

**16th Meeting of the Clinical Quality and Governance Sub Committee
To be held remotely via Zoom**

at 10.00am on 14th January 2022

Agenda

Chair : CC

Item	Description	Purpose ¹	Lead
1.	Welcome	I	AM
2.	Apologies for absence		AM
3.	Minutes of the last meeting held on 29th October 2021	S	Chair
4.	Action List from previous meetings	I	Chair
5.	Evidence of Excellent Practice Register	I	GL/RT/AR
6.	Clinical Risk Register	S	RT
7.	Clinical Quality & Governance Report •	I	RT/AR
8.	CAP 2021/22	I	GL/RT/AR
9.	Minutes of Meetings & Other Documents Uploaded (links) <ul style="list-style-type: none"> • Clinical Heads November 2021 • Prescribers Meeting October 2021 • Medical Business Meeting December 2021 • Safeguarding Audit Report • VOICES Report March – September 2020 • IPU Service Partial Data Dashboard • Homecare Service Data Dashboard 	I	GL/RT/ AR
10.	Any Other Business	I	Chair
11.	Dates of Future meetings <ul style="list-style-type: none"> • 1st April 2022, 10am-12 – in person in St Bedes Rm B • 1st July 2022, 10am-12 – virtual • 7th October 2022 - in person in St Bedes Rm B 	I	Chair

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

St Raphael's Hospice
Minutes of a Meeting of the Clinical Quality & Governance Committee
Held using Zoom Video Conferencing
At 10:00 on Friday 29th October 2021

Members: Dr Carrie Chill – Board Advisor & Committee member (CC)
 Alan Cogbill – Trustee & Committee member (AC)
 Dr Eva Kalmus – Co-opted Committee member (EK)
 Norman McWhinney – Board Chair & Committee member (NM)
 Dr Joy Tweed – Trustee & Committee member (JT)

In attendance: Gail Linehan – Joint CEO (GL)
 Nick Stevens – Joint CEO (NS)
 Alex Rudkin – Quality Development Manager (AR)
 Dr Jenny Strawson – Consultant (JS)
 Rebecca Trower – Clinical Director (BT)
 Anna Machin (Clerk – AM)

Actions arising

Agenda item	Action	Responsible	Timeline	Ref.
5. Clinical Risk Register	Share FAQs from drop-in sessions on Agenda for Change with all staff	Gail Linehan, Nick Stevens	Mid-November	21/10/29-01
	Update risk register with suggested change	Gail Linehan, Nick Stevens	Immediate	21/10/29-02
7. Clinical Quality & Governance Report	Provide update on paediatric palliative trainee post and support for younger patients	Jenny Strawson	Meeting during 2022	21/10/29-03

1. Apologies for absence

Joy Tweed took the Chair and welcomed Eva Kalmus to the meeting. There were no apologies sent to the meeting.

2. Review of minutes from last meeting

The minutes of the 16th July 2021 meeting were reviewed and approved as an accurate record of proceedings.

3. Action list from previous meetings

Committee members reviewed the matters arising:

- 21/05/14-02 – Ensure HR Committee consider position on staff contracts and vaccination - There is now an inclusion in all new staff contracts that the hospice recommends/expects staff (but does not mandate) to have all the required vaccinations

to ensure safe working. A watching brief will be kept on developments in the Care sector with regards to mandating vaccines.

- 21/07/16 – 01 - Explore option to recruit agency nurse for night shifts – two agency RGN positions are in post and performing strongly and one further post will be advertised to help prepare for the winter months.
- 21/07/16 - 02 - Share detail on FTE required to bring RGN team to establishment – This is included in the meeting agenda.
- 21/07/16-03 - Share update on IT risks - out-of-hours support is in place and available at times when John Groom is on leave.
- 21/07/16-05 - Encourage IPU staff reflections on time spent in training and working with other colleagues – a feedback day is planned for November 2021.
- 21/07/16-06 - Consider approach to using Datix to collect examples of excellent practice – this is factored into the roll-out of the second module/
- 21/07/16-07 - Consider further ways to help inform patients of Hospice support compared to other services – the Information Booklet will be reprinted in November.

4. Staff staffing levels – IPU

Rebecca Trower has reviewed the required levels to safely staff 12 beds on each shift with HCAs and RGNs. 13.9 WTE staff would be needed including Bank staff and excluding the Manager. All patients have individual rooms, which is general practice now in Hospices, but leads to slightly higher ratios. Over time the balance of staffing and ratio of HCAs and RGNs would need to be adjusted through natural attrition.

The Committee asked about the retirement profile of the team, appetite for 12-hour shifts, and liaison with CCG with regards to cover. Rebecca Trower confirmed that the Community team is closer to retirement than IPU overall, some staff prefer 12-hour shifts and overall more flexibility is now being given, and a request for consideration of funding from the CCGs has been requested, if the Hospice is to continue providing 2 x CNS on each weekend day, which will be followed up at the November meeting.

5. Clinical Risk Register

The Committee asked for update on the challenges with recruitment to nursing roles that has been raised with the Board and Committee. Rebecca Trower confirmed there are three WTE staffing vacancies currently and an HCA vacancy. To address this, the Hospice would take more HCAs on 12-month contracts and is using the Nurse Associate programme. Looking longer-term, in 2 years' time there will be more trained nurses coming into the sector.

The immediate challenge has been mitigated by the two agency nurses, new Bank nurses, and HCAs who are performing well. However Covid-19 numbers are rising in the community and flu season is approaching so this is being monitored closely on an ongoing basis.

The Pay Scales have been reviewed following Board approval to introduce the Agenda for Change for Clinical staff. The information that initially went out to staff mistakenly did not include the 3% uplift agreed with the NHS, and separately some staff understood their pay to have been reduced when they viewed the upper limits on banding, rather than the fact that the combination with the upper London weighting led to increased pay.

The Joint CEOs responded to this by immediately sharing an apology for the miscommunication, offering one-to-one meetings and arranging in-person drop-in sessions to share information and answer questions. The main lesson learned was to have held these meetings with staff prior to making the change. 11 staff have so far agreed to the Agenda for Change pay level.

The Committee recognised the challenges with implementing this change and that the leadership had moved quickly to address concerns raised by staff openly and honestly. It was suggested that the 'FAQs' from the drop-in sessions should be shared with all staff by email. A Union representative could also be considered in future as a feedback channel with staff. It was agreed that the risk register would be updated with one risk on staff relations impacting on retention, and one risk relating to the recruitment of staff.

The Committee noted the remaining high-level risks. The Hospice has reverted to more stringent Covid-19 protocols in light of cases rising nationally. Staff resilience is top of mind moving into winter, with strong support within teams, the Employee Assistance Programme (EAP) in place, and encouragement to staff to take up flu vaccines. The staff survey will be launched in mid-November and is administered by an external organisation. A recent phishing email had been responded to quickly by IT within five minutes and additional information security measures are being put in place including two-factor authentication.

6. Evidence of Excellent Practice register

The Committee noted the Register in particular the strong partnership working between Drs Ambreen and Busi and strong feedback from medical students on their time at the Hospice.

7. Clinical Quality & Governance Report

Rebecca Trower shared key highlights from the Report:

- There is no waiting list for Bereavement Support with high success in recruiting Psychology Students to add capacity. The relaunched Wellbeing Centre offer has been well received, with a slight drop-off in attendance during the recent week due to Covid levels rising. The refresh of the IPU and Reception has been positively commented on by staff, patients and families.
- There has been increasing take-up for the Covid-19 vaccine amongst staff. The Community team is at establishment. The team hold regular caseload reviews using the OACC approach to inform the frequency of visits which is working well so far. A paediatric palliative trainee will join the team one day per week for the next 18 months. The Committee asked for an update on this post and support for younger patients at a future meeting.
- Strong training is given to new colleagues by the Education team and a presentation from the Hospice's Clinical team will be given at the upcoming Hospice UK Conference.

Alex Rudkin updated on the DATIX roll-out due in mid-November and strong buy-in from the Medical team, including Dr Jenny Strawson as Caldicott Guardian. The Audit Programme is linking in closely to the Outcomes Measurement Group.

The Committee noted that referral numbers have increased and received assurance that the data on Falls related to one patient who had not incurred any serious injury.

8. Clinical Action Plan 2021/22

The Committee noted the Plan, and that three items are fully completed.

9. Minutes of meetings and other documents

The Committee recognised the good practice in place by sharing joint on-call resource with Princess Alice Hospice and asked for an update on this at the next meeting.

10. Any Other Business and Dates of future meetings

There were no further items raised under Any Other Business.

The meeting ended at 12.00pm.

Approved..... Date.....

ITEM 04 ACTION LIST

SAINT RAPHAEL'S HOSPICE CLINICAL QUALITY & GOVERNANCE SUB-COMMITTEE ACTION LIST FOR JANUARY 2022 MEETING

Reference	Lead	Description	Target Date for Completion	Comments
21/07/16-04	RT	Share update on equality & diversity Working Group on patient behaviour towards staff	October 2021	Not yet commenced – for discussion
21/10/29-01	GL NS	Clinical Risk Register : Share FAQs from drop-in sessions on Agenda for Change with all staff	Mid- November 2021	Not circulated. Questions answered FtF as required.
21/10/29-02	GL NS	Clinical Risk Register : Update risk register with suggested change	Immediate	Accommodated within register
21/10/29-03	Dr J Strawson	Provide update on paediatric palliative trainee post and support for younger patients	Meeting during 2022	

Ref No.	Recorded By	Date	EXAMPLES OF EXCELLENT PRACTICE - Description	Link to evidence	PT id	KLOE	Key Staff	Related System
2021/48	JS	19/11/2021	Example of CPCT responsiveness- urgent referral received by Karen in HPOC, liaised with GP, given hospice consultant mobile number, identified need for urgent home visit facilitated by Dr AA who working alongside Heather in triage, supported ACP and symptom control, advised GP re end of life medicine prescriptions and MAAR charts, identified need for palliative oxygen, HOOF A requested by Dr Strawson, oxygen delivered with 4 hours by Air Liquide - the patient died peacefully the next day. Dr AA followed up with a bereavement call and her family with very grateful for our quick response.		18053	R,C,E	Dr Ambreen Akhtar, Heather Sydall, Karen Fall	
2021/49	RT	06/12/2021	We supported him in organising his medications/ care to achieve his dying wish (Salmon fishing in Iceland). He also called us for advice from Iceland as he had such high esteem and trust in SRH. He was a keen photographer. He had been published in a Icelandic magazine but never had been published in the UK. His face lit up when the communications team suggested the featuring him in the Raphaelite which is the SRH Newsletter and the Head of comms wrote a lovely piece on him.		16589	S.C		Clinical and Communications
2021/50	RT	06/12/2021	Reflection by a HCA (DM): Obviously concerned about coronavirus and how it could affect myself and my family because known positive patients were being admitted to the ward. The biggest impact on my mental health was the restrictions placed on patients visiting. We had one patient admitted who had seven children, I am one of seven children so I think it hit home! Maintenance made a ramp that enabled us to push patient into the garden and all his children lined up behind the fence, I can honestly say that every member of staff experienced such joy to be able to share such an emotional time, even thinking about it now makes us smile. There are many examples of what we as a team were able to achieve for our patients and our mental health.			R.C.S	Facilities	
2021/51	JS	01/12/2021	Heather on triage received a call at 1715 from a doctor working for Sutton Health and Care at home team asking for specialist palliative care advice, passed to Consultant Dr Strawson, advice given to ensure patient comfort overnight, signposted to refer patient as urgent and pt put on next morning's MDT and highlighted as requiring an urgent same day visit. CNS Kevin did a home visit, liaised with GP and DNS, prescribed a syringe pump and updated community MAAR charts, referred to Hospice at Home who supported pt and family until her death at home on 3/12/21. I think this case demonstrates how responsive the CPCT are and our excellent engagement with other key providers to ensure effective and excellent care.		11190	R,C,E	CPCT	
2021/52	AR	08/12/2021	SRH - Awarded runner-up in the Merton Best Business Awards 2021	Evidence of excellence copy\Merton's Best Business Awards - Runner up1.msg				
2021/53	LB	13/12/2021	Student nurse feedback from a pre-reg 2 nd year Msc student based on IPU for 7 weeks Sept- Nov 21- gave 5/5 on all aspects of the placement. "I genuinely had a wonderful experience at this placement. I was made to feel welcome and part of the team. I always looked forward to my shifts".	Evidence of excellence copy\Depository of excellence.msg		S,C E, W		
2021/54	LB	13/12/2021	Foundations of palliative care for HCPs working in the community (2 day course) Free of charge 15 HCPs attended from Sutton and Merton "Informative" "Useful" Pre course evaluation majority of attendees scored their knowledge of palliative care as 2-3 out of 5. Post evaluation, majority scored 5/5. All stated they completely understood the services offered at the hospice after the course.	Evidence of excellence copy\Depository of excellence.msg		E		
2021/55	LB	13/12/2021	HCA 2 nd checker for controlled drugs and drugs liable to misuse training undertaken for 8 HCAs & 1 PA in November 2021- this will improve patient care but reducing waiting times for medications. It also allows HCAs to continue their professional development.	Evidence of excellence copy\Depository of excellence.msg		S, E, R		
2021/56	SM	13/12/2021	Email feedback from a Bereavement Service client who also attended the Bereavement Support Group "...Please give my best wishes to everyone. I gave them all my mobile number at the last session I. I would be very happy to hear from anyone if they feel up to having a chat in the future. With very best wishes (and huge thanks) to you personally. I found the sessions really helpful. It was so good to talk to others who 'understood'".	N:\Care Quality Commission\Excellence in Practice\Evidence of excellence copy\Example of excellence for the CQC file .msg		C, E, W		
	JF	24/12/2021	Patient 12636 discharged to Trinity court NH on 24/12/21 community CNS reported back that the patient had said that there's one special person who makes her laugh and that nurse was HCA Denise Manning. Denise as been informed of this.			C		
	TY	24/12/2021	Pt 12636 was discharged with the phnominal support of Julie Ford who went the extra mile to ensure she had a placement before Christmas. She spent a lot of time liaising with CCG and the NH placement to ensure a seamless discharge.			C, R, E		
	TY	23/12/2021	PT 12636 had very little by way of personal belongings and SSN JF bought her some night clothes and socks from her own funds to ensure she was comfortable			C, R, E		
	TY	25/12/2021	Paula Di Palma - Housekeeping manager - cooked Christmas lunch for that patients and also made up the christmas present so each patient had something to open on Christmas morning.			C		
	TY	23/12/2021	Paula Berry visited the wife of pt 16253 who died at the Hospice to deliver a hamper from SRH and spent some time with her as she was on her own			C		

Serial	Cause of Risk	Description of Principle Risk to Charity	Current Controls to prevent occurrence	Current Impact	Current Probability	Raw Score	Additional Controls	Residual Impact	Residual Probability	Residual Score	Monitoring Process	Date Action Required By:	Who is responsible for action
1.	Workforce: Registered General Nurses Recruitment of appropriately qualified nurses to support the delivery of care on the In-Patient unit.	Night duty cover remains problematic. If RGN cover on night duty not sufficient, the number of patients that can be safely supported will be affected as safe staffing is across 24hours. Increasing difficulty in recruiting Band 5 nurses for day duty - staff undertaking extra shifts to cover requirement risk burnout. Managing unexpected sick/compassionate leave can put pressure on the staff cover.	Current qualified nursing staff levels are adequate to support 8/10 IPU beds on day duty with full current complement of staff. Significant current deficit on night duty. COVID is impacting staffing levels due to requirement to self isolate. Active recruitment of Band 5 nurses to fill permanent and Bank to support core team at times of AL/SL or increased high dependency. Requirement for continued review of night RGN cover for safety assurance. Staff flexibility from day duty to night duty- Consultation is complete and rotation has commenced. On the job training, mentoring and educational support to obtain required qualifications e.g. Support of the TNA programme for HCAs	4	4	20	In situations where staffing levels are adversely affected there would be a managed reduction of available beds. Caveat is that even with one bed open there is a requirement to have 2 RNs on duty. Engaging with local and national training schemes to demonstrate the attractiveness of the hospice as an employer. Reviewed sickness and maternity leave policy- both amended to increase benefit October 2021 - payscale review and implementation of AfC aligned rates to remove the financial disincentive in recruitment January 2022 - bank RGN and HCA numbers increased. Agency nursing staff used when possible. Current RGN vacancy 15-18%.	4	3	16	Recruitment rates		CD
2.	IT PAS System Failure	Inability to access contemporaneous clinical records.	Contactable team OOH (not formal contract). Back up resource - outsourced at times of AL. Back up to PAS system facilitating access to the PAS. Risk is that recent recording may not be captured.	5	2	15	Daily back up of PAS. Risk Assessment undertaken related to IT risk to PAS. Highlighting gaps. Access to OOH IT Consultant response in place.	4	2	12			
3.	Impact on relationship of trust with clinical staff due to lack of clarity and communication re: introduction of alignment with AfC salary scales and Banding.	3% uplift granted to NHS staff in September not included in information letter sent to Clinical staff. Hospice understanding was that 3% had not been accepted therefore not included. Loss of trust in CEOs/organisation.	Corrected information communicated via letter to all clinical staff with apology from CEOs for any undue upset. Four staff meetings held to clarify alignment and face to face apology to all staff who attended. Assurance that staff would not be disadvantaged financially. Legal advice obtained- acknowledged it was contractual change however as it was a payrise(positive impact) no requirement to consult.	4	3	16	Reflection for learning. Raised awareness of sensitivity related to staff pay. Future action will include consultation with staff related to matters of salary. Choice for staff to agree to AfC alignment or to remain on current pay framework. Two opportunities in 2021 to accept alignment with associated backdating to October 1st. Further opportunity to switch in April 2022 without backdating of 3%. Open door access to CEOs. Potential positive impact once initial salary cheques are received and improved offer is clear.	2	1	4	Feed back in Staff Survey (08/11/2021)		CEOs
4.	Clinical Incidents	Patient Safety (Falls/Pressure Ulcers/Medication Errors). Risk of complaints from patients/families Requirement to report outside the organisation to CQC Pre-empt a CQC Inspection Reputational damage	Reporting of all incidents related to clinical care Hierarchy of investigation Outputs- Learning informs improved procedures and processes Regular review of incidents- closing the loop from reporting to action and learning Report to EXEC, Clinical Governance Committee & Advisory Committee, Dissemination to all hospice teams to inform learning	4	2	12	Continued staff training and awareness of new techniques and products. Report at Clinical HoDs. Report by managers at team meetings. Opportunity to participate in reflection and sharing learning and outcomes. Feedback to complainants regarding change in practice. Encourage an environment of comprehensive reporting to support learning and quality improvement. Introduction of Datix in Q3 2021 will support reporting and monitoring.	4	1	8	Review of Data and subsequent themes.	ongoing	CD & Governance Lead
5.	Staff Resilience negatively impacted during long pandemic	1. Inability to continue delivering service to the desired standard. 2. Consequential impact on EVE	1. Peer Support implemented for managers- aim to equip staff effectively. 2. HR proactive and available to hear and escalate issues 3. HR Mental Health Helpline. 4. Regular and open communication from Senior Team. 5. Weekly testing for staff. 6. Vaccine roll out to most staff	3	3	12	1. Continue to provide some other welfare benefits to acknowledge difficulties i.e. social meal cost contribution. 2. Supportive communication across teams. 3. Access to vaccinations improved. Increase in use of LFTs. 4. Increased infection control measures in view of rise in community infection. 5. Re-implementation of staff survey (Nov 8th 2021) 6. Regular review of organisation support for staff sickness / isolation to ensure staff resilience and service provision	3	2	9	Manager feedback		EXEC
6.	Corona Virus	Infection spread within hospice	All staff emails alert. Signage directing all staff & visitors to hand-washing on entering and leaving the ward / rooms and use of hand sanitiser. Staff adherence to control of infection policy. As per government guidance clinical staff that can work from home are facilitated to do so. Community service provision has changed from face to face to telephone contact or virtual contact via skype.	3	2	9	Corona Virus Policy constructed to address all operational issues. PPE supplies checked. Contingency planning clarified for any identified case within the Hospice - as per government guidance. Single room nursing. Reduced face to face visiting dictated by urgency. Increased telephone contact. Introduction of virtual assessment. february.21, FFP3 mask testing. Deep clean of IPU. Refresher PPE training and advice and support from PHE. Weekly PCR & LFD testing for all staff. Independent review of infection control undertaken in October 2021. January 2022 - links with SHH Infection Control Lead - to be formalised in SLA	3	2	9			

Serial	Cause of Risk	Description of Principle Risk to Charity	Current Controls to prevent occurrence	Current Impact	Current Probability	Raw Score	Additional Controls	Residual Impact	Residual Probability	Residual Score	Monitoring Process	Date Action Required By:	Who is responsible for action
7.	Sustainable and relevant service provision	Reticence of some staff to embrace change to working practice as outlined in Clinical Action Plan (CAP).	Proactive leadership to communicate and support change in working practice in line with CAP with Managers and key staff.	3	2	9	CAP to be communicated to all staff to clarify the vision and direction of hospice clinical service provision. Concerns will be listened to and addressed. Monitoring of change and recognition of the improvements will be communicated to all staff on an ongoing basis through team meetings and education sessions.	3	1	6	Ongoing	Plans communicated after independence November 2020 - Managemnt planning to update Jan 2021	EXEC
8.	Complaints	Rumours Local press coverage Potential for public concern Elements of public expectation not being met Loss of confidence in the service Reputational damage	All complaints both verbal and written treated with the same level of scrutiny Complaints procedure in policy for staff to follow- escalation process Complaints documented and reported via Quality Manager Reported at Clinical Quality Improvement and Clinical Quality and Governance meetings Complainants (both verbal and written) are offered the opportunity to meet and discuss concerns with Director of Care All complaints discussed at hospice team meetings for awareness and learning across the organisation Bi-annual review by EXEC Required action taken to address concerns with staff members where individuals have been identified by the complainant File notes kept of discussions by HR	3	2	9	Use of root cause analysis for significant incidents. Feedback to complainants regarding change/improvement in practice. Scoping to establish all clinical staffs access to communication skills training Training on care delivery Information shared re: Duty of Candour and scope of the policy Reporting of any concerns- no blame but responsibility	3	1	6	Ongoing		CD
9.	Breaches of confidentiality involving person identifiable data (PID), including data loss	If low risk breach- dealt with locally as per policy- CUI reporting More serious breach - RCA may be required- may have wider implications if data not encrypted If serious IG breach may be media coverage Potential loss of public confidence to keep PID safe	All staff paid and unpaid trained on IG on induction and annual mandatory training. Policy communicated to whole organisation Clinical staff have nhs emails (encrypted) Regular organisational sweeps in all departments	3	2	9	IT monitoring and oversight of PID in received and sent emails. Monitoring includes audit and test Phishing emails via IT Dept. Intermittent checking in areas such as photocopier/clear desks. Established link with Capsticks solicitor who provides ad hoc advice on data access issues January 2022 - Information Governance Check list audit / Clinical Record documentation audit	3	1	6			IT/CD
10.	Corona Virus	Staff Anxiety re: CV	Staff advised to undertake weekly PCR & LFD testing and vaccination. EAP accessible by all staff for wellbeing support. Working from home supported where possible. Review in line with government guidance.	3	2	9	Monthly HoDS to include any COVID issues and regular EXEC emails providing update and reassurance.	3	1	6			
11.	Corona Virus	Staff safety at work	IPU - wearing face masks at all times as difficult to maintain social distancing in environment. Full PPE as appropriate. CPCT - social distancing in place in offices. Admin Corridor : staff using available office space to meet social distancing. Psychosocial and other teams working from home where possible and service delivery can be maintained. Face coverings worn in all public areas. Offices have signage stating masks to be worn when more than one person is in the office.	3	2	9	Office reorganisation to make best use of space and required occupation. Regular infection control meetings and review of guidance. Staff confidence increased in social distancing regulations October 2021 - FFP3 mask use for community team implemented. October 2021 - Fit mask testing extended to Housekeeping. January 2022 = Fit mask training (Train the Trainer) arranged and testing for 2 FFP3 masks to be implemented. All IPU staff where FFP3 for all amber / red patient contact as per risk assessment.	3	1	6			
12.	Lone working	Staff/volunteers work singularly in the community within referred patients homes. Risk of accident/incident in a patients home and individual risk to staff member. Risk in travel to and from home visits	Policy and procedure in place to support community working (SOP). Supplied with a mobile phone for contact with the hospice or other healthcare professionals. ACC informed of access and egress. Lone worker alert devices in place.	3	1	6	Lone Worker Policy informing steps to follow if a colleague does not return to base at expected time. Clarification and supported training on use of safety devices. EXEC OOH on call in place for contact and advice on further action.	3	1	6	On going		CD
13.	Brexit - Risk of medication shortages via suppliers	Required medication (opioids, neuropathic agents, anti seizure etc.) not available in specified dose ranges to support symptom management. Impact on patients.	Liaison with clinical pharmacy Ashtons - Reassurance that adequate supplies in stock.	2	2	6	Regular updates from clinical pharmacist. Communication with wider CCG pharmacy colleagues.	2	2	6	Ongoing		CD
14.	Corona Virus	Infection brought in on clothing	Staff instructed not to wear uniform into work. Change in work, at beginning and end of shift. Scrubs supplied.	2	2	6	Wash bags provided to all staff in which to place uniform for transporting home. Advised wash uniform in bag at 60 degrees. CPCT supplied with uniforms to facilitate essential community visits as well as all PPE	2	2	6			

ITEM 08

Clinical Quality and Governance Report

Contents

Aim	1
Recommendation	1
Report.....	2
Update on Organisational Response to the Covid 19 Pandemic.....	2
Clinical Services	2
Medical Team	3
Education/Training.....	4
Capacity Tracker	4
Governance meetings.....	5
Clinical Audit, Monitoring and Research.....	6
Data Dashboards.....	7
Quality Account	8
CQC and Organisational Assurance.....	8
Audit/Research 2021/22	9
Clinical Risk Management	22
Clinical Complaints	26
Complaints Overview.....	28
Records – Access Requests.....	29
Notifications	29
Clinical Commissioning Group (CCG) Data.....	29

Aim

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

Recommendation

The report be noted.

Report

Update on Organisational Response to the Covid 19 Pandemic

We continue to flex and respond to the government guidance in terms of managing the organisation safely as the Covid figures rise and fall. Our staff remain incredibly adaptable and altering the way we practice has now become second nature.

Our Managing Covid-19 policy is regularly reviewed and updated, with safety remaining uppermost but compassion influencing the way in which we amend our guidelines to ensure that considerations such as visiting guidance are sensitively and pragmatically addressed.

For example, all visitors undertake a LFD test prior to entering the IPU, meaning that the number of people visiting can remain at a reasonable level.

Staff maintain regular testing and a few have been affected by the Omicron variant over the Christmas period. However, the uptake of vaccines and boosters is reassuring and hopefully has positively influenced and will continue to influence our ability to carry on providing a responsive service.

We continue to work closely with SWL CCG and our local hospices and palliative care providers to ensure that we are reaching as many people as possible who need our support and expertise. As a positive, Covid has encouraged us to all work more closely and collaboratively with our healthcare and commissioning colleagues (every cloud....)

We have been visited by the Infection Prevention and Control (IPC) Lead from St Helier Hospital and her team will be working more closely with us in the future. This is partly to ensure that we are meeting the required standards of IPC but moreover to take the workload and responsibility away from our education team so that they can return to their previous remit.

HoDs continues on a monthly basis to ensure that information is shared and communication is effective.

Clinical Services

Our **Psychological Support Team** remains extremely busy with numbers of clients with bereavement support needs on the increase. This has meant that even with the student placements, we have a growing waiting list. The team continually review the caseload and the way in which they work to ensure that they are providing support in the most effective and time efficient way – but the impact on Covid and delays in healthcare treatment etc have led to an anticipated increase in need. The team signpost where they feel it's appropriate.

The bereavement group that Steve jointly ran with Sr Ann was well attended and received positive feedback.

Our **Wellbeing** Living Well programme completed its second cycle and numbers of attendees to the Wellbeing centre have steadily increased over the past quarter. Social prescribers who have visited the centre are now starting to refer and we expect to see numbers continue to steadily rise over the coming year. Unfortunately, Covid put a stop to the centre holding the planned Christmas party but similarly to last year, the party then became a virtual event which was still reasonably well

attended. This also meant that a couple of bedbound patients were able to participate; both rewarding for the patients and our staff.

The **IPU** is looking bright and fresh and has been welcoming patients and families again since September. The new reception area on the IPU is working well and provides a central point of contact for staff and visitors entering the IPU.

As always, we have flexed our beds depending on staffing levels. We have had a number of student nurses who have spent their placements with us with good feedback. It is helpful for our learning as well as theirs, and we hope that giving students an understanding of what we do will encourage them to consider moving into specialist palliative care at the end of their training.

We have been looking at the IPU culture within the nursing team and held a number of meetings where staff have been encouraged to look at how we can work better as we move forward.

Many are keen to retain skills they have brought with them from other settings or increase their skillset to take on greater responsibility. There is also an appetite for flexibility in the way that shifts are structured.

We are therefore looking at making some changes and shifting some responsibilities amongst the senior staff in order to be able to focus on these areas. HCAs have already undertaken 'second checker' training so that they can witness disposal of some medications, freeing up registered nursing time for other tasks.

Staffing remains stretched at times and we are actively recruiting where we can. We now have an increased number of bank staff and are currently advertising for a variety of roles. We know that other hospices are in similar positions as the nursing shortage is further impacted by Covid and the ramifications that this brings. We recognise that the Band 4 Nursing Associate role has a valuable and increasing part to play in supporting our workforce, we have Band 4 staff both in training and in substantive posts.

The **CPCT's** new model of three locality teams has been running for more than six months and a formal review is now due. The team is at full establishment but there are some staff retiring/reducing their hours in the near future and so these vacancies will be advertised ahead of time to try and maintain the capacity. Weekend face to face visits have increased over the past quarter, demonstrating a need for 2 CNS' on weekend days and bank holidays. This does impact on staffing numbers during the week and we are in discussion with SWL CCG regarding how we support this as the year progresses. The Hospice@Home team have been particularly busy over the past quarter and their input is highly valued by the patients and families they support – with consistent positive feedback and compliments. The medical team now have staff members based in the CPCT office which is working well as an easily accessible resource for the CNS' and Practitioners as well as a shared understanding of the complexities, community palliative care brings. Two more of our CNS' completed the European Certificate In Essential Palliative in December.

