | | |
| | | | |
| **Team wellbeing** | Thanks to all for sharing | | |
| | | | |
| **Rota / staffing** | Busi and Ambreen swapping CPCT and IPU every 4 months – due start Sept 2024.<br><br>Jenny and Naomi to swap CPCT and IPU from July – date to be confirmed<br><br>Cover for IPU Fridays and Mondays – thank you to AA and SA for providing medical cover for IPU on Fridays and Mondays.<br><br>NC thanked team for flexibility around ward cover/ handover around lead consultant meetings<br><br>Gaby started 2 sessions at Epsom Hospital (usually Wed/ Thursday afternoons, maybe Mondays). Initially until end July 24, to help out with consultant cover there and save StRH money.<br><br>Next GP VTS, Priya, due to start in August will be doing 6 months with us rather than three but will only be with us 2 days a week – Mon and Tuesdays. This may make Mondays quite "heavy" as Dr Omar also going to be working Monday mornings from next week. Can also rotate to CPCT in time.<br><br>Pain and anaesthetic trainee, Dr Ahsan Kamran started Fridays from 17.5.24. Unclear how long he will be with us ?till August, possibly longer.<br><br>Encouraged everyone to log onto Natural HR. Carry over leave to be used by July. | **NC to d/w JS, ?move IPU MDT day**<br><br>**ALL** |

| | | |
|---|---|---|
| | Next week – adequate medical cover but may need to adjust SPA/ Community cover to ensure adequate IPU cover. | **SA will send draft rota round today for consideration** |
| | | |
| **Clinical challenges** | SA shared challenging community visit with rapid change in patient not met before; declined hospital admission, no family present.<br><br>Challenge in the lack of psychosocial support for those on the ward mentioned – delays and difficulties in getting in patients seen in a timely fashion.<br><br>NC raised discharging patients home when situation uncertain/ unstable and symptoms optimally managed but not fully controlled. | **NC will d/w psych team** |
| | | |
| **Infection control** | <u>COVID</u><br>New guidance from DOH has been produced and infection control policy reviewed and distributed today.<br><br>Jovy gave guidance as to how to obtain COVID treatment to Becca Wallis for inclusion in policy and not returned | **JG will speak to Penny and Julie to track down** |
| | | |
| **Education** | CR examining for the European certificate at PAH on 19.6.24<br>AA and Maura Flint presenting to RMH SpRs on 04.07.24<br>SA presenting at non-medical prescribers meeting on 11.06.24<br><br>CR booked onto pall care update in June | **CR will feedback learning** |
| | | |
| **Datix** | JG spoke to IT about self deleting folder to ensure confidential information in Doctors folder deleted in a timely fashion however this is "not possible"<br><br>SA has raised a Datix regarding a community incident in which a patient was incorrectly commenced on a syringe pump with *all* meds rather than just Alfentanil for pain, despite verbally handing over to DNs and DNs calling to ask before staring the pump and being told Just the Alfentanil to be included. No harm resulted and the pump was stopped and a new chart written with only Alfentanil listed. | |
| | | |

| | | |
|---|---|---|
| **Audit & Research** | CHELseaII<br>16 patients recruited – thank you. Please keep vigilant for any potential patients<br><br>Audits:<br>Aim is every doctor to perform a minimum of one audit per year – AA and JG doing joint audit. SA to commence audit along with JG ?supervise JG<br><br>Audit meeting held last week – 28th May – BDS presented OACC data for community. | |
| **Deep Dive** | Brief discussion on assisted dying following presentation at PAH teaching on Monday. | To consider at journal club |
| | | |
| **AOB** | SA – There is now capacity for rapid burial of patients who die at the weekend if this is needed. Process described in on call policy. | |
| | | |
| **Date of next meeting** | **3/7/24** | |