Medical Team

The Medical On call collaboration shared between St Raphael's, Kingston Hospital and Princess Alice Hospice began in early October, meaning that the frequency of on call is now reduced for staff, but the area covered is wider. There have been a few teething problems as one would expect with different databases and protocols etc but nothing especially untoward and the collaboration is a positive move for all involved.

The doctors continue to provide support, advice and guidance across all our clinical areas and remain flexible to ensure appropriate responsiveness where it is needed.

They have participated in provision of education both internally and externally, with local providers and stakeholders, as well presenting 'the role of the Physician Associate' at the Hospice UK Conference in Liverpool in November. This was well received and raised interest with other hospices.

The team have been particularly proactive in undertaking clinical audit in a variety of areas which in turn, will help us to review and develop the SRH Audit programme.

Staffing wise, we have a number of trainee doctors including GPVTS and our Paediatric Palliative Medicine Trainee. We have also recently received confirmation that Rachel Clingan, our trainee registrar will be staying with us until next October. We have also recruited a Consultant Psychiatrist as a volunteer – Kris has a special interest in palliative care and has offered a four hour weekly session to support us in return for his own learning of specialist palliative care.

Education/Training

Our Palliative Care Educators have been carrying the mantle for infection control for some time now and have been a huge support and resource to the organisation during the changing guidance since omicron.

Apart from the IPC role, they have continued to provide education both internally and externally. A two day 'Foundations in Palliative Care' was held in November for external healthcare professionals and was well attended and received. This will be repeated in 2022.

They have put together competencies for some of our trained staff and were responsible for the HCA 'second checker' training and will be focusing on increasing the skill set of our HCAs over the coming months.

Capacity Tracker

We continue to contribute our inputs into the NHS capacity Tracker which is aligned to the HUK grant from Treasury. Request for our routine submission of additional data to Hospice UK to support their funding allocations was received on Christmas Eve and we have implemented this additional return that is effected twice weekly.

Governance meetings

The Hospice's 'Governance' meetings feed into the work of all the Hospice Sub-committees.

Presently, there are 8 clinically focused forums that currently feed into the CQ&G Sub.

The Health & Safety Committee feeds into the F&R Sub.

The Staff Consultative Group and the Education, Training & Development Committee feed into the HR Sub.

Governance Meetings - Clinical	Date last held	Date of Last Minutes Reviewed at CQ&G Sub	Next meeting
Clinical Audit and Activity Data	Jan'22	Jun'21	Feb'22
Clinical HoDs	Dec'21	Nov'21	Feb'22
Medical Business	Jan'22	Dec'21	Nov'21
Drugs & Therapeutics	Nov'21	Jul'21	Feb'22
Falls	Dec'21	Apr'21	Jun'21
Outcome Measurement Group	Nov'21	Sep'21	Jan'22
Infection Control	Nov'21	Feb'21	May'22
Prescribers	Oct'21	Oct'21	Dec'21

The Hospice's Quality Improvement Committee last convened in December 2020 and it has been agreed that its content has now been effectively absorbed within existing and new meeting fora.

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 either from the Joint CEOs (IG), the Clinical Director (Clinical), the Head of Income Generation (Retail and Fundraising) or the Head of Quality and Improvement. 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.
- Quarterly submission to Hospice UK's Quality Metrics project began in July 2017 and are ongoing with the latest submission expected in January 2022. The submission categories cover pressure sores, patient medication incidents and incidents of patient falls.
- All falls are reviewed at meetings of the Falls Group. Its last meeting took place in November 2021 and its next meeting is scheduled for June 2022. The Falls Policy was last reviewed and re-published in October 2020.

Clinical Audit, Monitoring and Research

Proactive audit of the prescription charts remains a weekly undertaking for our clinical Pharmacist and results are routinely shared via the Live Care system and reported to the D&TC. Our Ashton's Clinical Pharmacist is Ebun Lufadeju.

Review of progress with the clinical audit program and opportunity to feedback results will be provided by the Clinical Audit and Activity Data forum (CAAD). Its last meeting was held in January 2022.

The Audit/Research Programme 2021/2022 with timeline is set out on page 9. It itemises 28 projects spanning, clinical audit, quality improvement and data monitoring. Ownership is delegated across the clinical team and Quality office and the medical team projects have Dr Tamura-Rose as audit overseer.

Data Dashboards

Clinical data dashboards that inform the service areas of the IPU, Well-being Centre, Community and Psycho-Social teams are developing. An index of tracked data that is presented and communicated to the clinical team is held and includes such items as:-

Report Reference	Title	Lead	Created	Function	Primary Aud.	Exec / CCG Interest	Freq.	Resp.	Is Data Presented?	Presentation Tool / Depository
20/001	CMC Monitoring	BG	Jan-20	To improve CMC data capture	CPCT	Yes	Weekly	AR	Yes	N:\CrossCare\Data Analysis\Community Team\CMC.xlsx
20/002	NoK Details	SM	Jan-20	To improve NoK data capture	Psy / Qual / Donor Support	No	Monthly	AR	Yes	N:\CrossCare\Data Analysis\Next of Kin\NoK Details Monitoring.xlsx
20/003	Community Team Visit Responsiveness	LB	Jan-20	To support responsiveness evidence	CPCT	Yes	Quarterly	AR	Yes	N:\CrossCare\Data Analysis\Community Team - Type of Review Data (AR) December 2019 +.xlsx
20/004	Sharing Information Consent	TC	2018	To monitor and improve Sharing Information Consent data capture	CPCT	No	Monthly	AR	Yes	N:\CrossCare\Data Analysis\Community Team\Information Sharing.xlsx
20/005	Safeguarding Monitoring	RW	Feb-20	To highlight patients with safeguarding concerns and track follow up	CPCT	No	Monthly	JL	No	N:\Clinical\Weekly Crosscare Reports
20/006	Referrals Monitoring	JO'G	Mar-20	To monitor and improve Referrals data capture	CPCT	No	Monthly	AR	Yes	N:\CrossCare\Data Analysis\Community Team\Referrals.xlsx
20/007	Referral to RIP Monitoring	JO'G	Mar-20	To monitor time between referral and death	CPCT	No	Monthly	AR	Yes	N:\CrossCare\Data Analysis\Community Team\Referral and RIP.xlsx
20/008	Active Caseloads	NS/GL	May-20	To monitor active caseload levels	Exec	Yes	Weekly	AR	Yes	N:\CrossCare\Data Analysis\Active Caseloads\Active Caseloads as at 22-10-2020.xlsx
20/009	Daily Activity Data - capacity tracker support	NS/GL	May-20	To monitor activity recorded on Crosscare	Exec	Yes	Daily	AR	Yes	N:\CrossCare\Data Analysis\Hospice UK COVID-19 Data Submission\Activity Data for Hospice UK COVID 19 Daily Report.xlsx
20/010	Referrals by Postcode	DN	Jun-20	To monitor referrals by postcode	Fundraising & Exec	Yes	Monthly	AR	Yes	N:\CrossCare\Data Analysis\Postcodes\Referrals 2019-20 by Postcode wip (AR).xlsx
21/001	PPoD vs Actual PoD Monitoring	RT	April 2021	To monitor PPoD achievement rates	Exec	Yes	Quarterly	AR	Yes	N:\CrossCare\Data Analysis\PPoD & RIPs\Deaths & PPD.xlsx

Report Reference	Title	Lead	Created	Function	Primary Aud.	Exec / CCG Interest	Freq.	Resp.	Is Data Presented?	Presentation Tool / Depository
21/002	Community Risk Assessment Monitoring	TC	To create	To monitor completion of the community RA	CPCT	Yes	Monthly	AR	It will be	TBA
21/003	DoLs Monitoring	TBA	To create	To monitor DoLs applications and follow up	Exec	Yes	Weekly	AR	No	TBA
21/004	Wandsworth Activity Profiling	RT	To create		Exec	Yes	Quarterly	AR	It will be	TBA

Quality Account

The Hospice last submitted its **Quality Account** for 2020/2021 to the NHS Choices web site in June 2021 and is available on the Hospice's website at

<https://www.straphaels.org.uk/Handlers/Download.ashx?IDMF=a1a6bf91-8067-44e8-b3e1-aaeca9a274b6lt>.

The next Quality Account is expected to be submitted before 30th June 2022.

CQC and Organisational Assurance

The CQC last inspected the Hospice in [November 2019](#) and awarded a Good rating. The report is available via the Hospice website.

An expanded working party periodically populates and keeps under review the Key Lines of Enquiry self-assessment documentation.

The CQC have published Temporary Monitoring Arrangement KLOEs that underpin their support calls that are expected more frequently than previously as part of their relationship building and assessment program. Last submission to support the latest telephone monitoring call was on 23rd February 2021 and was included in the papers for the February CQ&G Sub-committee meeting.

The self-assessment against the KLOEs will support our preparation for an inspection. We understand now that the CQC have abandoned the requirement for completion of a Provider Information Return with inspection methodology expected to embrace unannounced inspection. Allied to the workings of this group has been the creation of a depository for evidence of excellence that is included as an Agenda item for the CQ&G Sub. We hope our KLOE work will support our evidence base to achieve an 'Outstanding' rating at our next inspection and maintain it in the future.

Transfer of registered manager arrangements from Gail to Becca have been completed by the CQC and we can expect an inspection at any time. Current advice is that owing to the pandemic the CQC have suspended elective inspection visits in January 2022.

Audit/Research 2021/22

Overview in October 2021

25 projects scheduled in 2021/2022 :

2021/22 Listing

Project Ref.	Title	Lead	Status	Report Link	Results
2021/22-01	Community - Carer & relative questionnaires for the Hospice @ Home Service	H@H Quality Office	Ongoing		
2021/22-02	IPU & Community - VOICES survey of bereaved next of kin 3-6months post bereavement	Clinical HoDs Quality Office	Ongoing - Latest Report for Apr-Sep 20 published 20-12-2021	N:\Clinical\Clinical Governance\Clinical Audit\Audit Report Library\2021\VOICES 2020 Report JCAR 20-12-2021 v1.0.pdf	For extensive results - see report April - September 2020. Responding to the Friends & Family question, of the 53 who did record an answer, 40 (75%) rated the hospice as 'Very Good' (c.f. 82% in 2019/20), 8 (15%) rated the hospice as 'Good' (c.f. 13% in 2019/20), 3 (6%) rated it as 'neither good nor poor' (c.f. 0% in 2019/20). 1 (2%) rated it as 'Poor' (c.f. 0% in 2019/20), none (0% c.f. 2% in 2019/20) rated it as 'Very Poor,' and 1 (2%) did not know the answer to this question (c.f. 4% in 2019/20).
2021/22-03	IPU - Patient Satisfaction	TY/Volunteers Quality Office	Re-start December 2021		

Project Ref.	Title	Lead	Status	Report Link	Results
2021/22-04	IPU – Infection Control : Environment & Hand-washing Audit	IPU - S Dunmall Community - J Smith Quality Office	Ongoing	N:\Infection Control\Weekly spot checks\Spot Check Data\Graphs	
2021/22-05	IPU - Medicines Management Audit	Ashton's Clinical Pharmacist	Ongoing		
2021/22-06	Non-pharmacological intervention Audit (ISR Recs 2-5) - prevalence / effectiveness monitoring	IPU based : TC/TY/JS	Pended for discussion for 2022/23		
2021/22-08	IPU - Re- Audit against Audit NICE Guidance NG31 Care of Dying Adults at the End of Life	Dr Busi Da Silva	Data Collection Phase		
2021/22-09	Controlled Drugs Annual Audit	R Trower	Ongoing		
2021/22-10	IPU - Re-audit of Discharge letter to include medication recording on Discharge from IPU corroboration with the EPR 'Medication Module'	Dr AA	Data collection complete Report in Jan2022.		

Project Ref.	Title	Lead	Status	Report Link	Results
2021/22-12	OACC measures (Step 1 - Phase of Illness + Karnofsky performance status; Phase 2 - iPOS)	OACC Task & Finish Group JS - IPU GT-R - Community	Policy Published. Training delivered Aug / Sep 2021 Into Practice Oct 21 Data Collection Tool for Dec 21		
2021/22-13	IPU : Patient Handling / Pressure Areas / Mouthcare	IPU - TY, PJ	Aug / Sep '21 Audit Data Gathered Oct'21 Database design and entry Jan'22 Rpt		

Project Ref.	Title	Lead	Status	Report Link	Results
2021/22-14	IPU - Mortality and Morbidity Meeting Audit	Dr AA	Published	N:\Clinical\Clinical Governance\Clinical Audit\Audit Report Library\2021\IPU Mortality & Morbidity Meeting Audit November 2021.pdf	<p>May to July 2021</p> <p>This audit demonstrates that the IPU mortality meetings provide an opportunity for the IPU MDT to reflect on all deaths and consider our approach when there are challenges or family concerns have been voiced.</p> <ul style="list-style-type: none"> - The meeting also promotes team reflection on good practice and areas of excellence. - The most common challenges were around discharge planning, complex symptom control, and communication with families around the above topics as well as around the side effects of medication. - Areas of excellence identified were: strong MDT working and support of families, provision of spiritual and psycho social support, meeting PPD and medical out of hours support for admitting patients in order to achieve this. - Documentation was adequate. - We are not currently highlighting/identifying achievement of PPC/D as excellent in all cases where arguably this should be seen as a positive achievement

Project Ref.	Title	Lead	Status	Report Link	Results
2021/22-15	Discharge Planning	Med Team Dr JS	Published	N:\Clinical\Clinical Governance\Clinical Audit\Audit Report Library\2021\IPU Discharge Planning Audit Report August 2021.pdf	<p>April to May 2021</p> <p>These results show that the standards for assessing for and initiating discharge conversations are currently being met. Most patients had discharge discussions less than 72 hours into their stay in line with standard 2.1.2.</p> <p>The tentative dates (of 7-10 days post admission) suggested in 2.1.2 were met in only half of the discharges. These dates were not recorded in the electronic record for any of the patients as the policy states, so this could be a contributing factor to why they were not met.</p> <p>Discharge planning is started in appropriate patients with only a small percentage having to be stopped due to deterioration, and the patients who were discharged also survived on average for a month afterwards, with no failed discharges. Most patients were stable at discharge, with suitable reasoning for discharging the unstable patients, which must contribute to the success of discharges.</p> <p>The commonest discharge destination was home, and commonest place of death was the hospice. PPD was successfully met in 89% of cases, showing the strength of advanced care planning in the hospice.</p> <p>In half of the completed discharges,</p>

Project Ref.	Title	Lead	Status	Report Link	Results
					<p>patients experienced delays to their leaving. The main cause of these were patient illness, then followed by administrative issues including medications not being ready, transport not being ordered in time, and care not being in place.</p> <p>In just over a third of patients where discharge was discussed there was patient or relative distress recorded. 3 of these complaints were about relatives not being properly informed about changes to discharge which is a failure to meet standard 2.1.13 on these occasions.</p> <p>Patients who experienced distress/ concerns were associated with longer hospice stays than the rest of the patients. This may be because patients get used to a certain level of care, which is suggested by the fact that 3 of the concerns were about the patient not wanting to leave the care of St Raphael's and worried about coping.</p> <p>Concerns were only raised on one occasion that was associated with early mention of discharge, despite the majority of patients having these discussions early. This indicates that early discussion of discharge is unlikely to be a major cause of additional patient/ relative distress.</p> <p>Consider explicitly documenting that the</p>

Project Ref.	Title	Lead	Status	Report Link	Results
					<p>patient has been assessed for discharge suitability in the Crosscare notes, and if suitable then recording the tentative dates in line with the discharge policy. Reiterate the importance of informing relatives to staff, as was the greatest cause of relative distress during discharge, and be aware that for patients with longer admissions discharge is associated with more patient distress so these discharges may require more time and support.</p>

Project Ref.	Title	Lead	Status	Report Link	Results
2021/22-16	Referral to PS triggers	Psychological services SM	Pended for discussion for 2022/23		
2021/22-17	Bereavement Questionnaire	Psychological services SM	Pended for 2022/23		
2021/22-18	Non-medical Prescribing Activity Comparative : FP10.	Community KH	Not yet started		
2021/22-19	Advance Care Planning -(timelines)	Community Dr G T-R TC	Data Collection Phase		

Project Ref.	Title	Lead	Status	Report Link	Results
2021/22-20	Activity Monitoring Data CMCNoKCPCT Responsiveness Sharing Information Safeguarding Referrals Referrals to RIP Active Caseloads Daily Activity Data - capacity tracker Referrals by Postcode Community RA DoLs PPoD Wandsworth Activity	Quality Office + CAAD	Ongoing		
2021/22-21	IPU & Community & Psychological Support Services - Activity Data Dashboards Development	Quality Office + CAAD	Ongoing		
2021/22-22	Incidents	Quality Office + Incident Review Mtg	Ongoing		
2021/22-23	Falls	Quality Office + Falls Mtg	Ongoing		

Project Ref.	Title	Lead	Status	Report Link	Results
2021/22-24	Complaints	Quality Office + Exec	Ongoing		
2021/22-25	IV & Paracentesis	Jenny & Jovy	Data Collected Report expected Jan 2022		

Project Ref.	Title	Lead	Status	Report Link	Results
2021/22-26	Safeguarding Documentation	Rebecca Wallis	Published	N:\Clinical\Clinical Governance\Clinical Audit\Audit Report Library\2021\Safeguarding Audit Report Jan 2020 - May 2021 v2 issued 12-12-2021.pdf	<p>1.0 Conclusions</p> <p>1.1. All safeguarding events raised to the LA were raised with the CQC – 100% compliance.</p> <p>1.2. 70% of patients had documentation as to whether consent was gained or not from them before the safeguarding concern was raised to the local authority.</p> <p>1.3. 30% had no documentation on consent or capacity.</p> <p>1.4. Of that 70%, half of the patients did not consent to the referral and 86% of those patients had a clear rationale for why not and why the safeguarding referral was still being raised.</p> <p>2.0 Areas for Improvement / Actions</p> <p>2.1 Documenting the capacity of a patient when making a safeguarding referral to the local authority.</p> <p>2.2 Documenting the rationale for making a best interest decision when the patient had not provided or been able to provide explicit consent.</p> <p>2.3 Update current safeguarding flow chart and training to highlight importance of documenting consent and whether or not the safeguarding referral is being made in best interests.</p> <p>3.0 Auditor Comments / Discussion</p> <p>3.1 In the majority of patients, consent or the rationale for raising the concern without consent, was documented in the</p>

Project Ref.	Title	Lead	Status	Report Link	Results
					<p>referral form sent to the local authority as there are clear prompts. This may reflect what is now needed within the hospice documentation system (Crosscare).</p> <p>3.2 Of 15% that were not followed up, 100% either died or were moved to a place of safety before safeguarding team acted.</p>
2021/22-27	Admissions Clerking	Jovy Giles	Report under draft		
2021/22-29	Adjuvant Methadone	J Strawson	Deferred for consideration as part of 2022/23 plan		

Project Ref.	Title	Lead	Status	Report Link	Results
2021/22-30	DNACPR documentation	J Strawson	Report drafted for comment - Dec'21		
2021/22-31	Clinical Records Documentation	R Trower	Report drafted for comment - Dec '21		

Clinical Risk Management

Clinical Unexpected Incidents

Overview of incident data for January – December 2021 is shown below:-

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2021	2020	2019	2018	2017
Admissions to IPU	9	10	17	21	12	12	2	1	13	16	9	16	97	195	212	211	214
Beds	6	6	6	8	8	8	8	8	6	7	8	8					
Bed Occupied Days	154	85	164	175	185	203	71	1	149	171	205	180					
Bed Available Days	186	168	186	240	248	240	248	248	180	217	240	248					
Bed Occupancy (variable beds)	82.80%	50.60%	88.17%	72.92%	74.60%	84.58%	28.63%	0.40%	82.78%	78.80%	85.42%	72.58%					
Bed Occupancy (10 beds)	49.68%	29.31%	52.90%	58.33%	59.68%	67.67%	22.90%	0.32%	49.67%	57.00%	68.33%	60.00%					
CD Medication Incident			3	3	13	6		1	4	1	2	2					
CD Medication Near Miss			1						1				2	1	1	3	7
Adverse Reaction (Opioid Toxicity)													0	0	1	10	8
Adverse Reaction													0	0	0	1	2
Non-CD Medication Incident	1			2						2	1	1	7	4	12	22	27
Non-CD Medication Near Miss													0	0	1	5	12
Pressure Sore on Admission	2	1			2	3			1	3		4	16	19	16	20	23
Pressure Sore during Admission						1	1		2	1	1		6	4	3	8	4
Sharps													0	0	0	2	0
Infection													0	0	0	0	2

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2021	2020	2019	2018	2017
Readm <7days													0	0	1	4	1
Unexpected Transfer													0	0	0	2	
Near Miss(non-medication & non-IG)					1								1	1	1	2	1
PE													0	0	0	3	4
Staffing													0	0	1	1	
IG						1	1				1	1	4	3	0	7	12
IG near miss				2	1	1					1		5	1	0	1	4
Manual Handling				1					1				2	1	5	10	2
Slips, trips, falls			2		1	1	1		10	1	1	2	19	20	21	29	18
Verbal Violence													0	1	0	0	1
Bump													0	0	0	0	2
Other - Admin/property/Documentation/Clinical		1	1		3					1	4	2	12	14	12	18	15
* Incidents reported to Community – non-SRH									2			2	2	8	12	25	24
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			
Total 2019 *excluded	1	14	13	7	8	7	6	6	5	16	10	6			99		
Total 2018 *excluded	21	14	11	10	18	24	15	8	13	16	17	9				176	
Total 2017	13	11	19	15	15	17	12	2	16	16	15	12					163

Rise in reported cd medication incidents in 2021 partly understood by spike in May 2021 that saw a single calculation error for morphine sulphate repeated by 5 staff members. Monthly spikes in reporting seen in July and September 2021. September's spike understood by one patient who had repeated incidents of falls – all either low or no harm. Reporting via DATIX commenced on 15th November 2021.

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.

<i>Clinical Significance</i>	Jan	Feb	Mar	Jan - Mar	Apr	May	Jun	Apr - Jun	Jul	Aug	Sep	Jul - Sep	Oct	Nov	Dec	Oct - Dec	2021	2020	2019	2018	2017
Admissions to IPU	9	10	17	36	21	12	12	45	2	1	13	16	16	9	16	41	138	193	212	211	214
Bed Occupied Days	154	85	164		175	185	203		71	1	149		171	205	180						
Bed Available Days	186	168	186		240	248	240		248	248	180		217	240	248						
Bed Occupancy %	82.80 %	50.60 %	88.17 %		72.92 %	74.60 %	84.58 %		28.63 %	0.40 %	82.78 %		78.80 %	85.42 %	72.58 %						
Fall No Harm			1	1			1	1	1		6	7	1	1	1	3	9	14	15	21	
Fall Low Harm			1	1		1		1			4	4			1	1	6	6	6	10	
Fall Moderate Harm				0				0				0				0	0	0	0	1	
Med Level 0			3	3	3	3	1	7			4	3	2	2	2	6	13	9	13	6	
Med Level 1	1		1	2	2	9	3	14		1	1	2		1	1	2	18	10	21	37	
Med Level 2				0				0				0				0	0	0	3	10	
Med Level 3				0				0				0				0	0	0	0	3	
Minor			1	1	2	5	4	11	1		1	2	2	6	3	11	14	15	19	38	
Moderate		1		1	1	1		2				0				0	3	6	2	21	
Serious				0				0				0				0	0	1	1	3	
Pressure Sores	2	1		3		2	4	6	1		3	4	4	1	4	9	13	23	19	27	
Totals 2021	3	2	7	12	8	21	13	42	3	1	19	22	9	11	12	32	109				
Totals 2020	7	6	7	20	6	11	15	32	5	5	4	14	3	8	8	19		85			
Total 2019	1	14	13	28	7	8	7	22	6	6	5	17	16	10	6	32			99		
Total 2018	21	14	11	46	10	18	24	52	15	8	13	36	16	17	9	42				176	
Total 2017	13	11	19	43	15	15	17	47	12	2	16	30	16	15	12	43					163

Clinical Complaints

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

ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASS	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE	STATUS
2021/12	ORAL	Wife	22/10/2021	Patient's wife expressed to CNS how she felt that her husband's discharge from SRH to Fieldway Nursing Home had been rushed and that she had not been given enough time to consider the NH. She stated that she had raised concern over how far away the NH was from her home and that travel with her 2 children may be difficult. However, she felt her concerns weren't listened to. She also felt that she should have been advised of the NH vaccination rules for visitors as her husband's brother couldn't visit because he wasn't vaccinated.	CPCT Comms	CNS asked CHC for list of nursing homes nearer the wife's address that they would consider funding if decision is made to transfer. Explained to wife that it is government advice regarding visiting rules in Nursing Homes and that it is unlikely that any would entry of an unvaccinated visitor. Palliative Care Consultant (NC) telephoned wife and had a 70 minute conversation in which the wife mainly outlined her frustrations and difficulties with Fieldway NH. She does feel her husband's discharge to Fieldway Care Home from SRH was rushed but was contacted by the home before the Hospice was. She did get the chance to visit the care home prior to accepting the place. She had expressed a wish to take longer in accepting the place but was told by Hospice IPU staff that we really had to accept it. Palliative Care Consultant (NC) does not feel giving a longer time would have altered her concerns/ experience. NC tried to explore if she would wish to take the complaint to the clinical director and she said she would be happy to meet or discuss with her. NC does not think she wished that. NC advised that she can call at any time. She expressed a wish for regular phone calls like this one but NC did say it would become less and less helpful now that her husband was off the ward as NC would get less and less in touch with how he is. NC has said the Community team are going to be continuing to review the situation and suggested she await contact from CHC as CNS (RW) has emailed asking for them to be in touch with Sylvia regarding possibly alternative nursing home places. She thanked NC for the call.	Upheld	Closed

ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASS	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE	STATUS
2012/13	ORAL	Daughters	23/12/2021	<p>Daughter of a patient known to the CPCT is very unhappy with the care and management of patient's condition.</p> <p>Main concerns:</p> <p>1: Feels there should have been consultant assessment since the beginning of the week (had three bad nights where patient has been distressed).</p> <p>2: Feels syringe driver should have been started on Saturday.</p> <p>3: Feels lack of co-ordination in services.</p> <p>4: Feels palliative care has been inadequate.</p> <p>5: Feels there needs a to be a review of the case</p>	CPCT Care	<p>Acknowledged her concerns and offered to raise as a complaint</p> <p>Spoke through with daughter about the decisions that have been made this week</p> <p>Explained Community Team Manager's actions today (liaised with DNs about their visit today and ensure medication was being increased in syringe driver)</p> <p>Explained CNS and Dr visit is planned for tomorrow</p> <p>Informed clinical director</p> <p>Clinical Director telephoned both daughters to discuss their complaints and concerns on same day as complaint received. No further action required.</p> <p>On reflection, team have worked within their resource but acknowledge that it is distressing for the family to witness their mother's deterioration and agitation. CD doesn't feel that there is any action that would have been taken differently should the situation recur but family will be offered bereavement support and PS team will be updated regarding specifics re family distress</p>	Upheld in part	Closed

Complaints Overview

2021 - Complaints	CPCT / H@H Care	CPCT / H@H Comms	IPU Care	IPU Comms	IPU Care & Comms	Bereavement Comms	Volunteer Services Comms	Fundraising /Shop Comms	HR	Total	Merton	Sutton	Other	UPHELD
January	0	1	0	0	0	0	0	0	0	1	0	1	0	1
February	0	0	0	0	1	0	0	0	0	1	1	0	0	1
March	1	0	1	0	0	0	0	0	0	2	0	2	0	2
April	0	1	0	0	0	0	0	0	0	1	1	0	0	1
May	1	0	0	0	0	0	0	0	0	1	0	1	0	1
June	0	1	0	0	0	0	0	0	0	1	0	1	0	1
July	0	1	0	0	0	0	0	0	0	1	1	0	0	1
August	0	0	0	0	0	0	1	0	0	1	0	0	1	0
September	1	1	0	0	0	0	0	0	0	2	1	1	0	2
October	0	0	0	1	0	0	0	0	0	1	1	0	0	1
November	0	0	0	0	0	0	0	0	0	0	0			
December	1									1	1			
2021	4	5	1	0	1	0	1	0	0	13	6	6	1	10
2020	4	1	2	3	1	1		1	2	15	6	6	0	14
2019	0	0	3	3	0	1		2	2	14				9
2018	2	5	10	4	1	0		1	0	27				19

Records – Access Requests

- In 2021, there were 5 access to health records request : 1 x wife (January), 1 x partner (April), 1 x Solicitor (May), 1 x solicitor (September), 1 x son (October))
- In 2021, there were 4 sharing requests : 2 x SWL LeDeR (January, February), 1 x bereavement services link group (March), 1 x Coroner (October)

	DSARs	Access To Health Records	Sharing
2021	0	5	4
2020	0	3	4
2019	1	4	0

Notifications

There were 10 serious injury notifications made to the CQC in 2021 all concerning pressure sores grade 3 or above.

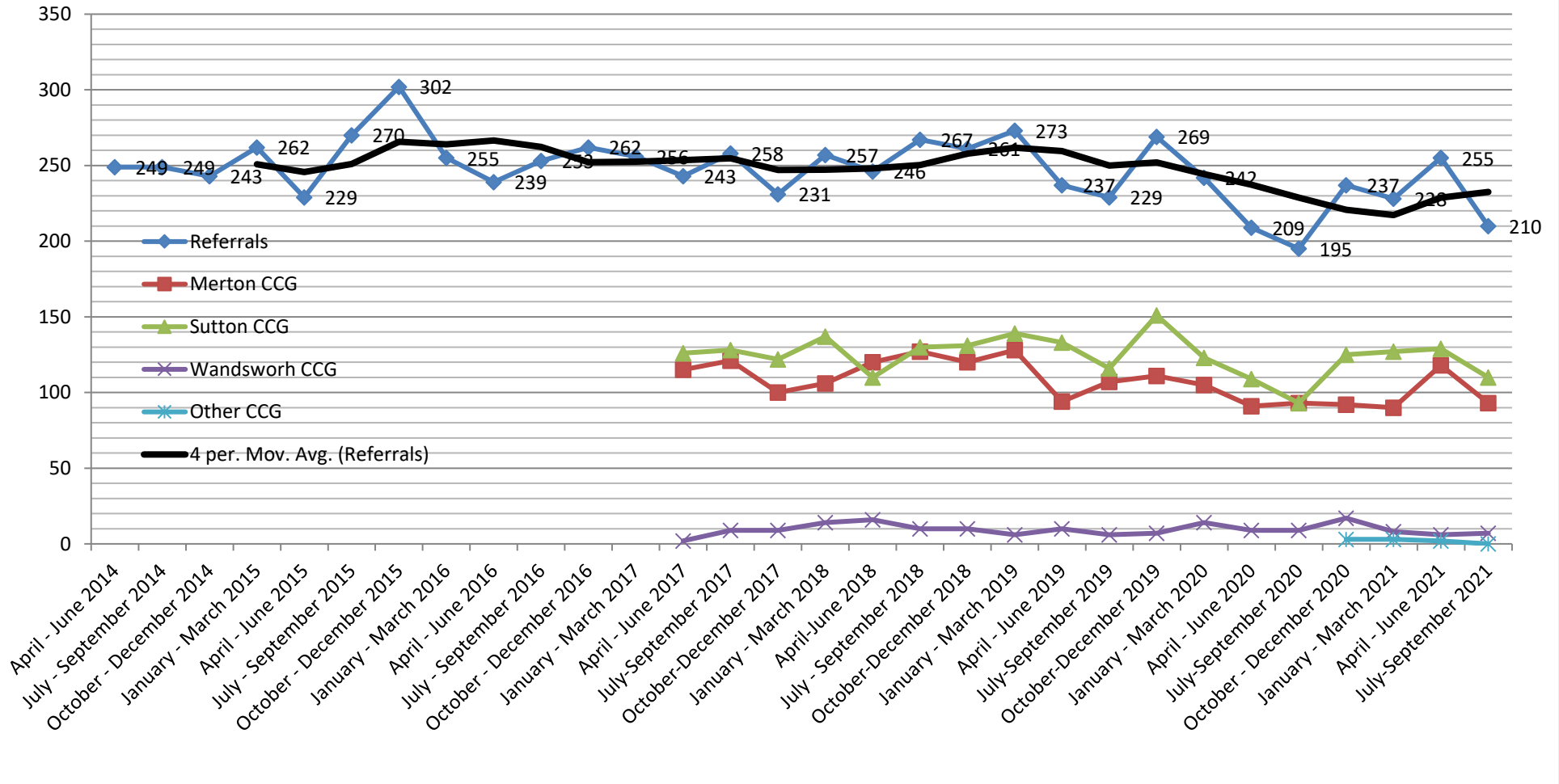
There were 19 safeguarding notifications made to the CQC in 2021: 17 concerning individuals, 1 care agency and 1 care home. All 19 were reported to the local safeguarding teams.

Clinical Commissioning Group (CCG) Data

Submission of Activity data for the preceding quarterly period is routinely supplied to the SWL CCG prior to our contract review meetings. The latest data period Q2 (Q2, July-September 2021) was submitted in November 2021. Next submission (Q3, July-September 2021) is due before our meeting in February 2022. A selection of graphical representations for some of the data items produced for the Homecare and Inpatient Service presenting data up to end of September 2021 is included with papers.

Hospice Referrals

Hospice Referrals



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

Clinical Action Plan 2021-2022

Introduction

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

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

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

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

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

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

UPDATE OVERVIEW

DATE	100% completion	75% completion	50% completion	25% completion	0% completion
23-Mar-21	0	4	3	2	11
23-Apr-21	0	4	4	2	10
09-Jul-21	0	6	3	7	4
13-Jul-21	0	6	5	7	2
22-Oct-21	3	5	6	4	2
13-Dec-21	6	8	3	2	1

Clinical Action Plan

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Latest Completion Status	Previous Completion Status
CAP01	Review suitability of staff support / clinical supervision/reflection mechanisms : consideration of Schwartz rounds	<p>To facilitate and enable clinical discussion relative to the care of dying patients and their families.</p> <p>To provide a safe forum to support emotions and stresses.</p> <p>To enhance understanding of the professional environment in order to support practice development.</p> <p>To develop the IPU's skill set in undertaking level 1 psycho-social support for patients and families.</p> <p>To reduce silo-working and facilitate inclusivity of all staff in shared learning</p> <p>Provide opportunity to rotate to Community Team for further</p>	<p>Staff protected time</p> <p>External facilitation</p> <p>Psychological Services lead training time</p> <p>Employment contract updates</p>	<p>Engagement isn't compulsory</p> <p>Staff will leave</p> <p>Potential for variability in skills and abilities across days and nights.</p>	<p>Staff and facilitator time</p> <p>Schwartz training and set up.</p>	<p>Caring</p> <p>Effective</p> <p>Well-led</p> <p>Responsive</p> <p>Safe</p>	<p>Clinical supervision for all staff remains ongoing.</p> <p>100% compliance against plans affected by COVID</p> <p>SLT Peer Support being delivered regularly</p> <p>Psycho-social training to up-skill IPU team to deliver level 1 psycho-social support. Pended post COVID. Educational Updates</p> <p>Schwartz rounds to be prepped for</p>	75%	75%
CAP02	Rotation of IPU staff across 24 hours Provide adequate competent staffing across days and nights	<p>To ensure consistency of approach and delivery to service provision across 24 hours.</p> <p>Assurance of clinical competence via night staff coming on to days for 1 week every 4 - 6 months and accessing education, development and competency assessment.</p> <p>To break down cultural barriers between day and night teams.</p> <p>All newly recruited staff will have internal rotation across days and nights built into contract.</p> <p>To support the one team approach.</p> <p>To ensure that staff across all shifts are accessing education and associated competencies.</p> <p>To ensure that staff across all shifts are accessing education and associated competencies.</p> <p>To ensure all staff are being developed and feel part of the wider team.</p> <p>New community team member induction includes IPU working for up to 1 month.</p>	<p>Consultation time for existing staff across day and nights with HR and Clinical Director</p>	<p>Staff will not engage with the process.</p> <p>Staff retention / recruitment</p>	<p>Current Staff Costs</p> <p>Possible requirement for identified external training</p>	<p>Caring</p> <p>Effective</p> <p>Well-led</p> <p>Responsive</p> <p>Safe</p>	<p>Consultation complete</p> <p>Implementation commenced January 2021</p> <p>Rotation days to nights in place. Nights to days on hold impacted by staffing shortages</p> <p>Aim to rotate nursing staff from the IPU into community 'for experience' from date tbc (on hold due to staffing shortages)</p> <p>Incorporated into new recruitment contracts</p> <p>Implementation happening for both days and nights.</p> <p>Affected by COVID re staff sickness</p> <p>New community team induction that includes IPU working implemented.</p>	100%	75%
CAP03	Increase counselling support for post bereavement care from 6 student counsellors to 8	To improve responsive access	Volunteer student counsellor recruitment and supervision	Reduced counselling provision by the Psychological Support Lead	N/A	<p>Caring</p> <p>Effective</p> <p>Well-led</p> <p>Responsive</p>	<p>August – September 2021</p> <p>July 2021 - recruiting for bereavement volunteers to provide telephone support</p> <p>October 2021 - Steve & Sr Ann hosting a bereavement support group in the Wellbeing Centre every 2 weeks</p>	100%	100%

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Latest Completion Status	Previous Completion Status
CAP04	Increase establishment of Band 5 nurses on the IPU to facilitate secondment to other clinical departments to support staff development and a 'One Team' approach.	To develop team of nurses with assurance of palliative care clinical skills. Increasing the establishment to allow flexibility to open more beds routinely in the longer term. Opportunity of secondment to other clinical services to enhance understanding of the wider palliative care practice	HR Recruitment Training Development	Difficulty in recruiting. Loss of momentum subject to recruitment	Cost of Band 5 nurse recruitment	Caring Effective Well-led Responsive	Advert for Band 5s and Band 6s in place for current vacancies. May 2021 - advert updated July 2021 - social media advertising in place October 2021 - adverts in place and pay reviewed in alignment with AFC to improve recruitment	25%	25%
CAP05	To maintain CNS Development posts	For succession planning. To ensure we have replacements for future retirees or those leaving through natural attrition. To ensure the service can operate in the future. To ensure competencies and training allows for development nurses to progress to CNS level and work within all departments	HR Recruitment	Cost to organisation in terms of care delivery if not planned. This could be mitigated by Trust application funding.	Salary costs	Safe Effective Responsive	3 positions : band 7 & 2 band 6s filled for 2021 Introduced European Certificate in Essential Palliative Care for all RGNs for professional development	100%	100%
CAP06	To include the audit of clinical risk assessment that supports individualised care planning in the clinical audit program	To ensure our planning is individualised and documentation is supportive. Individualised care planning and risk assessment that is comprehensive	Time to train Staff engagement	Sub-standard communication and documentation that supports care delivered / planned. Lack of engagement	None	Caring Effective Well-led Responsive Safe	Audit of risk assessment planned for 2021/22 audit program.	50%	50%
CAP07	Implementation, training and embedding of Outcome Assessment and Complexity Collaborative (OACC)	To measure outcomes and gain feedback and consider KPIs through its use. All departments using the Australian-modified Karnofsky Performance Status scale & Phase of Illness. To integrate aspects of the suite of measures into practice, documentation, training and audit.	Time Audit Multi-disciplinary education Collaboration with clinical teams to embed and integrate into daily practice	Becoming target driven in our care delivery – must remain mindful of patients and interrogate outcomes accordingly.	OACC education courses – facilitating key staff comprehension and practical application. Project management – team time	Caring Effective Well-led Responsive Safe	Key staff attendance at OACC training in February 2020 (TC, TY&JF). Project implementation task and finish group first met in December 2020 Draft Pol / Karnofsky March / April 2021 Phase and Karnofsky for 2021/22 audit program 2021/22 : Phase & Karnofsky 2022/23 : iPOS - IPU 2022/23 : iPOS - Community	75%	25%

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Latest Completion Status	Previous Completion Status
CAP08	Incorporation of basic and advanced communication skills training for clinical staff into the mandatory training programme and delivering it	To support expert communication with patients, families and colleagues. To develop less experienced staff in having difficult conversations To refresh and support clinicians on the topic.	Time Planning Facilitation	Increased complaints Staff burn out	Training Facilitation	Caring Effective Well-led Responsive Safe	Practice educators liaising with Steve M re IPU / H@H study day in March 2021 - complete 2021/22 program to include basic and advanced communication skills training in September / October 2021 - complete Training delivered to IPU and CPCT colleagues to enhance communication skills. Consideration of how / if Sage & Thyme may be accessed / implemented in 2021	75%	75%
CAP09	Implementation of Datix to manage Incident/complaint/complements	To facilitate ongoing review of Incident/complaint/complement	Time – (project leads for Datix implementation) HoDs – Testing and Training Time – Training on new system	None – adequate manual reporting system in place. Time/resource	Cost of implementation of Datix	Safe Effective Responsive	Testing: September – December 2020 Training Videos: April 2021 / August 2021 Policy amendments : April 2021 / August 2021 Full implementation for incidents – October 2021 Implementation for Complaints / Complements - January / February 2022	75%	75%
CAP10	To ensure there is participation in the planning and auditing of clinical practice across all clinical teams (IPU / Medical / Community / Psychological Support) in line with the Hospice's Clinical Audit program.	To support the assessment of practice against standards	Time Staff Training	Deficient assurance evidence	Resource	Caring Effective Well-led Responsive Safe	As per clinical audit program for 2021/22 Evidenced in CQ& G report and Quality report for SWL CCGs	75%	75%
CAP11	To complete VOED (Verification of Expected Death) documentation in the Community	To ensure clinical staff are competent to undertake conversation and completion of documentation to support VOED in the community.	Education Competency Assessment	Provision of a less than optimal end of life care service.	Resource Cost Time	Caring Effective Well-led Responsive Safe	December 2021 for all Band 6 & 7 staff to be assessed as competent.	50%	25%

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Latest Completion Status	Previous Completion Status
CAP12	Review of the CPCT service model	To ensure optimum use of resources in relation to demand	Time for consultation Engagement by medical and nursing teams	Disengagement by staff Negative impact on responsiveness Impact on external communications Staff retention / recruitment	Staff time	Well-led Responsive Effective	April 2021 initial discussion May/June Planning and Implementation Sep-21 Substantive Model in place Oct - Dec 21 Initial review Jan/Feb 22 - completion of review	50%	50%
CAP13	Successful embedding of the new wellbeing model	Expand reach to different client group	Staff establishment increase to 1.6 WTE Ad hoc speciality support	Comprehension of the non-clinical offer Underwhelming or overwhelming take up	Staffing Travel	Responsive Well-led Effective	12 months + Service launched - May 2021 Bereavement Support Group went live in late October 2021	75%	50%
CAP14	To increase community profile - GSFs - Nursing Home MDTs - GP Master Class - Foundation in Palliative Care for Community Nurses - Specialist OPD (Heart failure/ COPD/ Renal) To integrate Hospice into Acute Sector Site Specific Clinics to support fellow HCPs with appropriate referral to Hospice Services	To support a holistic approach to service delivery To encourage earlier referral to the Hospice services	Consultant and CNS time Education input / time : Media production	Capacity to provide Raised expectations Increased pressure on clinical teams	Time	Responsive Well-led Effective	01/01/2023 July 2021 : Prison visits, GP Palliative Care masterclass delivered monthly in 2021/22, representation at PCN meetings, attendance at heart failure clinics (Doc and CNS), Consultants support hubs, collaborative work with Challenging behaviour team 13/12/2021 : Foundations of Palliative Care - 2 day course delivered to HCPs in Sutton & Merton Successful student swap with Sutton Training Hub and Sutton Health and Care New engagement with student nurse program at Roehampton University Participation in local careers fayre to attract nursing staff Attendance at pan-London LBGTQ Hospice Alliance every two months	75%	25%

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Latest Completion Status	Previous Completion Status
CAP15	Identification and allocation of clinical lead for the Medical Team Designated areas of responsibility clarified for Consultants	Strategic approach to consultant development To clarify delegated responsibilities	Consultant Time	Decreased satisfaction with roles	Nil	Well-led Effective Safe	Apr-21 : 18-24 month rotation (DR J Strawson initially) Jul-21 : Specific areas of responsibility to be clarified when 3rd Consultant has joined the Team. Oct-21: Complete	100%	100%
CAP16	To demonstrate the impact of the Physician Associate position	To support future appointments and share experience with other Hospices	Medical time	Missed opportunity to service the rationale	Time	Responsive Well-led Effective	01/12/2021 July 2021 - Poster developed for Hospice Uk. October 2021 - Oral presentation at Hospice Uk in November 2021 PA poster presentation at March 2022 Palliative Care Congress accepted Multiple enquiries form other HC providers to learn about the PA role at SRH	100%	50%
CAP17	To review the palliative intervention offer (Paracentesis) - Bladder scanner use - Ultrasound course access	Reduce unnecessary Hospital admissions	Clinical time / training Manequin (Kevin / Kerry)	High / low demand	Time / Training	Safe Responsive	01/03/2022 May-21 : Bladder scanning training July -21 : Scoping other Hospices / costings / audit Dec- 21 : Handful of applicable data. Report Dec 21 / Jan 22.	75%	50%

Ref	Goal	Rationale	Resource	Risks	Cost	KLOE	Timeline / Progress	Latest Completion Status	Previous Completion Status
CAP18	To increase SRH collaborations with other Hospices / HCPs	Shared learning Enhance relationships Improved work/life balance	Planning / negotiation time Training	Intensity of workload at times Familiarity with other EPRs	Time	Well-led Effective Safe Responsive	01/09/2021 SWL Exec Hospice Mtg Sharing Practice Advanced Comms On-call medical collaboration with PAH & Kingston Hospital Clinical supervision collaboration initiative with PAH Research and ethics collaboration with PAH Exploring collaboration with RTH for Infection Control Clinical Directors Forum Quality & Service Improvement Network Group	100%	50%
CAP19	To review the reach and delivery of services provided by the Hospice @ Home service	To demonstrate effectiveness of service and ensure provision meets demand	Time	Staff sickness may undermine evaluation of full service provision	Time	Well-led Caring Effective Safe Responsive	Review re-scheduled for Jan 2022	0%	0%
CAP20	To increase identification of carers needs and provision of support	To meet the needs of carers	Staff time / training Knowledge of local resource sign-posting	Unfulfilled raised expectation Potential duplication of service offer	Time	Caring Responsive Well-led Effective	Carers invited to Living Well Program and other relevant sessions	25%	0%

Meeting: Clinical HODs Meeting			
Date: 01.11.21		Time: 13.30	
Chair : Rebecca Trower - RT		Minutes: Lynn Jackson	
Present: RT, TY, TC, JS, GTR, LB, MF, SM, JR (initial part of meeting)			
Apologies: NC			
Agenda item	Discussion	Actions & by whom	Anticipated date for completion
Review of previous minutes	Completed. Amendments – AA not JS attended Guilford course		
Matters Arising	<p>➤ IT /EMAIL SECURITY</p> <p>JG informed the group that due to a staff member's account being hacked – IT security update has been bought forward in line with best practise & as of Monday 8th November all staff will receive a prompt to change their SRH account password to be 10 characters long and must include a Capital letter, number & special character. These are then to be updated 3 monthly. NHS accounts will also be updated in the next few weeks.</p> <p>IT staff will be available to ensure smooth transition & support staff e.g with remote access etc.</p> <p>➤ AfC & implications</p> <p>SRH is aligning to AfC and adopting changes</p> <p>Affected staff have until 06.11.22021 to respond to their letter With a last deadline date of 16.11.21 if they wish their pay to be backdated to 01.11.21. Any staff responses after this date will have their AfC started 01.04.22.</p>	<p>IT to email all staff re update changes</p> <p>IT</p> <p>Staff , HR</p>	<p>November 2021</p> <p>16.11.21</p>

	<p>➤ Psychiatry links. To discuss ideas about how to establish a Psychiatry point of contact and/or Psychiatric placements within SRH.</p> <p>GTR to pursue possible link with SHH</p> <p>A volunteer Psychiatrist has approached SRH</p>	<p>GTR RT to follow up & establish links</p> <p>RT & SM to meet volunteer to discuss best way forward</p>	<p>ongoing</p>
Topic			
Infection Prevention	<p>➤ Independent IPC review</p> <p>Sarah Hopper – PAH carried out a IPC review on 28.09.21. Her findings returned a result of 92%</p> <p>RT read Sarah's letter to the group</p> <p>Actions to improve include - Sharps – IPU – TY has actioned already PPE audit Patient Risk assessment tool Visits policy FFP3 mask useage.</p> <p>The group congratulated LB & MF for their work</p>	<p>RT to send result to AR.</p> <p>AR to include letter on excellence register – to show safe practice.</p>	<p>November 21</p> <p>November 21</p>
Medical Devices	<p>Syringe Pump fund – currently stands at £16K More syringe drivers to be bought as more patients are using 2 drivers</p> <p>01.12 – MerceL SD training – competencies to be completed as different drivers</p> <p>Bed & Mattress audit is being carried out</p> <p>JS carried out bladder scanner audit</p>	<p>TY/IPU</p> <p>LM/MF</p> <p>JF</p> <p>RT to follow up with SPIRE</p>	<p>ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>
Medicine Management	<p>Discharge/changes to TTO's are currently being delayed by Ashtons due to order time required– this has consequences upon IPU discharges as discussed by GTR as patients who are fit for discharge cannot be due to delay in medications from Ashton's.</p>	<p>RT, TY, NC, Eburn To discuss</p>	<p>Ongoing</p>

	<p>Possible use of local pharmacies for TTO's using FP10's discussed</p> <p>NC to meet with new CCG pharmacist Ebun on Wednesday's monthly</p> <p>RT to email Merton CCG re Medication Portal access</p> <p>TC informed the group that V4 of Maar charts is due</p>	<p>NC</p> <p>RT</p> <p>TC to update when V4 live</p>	<p>Ongoing</p> <p>Ongoing</p> <p>ongoing</p>
Incidents & Accidents/RCA's	<p>CUI reflection has seen an improvement in completion</p> <p>Datix to launch in November. This is a new system to SRH & Training videos will be available to staff. AR would like any feedback on the use of Datix</p> <p>IPU – non ordered medication – a review is required</p> <p>JS raised a CUI with regards opiod toxicity. Clinical challenges were discussed & documented.</p> <p>TC raised non organisational concerns i.e. DN incidents/concerns. TC informed CHODS of use of "Making the difference" community portal. AR asked Datix be used to capture our identification of concerns</p>	<p>AR – policy implementation & IT</p> <p>TC to meet with JS & GTR</p> <p>TC to send eail to CPCT staff</p>	<p>Ongoing</p> <p>JS to feedback to CHODS</p> <p>Ongoing</p>
Complaints	<p>1 x verbal complaint raised to CPCT</p> <p>1 x IPU raised by wife with regards patient transfer to nursing home</p>	<p>JS awaiting discharge leaflet to be published</p>	<p>ongoing</p>
Health & Safety	<p>A reminder with regards staff informing HR when they have had their Covid booster & flu vaccines</p> <p>Facilities have been working with Rentokill with regards pests in the IPU roof space.</p>	<p>HR Email to staff</p> <p>Facilities</p>	<p>December 21</p> <p>Ongoing</p>
New Policies/ Guidelines	<p>Covid policy will be updated & reviewed in line with Government guidelines</p> <p>Clinical policies to be reviewed</p>	<p>AR/ HODS</p> <p>AR/ RT/ TY/ TC</p>	<p>Ongoing</p> <p>Ongoing</p>

Documentation/ Crosscare	SM raised the issue of use of appropriate language when inputting information on patient record – subjective/objective entry ? Jason is working with Rebecca W/ LJ on the update of template for CPCT weekly Morbidity & Mortality report	GTR/SM to audit JL/RW/LJ	Ongoing January 22
Audit/Research	AR to meet with leads to review respectable projects	AR/ Leads	Ongoing
Education/Training Reflective Forums	3 students nurses are to undertake their placements at SRH Fit testing has taken place 02.11.21 HCA training + Jovi to undertake 2 nd check CD training which includes practical assessment & exam Safeguarding training External training “Palliative Care in the Community” is being facilitated by Education All staff/volunteers to have completed “Learning Zone “ by 25.11.21. Pascale will run report shortly after	IPU Education Education/ IPU Rebecca W Education/Drs Education/ Pascale/Staff/ Volunteers	Nov/Dec 21 Ongoing December 21 24.11.21 January 2022 January 2022
Recruitment/ Staffing	IPU – Agency x2 booked for day/nights have requested 1 more. TC looking at Dec off duty. NHS jobs website – we can’t be found ? IPU - Carol T – ward clerk will be off for 3 months CPCT – full staff – Lorraine Jeffereys – band 7 / Kate Weldon Training	TY HR Lucy M/ Sheena/ LJ & PE to support	Ongoing January 21 January 22
CQC/PIR	Gail is registered manager RT to be appointed as new manager. No known inspection date		

AOB			
	<ul style="list-style-type: none"> • Winter Pressures <p>Action plans to be reviewed discussed & shared in line with guidelines</p> <p>Meetings – the issue of meeting etiquette was discussed – it was agreed that Protected Time 12-2pm would be tried with regards no meetings during this time</p> <p>Also the issue of repetitive meetings was raised. Heads to look at overlaps & the need of meeting</p> <p>SM informed CHODS that referrals & caseloads have had a substantial increase & he was concerned with regards the sustainability. He informed the group that a FT member of staff is required to elevate the pressure.</p>	<p>HODS/ staff</p> <p>HODS</p> <p>SM to email RT with rationale</p>	<p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>

Date next meeting: 13th December 2021

Prescribers Meeting October 21st 2021

Minutes

Present – Kevin Hobson, Tracy Christmas, Jill Smith, Bernadette Griffin, Lorraine Jeffries, Dr. Naomi Collins

Community Prescribing

- Continues to be mainly weekends and Fridays! Team reminded to keep records of all prescriptions on personal log and computer log up to date.
- Some requests to G.P's for injectables on Fridays have not been done which has led to Prescribers having to organise if they're on that weekend. We'll remind rest of team to follow up with call to G.P. practice when ordering S/c meds before weekends.
- There have been requests for anticipatory Syringe Driver charts from some G.P's & D/N's. Team reminded that it is our practice not to prescribe anticipatory Syringe Drivers (unless indicated).
- MAAR charts have been reviewed in the community and altered to make more space when completing pt. details and drug info – Tracy will alert team and replace on our system when new forms have been formatted and agreed.

PACT Data

- Info received from Sutton for 1st quarter of 2021. Total cost for prescribed meds in that period remains relatively modest! - (Bernie £112, Kevin £80 and Jill £76).
- Interestingly Haloperidol seems to be the most expensive drug we've prescribed.

Prescription Safety

- Seals for new safety prescription bags are next to safe in CPCT office.
- Bags are small - taking 3 – 5 prescriptions out at a time seems to work
- Kevin and Tracy will look at ordering new log book for all prescriptions

Medicines Alerts

- Everyone is now receiving alerts / warnings that Alex is kindly sending out.

Education Updates

- Mixed feelings about the education updates for prescribers provided by St. Christopher's. Difficulty finding time to attend was main issue. Consensus was attending a study day may be easier option. Kevin will look at what's available for next year

AOB

- Discussions about advice given re calculating breakthrough analgesic doses – 1/10th rather than 1/6th – Naomi will check with Dr. Jenny.
- Consider inviting all Dr.'s to next prescribing meeting
- Invite Kim Smith to next meeting also. Aiming for early Dec!

SAINT RAPHAEL'S HOSPICE

**MINUTES OF THE MEDICAL BUSINESS MEETING
Held on 1st December 2021**

In attendance:	Jenny Strawson	Consultant (Chair)
	Ambreen Akhtar	Specialty Doctor
	Jovy Giles	Physician Associate
	Naomi Collins	Consultant
	Pascale Evans	Clinical Admin (minutes)

ITEM 1: Apologies for Absence

- 1.1 Busi Da Silva; Gaby Tamura-Rose; Rachel Clingan

ITEM 2: Minutes of the Last Meeting

- 2.1 Approved.

ITEM 3: Rota / staffing for the next three months

- 3.1 Hannah Saunders has completed her placement and we are awaiting her feedback form.

ITEM 4: Clinical Challenges

- 4.1 GPVTS Tristan needs to learn the process of TTOs.
- 4.2 Lesley Spencer is Ashtons palliative care adviser and has been in touch with the hospice team about how they respond to our needs. Overall there is a general loss of confidence in Ashtons as drugs are not always delivered by the day of discharge. Ideally TTOs should be delivered within 24 hours. Potential use of local pharmacist is still being discussed using FP10s but there is no guarantee that it would be better and the team are aware of the "grass greener" risk.
- 4.3 The team reflection meeting on a complex IPU case was not well attended, even via Zoom. The reason could be that the time had passed and the night team were not available. Nevertheless, the medical team will keep trying to facilitate such meetings.

Tristan

ITEM 5: Infection Control

- 5.1 FF3 masks are to be worn again on the IPU.
- 5.2 Staff are reminded to get their flu and booster jabs done and let HR know.

All

ITEM 6: Education

- 6.1 The presentation on the role of the physician associate delivered at Hospice UK annual conference was well received and generated a lot of interest.
- 6.2 Jovy's poster has been accepted by the Palliative Care Congress in March. Pascale will arrange bookings.
- 6.3 Jovy provided teaching during the Foundations of Palliative Care course and Ambreen facilitates regular sessions in the Wellbeing Centre. All presentations are stored under N:/Doctors/Teaching.
- 6.4 Flowcharts will be added to the induction packs for medical students and new doctors.
- 6.5 The deadline for mandatory training has passed and Pascale will check compliance for the team.

Pascale

Pascale

Pascale

ITEM 7: Audit and Governance

- 7.1 Ambreen will report on the results of her audit at the journal club on 13th December.
- 7.2 Tristan is keen to start an audit on organ donation. To be discussed.

Ambreen

ITEM 8: Any other business:

8.1 On call: there are still some transition/teething issues with the new joint on call with Princess Alice, for example Rachel having to attend PAH to sign a PRN on a night shift. Ambreen and Busi also feel that the on call shifts are long and tiring. All issues should be reported to PAH and Doctors should keep a record of number of hours spent during their shifts. To be followed up.

Jenny

8.2 Rachel reported that she sometimes found the admission meetings challenging as priorities of different teams and expectations of patients and families can vary, reflected that given the small number of beds and the limited resource can cause some conflict in opinions and this has been well recognised and reflected on as a team. Continue to keep civility and professionalism at the centre of discussions, but the team should be able to challenge decisions in a safe space.

Jenny

8.3 Dates of future meetings:

Date	Event	Venue/Time
5.1.2022	Medical Business Meeting	14.00 – 15.00 Training Room

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 rationale 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 20 safeguarding cases raised between January 2020 and May 2021. 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.

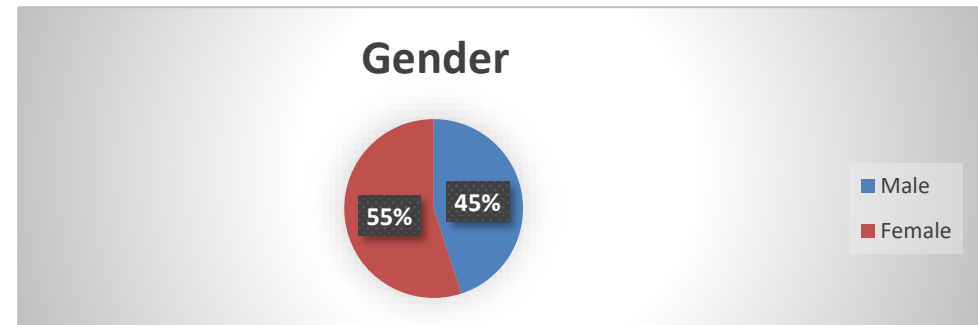
RESULTS

Introduction

Data reflects upon 20 community patients under St Raphael's Hospice who had safeguarding concerns raised between January 2020 and May 2021. 19 were raised by a Community Team CNS and one by a Community Team Doctor.