| DRAFT Minutes Medical Business Meeting<br>5th June 2024 | | | |
|---|---|---|---|
| **In attendance** | Chris Roughly | Specialty Dr | CR |
| | Ambreen Akhtar | Specialty Dr | AA |
| | Jovy Giles | PA | JG |
| | Naomi Collins | Consultant | NC |
| | Stephanie Ainley | SpR | SA |
| | Busi Da Silva | Speciality Dr | BDS |
| | | | |
| **Apologies** | Jenny Strawson | Consultant | JS |
| | Gaby Tamura-Rose | Consultant | GTR |
| | Bavan Sasi | GP VTS | BS |
| | Saskia Bridge | Psychiatry SpR | SB |
| | | | |
| **Minutes of the last meeting (8/5/24)** | Reviewed | | |
| | | | |
| **Team wellbeing** | Thanks to all for sharing | | |
| | | | |
| **Rota / staffing** | Busi and Ambreen swapping CPCT and IPU every 4 months – due start Sept 2024.<br><br>Jenny and Naomi to swap CPCT and IPU from July – date to be confirmed<br><br>Cover for IPU Fridays and Mondays – thank you to AA and SA for providing medical cover for IPU on Fridays and Mondays.<br><br>NC thanked team for flexibility around ward cover/ handover around lead consultant meetings<br><br>Gaby started 2 sessions at Epsom Hospital (usually Wed/ Thursday afternoons, maybe Mondays). Initially until end July 24, to help out with consultant cover there and save StRH money.<br><br>Next GP VTS, Priya, due to start in August will be doing 6 months with us rather than three but will only be with us 2 days a week – Mon and Tuesdays. This may make Mondays quite "heavy" as Dr Omar also going to be working Monday mornings from next week. Can also rotate to CPCT in time.<br><br>Pain and anaesthetic trainee, Dr Ahsan Kamran started Fridays from 17.5.24. Unclear how long he will be with us ?till August, possibly longer.<br><br>Encouraged everyone to log onto Natural HR. Carry over leave to be used by July. | **NC to d/w JS, ?move IPU MDT day**<br><br>**ALL** |

| | | |
|---|---|---|
| | Next week – adequate medical cover but may need to adjust SPA/ Community cover to ensure adequate IPU cover. | **SA will send draft rota round today for consideration** |
| | | |
| **Clinical challenges** | SA shared challenging community visit with rapid change in patient not met before; declined hospital admission, no family present.<br><br>Challenge in the lack of psychosocial support for those on the ward mentioned – delays and difficulties in getting in patients seen in a timely fashion.<br><br>NC raised discharging patients home when situation uncertain/ unstable and symptoms optimally managed but not fully controlled. | **NC will d/w psych team** |
| | | |
| **Infection control** | <u>COVID</u><br>New guidance from DOH has been produced and infection control policy reviewed and distributed today.<br><br>Jovy gave guidance as to how to obtain COVID treatment to Becca Wallis for inclusion in policy and not returned | **JG will speak to Penny and Julie to track down** |
| | | |
| **Education** | CR examining for the European certificate at PAH on 19.6.24<br>AA and Maura Flint presenting to RMH SpRs on 04.07.24<br>SA presenting at non-medical prescribers meeting on 11.06.24<br><br>CR booked onto pall care update in June | **CR will feedback learning** |
| | | |
| **Datix** | JG spoke to IT about self deleting folder to ensure confidential information in Doctors folder deleted in a timely fashion however this is "not possible"<br><br>SA has raised a Datix regarding a community incident in which a patient was incorrectly commenced on a syringe pump with *all* meds rather than just Alfentanil for pain, despite verbally handing over to DNs and DNs calling to ask before staring the pump and being told Just the Alfentanil to be included. No harm resulted and the pump was stopped and a new chart written with only Alfentanil listed. | |
| | | |

| | | |
|---|---|---|
| **Audit & Research** | CHELseaII<br>16 patients recruited – thank you. Please keep vigilant for any potential patients<br><br>Audits:<br>Aim is every doctor to perform a minimum of one audit per year – AA and JG doing joint audit. SA to commence audit along with JG ?supervise JG<br><br>Audit meeting held last week – 28th May – BDS presented OACC data for community. | |
| **Deep Dive** | Brief discussion on assisted dying following presentation at PAH teaching on Monday. | To consider at journal club |
| | | |
| **AOB** | SA – There is now capacity for rapid burial of patients who die at the weekend if this is needed. Process described in on call policy. | |
| | | |
| **Date of next meeting** | **3/7/24** | |