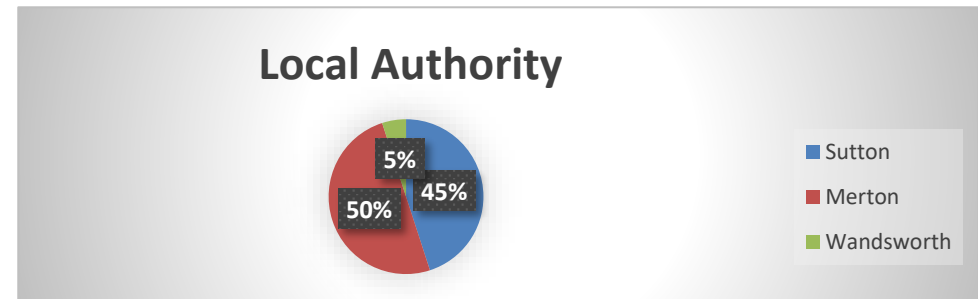
Demographics

	Safeguarding raised	%
Male	9	45%
Female	11	55%



Local Authority

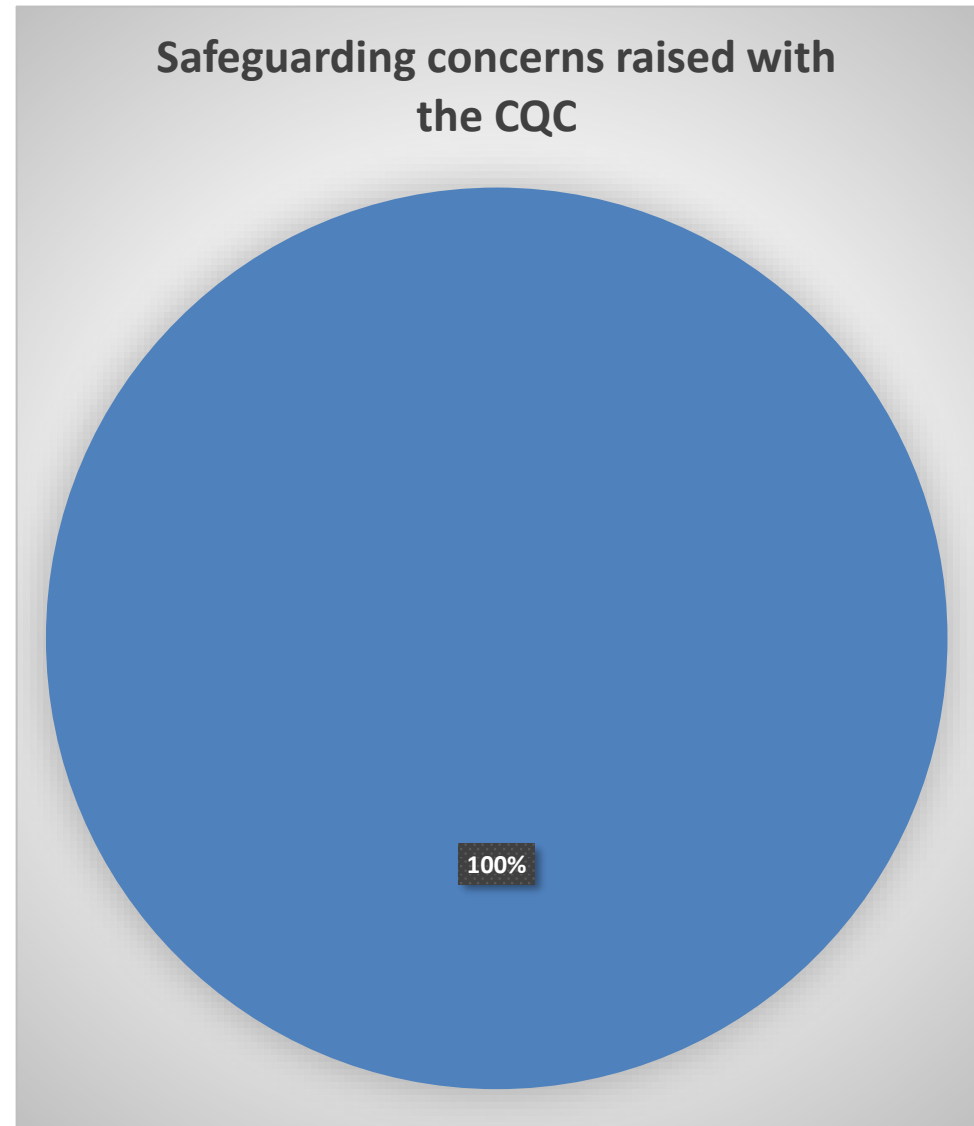
	Safeguarding raised	%
Sutton	9	45%
Merton	10	50%
Wandsworth	1	5%



Notification to CQC

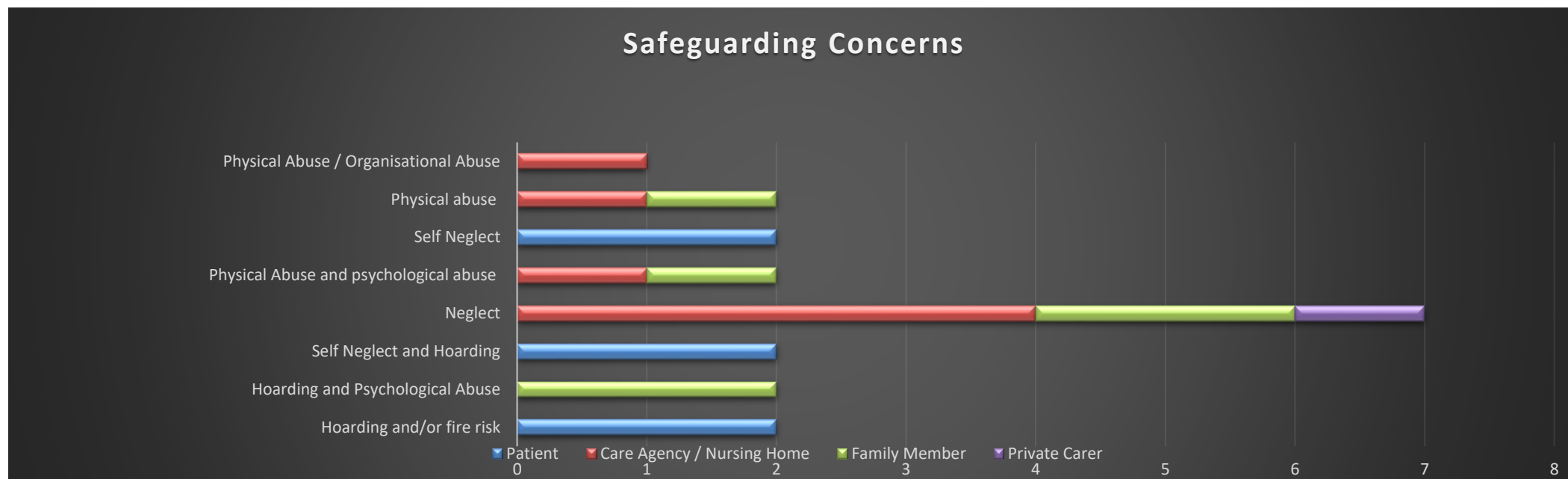
	Yes - Safeguarding notified to CQC	Compliance with Standard
Sutton	9	100%
Merton	10	
Wandsworth	1	

All safeguarding notifications were raised with the CQC.



Safeguarding Concern

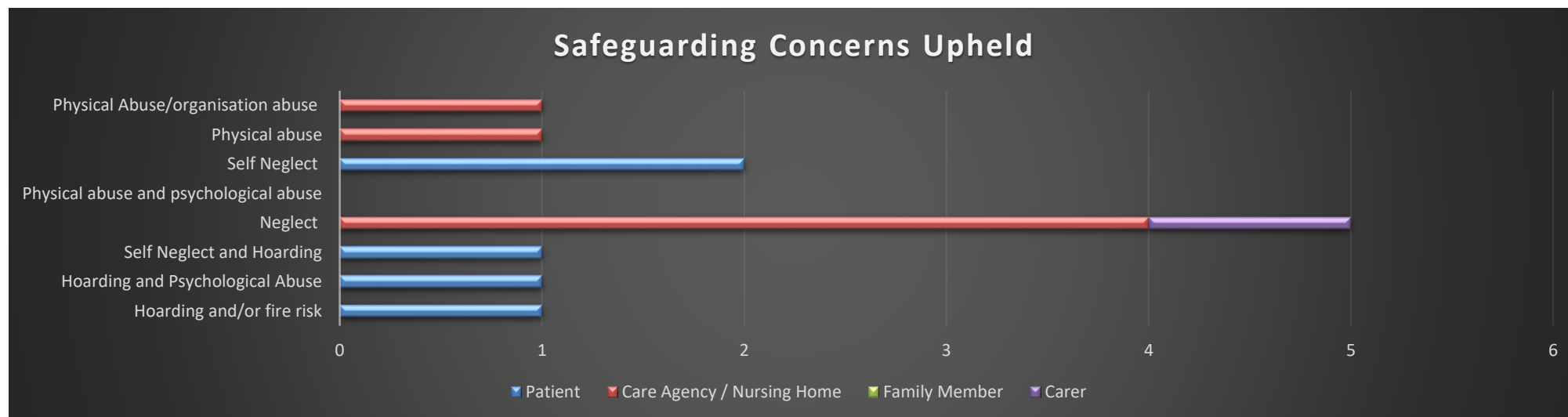
Safeguarding Concerns	Patient	Care Agency / Nursing Home	Family Member	Private Carer	Totals
Hoarding and/or fire risk	2				2
Hoarding and Psychological Abuse			2		2
Self Neglect and Hoarding	2	0			2
Neglect		4	2	1	7
Physical Abuse and psychological abuse		1	1		2
Self Neglect	2				2
Physical abuse		1	1		2
Physical Abuse / Organisational Abuse		1			1
TOTALS	6	7	6	1	20



Safeguarding Concerns Upheld by LA

Safeguarding Concerns	Patient	Care Agency / Nursing Home	Family Member	Carer	Totals
Hoarding and/or fire risk	1				1
Hoarding and Psychological Abuse			1		1
Self Neglect and Hoarding	1				1
Neglect		4		1	5
Physical abuse and psychological abuse					0
Self Neglect	2				2
Physical abuse		1			1
Physical Abuse/organisation abuse		1			1
TOTAL UPHELD	4	6	1	1	12
TOTAL RAISED	6	7	6	1	20

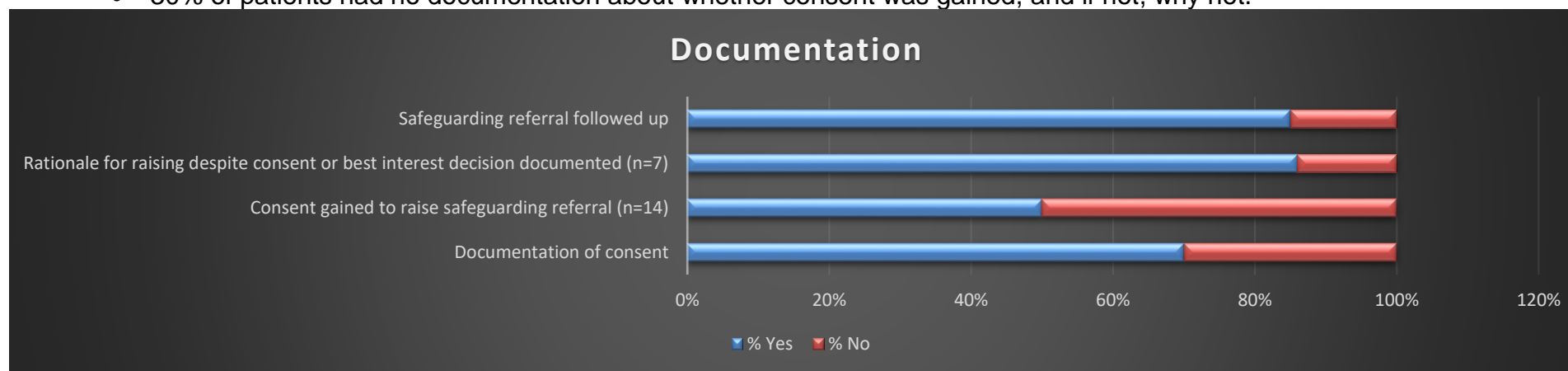
- 12/20 safeguarding concerns were documented as having been upheld by the LA (6 Sutton / 6 Merton).



Documentation

	Numbers		%	
	Yes	No	Yes	No
Documentation of consent	14	6	70%	30%
Consent gained to raise safeguarding referral (n=14)	7	7	50%	50%
Rationale for raising despite consent or best interest decision documented (n=7)	6	1	86%	14%
Safeguarding referral followed up	17	3	85%	15%

- Documentation of whether consent was sort or not to raise a safeguarding was present for 70% of the patients.
- Of that 70%, 50% of patients consented to the safeguarding referral.
- Of the 50% that did not consent, 86% of patient had a documented rationale for why the safeguarding concern was being raised.
- One patient did not consent and there was no rationale as to why the concern was then raised.
- 30% of patients had no documentation about whether consent was gained, and if not, why not.



5.0 Conclusions

1. All safeguarding events raised to the LA were raised with the CQC – 100% compliance.
2. 70% of patients had documentation as to whether consent was gained or not from them before the safeguarding concern was raised to the local authority.
3. 30% had no documentation on consent or capacity.
4. Of that 70%, half of the patients did not consent to the referral and 86% of those patients had a clear rationale for why not and why the safeguarding referral was still being raised.

6.0 Areas for Improvement / Actions

- 6.1 Documenting the capacity of a patient when making a safeguarding referral to the local authority.
- 6.2 Documenting the rationale for making a best interest decision when the patient had not provided or been able to provide explicit consent.
- 6.3 Update current safeguarding flow chart and training to highlight importance of documenting consent and whether or not the safeguarding referral is being made in best interests.

7.0 Auditor Comments / Discussion

- 7.1 In the majority of patients, consent or the rationale for raising the concern without consent, was documented in the referral form sent to the local authority as there are clear prompts. This may reflect what is now needed within the hospice documentation system (Crosscare).
- 7.2 Of 15% that were not followed up, 100% either died or were moved to a place of safety before safeguarding team acted.

St Raphael's

Your Local Hospice



VOICES QUESTIONNAIRE

2020

Compiled by: Audit Office

INDEX

.....	1
INTRODUCTION.....	3
AIMS.....	3
METHODOLOGY	3
Executive Summary	4
What can we learn?	8
What will we do or change?.....	8
Inpatient Care on Hospice Ward	10
Inpatient Stay	10
Care and Environment.....	11
Support.....	11
Communication and involvement	14
Food and Catering	17
St Raphael’s Community Services	20
Responsiveness.....	20
St Raphael’s Hospice Jubilee Centre	26
Circumstances surrounding his/her death.....	26
Bereavement Support	30
Bereavement Comments	32
2020 Palliative Care Consultant Comments	38
2020 Clinical Director Comments	41

INTRODUCTION

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

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

The information given in response to the survey will support us to improve people's experiences of care at the end of life.

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

AIMS

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

METHODOLOGY

The questionnaire used in this survey is taken from the National Survey of Bereaved People (VOICES) questionnaire. The next of kin / main carer of those Hospice patients that died during the period 1st April 2020 to 30th September 2020 were sent questionnaires 4-6 months post-bereavement. They were invited to complete the questionnaire under no obligation, and return completed surveys in pre-paid envelopes. This is a comparative audit report comparing the 2020 dataset with earlier audit from 2019/20.

Executive Summary

- a) The number of returned questionnaires has marginally decreased to 26% in 2020 (c.f. 28% in 2019/20, 25% in 2019, 29% in 2018/19 ;34% in 2018; 32% in 2017/18; 28% in 2017).
- b) Responses to the questions on the care and environment provided in the inpatient ward (IPU) are overwhelmingly positive, with all respondents agreeing that help with personal care and nursing care met their requirements and all agreeing that the environment respected the patients' privacy (see page 11).
- c) Definite assertion of the adequacy of emotional support decreased considerably to 69% in 2020 from 2019/20's 96% (page 12), whilst definitive assertion of the adequacy of religious/spiritual support maintained at 56% from 2019/20's 56%.
- d) Support regarding financial concerns or other practical problems was considered to be of slightly greater need – 6 respondents (29%) in 2020 (c.f. 13% in 2019/20). That need was considered to have been definitely met by 3 (50% in 2020 c.f. 75% in 2019/20).
- e) Definite assertion that symptoms other than pain in the IPU had been relieved has increased to 87% (c.f. 83% in 2019/20) and 100% recorded either definitely or to some extent in 2020 (c.f. 100% in 2019/20).
- f) Support regarding family concerns was considered to be of equal need – 42% in 2020 (c.f. 42% in 2019/20). That need was considered to have been definitely met by 75% in 2020 (c.f. 92% in 2019/20).
- g) Pain relieved completely, 'all of the time' has increased to 63% in 2020 (c.f. 54% 2019/20), marginally decreased from 'most of the time' at 0% in 2020 (c.f. 4% in 2019/20), slightly increased to 'some of the time' at 32% in 2020 (c.f. 29% in 2019/20) and 'partially' decreased to 5% in 2020 (c.f. 14% in 2019/20) (Page 13). Having pain relieved 'all of the time' may trigger more concern and possibly raises the question over the sedative effects of the medication used.
- h) 81% in 2020 (c.f. 90% in 2019/20) of family members of IPU patients were always kept informed of the patients' condition. 19% considered family members were usually kept informed (c.f. 10% in 2019/20). The percentage of respondents who considered the language used by doctors and nurses to explain the condition to be 'very easy' to understand maintained at 90% in 2020 (c.f. 90% in 2019/20). (Page 14) with an increase in 'fairly easy to understand' responses to 10% in 2020 (c.f. 6% in 2019/20). Their language comprehensibility was rated as 'fairly difficult' by 0% (c.f. 3% in 2019/20).

- i) The number of respondents that felt that decisions were made about the patients' care/treatment that they wouldn't have wanted has decreased to 5% in 2020 (c.f. 13% in 2019/20).
- j) Doctors and nurses 'always treating patients with respect and dignity' showed a decrease for both doctors and nurses – 90% for nurses and 90% for doctors (c.f. 100% for nurses and 97% for doctors in 2019/20)
- k) Definite assertion that the Hospice worked well with patient GPs and other external services has increased to 53% in 2020 (c.f. 45% in 2019/20). However, this should be understood in context that there were no respondents that felt that they didn't work well together and 16% in 2020 that didn't know (c.f. 31% in 2019/20)
- l) A smaller proportion of respondents regarded that being able to stay overnight in the Hospice was important – 38% (c.f. 54% in 2019/20) (page 15, Question 11).
- m) There has been a significant decrease in respondents considering that they had 'definitely received sufficient emotional support' – 45% in 2020 (c.f. 90% in 2019/20) (page 16), with the shift to 'Yes to some extent' – 45% in 2020 (c.f. 7% in 2019/20). Taken together, there is a decrease in 2020 – 90% being reflective upon the adequacy of emotional support as either definite or to some extent (c.f. 97% in 2019/20).
- n) Respondents were asked to rate care given to the patients by doctors and nurses on admission to the IPU and the responses in 2020 show a shift from 'Exceptional' down to 'Excellent.' 48% considered doctor care on admission to be 'Exceptional' (c.f. 65% in 2019/20), 43% considered it to be 'Excellent' (c.f. 32% in 2019/20) and 5% considered it to be 'Good' (c.f. 3% in 2019/20) and 0% considered it 'Fair' (c.f. 0% in 2019/20) and 5% recorded 'Don't Know' (c.f. 0% in 2019/20). Taking 'exceptional' and 'excellent' together there is a decrease in 2020 – 91% (c.f. 97% in 2019/20). Responses relating to nursing care again show shift to 'excellent' from 'exceptional': 57% rating nursing care as 'Exceptional' (c.f. 81% in 2019/20) and 43% as 'Excellent' (c.f. 19% in 2019/20) and 0% as 'Good' (c.f. 0% in 2019/20) and 0% as 'Fair' (c.f. 0% in 2019/20) (Page 17). Again, taking 'exceptional' and 'excellent' together, this has maintained in 2020 at 100% (c.f. 100% in 2019/20).
- o) Regarding the food provided on the IPU in 2020, there was a shift from 'Exceptional' to 'Excellent:' only 10% rated the food as 'Exceptional' in 2019/20 (c.f. 38% in 2019/20), 35% 'Excellent' (c.f. 19% in 2019/20), 40% 'Good' (c.f. 29% in 2019/20), 5% 'Fair' (c.f. 5% in 2019/20). (Page 17) and 10% recorded 'Don't know' (c.f. 10% in

- 2019/20). Combining ‘exceptional’ and ‘excellent’ ratings there has been a decrease in 2019/20 – 45% (c.f. 57% in 2019/20).
- p) 71% of respondents rated the patient bedroom as ‘Excellent’ which is a small decrease from 74% in 2019/20. The en-suite bathrooms were rated ‘Excellent’ by 62% in 2020 (c.f. 68% in 2019/20) (Page 19) which is a slightly larger decrease.
 - q) Satisfaction with the Community Services should be regarded with a degree of caution as it is difficult to isolate St Raphael’s impact amongst what may be a multitude of care providers. Responsiveness of visit is decreased – 74% (c.f. 84% in 2019/20); ‘Yes definitely’ answers for emotional support have decreased considerably – 43% (c.f. 68% in 2019/20); Religious or spiritual support have maintained at 45% (c.f. 45% in 2019/20), but that question has a smaller data cohort, since fewer respondents consider religious/spiritual support to be necessary.
 - r) A higher proportion felt that the patient required help with urgent problems during the evenings, between 5pm and 11pm, – 63% (c.f. 58% in 2019/20) and of those, a decreased proportion – 58% (c.f. 64% in 2019/20) felt definitely that enough support had been received. (page 22)
 - s) A very slightly higher proportion felt that the patient required help with urgent problems during the night (7pm – 9am) – 55% (c.f. 54% in 2019/20) and of those, a slightly lower proportion – 62% (c.f. 65% in 2019/20) felt definitely that enough support had been received.
 - t) A slightly lower proportion of respondents considered that the patient’s pain had been completely relieved all of the time by the CPCT – 39% (c.f. 42% in 2019/20) (page 23). [Note – complete pain relief on the IPU increased during this audit period – it was 63% (c.f. 54% in 2019/20)]
 - u) A lower proportion in 2020 – 85% (c.f. 89% in 2019/20) stated that they and their family received enough help and support from the Hospice CPCT.
 - v) The way in which the CPCT team explained the patient’s condition, treatment or tests shifted from ‘Very easy’ to understand - 55% (c.f. 61% in 2019/20) to ‘fairly easy’ in 2019/20 - 38% (c.f. 31% in 2019/20).
 - w) Care received from the CPCT altogether saw a decrease to 32% rating it as ‘Exceptional’ (c.f. 50% in 2019/20), 2% rated it as ‘Poor’ (c.f. 3% in 2019/20) (Page 24). Overall care as a whole provided by the CPCT near enough maintained on

2019/20 with either 'Exceptional', 'Excellent' or 'Good' yielding 96% (c.f. 97% in 2019/20).

- x) CPCT involving family/carers in decisions about the patients' treatment has increased to 93% in 2020 (c.f. 88% in 2019/20).
- y) Patient's explicit statement on their preferred place of death once again indicates that it is usually their home or the Hospice: Home – 59% (c.f. 53% in 2019/20) Hospice – 33% (c.f. 42% in 2019/20).
- z) 84% of respondents believed the patient died in the right place (c.f. 89% in 2019/20) (page 29).
- aa) 57% felt the patient achieved their preferred place of death (c.f. 65% in 2019/20) (page 27).
- bb) Bereavement support for those who died in the Hospice was considered definitely enough by 83% - a significant decrease compared to 2019/20's 96% (page 30).
- cc) 81% felt able to talk to someone from the Hospice as soon as they wanted about their bereavement (c.f. 77% in 2019/20) and 13% wanted it sooner (c.f. 8% in 2019/20).
- dd) Following receipt of the bereavement leaflet – a decreased proportion - 50% found it either definitely helpful or helpful to some degree (c.f. 81% in 2019/20). 36% did not receive the leaflet (c.f. 18% in 2019/20).
- ee) The proportion of respondents that considered contact from the bereavement team was either definitely helpful or helpful to some degree has decreased to 51% (c.f. 59% in 2019/20). 0% felt the contact was unhelpful (c.f. 0% in 2019/20). Responses stating that contact wasn't received decreased to 33% (c.f. 40% in 2019/20).
- ff) Responding to the Friends & Family question that was changed in the September 2019 – March 2020 survey, of the 53 who did record an answer, 40 (75%) rated the hospice as 'Very Good' (c.f. 82% in 2019/20), 8 (15%) rated the hospice as 'Good' (c.f. 13% in 2019/20), 3 (6%) rated it as 'neither good nor poor' (c.f. 0% in 2019/20). 1 (2%) rated it as 'Poor' (c.f. 0% in 2019/20), none (0% c.f. 2% in 2019/20) rated it as 'Very Poor,' and 1 (2%) did not know the answer to this question (c.f. 4% in 2019/20).

[Audit Periods Overview](#)

Click the link to view the table with the percentage scores and trends for all reported audit periods:

What can we learn?

- a) The survey return rate really bears no relationship to whether the survey is sent out in month 6 or month 4 following patient death. To continue the routine and monthly mailing of VOICES questionnaires in A3 format and ensure mailing is undertaken between 4-6 months post patient death.
- b) To improve the reconciliation of 'any actions' or 'comment' provided by respective Heads to critical comments raised in questionnaires. To commence use of Datix feedback module for the October 2021 – March 2022 (onward) cohort to effect such reconciliation.

What will we do or change?

- a) To consider an information gathering exercise to demonstrate the IPU nurses perceptions and confidence in addressing/identifying religious /spiritual needs? (Clinical Director/Head of Quality)
- b) To effect the routine survey of feedback from patients on the IPU prior to discharge. (IPU Nursing Team)
- c) To develop the PPD data item to facilitate the exaction of data that clarifies the reason should PPD not be achieved. (Head of Quality)

Update on Last Report Actions : October 2019 – March 2020

- a) Audit Program 2021/22 : to agree symptoms (other than pain) for assessment and treatment audit (RT) : *not prioritised for 2021/22 program*
- b) Education : to source and deliver communication skills training annually to clinical staff (GL) *incorporated into 2021/22 education program*
- c) Education : to deliver training to support IPU staff in delivering informal emotional and psychological support (MF/LB/SM): *Face to face delivery session for 2021/22*
- d) Information Material : prioritise review/revision/production of patient / family information material supporting the Community and Psychological Services (Bereavement) Teams (Info Project Team): *ongoing*

OVERVIEW

In April – September 2020, there were 227 questionnaires mailed and 59 questionnaires returned, providing a return rate of 26% (c.f. 28% c.f. in 2019-2020, 25% in 2019, 29% in 2018-2019, 34% in 2018, 32% in 2017/18 & 28% in 2017

Demographics:

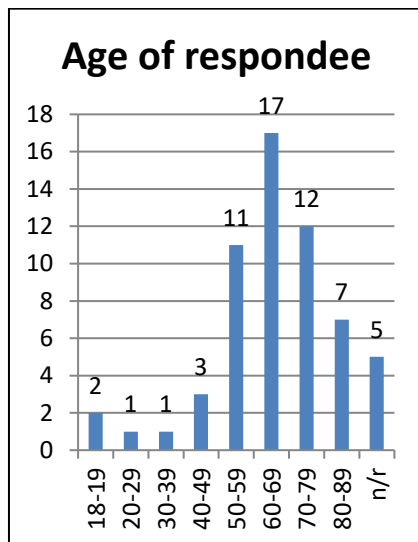
Gender of Respondent

Period	Male	Female	<i>n/r</i>
2020	18 (32%)	39 (68%)	2
2019-20	19 (33%)	38 (67%)	1
2019	18 (36%)	32 (64%)	0
2018-19	19 (28%)	49 (72%)	1
2018	22 (31%)	50 (69%)	0
2017-18	16 (24%)	51 (76%)	0
2017	17 (35%)	31 (65%)	3

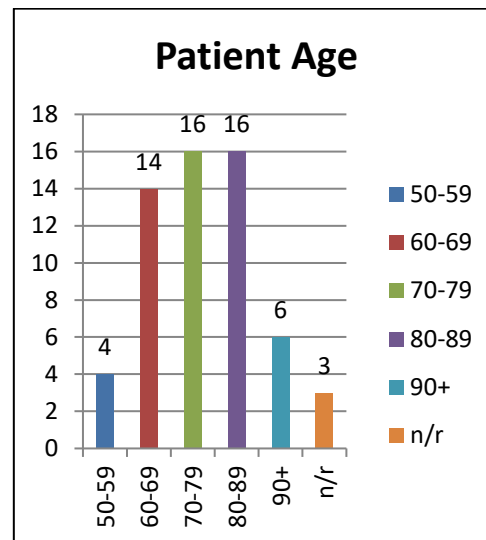
Gender of Patient

Period	Male	Female	<i>n/r</i>
2020	27 (49%)	28 (51%)	4
2019-20	26 (46%)	31 (54%)	1
2019	23 (48%)	25 (52%)	2
2018-19	37 (54%)	31 (46%)	1
2018	38 (54%)	33 (46%)	1
2017-18	33 (49%)	34 (51%)	0
2017	23 (48%)	25 (52%)	3

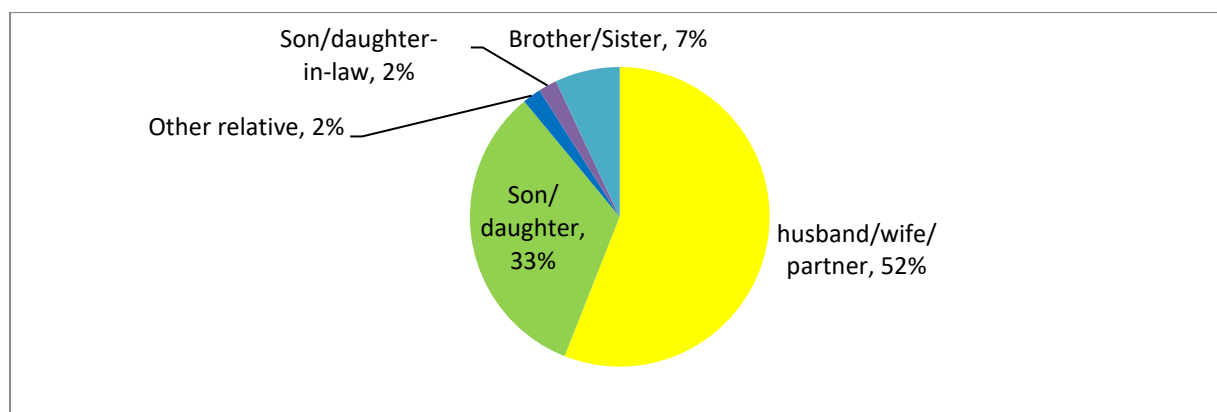
Age of respondent



Age of deceased



Respondent's relationship to patient

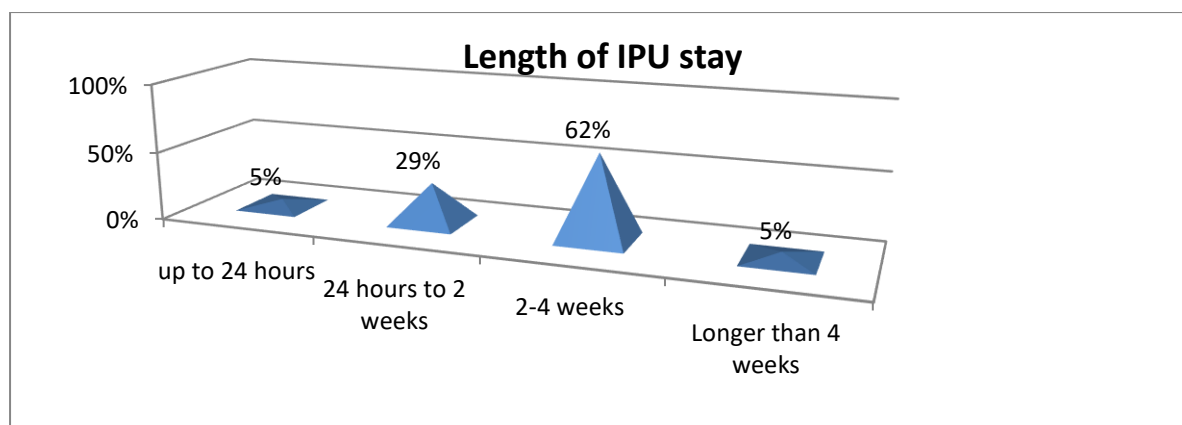


45 (87% c.f. 82% in 2019-2020) of the 52 respondents who answered the question identified themselves as being 'White' (British/Irish/Other) with the remaining 7 (13%) identifying themselves as "Asian Indian," "Mixed Other," "Black Caribbean" and "Africa American." 45 (87% c.f. 81% in 2019-2020) of the 52 patients who had the question answered on their behalf were identified as being white and the other 7 (13%) as 1 "Asian Indian," 1 "Asian Bangladeshi," "2 Black Caribbean," and 1 "Mixed White Other."