| Patient | Q1 2018 | Q2 2018 | Q3 2018 | Q4 2018 | Q1 2019 | Q2 2019 | Q3 2019 | Q4 2019 | Q1 2020 | Q2 2020 | Q3 2020 | Q4 2020 | Q1 2021 | Q2 2021 | Q3 2021 | Q4 2021 | Q1 2022 | Q2 2022 | Q3 2022 | Q4 2022 | Q1 2023 | Q2 2023 | Q3 2023 | Q4 2023 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| IPU Admissions | 63 | 48 | 52 | 62 | 42 | 56 | 52 | 57 | 63 | 41 | 34 | 36 | 59 | 16 | 41 | 44 | 61 | 54 | 48 | 57 | 53 | 50 | 47 | 55 |
| IPU Occupancy % | 84 | 77 | 91 | 86 | 87 | 84 | 83 | 82 | 68 | 84 | 86 | 75 | 77 | 33 | 79 | 86 | 82 | 72 | 83 | 82 | 80 | 86 | 78 | 77 |
| IPU Occupied Bed Days | 761 | 804 | 754 | 750 | 604 | 643 | 713 | 596 | 864 | 517 | 584 | 403 | 563 | 221 | 556 | 640 | 742 | 661 | 760 | 742 | 727 | 793 | 713 | 703 |
| Number of non-IPU patients who fell | 1 | 1 | 1 | | | | | 1 | | | | | | | | | | | | | | | 1 | |
| Number of non-IPU patient falls | 1 | 1 | 1 | | 1 | | | 1 | | | | | | | | | | | | | | | 1 | |
| Number of IPU patients who fell | 6 | 4 | 4 | 5 | 2 | 3 | 4 | 1 | 7 | 6 | 3 | 1 | 2 | 2 | 3 | 0 | 2 | 4 | 6 | 2 | 2 | 3 | 5 | 6 |
| Number of IPU falls | 9 | 5 | 5 | 5 | 2 | 4 | 7 | 1 | 9 | 6 | 3 | 2 | 2 | 11 | 3 | 0 | 7 | 4 | 10 | 3 | 4 | 3 | 6 | 7 |
| IPU Sustained injury | 3 | 3 | 2 | 2 | 1 | 2 | 1 | | 3 | | 1 | 1 | 1 | 4 | 1 | 0 | 1 | 1 | 4 | 1 | 0 | 2 | 0 | 1 |
| IPU Sustained injury % | 33% | 60% | 40% | 40% | 50% | 50% | 14% | 0% | 33% | 0% | 33% | 50% | 50% | 36% | 33% | 0% | 14% | 25% | 40% | 33% | 0% | 67% | 0% | 14% |
| Fall rate (per 1000 occupied bed days) | 11.83 | 6.22 | 6.63 | 6.67 | 3.31 | 6.22 | 9.82 | 1.68 | 10.42 | 11.61 | 5.14 | 4.96 | 3.55 | 49.77 | 5.40 | 0.00 | 9.43 | 6.05 | 13.16 | 4.04 | 5.50 | 3.78 | 8.42 | 9.96 |
| Injurious Fall rate (per 1000 occupied bed days) | 3.94 | 3.73 | 2.65 | 2.67 | 1.66 | 3.11 | 1.40 | 0.00 | 3.47 | 0.00 | 1.71 | 2.48 | 1.78 | 18.10 | 1.80 | 0.00 | 1.35 | 1.51 | 5.26 | 1.35 | 0.00 | 2.52 | 0.00 | 1.42 |

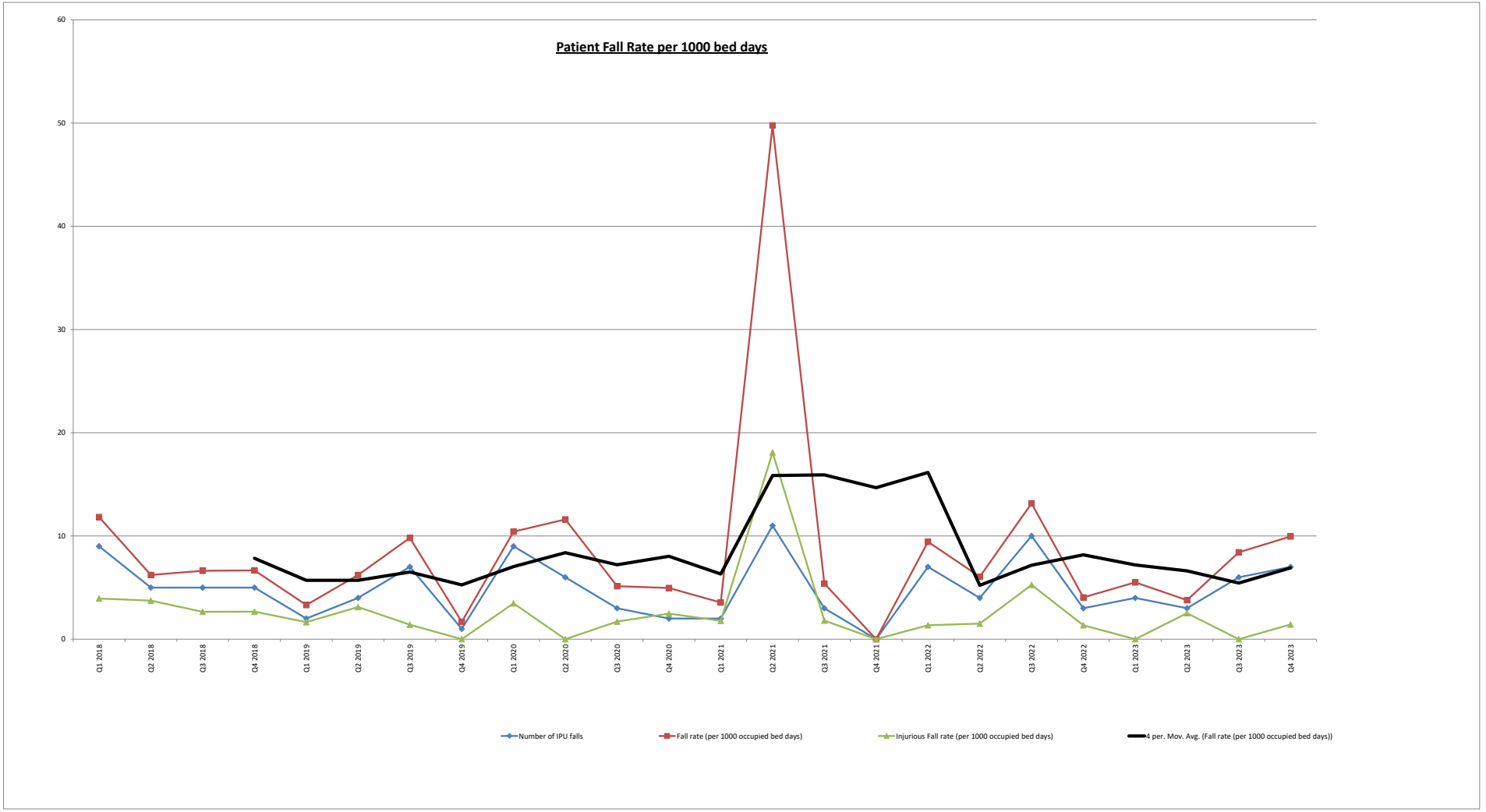
| Non-patient | Apr - Jun 2018 | Jul - Sep 2018 | Oct - Dec 2018 | Jan - Mar 2019 | Apr - Jun 2019 | Jul - Sep 2019 | Oct - Dec 2019 | Jan - Mar 2020 | Apr - Jun 2020 | Jul - Sep 2020 | Oct - Dec 2020 | Jan - Mar 2021 | Apr - Jun 2021 | Jul - Sep 2021 | Oct - Dec 2021 | Jan - Mar 2022 | Apr - Jun 2022 | Jul - Sep 2022 | Oct - Dec 2022 | Jan - Mar 2023 | Apr - Jun 2023 | Jul - Sep 2023 | Oct - Dec 2023 | Jan - Mar 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Staff Falls | | | | 2 | 1 | | | 1 | 1 | | | 1 | | 4 | | 2 | 3 | | 1 | | | 1 | 1 | 1 |
| Volunteer Falls | 2 | | | | | | | | | | | | | | 1 | 1 | | 1 | | 1 | | | | 3 |
| Contractor Falls | | | | | | | | | | | | | | | | | | | | | | | | 0 |
| Visitor Falls | | 1 | 1 | | | | 1 | 1 | | | | | | | | | | 1 | 1 | | 1 | 1 | | 2 |
| Sustained injury | 2 | | 1 | 2 | | | | 1 | 1 | | | 1 | | 3 | 1 | 2 | 2 | 2 | 0 | 0 | 0 | 1 | 1 | 5 |
| Totals | 2 | 1 | 1 | 2 | 1 | 0 | 1 | 2 | 1 | 0 | 0 | 1 | 0 | 4 | 1 | 3 | 3 | 2 | 2 | 1 | 1 | 2 | 1 | 6 |