Inpatient Care on Hospice Ward

Inpatient Stay

Q2) 21 (36% c.f. 53% in 2019-2020) of the 59 respondents stated that the patient had stayed in the IPU at some point. Of these, 6 (29% c.f. 71% in 2019-2020) had stayed between 24 hours and two weeks, 13 (62% c.f. 13% in 2019-2020) stayed between two and four weeks and 1 (5% c.f. 6% in 2019-2020) stayed for longer than 4 weeks. Only 1 (5% c.f. 6% in 2019-2020) stayed for less than 24 hours. None (0% c.f. 3% in 2019-2020) did not record an answer.



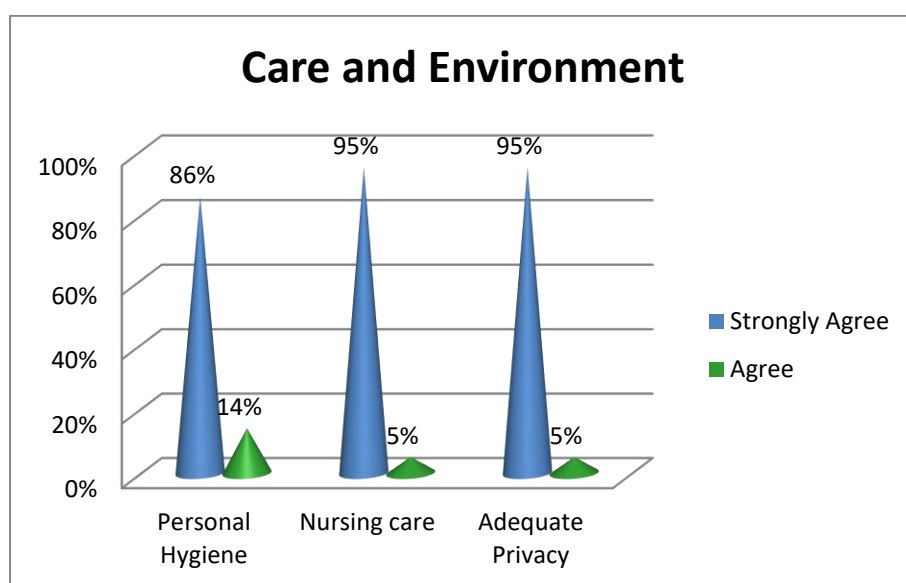
Care and Environment

Respondents were asked to rate the personal care available relating to hygiene and privacy. A five point Likert scale was used. The responses were overwhelmingly positive in both audit periods.

Q3A) 86% ‘strongly agreed’ that there was enough help with personal care such as washing, personal hygiene and toileting needs (c.f. 90% in 2019-2020), 14% ‘agreed’ (c.f. 10% in 2019-2020) and none (c.f. none in 2019-2020) neither agreed nor disagreed).

Q3B) 95% ‘strongly agreed’ that there was enough help with nursing care such as giving medicine and helping the patient find a comfortable position in bed (c.f. 87% in 2019-2020), a further 5% ‘agreed’ (c.f. 13% in 2019-2020) and none (c.f. none in 2019-2020) ‘Neither agreed nor disagreed’.

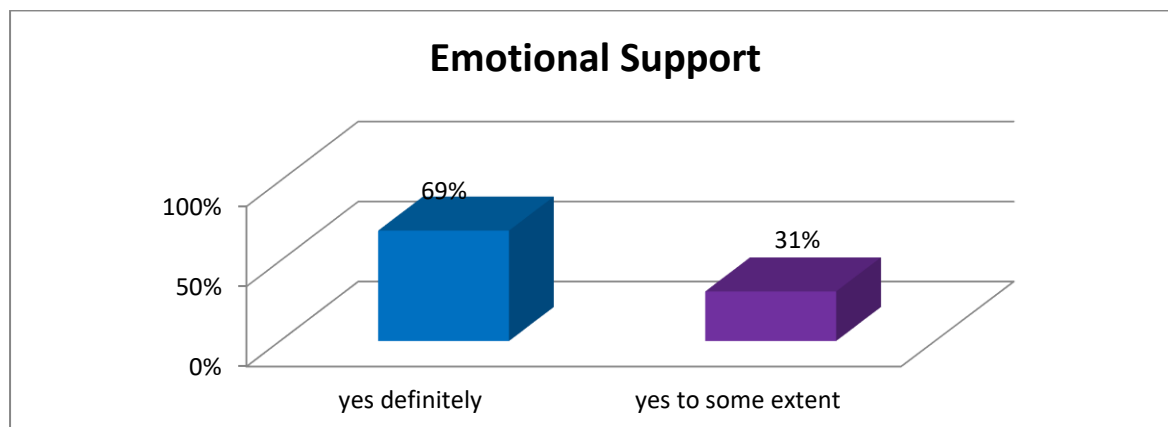
Q3C) With regards to the surrounding environment and bed area providing adequate privacy 95% ‘strongly agreed’ (c.f. 81% in 2019-2020) and the other 5% ‘agreed’ (c.f. 16% in 2019-2020) and 0% ‘disagreed’ (c.f. 3% in 2019-2020).



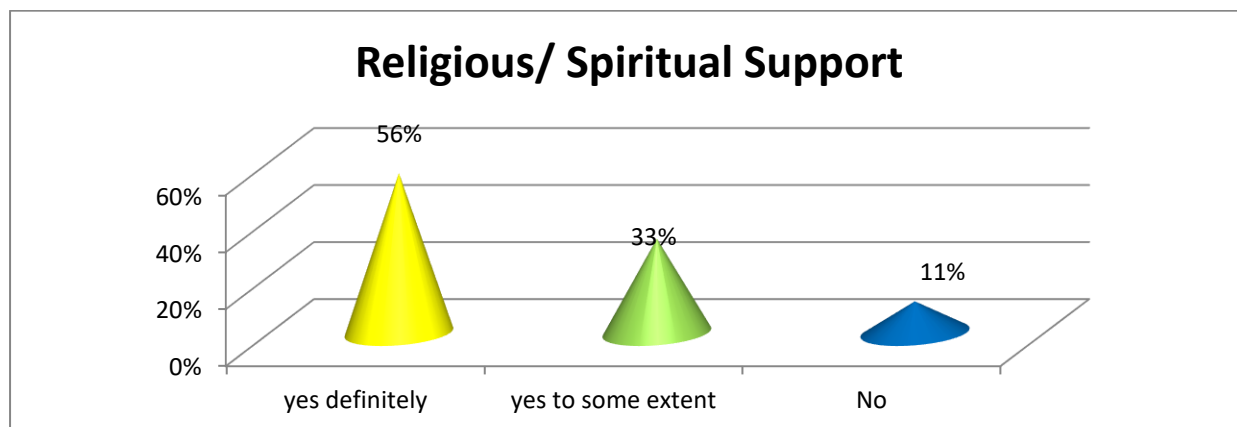
Support

Respondents were asked their opinions of support available for the patient. A five point Likert scale was used with ratings from ‘Yes definitely,’ ‘Yes, to some extent,’ ‘No, not when s/he needed it,’ ‘S/he did not need this type of help’ to ‘Don’t know.’

Q4A) When asked if there was sufficient emotional support, 76% of respondents responded with a definite yes/no answer (c.f. 87% in 2019-2020). Of these, 69% responded ‘Yes definitely’ (c.f. 96% in 2019-2020) and 31% responded ‘Yes to some extent’ (c.f. 4% in 2019-2020). None (c.f. none in 2019-2020) responded ‘No.’



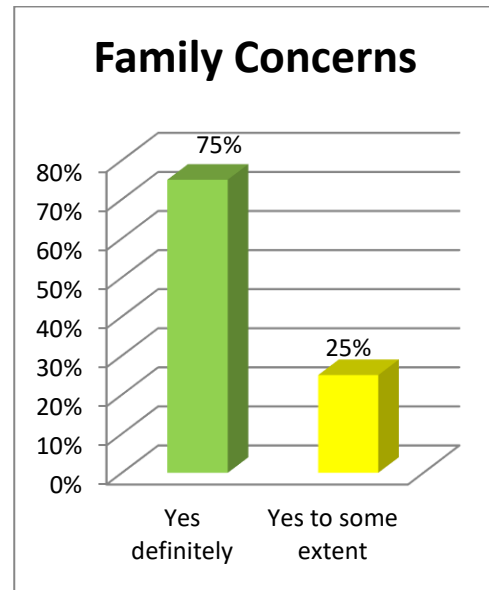
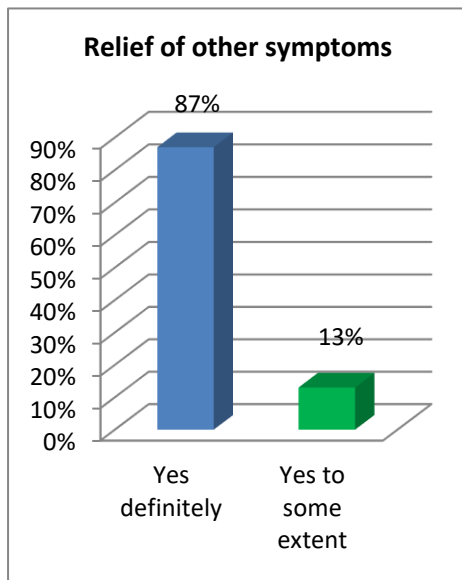
Q4B) Nine respondents felt the patients required religious/spiritual support. In answer to whether they received enough, 56% replied ‘Yes, definitely’ (c.f. 56% in 2019-2020), 33% replied ‘Yes, to some extent’ (c.f. 33% in 2019-2020), and 11% responded with ‘No, not when needed’ (c.f. 11% in 2019-2020).



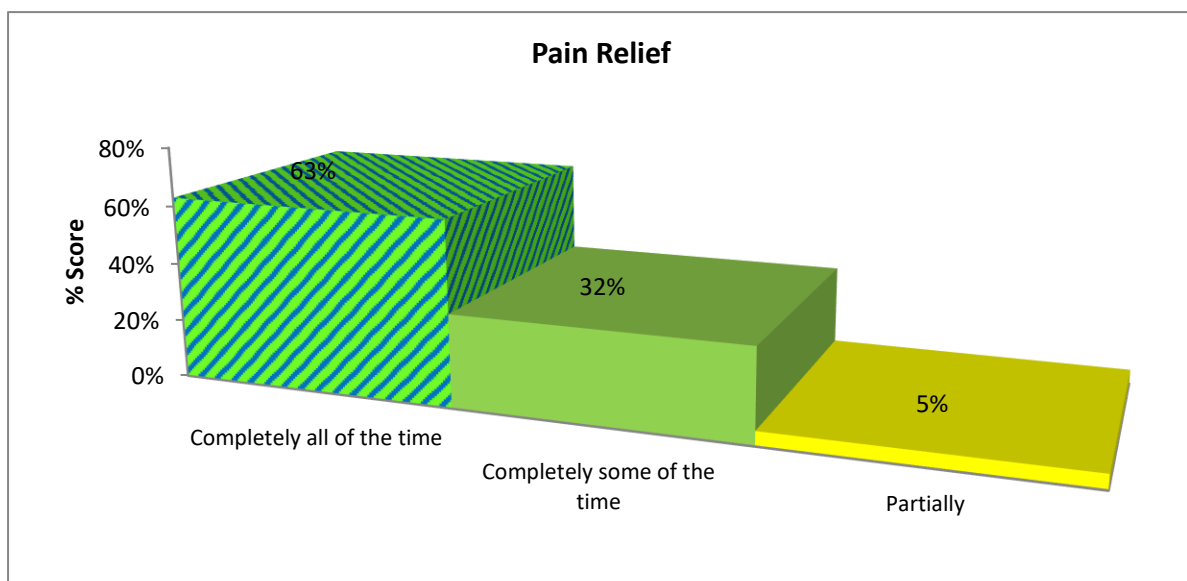
Q4C) 6 (29% c.f. 13% in 2019-2020) respondents considered the patient to be in need of support regarding financial concerns or other practical problems. 3 (50% c.f. 75% in 2019-2020) believed there was definitely enough support available and 3 (50% c.f. 25% in 2019-2020) believed there was some support available.

Q4D) With regard to enough support for relief of symptoms other than pain, 71% of respondents responded either ‘Yes’ or ‘No’ (c.f. 77% in 2019-2020). Of these, 87% considered there to have definitely been enough support (c.f. 83% in 2019-2020), 13% answered ‘Yes, to some extent’ (c.f. 17% in 2019-2020) and none answered ‘No, not when needed’ (c.f. none in 2019-2020).

Q4E) 42% of respondents considered that there was a need for support in family concerns (c.f. 42% in 2019-2020). Of these, 75% considered there was definitely enough support (c.f. 92% in 2019-2020) and 25% replied ‘Yes, to some extent’ (c.f. 8% in 2019-2020) and none replied ‘No, not when needed’ (c.f. none in 2019-2020).



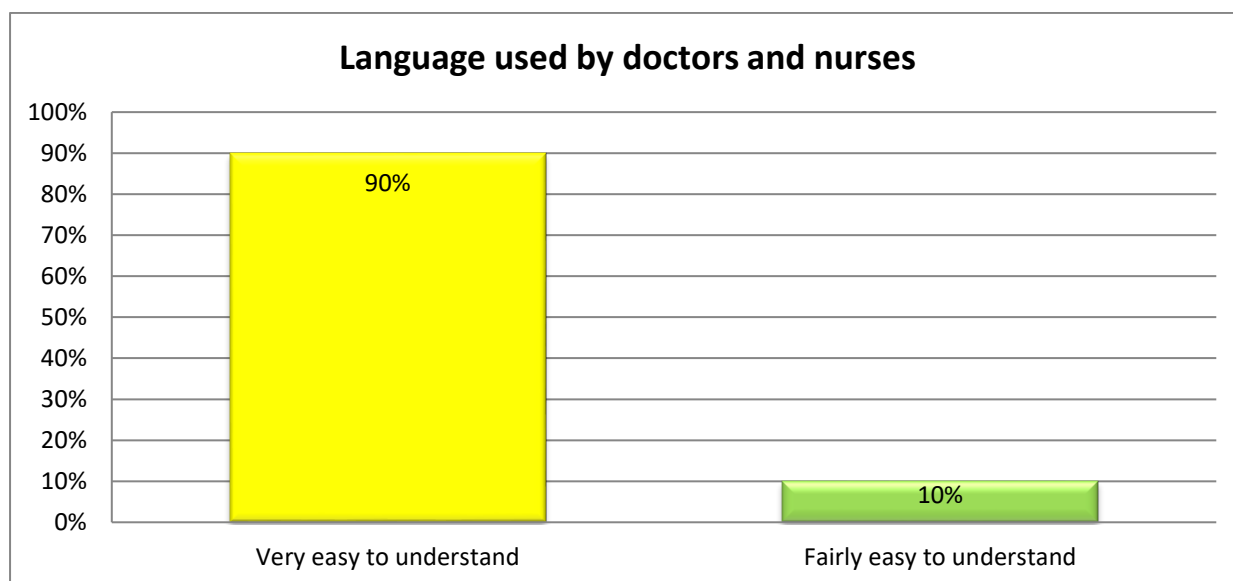
Q5) Respondents were asked how well the patient’s pain was relieved during their inpatient stay. 2 (10% c.f. 10% in 2019-2020) said that the question did not apply because the patient had no pain. Of the 19 inpatient respondents who answered the question, 0% did not know the answer (c.f. 0% in 2019-2020), 63% replied that the pain was relieved completely all of the time (c.f. 54% in 2019-2020), 32% that it was relieved completely some of the time (c.f. 29% in 2019-2020) and 5% considered it to have only been partially relieved (c.f. 14% in 2019-2020). None (c.f. none in 2019-2020) recorded that the patient’s pain had not been relieved at all.



Communication and involvement

Q6) Relevant to 21 patients who stayed in the Hospice inpatient unit. 17 (81% c.f. 90% in 2019-2020) reported that family members were always kept informed of the patient’s condition, 4 (19% c.f. 10% in 2019-2020) responded that this was usually the case.

Q7) The language used by doctors and nurses when explaining the patient’s condition, treatments or tests was thought to be either ‘very easy’ to understand by 90% of respondents (c.f. 90% in 2019-2020), fairly easy to understand by 10% (c.f. 6% in 2019-2020). None found them fairly difficult to understand (c.f. 3% in 2019-2020).

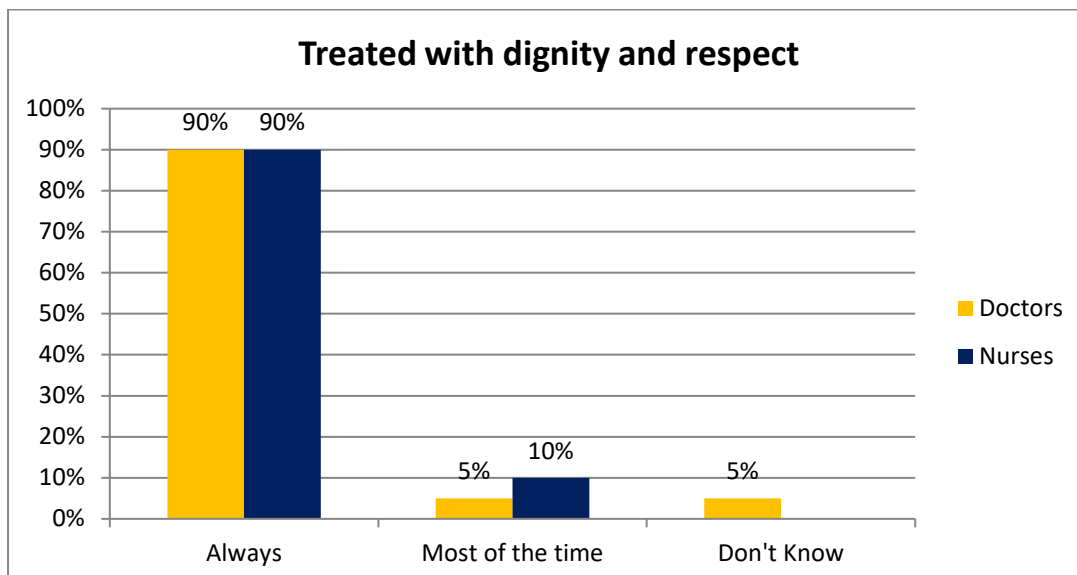


Q8) When asked the question: “During this admission, were there any decisions made about his/her care or treatment that s/he would not have wanted?” 95% responded with a positive ‘No’ (c.f. 87% in 2019-2020), 0% replied that they did not know (c.f. 0% in 2019-2020) and 5% replied with a negative ‘Yes’ (c.f. 13% in 2019-2020).

The one respondent who replied with negative ‘Yes’ recorded comments:

She did not want to leave St Raphael's. – Daughter of patient

Q9) The respondents were asked “How much of the time was s/he treated with respect and dignity by the Hospice doctors and nurses?” The questions were asked separately for both nurses and doctors. For doctors, 90% stated ‘Always’ and 5% stated ‘most of the time,’ and 5% recorded ‘Don’t Know’ (c.f. 97% stated Always and 3% stated most of the time in 2019-2020). For the nurses, 90% stated Always and 10% stated ‘most of the time.’ (c.f. 100% stated ‘Always’ and 0% stated ‘some of the time in 2019-2020.’)



Q10) Answering the question as to whether the respondent felt that the Hospice worked well with the patient’s GP and other external services : 53% stated ‘Yes definitely’ (c.f. 45% in 2019-2020) and a further 32% agreeing ‘Yes to some extent’ (c.f. 21% in 2019-2020). 16% answered ‘Don’t know’ (c.f. 31% in 2019-2020), 0 recorded ‘No’ (c.f. 0% in 2019-2020) and 0% recorded that they did not work together (c.f. 3% in 2019-2020).

Q11) Being able to stay in the Hospice overnight with their loved one was seen as important to 38% of respondents who recorded an answer (c.f. 54% in 2019-2020). Of these, 63% were able to stay, and of these 63% who did get to stay, 100% found it helpful (c.f. 92% in 2019-2020).

Comments on the subject of staying overnight:

Could not stay because of COVID regulations – Wife of patient

Due to COVID this was unfortunately not possible – Sister of patient

Due to COVID 19 it was very difficult to spend enough time with my wife – Husband of patient

COVID restrictions prohibited stays – Wife of patient

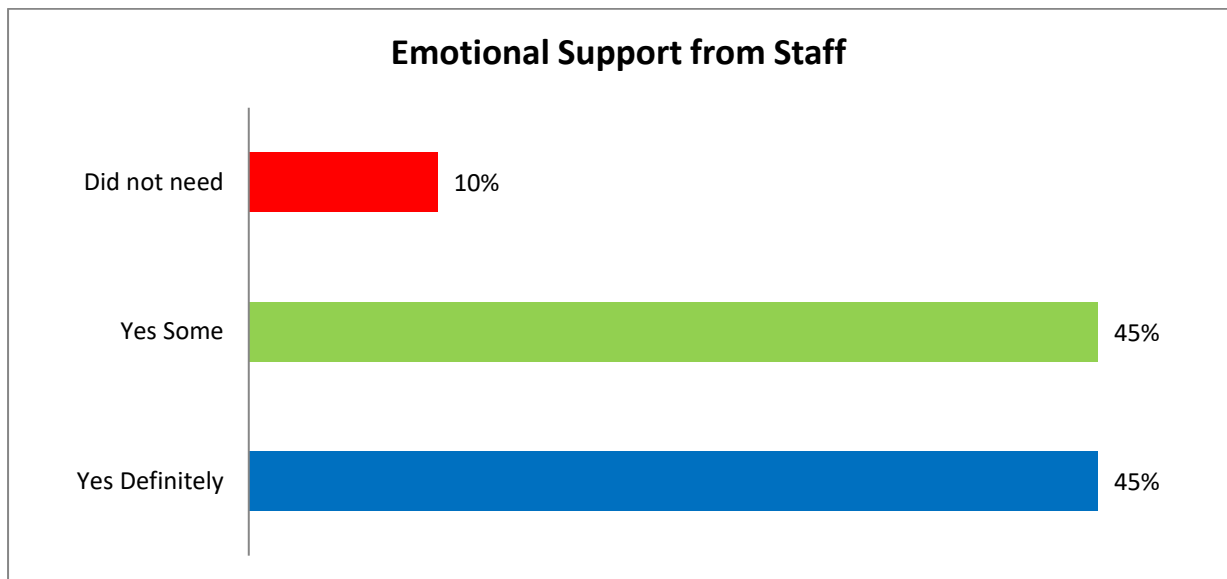
I did not mind either way – Daughter of patient

Not necessary and I have a disabled husband to look after due to a major stroke – Other relative of patient

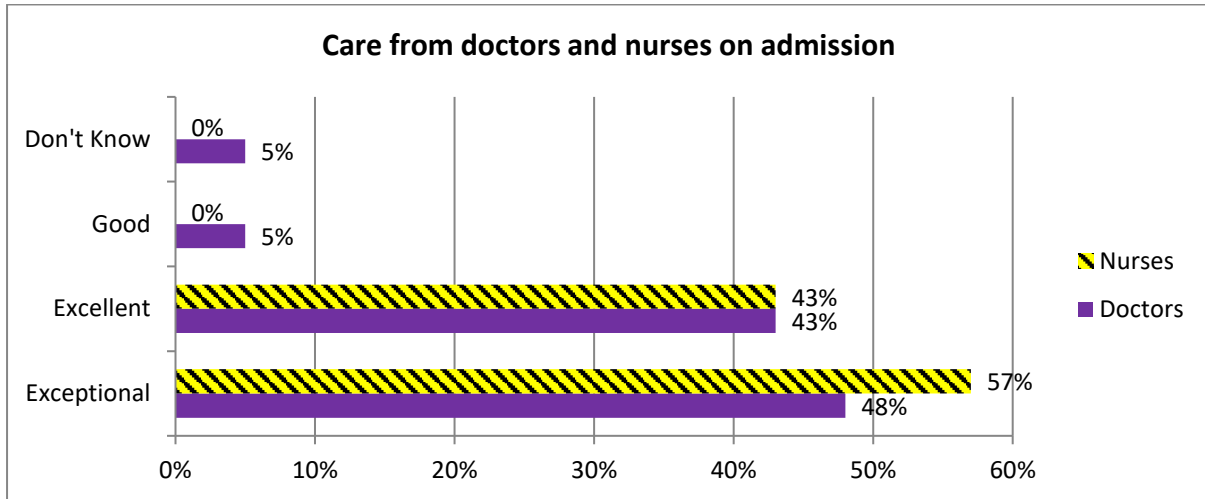
I was very ill myself – Wife of patient

During COVID staying was not an option – Sister of patient

Q12) Respondents were asked whether they felt that they had received sufficient emotional support from the Hospice staff. Responses showed 45% answering ‘definitely yes’ (c.f. 90% in 2019-2020), 45% answering ‘yes, to some extent’ (c.f. 7% in 2019-2020), and 10% replying that they did not require this kind of help (c.f. 3% in 2019-2020). None (c.f. none in 2019-2020) recorded that they did not receive this kind of help, despite requiring it.

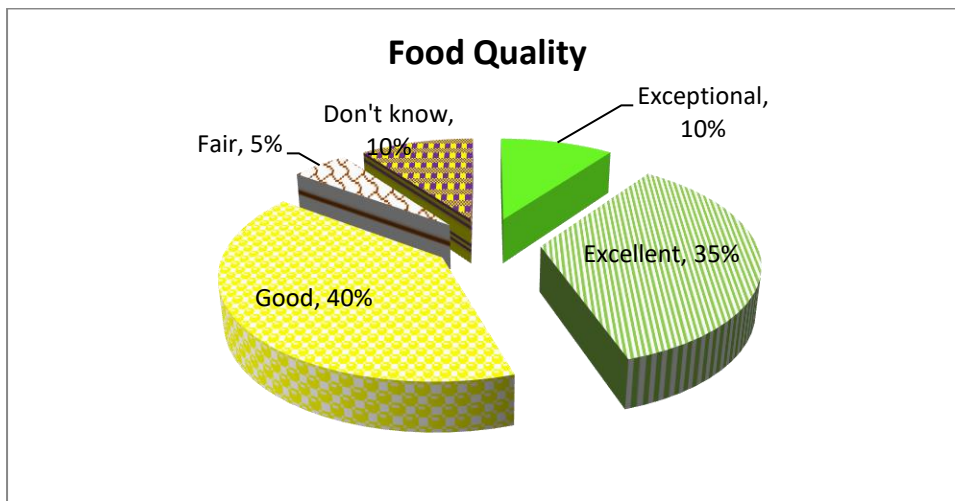


Q13) Respondents were asked to rate care given to the patients by doctors and nurses on admission and the responses were universally positive. 48% considered doctor care on admission to be ‘Exceptional’ (c.f. 65% in 2019-2020), 43% considered it to be ‘Excellent’ (c.f. 32% in 2019-2020) and 5% considered it to be ‘Good’ (c.f. 3% in 2019-2020) and 5% recorded ‘Don’t Know’ (c.f. 0% in 2019-2020). Responses relating to nursing care were higher, with 57% rating nursing care as ‘Exceptional’ (c.f. 81% in 2019-2020), 43% as ‘Excellent’ (c.f. 19% in 2019-2020) and 0% as ‘Good’ (c.f. 0% in 2019-2020).