| Patient | 2018/19 | 2019/20 | 2020/21 | 2021/22 | 2022/23 | 2023/24 |
|---|---|---|---|---|---|---|
| IPU Occupied Bed Days | 3069 | 2556 | 2368 | 1980 | 2905 | 2936 |
| | | | | | | |
| No. of IPU falls | 24 | 14 | 20 | 16 | 24 | 20 |
| IPU Falls Sustained injury | 10 | 4 | 5 | 6 | 7 | 3 |
| IPU Fall rate (per 1000 occupied bed days) | 7.82 | 5.48 | 8.45 | 8.08 | 8.26 | 6.81 |
| Injurious IPU Fall rate (per 1000 occupied bed days) | 3.26 | 1.56 | 2.11 | 3.03 | 2.41 | 1.02 |

## 2023/24 Review

**Patient falls** (20) are within historical range - noting reduction in the number of falls on 2022/23 (24) but an increase in the number of patients who fell - 16 in 2023/24 c.f 14 in 2022/23. IPU fall rate (6.81) is the lowest it has been since 2019/20 (5.48) and injurious fall rate (1.02) is the lowest in the past 6 years. Reporting of falls via DATIX began in November 2021 and staff are commended for their attention to reporting and embrace of development and learning consequential to reported events. Patient fall events in 2023/24 led to investigations into sensor mat trigger operating effectively, increased frequency of monitoring, one to one monitoring, reiterations of use of call bell.
Injurious falls were low harm and included bump to back of head, cut and bruise to head.

**Non-patients falls** in 2023/24 (10) is higher than 2022/23 (8) and injurious falls in 2023/24 (70%) are higher than 2022/23's 50%. Proportionally, staff falls are at 30% of non-patient falls c.f. 50% in 2022/23; volunteer falls are at 30% (c.f. 25% in 2022/23; visitor falls are at 40% c.f. 25% in 2022/23. Visitor falls are exclusively customers in retail shops in 2023/24.
One customer fall event led to further action being taken that included installation of anti-slip tape on step at New Malden shop.
One staff fall event led to install of hazard tape on ramp at the SDC and recall of shop fitters to effect more substantial remedy.
Injurious falls were low harm and included cut to forearm and knee; cut arm; impact to hands; nosebleed, bump to head, laceration to forehead and hip & wrist pain.
There was one staff member who was taken to hospital as a precautionary measure.


Patient Fall Rate per 1000 bed days
60
50
40
30
20
10
0
Q1 2018
Q2 2018
Q3 2018
Q4 2018
Q1 2019
Q2 2019
Q3 2019
Q4 2019
Q1 2020
Q2 2020
Q3 2020
Q4 2020
Q1 2021
Q2 2021
Q3 2021
Q4 2021
Q1 2022
Q2 2022
Q3 2022
Q4 2022
Q1 2023
Q2 2023
Q3 2023
Q4 2023
Number of IPU falls
Fall rate (per 1000 occupied bed days)
Injurious Fall rate (per 1000 occupied bed days)
4 per. Mov. Avg. (Fall rate (per 1000 occupied bed days))

# Prescribers Meeting 30th May 2024

## Minutes

Present – Kevin Hobson, Tracy Christmas, Lorraine Jeffreys, Avril Lovegrove, Kate Lakin, Dr. Gaby Tamura Rose

Terms of Reference for Prescribers meeting
Terms reviewed by team and agreed
Kevin will rewrite and forward to Alex Rudkin for approval

Competencies
All competencies are due for review between now and July.
Please review Intention to Prescribe and RPS Competencies – if in agreement or you find any areas that need further review- please comment / sign / re date and forward to Tracy and Kevin.
Going forward we felt that competencies review should form part of the individual appraisal process.

Legislation re Prescribing CD's by Paramedic Independent Prescribers
After lengthy review by governing bodies and government, new law passed on 31st Dec 2023 allowing independent paramedic prescribers to prescribe 5 controlled drugs – Morphine, Diazepam, Midazolam, Lorazepam and Codeine.
Unfortunately Oxycodone is not included in the list.
We will need to look at how we can support the prescribing of Oxycodone in the future for paramedic prescribers at the hospice.

Prescribers Update / Education day
Our in house update day will be on Tues 11th June.
Our community colleagues have also been invited.

Medicines Alerts / updates

SWLN medicines newsletter recently highlight care when prescribing Macrogol.
Macrogol 8.5g sachets cost £129.81 for box of 28 whereas Cosmocol or Laxido (which contains same ingredients) costs £4.99 for box of 30!