Food and Catering

Q14) It should be noted that 5% of respondents who answered the question about the quality of food provided for patients at the Hospice replied that their loved one did not have any food at the Hospice (c.f. 32% in 2019-2020). Of those who replied that their loved one did partake of hospice food, 10% answered that the food was ‘Exceptional’ (c.f. 38% in 2019-2020), 35% that it was ‘Excellent’ (c.f. 19% in 2019-2020), 40% that it was good (c.f. 29% in 2019-2020), 5% that it was ‘Fair’ (c.f. 5% in 2019-2020) and 10% of the respondents (c.f. 10% in 2019-2020) did not know what rating to give it.



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

The care my brother received during his three weeks stay was exceptional. He was in a lot of pain on arrival, this was treated and managed and he was allowed to go home which was his wish.

Unfortunately he passed away ten days later. – Sister of patient

This admission was during the height of COVID. I think it made a difference to the hospice, but the staff really tried very hard to overcome any restrictions and their care was excellent.

Organised psychological support was too late for myself as my mum died when they offered the appointment. – Daughter of patient

My husband was amazed at how good everything was. He was a very fussy eater, but the food was very very good - so no complaints. – Wife of patient

Whilst I have ticked the box tracked "partially" for question five and question 19, this is in danger of downplaying the very important and supportive role played by the doctors and nurses from St Raphael's with regard to the care of my wife. Her pain was so severe that it could not be

completely controlled. – Husband of patient

The care for my brother was exceptional - my elderly parents were so well attended to when they visited him or provided with care and lovely cups of tea and sandwiches! My sister and I were also cared for - overall, patient felt at home and peaceful there. – Sister of patient

There were two comments that was neither outright praise nor criticism:-

Food was very difficult to consume at the end. – Husband of patient

Food can be more diverse, to meet all cultural needs. Excellent room and care received. – Daughter of patient

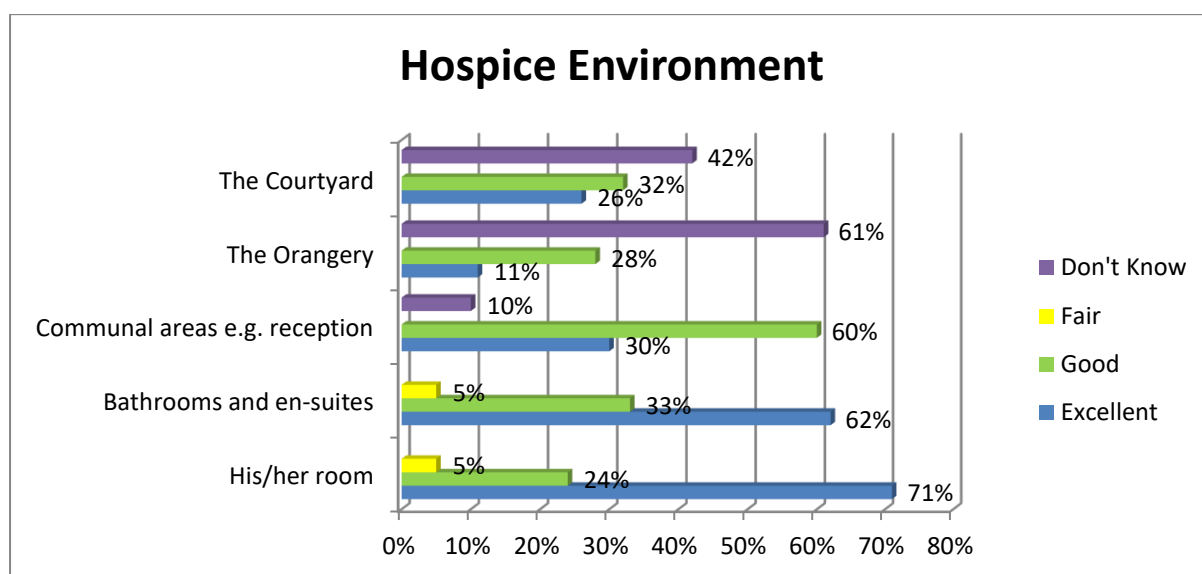
Q15 A-E) Respondents were asked to comment on different aspects of the Hospice.

The patient’s room was considered to be ‘Excellent’ by 71% (c.f. 74% in 2019-2020) and the remaining 24% rated the room as ‘Good’ (c.f. 26% in 2019-2020). 5% considered it to be fair (c.f. 0% in 2019-2020). 62% of respondents considered the en-suite bathrooms on the IPU to be ‘Excellent’ (c.f. 68% in 2019-2020), 33% rated them as ‘Good’ (c.f. 32% in 2019-2020), 5% rated them as ‘Fair,’ (c.f. 0% in 2019-2020).

When asked to rate the communal areas of the Hospice, such as the Reception, 30% of respondents rated them as ‘Excellent’ (c.f. 61% in 2019-2020), 60% rated them as good (c.f. 32% in 2019-2020), 0% rated them as fair (c.f. 6% in 2019-2020) and 10% recorded ‘Don’t Know’ (c.f. 0% in 2019-2020).

When asked to rate the Orangery, 11% rated it as ‘Excellent’ (c.f. 61% in 2019-2020), 28% rated it as ‘Good’ (c.f. 32% in 2019-2020), 0% rated it as ‘Fair’ (c.f. 3% in 2019-2020) and 61% answered that they did not know (c.f. 3% in 2019-2020).

When asked to rate the courtyard, 26% rated it as ‘Excellent’ (c.f. 58% in 2019-2020), 32% rated it as ‘Good’ (c.f. 32% in 2019-2020), 0% rated it as ‘Fair’ (c.f. 0% in 2019-2020) and 42% did not know how to rate the courtyard (c.f. 10% in 2019-2020).



St Raphael's Community Services

Q16) 44 of the total 59 respondents, 75% (c.f. 67% in 2019-2020) stated that the patient received care from the St Raphael's Hospice Community Palliative Care Team's (CPCT) Clinical Nurse Specialists, six were unsure whether they had or not, five answered 'no' they had not, and four simply left the entire section blank. The following data is extracted from responses relating to the 44 patients (75%) who recorded as having definitely received care. The total number of respondents varies slightly per question, since not all respondents answered every question.

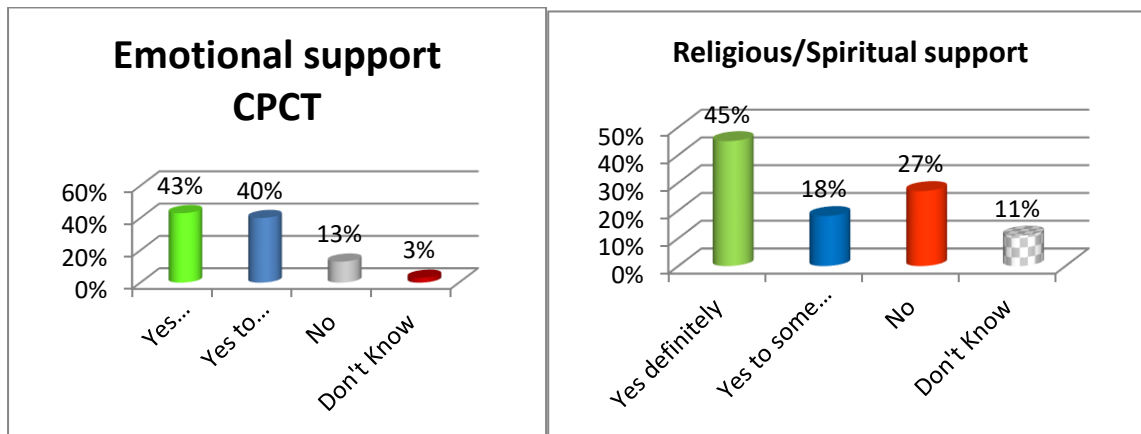
Responsiveness

Q17) Most respondents felt that the team visited as often as needed - 74% (c.f. 84% in 2019-2020) and 16% felt that the team 'only sometimes' visited as often as needed (c.f. 8% in 2019-2020), 7% replied 'no' (c.f. 5% in 2019-2020) and 2% replied "don't know" (c.f. 3% in 2019-2020).

Q18) The respondents were asked to comment on different aspects of CPCT care:-.

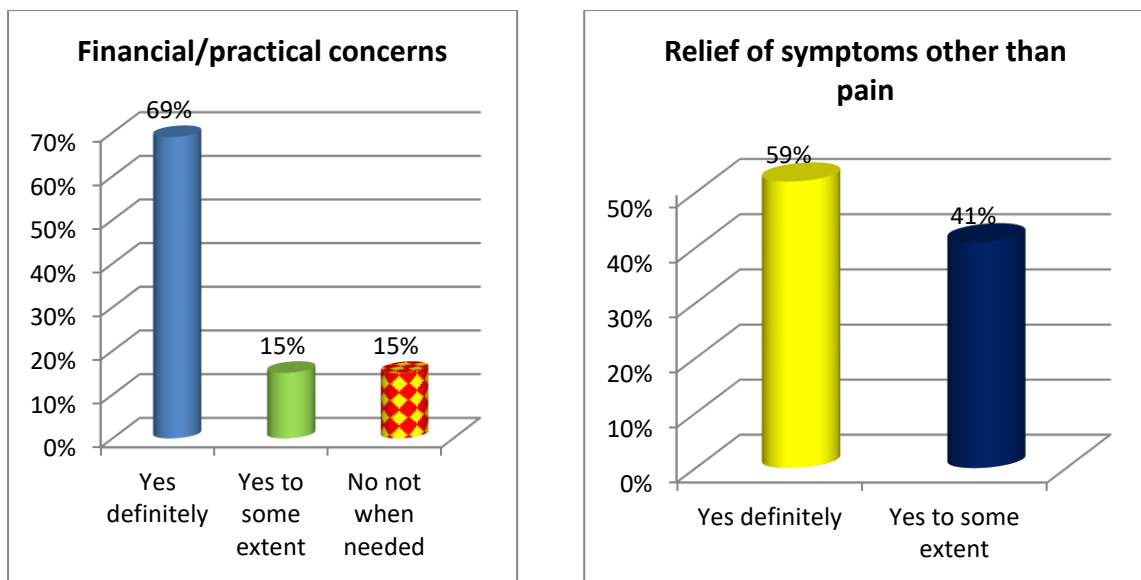
Q18A) When asked whether patient's received enough emotional support from the CPCT team, 30 (77% c.f. 84% in 2019) of the 39 respondents who answered the question acknowledged that the patient had a need for emotional support and of these, 43% replied 'Yes definitely' (c.f. 68% in 2019-2020), 40% 'Yes to some extent' (c.f. 23% in 2019-2020), 13% recorded 'No, not when needed' (c.f. 6% in 2019-2020) and 3% recorded 'Don't know' (c.f. 3% in 2019-2020).

Q18B) 11 (29%) of the 38 respondents who answered the question stated that the patient did require some kind of religious or spiritual support. In response to whether they received enough religious or spiritual support from the CPCT, 5 of these (45% c.f. 45% in 2019-2020) answered 'Yes definitely' and 2 (18%) replied 'Yes to some extent' (c.f. 18% in 2019-2020), 3 (27%) replied 'No, not when needed' (c.f. 18% in 2019-2020) and 1 (9%) replied 'Don't Know' (c.f. 18% in 2019-2020).

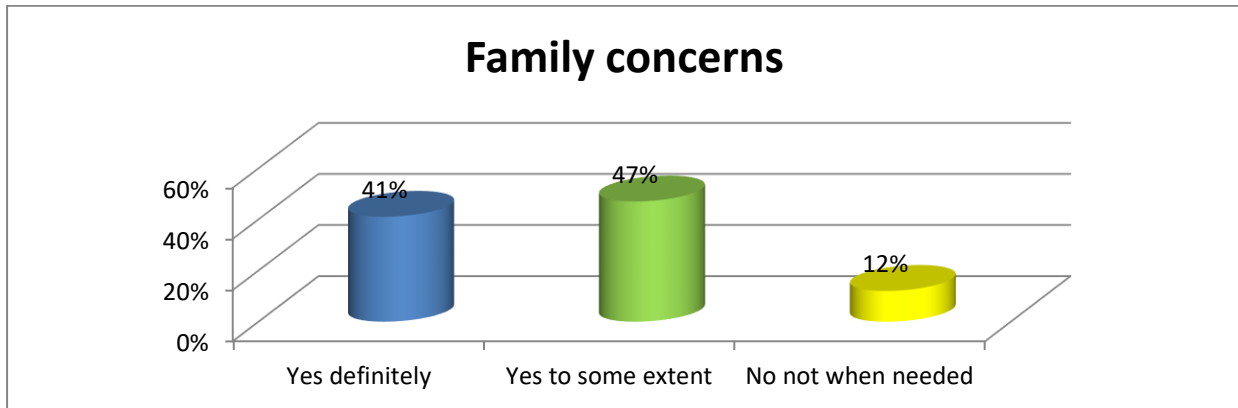


Q18C) 66% of respondents felt that the patient did not require help with financial concerns and other practical problems (c.f. 65% in 2019-2020) and no respondents (c.f. none in 2019-2020) did not know. Only 13 respondents felt that this support was needed and, of these, as to whether enough support was received, 69% replied ‘Yes definitely’ (c.f. 38% in 2019-2020), 15% ‘Yes to some extent’ (c.f. 46% in 2019-2020) and 15% ‘No not when needed’ (c.f. 15% in 2019-2020).

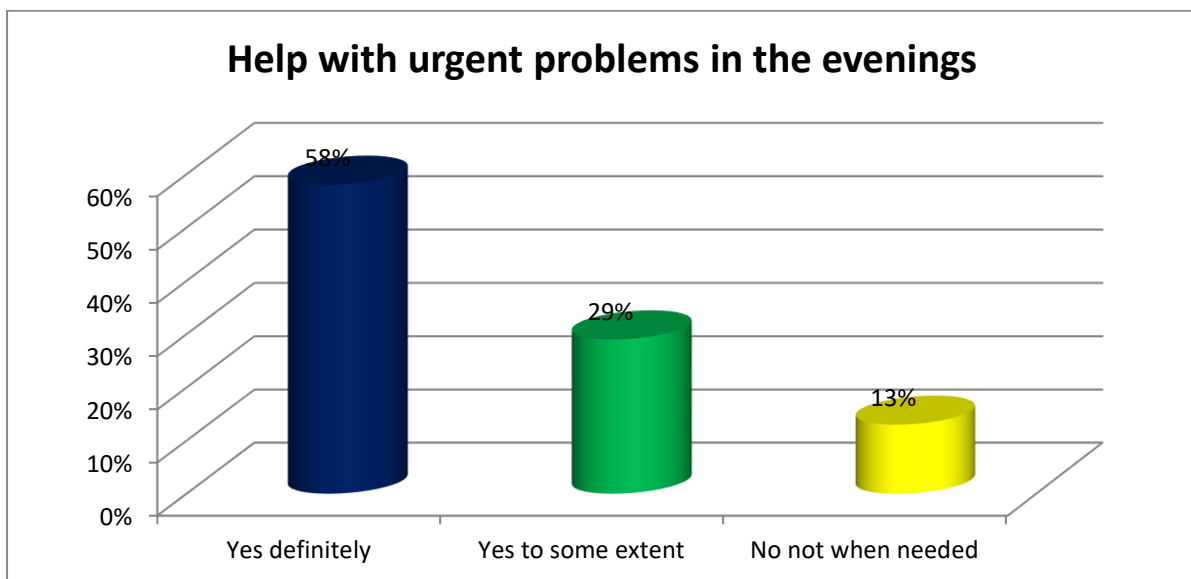
Q18D) 21% of respondents felt that the patient did not require help with relief of symptoms other than pain (c.f. 19% in 2019-20) and three respondents (8% c.f. 5% in 2019-2020) did not know. 27 respondents felt that this support was needed and of these, as to whether enough support was received, 59% replied ‘Yes definitely’ (c.f. 68% in 2019-2020), 41% ‘Yes to some extent’ (c.f. 25% in 2019-2020) and 0% ‘No not when needed’ (c.f. 7% in 2019-2020).



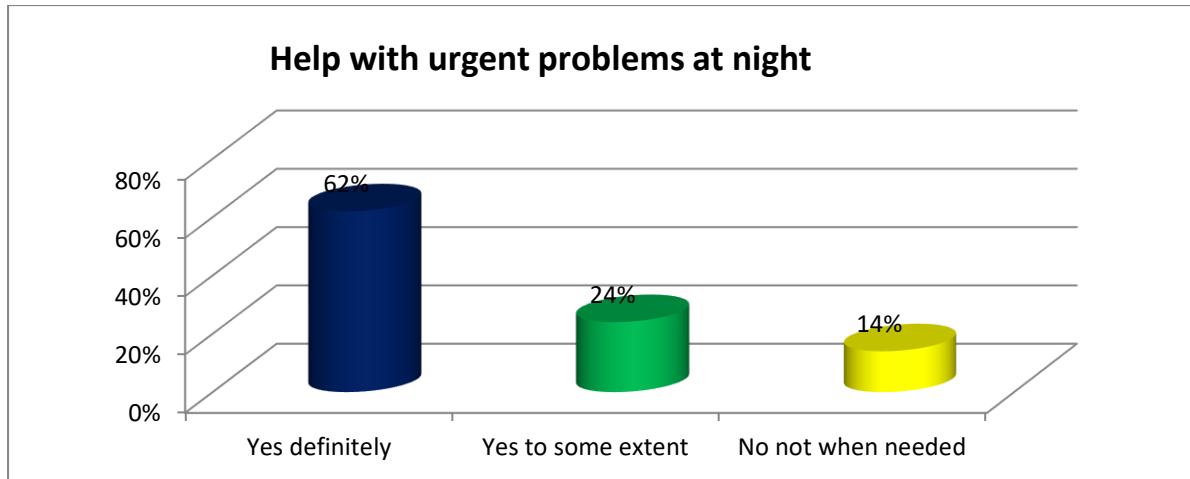
Q18E) 53% of respondents felt that the patient did not require help with family concerns (c.f. 43% in 2019-2020) and one respondent (3% c.f. 5% in 2019-2020) did not know. 17 respondents felt that this support was needed and of these, as to whether enough support was received, 41% replied ‘Yes definitely’ (c.f. 63% in 2019-2020), 47% ‘Yes to some extent’ (c.f. 32% in 2019-2020) and 12% ‘No not when needed’ (c.f. 5% in 2019-2020).



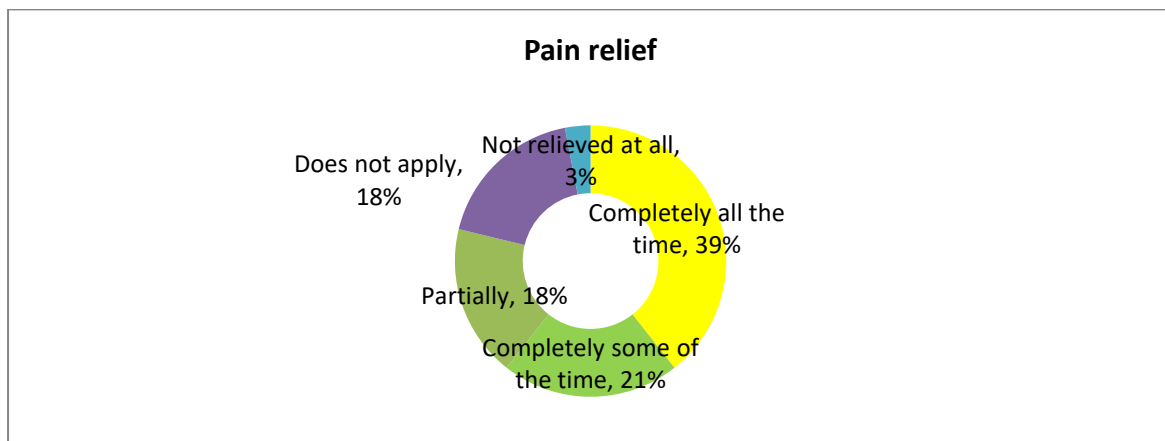
Q18F) 37% (c.f. 39% in 2019-2020) of respondents felt that the patient did not require help with urgent problems during the evenings (between 5 PM and 11 PM) and no respondent did not know (c.f. 3% in 2019-2020). 24 (63% c.f. 58% in 2019-2020) respondents felt that this support was needed and of these, as to whether enough support was received, 58% replied ‘Yes definitely’ (c.f. 64% in 2019-2020), 29% ‘Yes to some extent’ (c.f. 27% in 2019-2020) and 13% ‘No not when needed’ (c.f. 9% in 2019-2020).



Q18G) 45% of respondents felt that the patient did not require help with urgent problems during the nights (between 7 PM and 9 AM) (c.f. 43% in 2019-2020) and no respondents (c.f. 3% in 2019-2020) did not know. 21 respondents - 55% (c.f. 54% in 2019-2020) felt that this support was needed and, of these, as to whether enough support was received, 62% replied ‘Yes definitely’ (c.f. 65% in 2019-2020), 24% ‘Yes to some extent’ (c.f. 25% in 2019-2020) and 14% ‘No not when needed’ (c.f. 10% in 2019-2020).



Q19) 38 of the 44 respondents answered the question relating to their loved one’s pain relief provided by the CPCT. 39% reported that the pain was relieved ‘Completely all the time’ (c.f. 42% in 2019-2020), 21% ‘Completely some of the time’ (c.f. 29% in 2019-2020) and a further 18% considered that pain was only ever partially relieved (c.f. 8% in 2019-2020). One (3% c.f. 3% in 2019-2020) replied that the pain was not relieved at all. Furthermore, 0% did not know (c.f. 3% in 2019-2020) and 18% responded that this did not apply because the patient had no pain (c.f. 16% in 2019-2020).



Q20) 40 of the 44 respondents answered the question relating to whether they and their family got enough help and support from the Hospice CPCT. See table below.

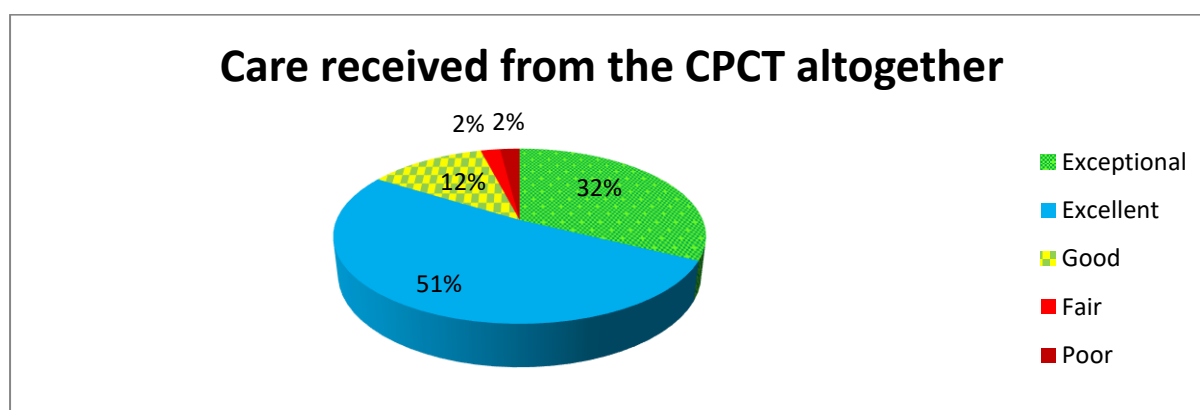
	2020	2019-20	2019	2018-19	2018	2017-18	2017
Yes as much as we wanted	85%	89%	82%	85%	79%	78%	83%
Yes, some, but not as much as we wanted	8%	8%	9%	8%	12%	7%	17%
No, tried to get more	3%	3%	6%	2%	4%	6%	0%
No, did not ask for more	5%	0%	3%	4%	5%	7%	0%
Did not need	0%	0%	0%	2%	0%	2%	0%

Communication with the CPCT team was altogether positive.

Q21) The way in which the CPCT team explained the patient’s condition, treatment or tests was considered ‘Very easy’ to understand by 55% of respondents (c.f. 61% in 2019-2020) and ‘fairly easy’ by 38% (c.f. 31% in 2019-2020), ‘fairly difficult’ by 0% (c.f. 0% in 2019-2020) and 5% recorded that they did not explain anything (c.f. 3% in 2019-2020). One (3% c.f. 6% in 2019-2020) recorded that they never spoke with the team. 40 of the 44 respondents answered this question.

Q22) 41 of the 44 respondents answered the question relating to whether the CPCT team had time to listen to them and 78% responded ‘Yes, all the time’ (c.f. 83% in 2019-2020) and 15% responded ‘Yes, some of the time’ (c.f. 14% in 2019-2020), just one (2% c.f. 0% in 2019-2020) recorded ‘No, not when needed,’ and two (5% c.f. 3% in 2019-2020) responded that they did not know the answer to this question.

Q23) Overall impressions were mostly very positive. When asked their opinion on the care as a whole from the CPCT team, 41 of the 44 respondents recorded an answer and of these, 32% recorded ‘Exceptional’ (c.f. 50% in 2019-2020), 51% ‘Excellent’ (36% in 2019-2020), 12% ‘Good’ (11% in 2019-2020), 2% ‘Fair’ (c.f. 0% in 2019-2020), and 2% recorded ‘Poor’ (c.f. 3% in 2019-2020).



Q24) 41 of the 44 respondents recorded an answer to the question as to whether the CPCT involved them in decisions about the patient’s treatment and care as much as they wanted. Of these, 93% recorded that they had been involved as much as they wanted (c.f. 88% in 2019-2020), 5% recorded that they would have liked to have been more involved (c.f. 6% in 2019-2020), 2% (c.f. 6% in 2019-2020) recorded ‘Don’t know.’

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

Id	CPCT Comment
1	CPCT worked to the best of their ability with us and had consideration for staff and patients in the hospice, bearing in mind their services were required during the COVID 19 pandemic. Thanks to all. – Wife of patient
3	As I was my wife's carer, respite assistance was quite helpful. A nurse sat with my wife for an hour or so, allowing me to leave the house for an hour or so. – Husband of patient
8	We felt we were lucky to have the support of such a good hospice. – Daughter of patient
11	My mum had dementia as well as cancer, and so ended up moving into a nursing home for end of life care. However, as her main carer, I was able to receive emotional support from the CPCT while my mum was still living at home. – Daughter of patient
22	Due to the corona virus it was harder to get some of the medication needed and other medical items but I feel the hospice staff did very well under extreme conditions. – Husband of patient
33	Due to lockdown most contact was by telephone, but CPCT were proactive in calling and always very helpful.- Wife of patient
48	I only have the highest praise for the nurses who helped us. My husband wished to remain at home. I wanted that also. – Wife of patient
53	CPCT excellent supportive service. Exceptional knowledge and compassion provided to the patient and family members from CPCT. – Daughter of patient
57	Face to face visits were limited due to the pandemic of COVID 19 but the telephone support was excellent. This support helped me to look after my husband at home where he wanted to be, with his family. – Wife of patient

And then there were three equivocal comments:

Id	CPCT Comment
4	My mother could not have help as she was dying during lockdown. No one would visit. – Daughter of patient
10	Due to her deteriorating condition "her" opinion is hard to judge. – Husband of patient
39	Because of COVID 19 the specialist community nurses were not making home visits. My mum would have definitely benefited from a home visit as it was difficult to describe her symptoms on the phone. I was surprised that they were not making home visits as the community district nurses continued to make home visits. – Daughter of patient

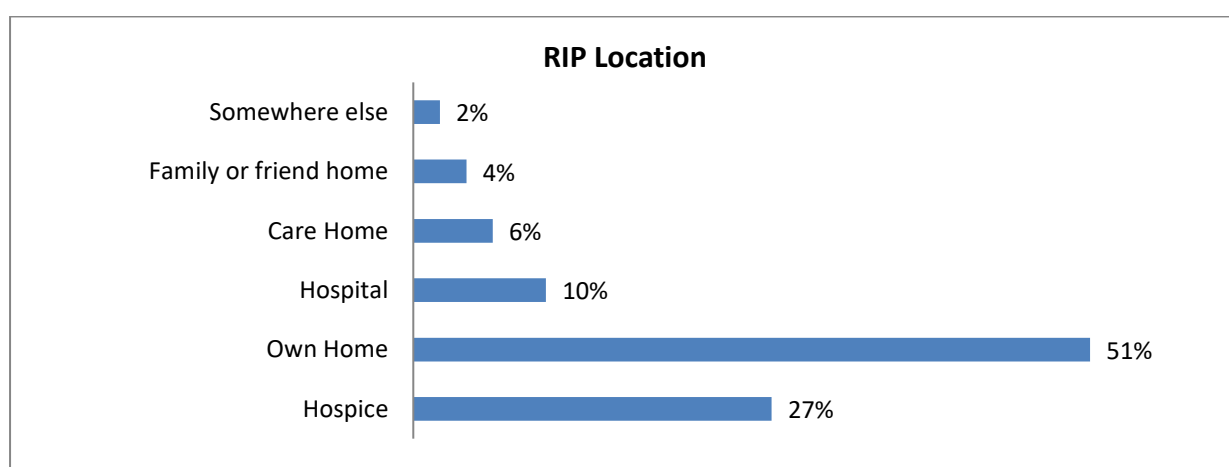
St Raphael's Hospice Jubilee Centre

Q25) & Q26) 3 of the 59 respondents said that the patient had visited the Jubilee Centre (c.f. 1 of the 58 in 2019-2020). They all recorded that they always benefited from it.

Circumstances surrounding his/her death

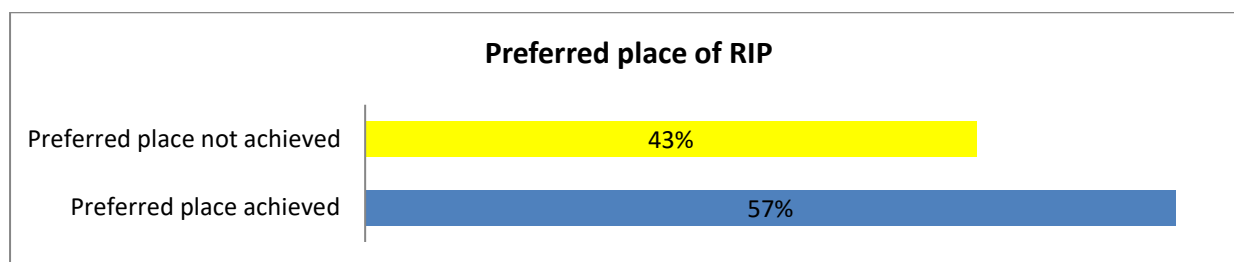
This section presents the views of the respondents regarding the circumstances of the patient's death and any expressed wishes. The questions were asked of all respondents.