Codeine Phosphate is now POM – prescription only medicine. This was changed after reports of abuse and addiction becoming a problem.

Glycopyrronium V Hyoscine Butylbromide (Buscopan)

Our local hospital colleagues are tending to use Buscopan as 1st line anti-secretory.
It has been shown to be as effective (although control of secretions remains a difficult symptom to control at times and may need different drug approach).
Hyoscine Butylbromide is also significantly cheaper.
The medical team will bring to next DTC meeting to discuss further.
If agreed, our guidelines will need rewriting.

EMIS – updating medicines

We seem to have lapsed updating charts on Pt. record system.
Some patient record of medicines have been left blank!
Team were reminded that we should review and record all medicines whenever we review Pt's and update EMIS regularly.
Also not to rely on G.P's records.

CPCT Prescribing since last meeting

Team reminded to record all prescribing activity on computer log and personal record log (with dates)

AOB

There has been an issue recently with prescribing anticipatory SD charts
Team were reminded that this is not common practice.
If anticipatory charts are written and kept in pt. notes – clear communication in notes and with community teams as to when they should be used is essential.

Next meeting – Aug / Sept

# Safeguarding Audit

## 1.0 Introduction

Safeguarding is protecting a ‘persons right to live in safety, free from abuse and neglect’. The patients that may be safeguarded are those who are felt to be vulnerable due to being unable to protect themselves from harm or neglect, are or may be unable to take care of themselves or need community care services for reasons such as age, illness or disability.

If there is known or suspected abuse, a safeguarding concern should be raised through the local authority.

As set out in the Care Act 2014, information can be shared without consent if it is in the public interest, in order to prevent a crime or protect others from harm. Whether consent has been gained or a rational to why information has been shared without consent should be documented in the event of raising a safeguarding concern.

This audit sets out to examine the Hospice’s compliance with CLIN14 Safeguarding Adults and, in particular, the documentation that supports consent.

## 2.0 Aims

1. To assess compliance against the standards.
2. To inform discussion and required actions on Safeguarding practice.
3. To inform discussion and required actions on the suitability and use of the EPR.

## 3.0 Methodology

Retrospective audit of all 13 safeguarding cases raised in 2023. Data collection criteria is based on local criteria. Excel data capture tool designed for data population via the EPR and clinical review of the EPR.

## 4.0 Standards

Standards are extracted from local policy CLIN14 Safeguarding Adults:-

1. 100% safeguarding events raised to the LA are notified to the CQC
2. 100% safeguarding events have documented whether or not consent was gained from the patient before raising a safeguarding concern to the local authority.
3. 100% of safeguarding events for which consent is not gained have a clear documented rationale to why not or whether it is being raised in best interests.

# RESULTS

## Introduction

Data reflects upon 13 community patients under St Raphael's Hospice who had safeguarding concerns raised in 2023.

## Demographics

| | Safeguarding raised |
|---|---|
| Male | 4 |
| Female | 9 |

## Local Authority

| | Safeguarding raised |
|---|---|
| Sutton | 8 |
| Merton | 5 |

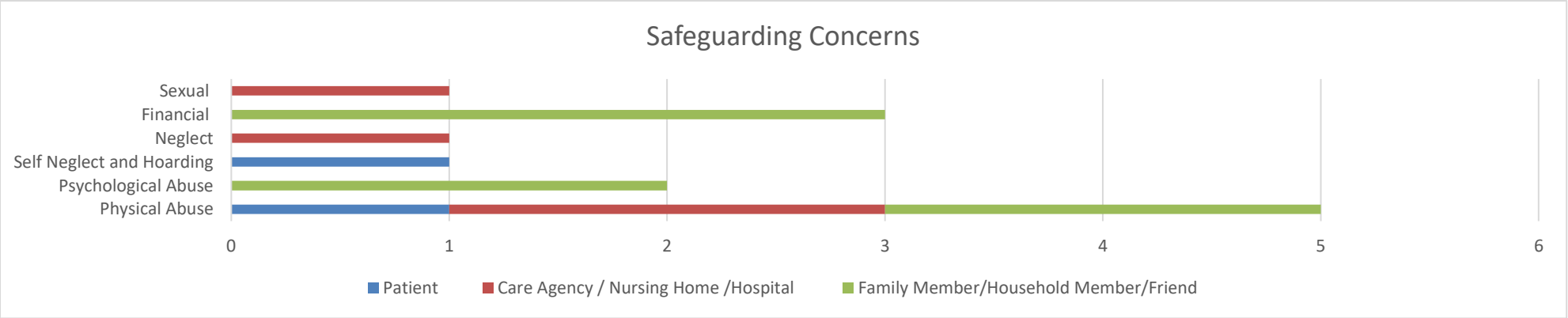
## Notification to CQC

| | Yes -Safeguarding notified to CQC | Compliance with Standard |
|---|---|---|
| Sutton | 8 | 100% Compliance |
| Merton | 5 | |

100% of safeguarding notifications were raised to CQC, an increase from 94% last year.

## Safeguarding Concern

| Safeguarding Concerns | Patient | Care Agency / Nursing Home /Hospital | Family Member/Household Member/Friend | Totals |
|---|---|---|---|---|
| Physical Abuse | 1 | 2 | 2 | 5 |
| Psychological Abuse | | | 2 | 2 |
| Self Neglect and Hoarding | 1 | | | 1 |
| Neglect | | 1 | | 1 |
| Financial | | | 3 | 3 |
| Sexual | | 1 | | 1 |
| **TOTALS** | 2 | 4 | 7 | 13 |




In comparison to previous years, there has been a significant decrease in hoarding or self-neglect being reported (28% previously in comparison to 15% this year). There has also been an increase in family/friends/household members being reported as the suspected perpetrator (38% last year to 53% this year).

**Safeguarding Concerns Upheld by LA**

| Safeguarding Concerns | Patient | Care Agency / Nursing Home | Family Member/Household Member/Friend | Totals |
|---|---|---|---|---|
| Physical Abuse | 1 | 1 | 1 | 3 |
| Psychological Abuse | | | 2 | 2 |
| Self-Neglect and Hoarding | 1 | | | 1 |
| Neglect | | | | |
| Financial | | | 3 | 3 |
| Sexual | | 1 | | 1 |
| **TOTALS** | 2 | 2 | 6 | 10 |

With two of the physical abuse cases, it was unknown what, if any, action the LA took. One was followed up but LA did not respond, and one was raised after death. Neglect case was also raised the day before the patient died and this was not followed up.
77% of safeguarding concerns were upheld by local authority; an increase of 6% from last year.

## Documentation

| Documentation | Numbers | | | % | |
|---|---|---|---|---|---|
| | Yes | No | | Yes | no |
| Documentation of consent (n=32) | 12 | 1 | | 92% | 8% |
| Consent gained to raise safeguarding referral (3n=2) | 9 | 4 | | 69% | 31% |
| Rationale for raising despite consent or best interest decision documented (n=32) | 3 | 1 | | 75% | 25% |
| Consent gained from family (n=18) | 0 | 1 | | 0% | 100% |
| Safeguarding referral followed up (n=32) | 11 | 2 | | 84% | 16% |

12 out of 13 patients had documentation regarding consent and/or capacity. The one patient that did not was a wellbeing centre patient who had safeguarding raised after a concerned family member called in.
On two occasions the safeguarding referral was not followed up either by the staff member or the safeguarding leads. One patient had safeguarding raised after death. One patient died on the day after referral.

## 5.0 Conclusions

1. There has been an increase in compliance in CQC notifications, from 94% to 100%.
2. 92% of patients had documentation about consent, a decrease from 100%, equating to one patient. This patient already had a very similar safeguarding raised regarding their friend/carer in the months prior and the family member was raising it again. Previously, the patient had consented to the referral.
3. For all other cases, those who did not consent to the referral or did not have capacity had a rationale documented about why it was being raised despite this.

## 6.0 Areas for Improvement / Actions

1. Safeguarding leads to work with IT to see how we ensure reports do not miss those who have died.

2. Continue good practice of documenting consent for all safeguarding referrals.

3. Continue to reinforce importance of documenting consent.

## 7.0 Auditor Comments / Discussion

The results continue to be very positive. The one case in which consent was not documented concerned a complex case dealt with by the wellbeing centre staff which had already been raised previously. This may have led to consent not being sought again. It may have also not been appropriate to gain consent from the patient again given the situation. However, this was not documented. It is important that in the face to face training we continue to highlight the importance of documenting whether consent has been gained and if not, the reasons around this.