Q27) Of the 59 respondents, 8 did not record an answer to this question. Of the remaining 51, 27% reported that their loved one died in the Hospice (c.f. 49% in 2019-2020), 51% that they had died in their own home (25% in 2019-2020), 10% that they had died in hospital (c.f. 14% in 2019-2020), 6% that they had died in a care home (c.f. 7% in 2019-2020), 4% (c.f. that they had died in a family member/friend's home and one patient (2%) died "somewhere else."



Q28) 39 respondents said that their loved ones explicitly stated where they wanted to die, 10 did not say, 2 were unsure and 8 recorded no answer. Of the 39 who recorded that the patient stated their preferred place of death, 13 – 33% said they preferred a hospice (c.f. 42% in 2019-2020) and 23 (59% c.f. 53% in 2019-2020) their own home. One (3%) did not mind, and one (3%) recorded 'Somewhere Else,' and one (3%) changed their mind.

Q29) Of the 37 respondents who recorded that the patient had explicitly stated a specific preferred place of death (so not including the one who did not mind or the one who changed their mind), this was achieved in 21 (57%) of cases (c.f. 65% in 2019-2020).



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

Preferred place	Achieved 2020	Not 2020	Achieved 2019-20	Not 2019-20	Achieved 2019	Not 2019	Achieved 2018-19	Not 2018-19
Hospice	6	7	13	3	4	7	9	3
Either Home or Hospice	0	0	0	0	0	0	0	0
Own Home	15	8	11	9	17	6	13	12
Somewhere Else	0	1	0	1	0	0	0	0
Friend/Family Member's Home	0	0	0	0	0	0	1	0
Son's Home	0	0	0	0	0	0	0	0
Daughter's Home	0	0	0	0	0	0	0	0
Hospital	0	0	0	0	0	0	0	0
Care Home	0	0	0	0	1	0	1	0
TOTAL	21	16	24	13	22	13	24	15

Q30) Respondents were asked whether their loved ones had enough choice about where they died. Of the 37 that did say where they wanted to die, one did not record an answer. Of the other 36, 25 – 69% reflected their loved one had had enough choice about where they died (c.f. 83% in 2019-2020), 8% were 'Unsure' (c.f. 3% in 2019-2020) and 8 (22% c.f. 14% in 2019-2020) said they did not have enough choice.

Actual place of death	Yes	Unsure	No	N/R
Hospice	7	1	5	0
Own home	17	2	3	1
Somewhere else	1	0	0	0
Total	25	3	8	1

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

30 comment on enough choice
Due to COVID 19 the restrictions on relatives' visiting hours meant mum wanted to stay at home with immediate family around her. – Daughter of patient
Decided at the start she would like to go to a hospice as she did not want to be seen that way, by me on my own who was caring for her. But no room! – Daughter of patient
She was told she may be moved to a care home which upset her. Her condition worsened after this. She died five days later. – Other female relative of patient

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

30 COMMENT ON ENOUGH CHOICE
We talked about this. She was in agreement. That I would look after her at home, with the help of carers as long as I was able. This is what happened. And she passed away with me at her side. I had done my job. I was very happy. – Husband of patient
In the last four to five weeks there weren't really any choices. – Husband of patient
We were given a hospital bed as well as support from nurses, district nurses and our GP – Wife of patient
Everything was explained as to how this would be managed. – Wife of patient
We were lent a number of aids that made staying at home practical. – Husband of patient

Q31) On balance, when responding to the question of whether the patient died in the right place, 50 answered the question and of these, 42 replied that they did – 84% (c.f. 89% in 2019-2020), 1 (2% c.f. 0% in 2019-2020) was unsure, and 7 – 14% replied that they did not (c.f. 11% in 2019-2020).

Actual place of death	Yes	Unsure	No
Somewhere Else	1	0	0
Care home	1	0	2
Family/ Friend Home	2	0	0
Hospice	12	1	0
Hospital	3	0	2
Own home	23	0	3
Total	42	1	7

Two of the seven respondents who felt their loved ones died in the wrong place recorded comments.

31 comment on place
Due to COVID 19, i would have liked my husband to die in the hospice as he needed a lot of medical care but it was safer to keep him at home. – Wife of patient
His passing was very quick (three hours) over the weekend. It happened too suddenly for him to be transferred to St Raphael's as he wished. – Sister of patient

Six of the 51 respondents who believed the patient had died in the right place recorded comments:

31 comment on place
She liked the hospice and all the staff. – Other female relative of patient
Mum died of terminal cancer. COVID 19 was not contributory so yes. – Daughter of patient
Mum was admitted to St Raphael's hospice in May 2020 for symptom control and was discharged after three weeks - however, she fell and broke her hip and spent a week in hospital but I decided to have her transferred to St Raphael's when it became apparent that she was near the end of life. – Daughter of patient
He went peacefully in his sleep, surrounded by loved ones. – Wife of patient
People cannot be trusted to make fair decisions. They do not seem to care. – Daughter of patient
Dying in his home meant that I and our children could be with him right to the end. – Wife of patient

Bereavement Support

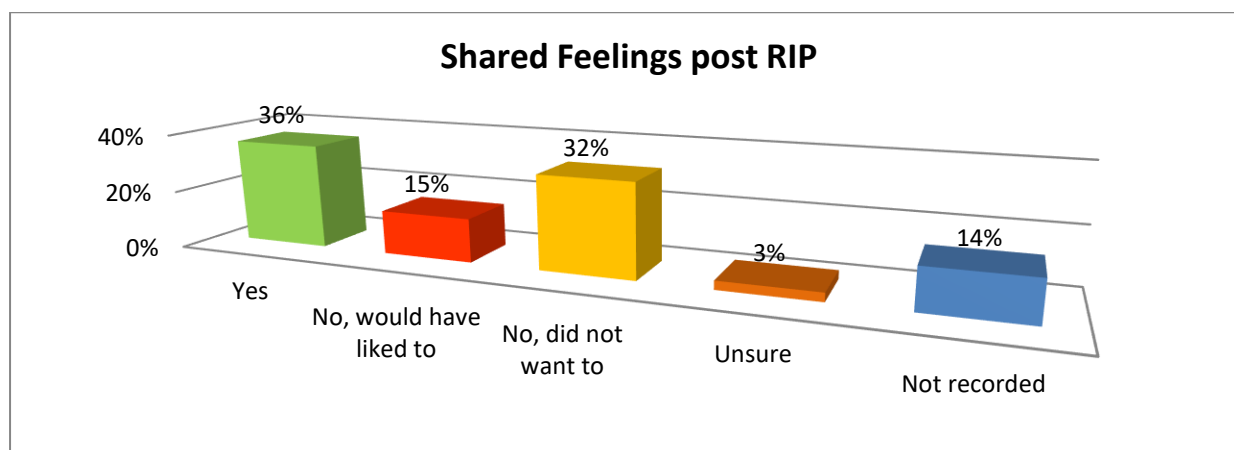
Q32) Of the 14 respondents who stated their loved ones died in the Hospice, only 12 recorded an answer, and of these 83% felt that they were definitely given enough support by staff (c.f. 96% in 2019-2020), 17% replied ‘Yes, to some extent’ (c.f. 4% in 2019-2020), and 0% responded ‘No, not at all’ (c.f. 0% in 2019-2020).

Two respondents recorded comments:

32 FAMILY HELP COMMENT
All the doctors and nurses were fantastic. – Granddaughter of patient
Covid 19 lockdown started – Brother of Patient

Q33) & Q34) Respondents were asked whether since the patient’s death had they talked to anyone from St Raphael’s about their feelings regarding their loved one’s illness and death.

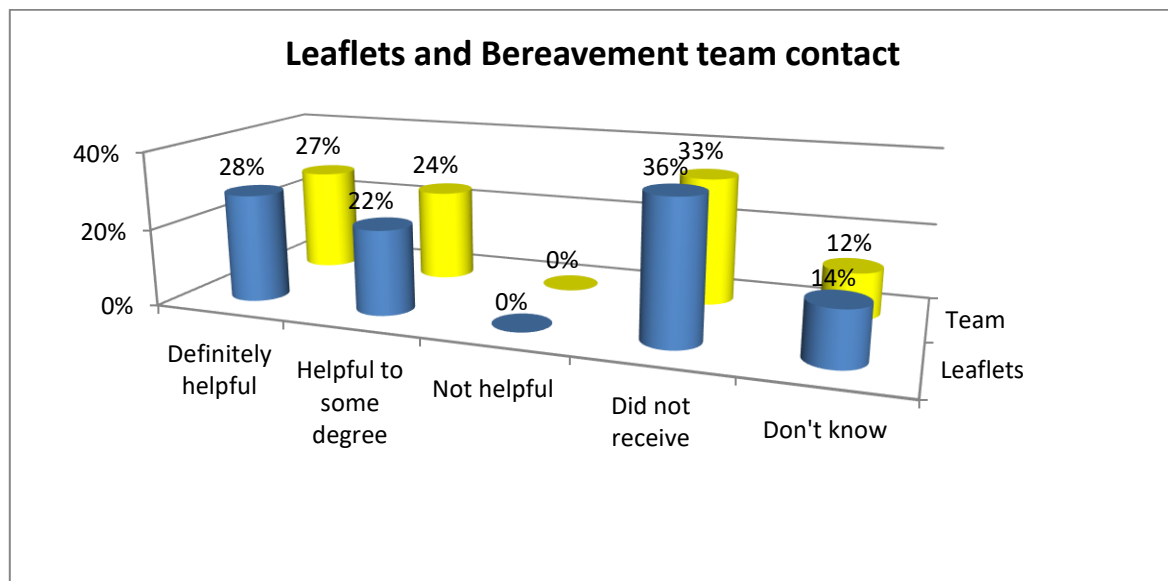
19 of the 59 respondents had not spoken to anyone, and said that it had been their choice. 9 replied that they would have liked to, 2 were unsure and eight did not record an answer. 21 replied that they had (c.f. 16/58 respondents had in 2019-2020). Of these 21, 4 (19%) spoke with a bereavement service volunteer, 5 (24%) spoke with a counsellor, 2 (10%) spoke with nurses, 2 (10%) spoke to both a bereavement service volunteer and a nurse, 1 (5%) spoke to a doctor, 3 (14%) spoke with ‘other,’ 1 (5%) spoke with a counsellor and a doctor, 1 (5%) spoke to both a bereavement service volunteer and a counsellor, 1 (5%) spoke to a social worker, and 1 (5%) did not share who precisely they spoke to.



Q35) Respondents were asked whether they felt able to talk to someone from the Hospice as soon as they wanted and of the 21 who had spoken to someone, 13 (81% c.f. 77% in 2019-2020) of the 16 who recorded an answer responded that they had talked to them as quickly as they wanted to, 2 (13%) said they wanted it sooner (c.f. 8% in 2019-2020), 1 (6% c.f. 15% in 2019-2020) were unsure, and 5 did not record an answer (c.f. 3 in 2019-2020).

Q36 A) When respondents were asked whether they had received a leaflet from the Hospice giving information about what to do after their bereavement, 9 did not record an answer, and of the 50 who did record an answer, 14 (28% c.f. 67% in 2019-2020) found it ‘Definitely helpful,’ 11 (22% c.f. 14% in 2019-2020) ‘Helpful to some degree,’ seven (14% c.f. 0% in 2019-2020) did not know, 0 (c.f. 0 in 2019-2020) found it ‘Not helpful’ and 18 (36% c.f. 18% in 2019-2020) did not receive it.

Q36 B) When respondents were asked whether they had received contact from the Hospice Bereavement Team, 10 did not record an answer and of the 49 who did record an answer, 13 - 27% found it ‘Definitely helpful (c.f. 46% in 2019-2020),’ 12 - 24% ‘Helpful to some degree (c.f. 13% in 2019-2020),’ 6 - 12% did not know (c.f. 2% in 2019-2020), two - 4% found it ‘Not Helpful’ (c.f. 0% in 2019-2020) and 16 - 33% did not receive contact (c.f. 40% in 2019-2020).



Bereavement Comments

These comments on this topic were all dissatisfied to some extent:

Bereavement comments - Dissatisfied
I desperately would like some form of counselling or to be part of a bereavement group. – Wife of patient
Due to COVID-19 - nothing really available. – Husband of patient
Due to the pandemic, counselling was not available, which I would have liked. – Daughter of patient
I believe these services were not offered because of COVID restrictions. – Wife of patient
They could have been more professional, helpful and kind. – Wife of patient
Counselling service would have been of great benefit but understand this is not a normal time. – Daughter of patient
We as a family did not need the above help and advice, but we were offered it and I imagine for lots of people it would be extremely helpful. – Daughter of patient

This comment on the other hand expressed unequivocal satisfaction:

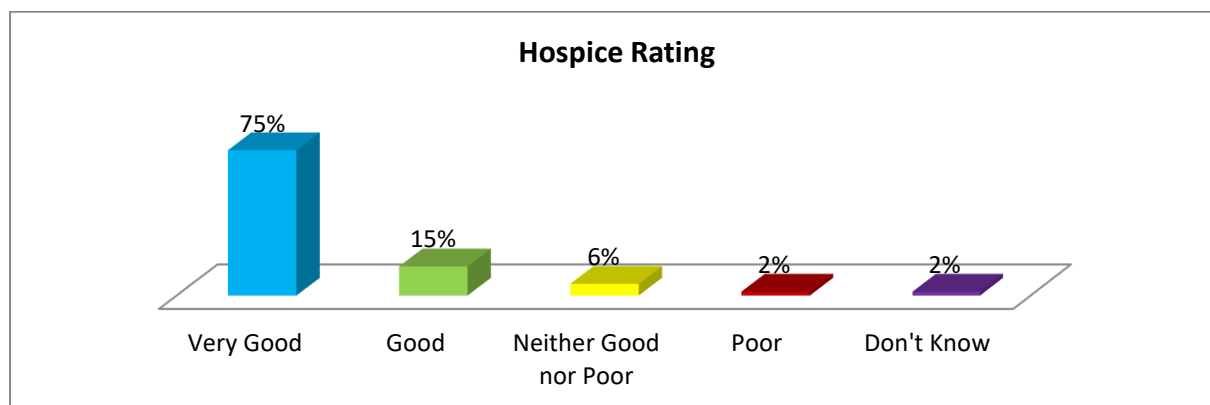
Bereavement comments - Satisfied
I also got beautiful messages of condolence from a sister there. – Wife of patient

Comments concerning bereavement support were fed back contemporaneously to the Psychological Support Team Manager and relatives were contacted accordingly.

Q36 a)

Friends and Family section

When respondents were asked to rate their overall experiences of the hospice, 6 of the 59 respondents did not record an answer. Of the 53 who did record an answer, 40 (75% c.f. 82% in 2019-2020) rated the hospice as 'Very Good', 8 (15% c.f. 13% in 2019-2020) rated the hospice as 'Good', 3 (6% c.f. 0% in 2019-2020) rated the hospice as 'neither good nor poor,' 1 (2% c.f. 0% in 2019-2020) rated the hospice as 'Poor,' none (0% c.f. 2% in 2019-2020) rated it as 'Very Poor,' and 1 (2% c.f. 4% in 2019-2020) did not know the answer to this question.



Most comments were positive:

ID	36a friends and family comment	Your Relationship
1	No matter how many times I rang, I was able to speak with a nurse, get advice on care and medication. Never rushed on the phone and always reassured.	Wife
3	The service was very proactive. An assessment was made early on and a number of gadgets were lent to us to help my wife stay at home with myself as carer. The nurse prescribed additional medication to help. We found the nurses very caring. They could not do enough to help us. The whole experience with the hospice was very positive. I will be forever grateful for the love and care we received.	Husband
6	Staff were caring and helpful. All treatment was discussed and clearly explained. Room was private and quiet.	Wife
7	We had sitters for patient on a weekly basis 1 1/2 hours. This enabled me to do shopping mostly. This was very much appreciated by me. - The sitters were all great.	Husband
8	All members of staff we encountered were lovely, caring people. Very reassuring to be able to call at any time for advice or help. Brilliant hospice!	Daughter
9	Help with mum's pain and medication	Son
10	The atmosphere was superb. Serious when it needed to be, but fun when the opportunity was there for a smile.	Husband
11	Very good, but it was disappointing about the counselling, although I do understand the reasons why.	Daughter
12	I was extremely grateful because i'm not sure I could have managed him in his final days although i had planned to do so.	Wife
13	Everyone was supportive without being intrusive.	Wife
16	The hospice cared for my husband at home for three weeks before he died. He pined to come home from Mayday. He was very happy that a named staff member saw him. He died peacefully at home. He would have been 94 years old on 15th November. Family was there. We would have been married 70 years this December. The nursing care was the best ever.	Wife
18	I felt the service was good with the supply of equipment. The nurses' visits were informative to my wife and I, though there was no treatment available.	Husband
19	Amazing multidisciplinary teams. Very helpful in all aspects of care.	Wife
20	Friendly	Husband
22	The service was very good, considering the coronavirus made things more difficult than usual.	Husband
23	During the pandemic, the staff coped really well. I realise they could not offer usual services, but patient was very happy and comfortable during his stay.	Sister
24	Very caring and lovely surroundings i.e. garden. Felt supported.	Daughter
25	Everyone was kind and helpful to us.	Daughter
26	Everyone was very kind and helpful	Son
27	First time I've dealt with a hospice. There was some confusion over who or how many could visit at one time.	Other female relative
ID	36a friends and family comment	Your Relationship

28	Patient had a short stay and loved it there. He went back a few days prior to his death because we know that was where he wanted to die. I, as a bible student understand why we eventually die and know that the dead are "sleeping" in Jehova's memory and they will be resurrected back to a clean, peaceful earth ps 37:9,10,11.	Wife
31	Everybody I had any contact with was very caring and sensitive	Wife
33	Caring and proactive	Wife
34	My sister could not have been cared for better. She was treated not only as a patient, but also as a person and the nurses were so kind and caring and made her laugh. They couldn't do enough for her. During Covid, St Raphael's were as flexible as they could be with visiting and were always there for me to talk to. They sat with her, spoke to her and gave her all the care and attention they could. It was so comforting to know that.	Sister
35	Team always available when needed. Always came out even with covid restrictions.	Daughter
36	Everyone was very kind and helpful.	Son
37	The receptionists and care staff were always empathetic and quick to respond to requests for visits or return phone calls. I was counselled by (a named staff member) and I will always be most grateful for her kindness.	Sister
38	There was always someone for either my wife or myself, to talk about virtually anything. Obviously during Covid, it was on the phone, but still very good.	Husband
39	My mum received very good care from the nurses during her two stays at the hospice - she was treated with compassion and dignity at all times.	Daughter
41	All the staff we dealt with were lovely, sensitive and caring. Great with our mum and helpful to us as we cared for her. All the staff at St Raphael's were great and we, as a family, are very grateful for your care and support for us and for our mum. Thank you.	Daughter
44	It was very helpful to speak to a nurse for advice.	Wife
46	The hospice thought of everything we needed ie bed, commode etc. There was always someone I could talk to on the phone.	Wife
47	My wife the patient was chronically ill for several years prior to her death and for about the last six months of her life she was paralysed from the waist down and bedridden. She was tended to by doctors from St Helier and several other hospitals, our GP practice and from St Raphael's hospice. In addition she (and I) depended very heavily on regular visits, sometimes several times a day from district nurses and less frequently nurses from St Raphael's. We also had help from carers - twelve hours a day, every day. In the later stages of her life, when it was unavoidable, the only way she could leave the house was by ambulance, which added to her discomfort. During a home visit by a doctor from St Raphael's she was asked if she would go as an inpatient for a short period of time so that her pain could be better managed. She refused. She took the view that people only went into a hospice to die. A few weeks later her pain was so severe that she did agree and was consequently admitted. She was in a single room which was en-suite and for the first time in many months she was given a shower and had her hair washed. She was made to feel more like a guest rather than just another patient. All of the staff, barring none, at St Raphael's were very kind, caring and had a sense of humour - not only with my wife, but towards her visitors as well. Her pain control was also better managed. Her stay in St Raphael's was a real fillip for her. When she returned home her view of the hospice was completely changed and she said she wouldn't mind going back if she had to. I feel that St Raphael's hospice made a huge positive difference to my wife's end of life care for	Husband
ID	36a friends and family comment	Your Relationship

47	which I am more than grateful. We have been together for over seventy years and married for over sixty-one of those years and to see my darling wife suffer the way she did without me being able to share her burden left me feeling rather helpless and St Raphael's helped me both mentally and physically. Thank you.	Husband
48	Your occupational therapist helped us to get a much needed stairlift to use. Your nurses are dedicated and compassionate. I was overwhelmed to get such help and support - very grateful for all you did. Thank you.	Wife
51	My mother originally wanted to die at home, but after being taken to St Raphael's, she wanted to die in St Raphael's.	Daughter
52	My husband was given wonderful treatment during his time at St Raphael's last September. My only concern still is that my son and i did not see him die peacefully. We had been given a leaflet prior to his dying explaining certain details, but we were not prepared for how distressed he was until his last breath. However, nothing can ever change that. I would want you to know that in no way is this a complaint, but taking this opportunity to mention how we still feel, having received your questionnaire.	Wife
53	St Raphael's made an extremely difficult time more bearable.	Daughter
54	The cancer HCAs were brilliant and gave huge amounts of support, care and help.	Daughter
56	I had a very good counsellor who helped me a lot.	Wife
57	Because all the advice, support, provision of equipment was available as soon as there was a change in my husband's condition which helped us to care for him at home. The emotional support was invaluable too.	Wife
58	Patient's care was exceptional and he had complex symptoms pain and lymphotoedema - this took some expertise to manage and the hospice team managed it well. The family care to my parents, my sister and i was excellent. Thank you.	Sister
59	This was end of life care only - but it was really good. (Named staff member of CPCT) was brilliant and helped a great deal	Daughter

A few comments included criticism:

ID	36a friends and family comment	Your Relationship
4	Don't feel we got the support and help needed, due to lockdown. Just one call a day isn't enough.	Daughter
5	No one came to see him when I told them how badly he was doing. He was given oramorph for panic attacks. When I asked for him to go into hospice for respite, they said no.	Wife
15	There was no help to deal with the bereavement process. No one reached out to help at all. They were great when looking after my mum.	Daughter
40	I feel let down as only our CPCT nurse contacts us after the death.	Husband
42	The resources available were very stretched at the time, no spaces at the hospice and we felt alone and without help a number of times.	Son

These three comments cannot be classified as either praise or criticism:

ID	36a friends and family comment	Your Relationship
29	My brother has liver cancer and no one has been in touch with him at the moment.	Wife
49	She died six months ago. Details of her final illness are now a blur in my memory	Husband
50	We only saw someone from St Raphael's a day or so before she died and then the day	Daughter

N:\Clinical\Clinical Governance\Clinical Audit\Audit Report Library\Drafts\Surveys\VOICES 2020 Report JCAR 20-12-2021 v1.0.docx

Classification : Confidential Internal ; Author: JC/AR

Version 1.0 ; Superseded version : 0.3

Issued: v1.0 issued 20-12-2021

	she died they changed her clothes.	
--	------------------------------------	--

What could we have done better?

Id	What could the Hospice have done better?	Your relationship
2	Her legs were swollen. She was measured for socks but these never arrived.	Husband
5	More home visits. Support for patient and spouse	Wife
6	I was told that I would be contacted if my husband was nearing death, but he died in the early hours of the morning and i was contacted just after he had died. This was obviously quite distressing apart from the death itself.	Wife
15	Help people deal with watching relatives at home.	Daughter
27	Let the patient decide who they want to see.	Other female relative
39	I was not given important information by the doctors as to the fact that my mum's death would have to be referred to the coroner because of her fall. This caused a delay in her body being released into the care of the undertaker and caused me a great deal of distress and anxiety.	Daughter
41	Mum had a very short time frame between diagnosis and death, but we had several nights when her pain was seriously uncontrolled. On each occasion it was over an hour before someone arrived to top up pain relief.	Daughter
44	I would have liked a nurse to see him two days before he died, but he didn't want to.	Wife
50	The ladies that came were lovely. The distrust however is already there from hospital/ nurses/ community care! I don't even know who half of them were.	Daughter
53	Offer overnight stay during Covid period	Daughter
54	The medical team were not so accessible and we saw less of them.	Daughter
55	I am appalled by this (referring to being sent the questionnaire). How can you be so insensitive? It is hard enough being bereaved without being able to see my family or get any counselling, but to then be asked to fill in a survey about the death! Please think before sending these out. (The questionnaire was returned anonymously).	Recorded not
58	Psychosocial care - we were visited by a team member to do a memory box (for my six year old daughter), but sadly the patient was too sleepy to take part. It would have been good to talk to the patient earlier in the admission about it.	Sister

2020 Palliative Care Consultant Comments

Medical Team Feedback (Dr Jenny Strawson on behalf)

I feel it is important to note that the audit period from April 2020-Sept 2020 includes the peak period of the first COVID wave and that this saw a dramatic change in service delivery across both the IPU and community. The challenges encountered by the hospice (and all health organisations) cannot be underestimated and will have impacted the patient and family experience like never before, including restriction on visiting the IPU and restricted visiting service in the community.

I note a slightly lower return rate of 26% - as with any postal questionnaires, those offering feedback may not be representative of the service as a whole – nonetheless it is vitally important that we listen and learn from the feedback given.

It is interesting to note that the majority of respondents are female 68%.

IPU:

Care and environment/food – scores were across the board improved for privacy, being made comfortable in bed, access to medication and just slightly reduced for access to personal care. Food provided is rated as good, excellent and exceptional. We would hope to see a further improvement in responses following our recent hospice refurbishment.

Emotional Support – the reduced response to ‘yes definitely’ may reflect the reduced access to face to face psychological support available during the first wave of Covid, as part of infection control measures to reduce footfall on the ward. An action from the last survey was to offer training in basic emotional support for the IPU nursing team and this should be prioritised.

Spiritual support: 11% respond that spiritual support was not available when needed, the same percentage as the previous audit period, again it is likely that access to spiritual support from faith leaders may have been restricted due to Covid (while we were happy for faith leaders to visit, some were shielding or felt the risk was too high).

Communication and Family support: It is unfortunate to see a reduction in perceived family support – due to the marked restrictions on visiting the IPU during the peak COVID period, the support offered face to face is likely to have declined during this period. Going forwards if restrictions continue staff should be encouraged to update and support families regularly by telephone – specific training on telephone consultations/communication should be considered.

Staying overnight: As predicted there are a number of comments about restricted overnight stays due to Covid. The visiting rules have been revised to reflect the distress this can cause.

Relief of symptoms other than pain: It is very positive to see this feedback to have improved.

Relief of pain: It is encouraging to see that the feedback improved for pain being relieved ‘all of the time’ and ‘some of the time’, demonstrating the specialist clinical care we offer. Continuing to prioritise regular education for clinical staff will hopefully ensure this excellence in symptom control

continues to be delivered. I do not agree with the caveat in the executive summary ‘Having pain relieved ‘all of the time ‘ may trigger more concern and possibly raises the question over the sedative effects of the medication used.’ – patients are closely monitored for medication related side effects and sedation is never considered a normal part of good pain control.

Communication/decision making: The language used by the clinical team remains ‘very easy to understand’ (90%) which is very positive feedback and it is great to see feedback improve for the question ‘were there any decisions made about his/her care or treatment that s/he would not have wanted?’ to 95%. This demonstrates a clinical culture of involving patients and families in the decision making process.

Being treated with respect and dignity: While the figures for ‘all the time’ are still high, there has been a decrease. Going forward training has been delivered to the IPU team on recognising the importance of civility in the workplace, as the evidence shows us that being respectful to each other is likely to lead to the same behaviour towards our patients and families. Furthermore, given the huge physical and emotional stress of COVID as an organisation we need to prioritise ways of improving staff wellbeing and reducing burnout – as burnout leads to reductions in the delivery of compassionate care - progressing plans to offer Schwartz rounds is one way we can do this.

Care from nurses and doctors on admission: the responses are very positive with the care being exceptional and excellent.

COMMUNITY:

Overall care: These results are very encouraging and care received was consistently exceptional, excellent and good.

Responsiveness: The majority of people felt they were visited as often as need with a small minority (7%) feeling they weren’t. During the peak of Covid visiting was restricted to reduce infection and the team operated on more telephone contact, virtual assessment and visiting only if needed, this no doubt will have impacted the patient experience.

Evening/night support: The results are overall very positive, but there is a slight increase in the number who felt they needed help and did not get it – it is hard to unpick if this is within our remit – or if this reflects the limited access to DN support overnight and there is likely to have been strain on the 111 service. Recent work on patient information leaflets on who to call may help to improve this to some extent.

Emotional/spiritual /financial support: The drop in some of these figures is likely to reflect the pressures on the system brought about through Covid. However, training in the basics of emotional support for all team members should be considered.

Relief of symptoms other than pain: These symptoms are shown to be managed well overall (yes definitely and to some extent)

Relief of pain: while there is a slight drop, we know that pain is multidimensional and that pain relief alone cannot always relieve pain entirely. Limited access to family and social interactions and the

anxiety around Covid and lockdowns may have contributed to these figures. Nonetheless, aiming to improve symptom control and pain control is always our priority and ensuring regular CPCT education on symptom control is key.

Communication: The figures for understanding discussions remain good with language used being very easy or fairly easy across the board. Continuing to offer advanced communication skills training and SIM based training will help to keep this standard high as well as having high quality written information to give patients and relatives.

PPD: This can be difficult to meet all the time due to the limited number of hospice beds available and equally the access to District Nurses and the care available in the community, especially care overnight. One of the difficult conversations we have to have on the IPU is around moving on from the hospice, especially if their specialist palliative care needs have been met but they require 24 hour care in a NH. Restricted visiting around Covid made the decision to move to a NH even more challenging.

Dr G Tamura – Rose (additional comments)

I also think it is worth noting in the respondent's relationship to patient (page 11 of the report) the limited BAME representation in the respondents (is the questionnaire available in alternative languages?), along with the comment on page 19 "the food can be more diverse, to meet all cultural needs", serving as ongoing impetus for us to be more representative of the population we serve (email with some photos of the welcome sign we discussed at a KLOE meeting recently to follow...)

For me, one of the more useful aspects of these reports are the free text comments, and I wonder how widely these are shared? Comments on page 35 from ID 1, 3, 10, 47 struck me as particularly poignant.

ID 39 on page 38 may prompt us to do some teaching on when to refer to the coroner (for all staff to be aware) to help better prepare families?

ID 50 on page 38 I know is not a direct criticism of us, however our new "My Name Is" badges and headshot boards may help with this

ID 55 on page 38 – do we warn them that this questionnaire will be sent in the post to them?

2020 Clinical Director Comments

It is always reassuring to read the positive views of so many of those touched by our service and as has been the case previously, the majority of the respondents have provided encouraging feedback.

The provision of care and symptom management on the IPU continues to be of a high standard despite the challenges faced by all with Covid restrictions and consequential changes in clinical practice.

There are areas for future focus such as the gradual rise in need for help and support out of hours for our community service users; as explained in the report, it is difficult to ascertain whether these needs are predominantly of a practical nature. We have already begun to address the demand for increased support and advice at weekends and will continue to explore how our financial resource can be increased in order to sustain this.

However the feedback in terms of the CPCT 'visiting as often as needed', demonstrates a responsive service.

The reported decrease in adequacy of emotional support may relate partially to the impact of Covid – an unknown illness trajectory coupled with restrictions on physical contact/visiting is likely to have led to an increased need for emotional support for all.

Since this period and following further learning about Covid transmission, we have relaxed our visiting restrictions a little and in conjunction with undertaking risk assessments, we tend to have a more bespoke attitude to individual situations.

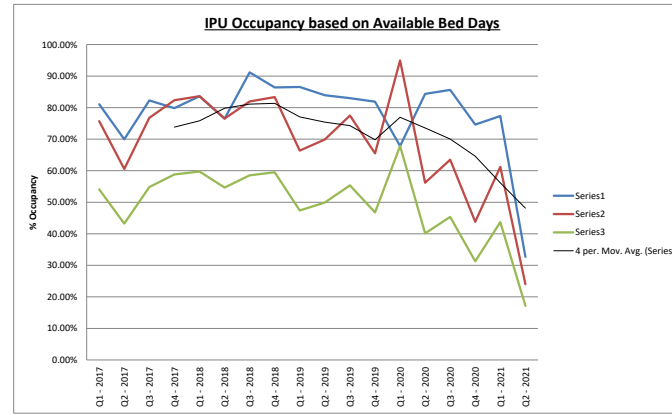
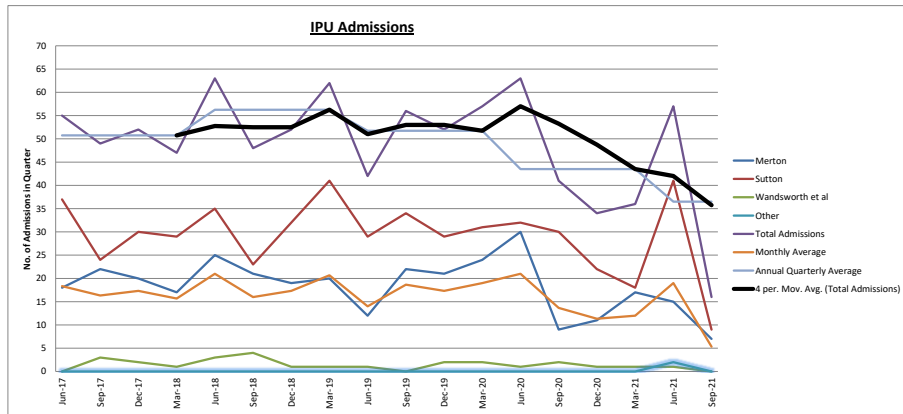
Our Psychological Support service was depleted due to personal bereavements and sickness within the team at that time but nevertheless, still managed to provide a reasonably robust bereavement service through virtual means and the student placements introduced by the PS Lead. We need to investigate and address the reason for a reduction in posting of bereavement leaflets to ensure that our service users are aware of how to access support and what to expect when a loved one has died.

Our communication with GPs and external agencies has improved (this was one of our areas for focus from the previous period) – through working virtually and focusing on more efficient and effective communication with our community colleagues although we are aware that there is still work to be done in clarifying how to access the different services available for our service users.

Achievement of Preferred Place of Death is disappointingly low although again, this could be partially attributed to Covid and the acute decline of some of our patients as well as the limited access to the IPU owing to low staffing levels. Interestingly, most respondents felt that their loved one died in the right place and so further work is needed in order to ascertain whether the patient had changed their mind about PPD but the data had not been amended.

IPU							
No. of Admissions in Quarter							
	Merton	Sutton	Wandsworth et al	Other	Total Admissions	Monthly Average	Annual Quarterly Average
Jun-17	18	37	0		55	18	50.75
Sep-17	22	24	3		49	16	50.75
Dec-17	20	30	2		52	17	50.75
Mar-18	17	29	1		47	16	50.75
Jun-18	25	35	3		63	21	56.25
Sep-18	21	23	4		48	16	56.25
Dec-18	19	32	1		52	17	56.25
Mar-19	20	41	1		62	21	56.25
Jun-19	12	29	1		42	14	51.75
Sep-19	22	34	0		56	19	51.75
Dec-19	21	29	2		52	17	51.75
Mar-20	24	31	2		57	19	51.75
Jun-20	30	32	1		63	21	43.50
Sep-20	9	30	2		41	14	43.50
Dec-20	11	22	1		34	11	43.50
Mar-21	17	18	1		36	12	43.50
Jun-21	15	41	1	2	57	19	36.50
Sep-21	7	9	0	0	16	5	36.50
Dec-21					0	0	
Mar-22					0	0	

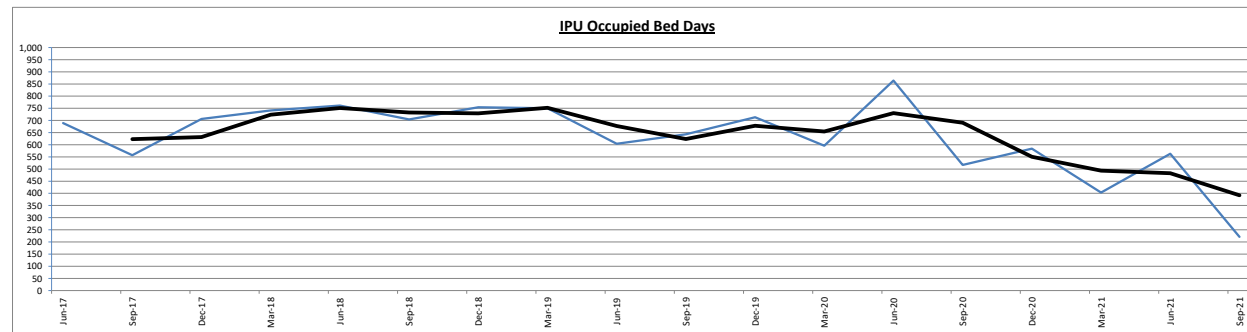
	IPU Variable Available	Based on 10 beds	Based on 14 beds
Q1 - 2017	81.06%	75.71%	54.08%
Q2 - 2017	69.97%	60.54%	43.25%
Q3 - 2017	82.28%	76.74%	54.81%
Q4 - 2017	79.85%	82.33%	58.81%
Q1 - 2018	83.63%	83.63%	59.73%
Q2 - 2018	76.52%	76.52%	54.68%
Q3 - 2018	91.17%	81.96%	58.54%
Q4 - 2018	86.41%	83.33%	59.52%
Q1 - 2019	86.53%	66.37%	47.41%
Q2 - 2019	83.94%	69.89%	49.92%
Q3 - 2019	83.00%	77.50%	55.36%
Q4 - 2019	81.87%	65.49%	46.78%
Q1 - 2020	67.82%	94.95%	67.82%
Q2 - 2020	84.34%	56.20%	40.14%
Q3 - 2020	85.63%	63.48%	45.34%
Q4 - 2020	74.63%	43.80%	31.29%
Q1 - 2021	77.34%	61.20%	43.71%
Q2 - 2021	32.69%	24.02%	17.16%
Q3 - 2021			
Q4 - 2021			



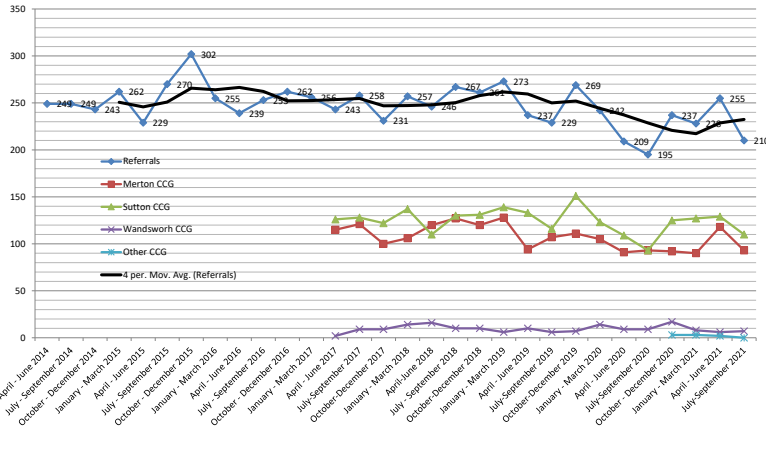
Comments to Sep 21: Admissions are declining across both CCGs ; decline accentuated from June 2020. Proportionately Merton admission are consistent at 38/39% over the past 4 financial years c.f. Sutton admissions of 58/59%. (N.B. Ward closure effectively for c 7 weeks in July/August 2021)

Comments to Sep 21: IPU Occupancy based on variable available bed data is distinct from static bed data. As such it represents the occupancy based on the staffing capacity to ensure safe provision of care. This is not the same as and is less than the occupancy figures that would be represented based upon on the routine availability of either 10 or 14 beds. Occupancy based on static bed availability figures is decreasing c.f the increasing trendline based on variable beds.

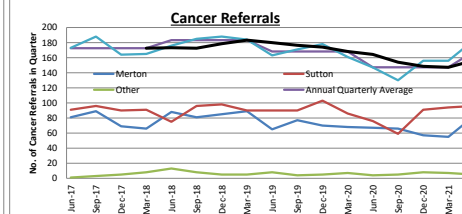
IPU Occupied Bed Days	Moving Average based on previous 12 months
Jun-17	689
Sep-17	557
Dec-17	706
Mar-18	741
Jun-18	761
Sep-18	704
Dec-18	754
Mar-19	750
Jun-19	604
Sep-19	643
Dec-19	713
Mar-20	596
Jun-20	864
Sep-20	517
Dec-20	584
Mar-21	403
Jun-21	563
Sep-21	221
Dec-21	



Hospice Referrals



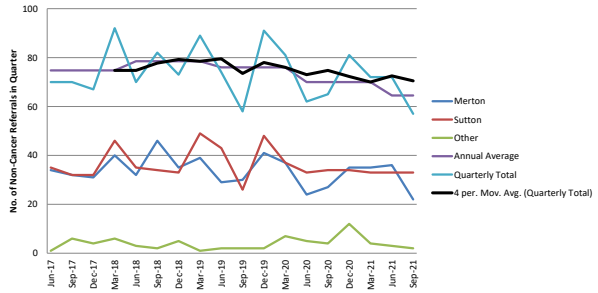
Community Team					
Cancer Referrals					
	Merton	Sutton	Other	Annual Quarterly Av	Quarterly Total
Jun-17	81	91	1	172.5	173
Sep-17	89	96	3	172.5	188
Dec-17	69	90	5	172.5	164
Mar-18	66	91	8	172.5	165
Jun-18	88	75	13	183.25	176
Sep-18	81	96	8	183.25	185
Dec-18	85	98	5	183.25	188
Mar-19	89	90	5	183.25	184
Jun-19	65	90	8	168.25	163
Sep-19	77	90	4	168.25	171
Dec-19	70	103	5	168.25	178
Mar-20	68	86	7	168.25	161
Jun-20	67	76	4	147.25	147
Sep-20	66	59	5	147.25	130
Dec-20	57	91	8	147.25	156
Mar-21	55	94	7	147.25	156
Jun-21	82	96	5	168.00	183
Sep-21	71	77	5	168.00	153



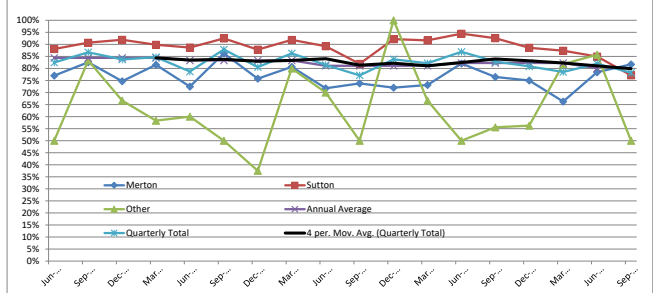
Community Team					
Non-Cancer Referrals					
	Merton	Sutton	Other	Annual Average	Quarterly Total
Jun-17	34	35	1	74.75	70
Sep-17	32	32	6	74.75	70
Dec-17	31	32	4	74.75	67
Mar-18	40	46	6	74.75	92
Jun-18	32	35	3	78.5	70
Sep-18	46	34	2	78.5	82
Dec-18	35	33	5	78.5	73
Mar-19	39	49	1	78.5	89
Jun-19	29	43	2	76.00	74
Sep-19	30	26	2	76.00	58
Dec-19	41	48	2	76.00	91
Mar-20	37	37	7	76.00	81
Jun-20	24	33	5	70.00	62
Sep-20	27	34	4	70.00	65
Dec-20	35	34	12	70.00	81
Mar-21	35	33	4	70.00	72
Jun-21	36	33	3	64.50	72
Sep-21	22	33	2	64.50	57

Community Team					
White Referrals (British / Irish / Other) excluding Ethnicity Not Stated					
	Merton	Sutton	Other	Annual Average	Quarterly Total
Jun-17	77%	88%	50%	84%	82%
Sep-17	83%	91%	83%	84%	87%
Dec-17	75%	92%	67%	84%	84%
Mar-18	82%	90%	58%	84%	85%
Jun-18	72%	89%	60%	83%	79%
Sep-18	86%	92%	50%	83%	88%
Dec-18	76%	88%	38%	83%	81%
Mar-19	81%	92%	80%	83%	86%
Jun-19	72%	89%	70%	81%	81%
Sep-19	74%	82%	50%	81%	77%
Dec-19	72%	92%	100%	81%	84%
Mar-20	73%	92%	67%	81%	82%
Jun-20	82%	94%	50%	82%	87%
Sep-20	76%	93%	56%	82%	83%
Dec-20	75%	89%	56%	82%	81%
Mar-21	66%	87%	82%	82%	79%
Jun-21	78%	85%	86%	80%	82%
Sep-21	82%	77%	50%	80%	78%

Non-Cancer Referrals



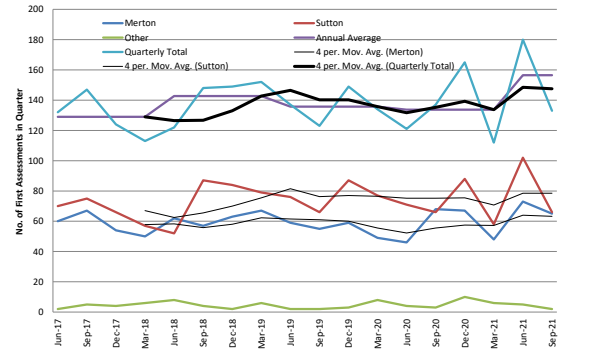
White (British / Irish / Other) Referrals



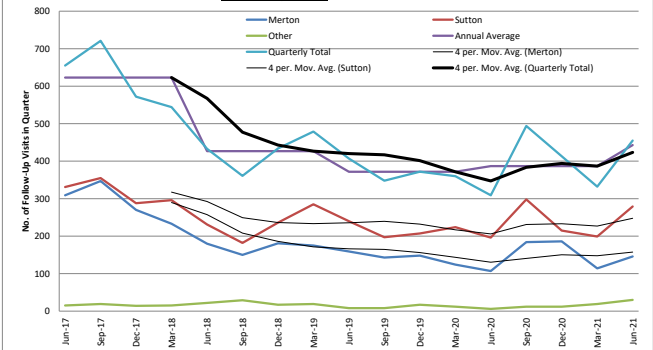
Community Team					
First Assessments					
	Merton	Sutton	Other	Annual Average	Quarterly Total
Jun-17	60	70	2	129	132
Sep-17	67	75	5	129	147
Dec-17	54	66	4	129	124
Mar-18	50	57	6	129	113
Jun-18	62	52	8	143	122
Sep-18	57	87	4	143	148
Dec-18	63	84	2	143	149
Mar-19	67	79	6	143	152
Jun-19	59	76	2	136	137
Sep-19	55	66	2	136	123
Dec-19	59	87	3	136	149
Mar-20	49	77	8	136	134
Jun-20	46	71	4	134	121
Sep-20	68	66	3	134	137
Dec-20	67	88	10	134	165
Mar-21	48	58	6	134	112
Jun-21	73	102	5	157	180
Sep-21	65	66	2	157	133

Community Team					
Follow Up Visits					
	Merton	Sutton	Other	Annual Average	Quarterly Total
Jun-17	309	331	15	623	655
Sep-17	347	355	19	623	721
Dec-17	270	288	14	623	572
Mar-18	233	296	15	623	544
Jun-18	180	231	22	426.75	433
Sep-18	150	182	29	426.75	361
Dec-18	181	236	17	426.75	434
Mar-19	175	285	19	426.75	479
Jun-19	159	240	8	372	407
Sep-19	143	197	8	372	348
Dec-19	148	207	17	372	372
Mar-20	124	224	12	372	360
Jun-20	107	196	6	387	309
Sep-20	184	298	12	387	494
Dec-20	186	215	12	387	413
Mar-21	114	199	19	387	332
Jun-21	146	279	30	443	455
Sep-21	188	227	16	443	431

First Assessments

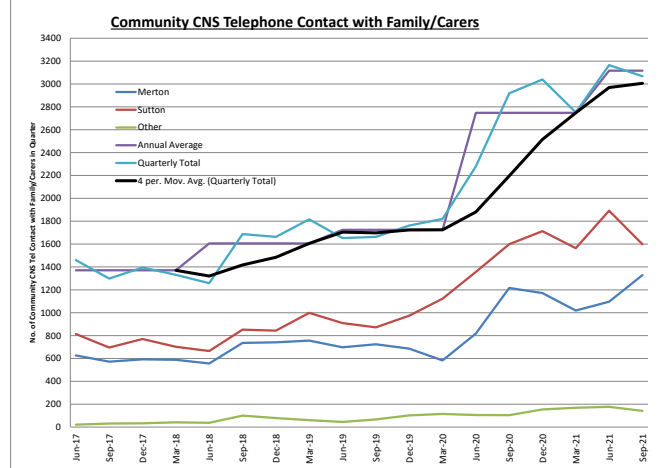
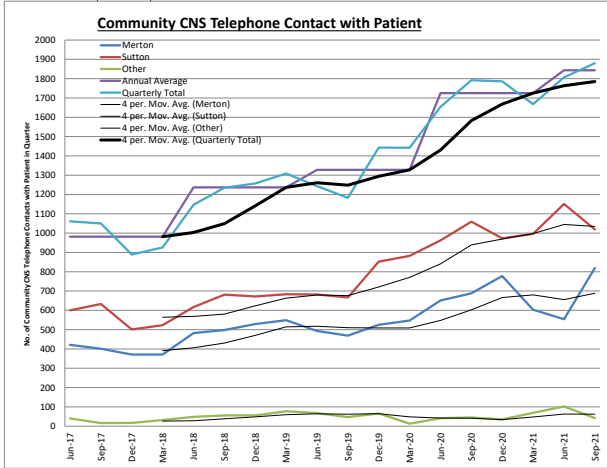


Follow-up Visits



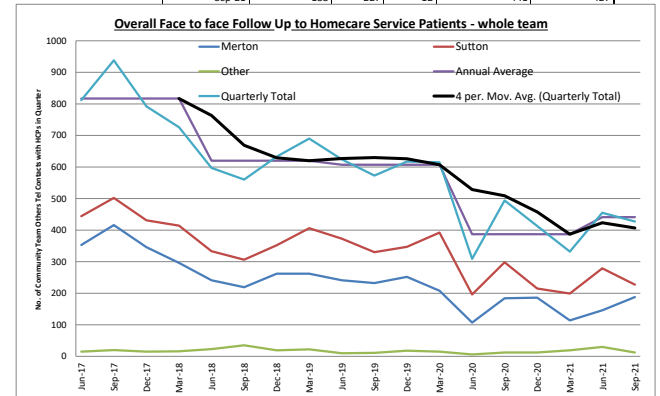
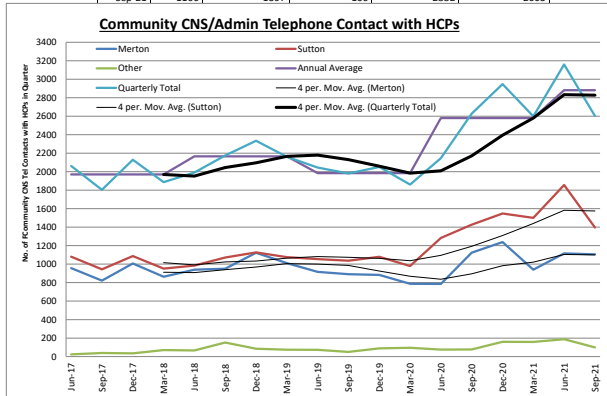
Community Team					
Community CNS Telephone Contact with Patient					
	Merton	Sutton	Other	Annual Average	Quarterly Total
Jun-17	421	600	40	982	1061
Sep-17	401	633	16	982	1050
Dec-17	371	501	17	982	889
Mar-18	371	523	32	982	926
Jun-18	482	617	48	1237	1147
Sep-18	498	681	56	1237	1235
Dec-18	529	672	56	1237	1257
Mar-19	549	683	77	1237	1309
Jun-19	493	682	68	1328	1243
Sep-19	469	667	47	1328	1183
Dec-19	525	852	66	1328	1443
Mar-20	547	882	13	1328	1442
Jun-20	651	962	41	1725	1654
Sep-20	688	1059	45	1725	1792
Dec-20	778	973	35	1725	1786
Mar-21	603	996	69	1725	1668
Jun-21	554	1151	102	1844	1807
Sep-21	819	1019	42	1844	1880

Community Team					
Community CNS Telephone Contact with Family/Carers					
	Merton	Sutton	Other	Annual Average	Quarterly Total
Jun-17	626	813	21	1371	1460
Sep-17	572	695	31	1371	1298
Dec-17	592	770	33	1371	1395
Mar-18	588	702	41	1371	1331
Jun-18	556	665	37	1606	1258
Sep-18	736	852	100	1606	1688
Dec-18	741	843	79	1606	1663
Mar-19	756	999	61	1606	1816
Jun-19	698	909	45	1725	1652
Sep-19	724	872	67	1725	1663
Dec-19	686	974	102	1725	1762
Mar-20	583	1123	115	1725	1821
Jun-20	818	1357	105	2748	2280
Sep-20	1216	1599	104	2748	2919
Dec-20	1172	1713	154	2748	3039
Mar-21	1019	1564	169	2748	2752
Jun-21	1096	1892	177	3117	3165
Sep-21	1329	1598	141	3117	3068

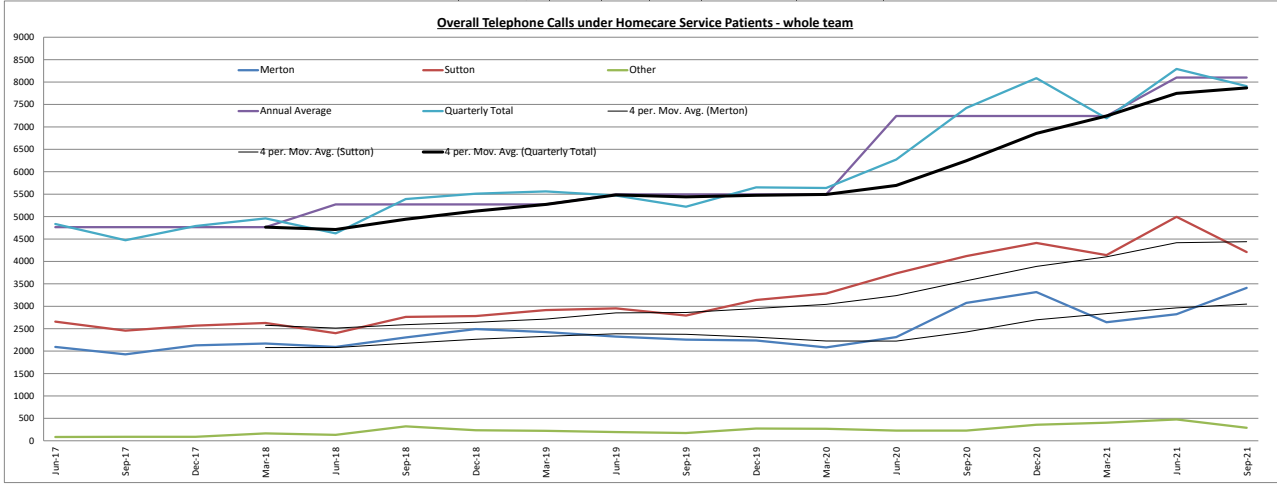


Community Team					
Community CNS/Admin Telephone Contact with HCPs					
	Merton	Sutton	Other	Annual Average	Quarterly Total
Jun-17	957	1081	24	1970.5	2062
Sep-17	821	944	39	1970.5	1804
Dec-17	1007	1087	35	1970.5	2129
Mar-18	864	952	71	1970.5	1887
Jun-18	940	985	66	2165.5	1991
Sep-18	951	1072	152	2165.5	2175
Dec-18	1123	1127	85	2165.5	2335
Mar-19	1011	1076	74	2165.5	2161
Jun-19	917	1055	73	1985	2045
Sep-19	891	1038	51	1985	1980
Dec-19	883	1080	89	1985	2052
Mar-20	787	979	95	1985	1861
Jun-20	786	1284	76	2580	2146
Sep-20	1124	1427	77	2580	2628
Dec-20	1239	1548	160	2580	2947
Mar-21	940	1500	159	2580	2599
Jun-21	1116	1856	188	2882	3160
Sep-21	1106	1397	100	2882	2603

Homecare Service					
Overall Face to Face Follow Up to Homecare Patients - whole team					
	Merton	Sutton	Other	Annual Average	Quarterly Total
Jun-17	353	444	15	817	812
Sep-17	416	502	20	817	938
Dec-17	346	431	15	817	792
Mar-18	296	414	16	817	726
Jun-18	241	333	23	620	597
Sep-18	219	306	35	620	560
Dec-18	262	352	19	620	633
Mar-19	262	406	22	620	690
Jun-19	241	373	10	607	624
Sep-19	232	330	11	607	573
Dec-19	252	347	18	607	617
Mar-20	208	392	15	607	615
Jun-20	107	196	6	387	309
Sep-20	184	298	12	387	494
Dec-20	186	215	12	387	413
Mar-21	114	199	19	387	332
Jun-21	146	279	30	441	455
Sep-21	188	227	12	441	427



Homecare Service					
Overall Telephone Calls under Homecare Service - whole team					
	Merton	Sutton	Other	Annual Average	Quarterly Total
Jun-17	2094	2656	85	4764	4835
Sep-17	1928	2456	89	4764	4473
Dec-17	2129	2569	90	4764	4788
Mar-18	2169	2627	164	4764	4960
Jun-18	2093	2400	133	5272	4626
Sep-18	2305	2763	323	5272	5391
Dec-18	2493	2782	235	5272	5510
Mar-19	2423	2915	223	5272	5561
Jun-19	2324	2952	195	5495	5471
Sep-19	2257	2792	172	5495	5221
Dec-19	2238	3141	273	5495	5652
Mar-20	2083	3285	269	5495	5637
Jun-20	2313	3733	227	7244	6273
Sep-20	3074	4120	228	7244	7422
Dec-20	3317	4413	358	7244	8088
Mar-21	2645	4142	404	7244	7191
Jun-21	2822	4995	476	8101	8293
Sep-21	3410	4210	289	8101	7909



Homecare Service					
Visits by neither CNS nor Doctor					
	Merton	Sutton	Other	Annual Average	Quarterly Total
Jun-17	40	100	0	166	140
Sep-17	62	140	1	166	203
Dec-17	52	111	0	166	163
Mar-18	51	106	1	166	158
Jun-18	41	90	0	128	131
Sep-18	39	85	1	128	125
Dec-18	44	81	2	128	127
Mar-19	56	71	2	128	129
Jun-19	54	89	0	145	143
Sep-19	57	93	2	145	152
Dec-19	46	79	0	145	125
Mar-20	46	115	0	145	161
Jun-20	20	47	0	29	67
Sep-20	12	17	0	29	29
Dec-20	12	7	0	29	19
Mar-21	0	1	0	29	1
Jun-21	0	3	0	5	3
Sep-21	4	3	0	5	7

Homecare Service					
Medical Team Face to Face Follow Ups					
	Merton	Sutton	Other	Annual Average	Quarterly Total
Jun-17	4	13	0	28	17
Sep-17	7	7	0	28	14
Dec-17	24	32	1	28	57
Mar-18	12	12	0	28	24
Jun-18	20	12	1	65	33
Sep-18	30	39	5	65	74
Dec-18	37	35	0	65	72
Mar-19	31	50	1	65	82
Jun-19	28	44	2	90	74
Sep-19	32	40	1	90	73
Dec-19	58	61	1	90	120
Mar-20	38	53	3	90	94
Jun-20	25	37	0	91	62
Sep-20	49	80	3	91	132
Dec-20	45	52	3	91	100
Mar-21	18	45	5	91	68
Jun-21	28	50	7	90	85
Sep-21	42	49	4	90	95