Safeguarding leads continue to work with EMIS leads on reporting so those who have recently died do not get missed from the monthly safeguarding reported.

**St Raphael's Hospice**

**Meeting of the Clinical Quality & Governance Committee**

**Held at St Raphael's, London Road, Cheam, Sutton, SM3 9DX with video call access**

**At 09:45 on Monday 17th June 2024**

| | |
|---|---|
| Members: | Dr Carrie Chill – Trustee & Committee member (CC - virtual) |
| | Alan Cogbill – Trustee & Committee member (AC – virtual – Chair for meeting) |
| | Bernard Marley - Trustee & Committee member (BM) |
| | Norman McWhinney – Board Chair & Committee member (NM) |
| In attendance: | Nick Stevens – CEO (NS) |
| | Dr Naomi Collins – Consultant (NC – items 2-3) |
| | Alex Rudkin – Director of Quality and Governance (AR - virtual) |
| | Rebecca Trower – Clinical Director (BT) |
| | Anna Machin (Governance – AM - virtual) |

**Actions arising**

| Agenda item | Action | Responsible | Timeline | Ref. |
|---|---|---|---|---|
| 2. Review of Quality Account and Management Plan | Finalise Quality Account and circulate for final Committee review | Alex Rudkin | Immediate | 17.06.24/01 |

## 1. Welcome, apologies for absence and declarations of interest

Alan Cogbill took the Chair and welcomed attendees to the meeting. Apologies were received and accepted from Dr Carrie Chill, who had provided input by correspondence in advance of the meeting. There were no declarations of interest in relation to items on the meeting agenda.

## 2. Review of Quality Account and Management Plan objectives

The meeting had been convened to consider the identification of three key objectives to include in the Quality Account, for submission by the end of June. This is the public-facing element of the Hospice's clinical planning. As shared in advance of the meeting, the two proposed objectives by the Executive team which are taken from the draft Management Plan are:

- 3.7 Develop the Bereavement Pathway Project.
- 3.12 Expand Provision of Bereavement Support Work to High down Prison as well as specialist palliative care psychotherapy to residents at end of life.

A third objective would then need to be chosen out of the other objectives listed in the extract that includes but is not limited to:

- 3.19 Maintain SRH presence in the boroughs of Merton/ Sutton/ Wandsworth via appropriate referrals.
- 4.1 Maintain engagement with external stakeholders to support unmet needs in EoLC training and deliver opportunity for the upskilling of Hospice staff, volunteers and external HCPs.

- 3.4 Evaluate the Patient Safety Incident Response Framework and position the Hospice accordingly.
- 3.13 Maintain a robust approach to Infection Control across clinical and non-clinical services.
- 3.28 Create an annual incident review report that highlights learning and staff/service development.

Those present recognised the upcoming plans for organisational change and that this was a factor in selecting objectives that would definitely be delivered, regardless of this. The Committee also noted recent changes in the PsychoSocial team, and received assurance that the objectives outlined in the Plan would be deliverable through internal capacity, student counsellors and also telephone bereavement counsellors although there is some current turnover in this latter group. New projects such as the Theatre project would be kept on hold for now. The Committee heard further detail on the plans for the Prison project, which has a specific staff member focused on delivery.

The Committee asked the team to share how the proposed objectives had been identified. It was confirmed that the priorities that are proposed sit outside 'business as usual' delivery, would not be impacted by organisational change, and then the goals on compliance/ infection control reflect new expertise and staffing levels coming into the team alongside aligning with NHS initiatives on patient safety.

The Committee understood this rationale, and given that ICB funding is not increasing in line with inflation or organisational need, agreed that it should be clear through these objectives that the Hospice is not launching any new areas of services, particularly in relation to the Community team. The objectives can show clear internal initiatives that build on the high internal quality of delivery.

It was agreed that there would be value in combining objectives 3.4, 3.13 and 3.28 into an overarching objective around delivering best in class patient safety including infection control, incident reporting and integration of the new NHS Patient Safety Incident Response Framework. This would also emphasise the Hospice's strong learning culture, and would benefit patients.

Alex Rudkin would draft this objective and share the updated Quality Account for final review by the Committee prior to submission.

**3. Any Other Business and Dates of future meetings**

There were no further items of business raised. The Committee thanked the team for the quality of reports provided.

The date of the next meeting was confirmed as Friday 12th July 2024 from 10am-12pm.

*The meeting ended at 11.25am*

Approved……..

Date……..