

Ref No.	Recorded By	Date	EXAMPLES OF EXCELLENT PRACTICE - Description
2024/35	TC	24/09/2024	Dear Heather and colleagues. Thank you so much for the care you provided to my husband and the advice you gave me.
2024/36	RT	01/10/2024	Please accept this donation. Your staff were so kind to my husband when they visited him when he was so ill. They could persuade him to do things that he refused to do for me. Like changing his incontinence pads. They mad ehim cups of tea etc. Thank you. PS. I hope thsi helps your financial situation. (Patient was cared for by H@H team 2 years ago. Response was due to recent publicity regarding SRH funding issues. Thank you letter drafted by FR)
2024/37	JF/AR	07/10/2024	To everyone in the Hospice who was involved in the care of my mother together with the staff and volunteers who to run it and the Orangery. During a time that was both stressful and emotional, I cannot thank you all enough for the kindness, warmth and support you showed Mum, myself and those who visited her. You all do an amazing job and I will be forever grateful to you all.
2024/38	TC	07/10/2024	I will be forever grateful to St Raphael's and the community nurses for the care given to my husband and myself. Thank you to all the nurses we never met who were there on the phone at anytime to help with care and advice with such patience and compassion. Special thank for the support with his pain relief and comfort gave me the courage to enable him to remain at home and die with the family nearby. Thanks so much.
2024/39	GT	09/10/2024	Feedback from a new Admin Volunteer after her first induction session 'Hello Ginny, It was lovely to meet you today. Please could you thank Sheena again for my lift home. I met some very kind people today, and consider it a privilege to be part of the team! See you next week. Kind regards, Clair
2024/40		10/10/2024	MEDEX feedback July 2024:- No care concerns x 6 SRH was absolutely marvellous, had much more care. Good communications re time left and family were able to get in. Care absolutely first class Excellent care all the way through Staff at the hospice were outstanding. SRH: Absolutely brilliant, angels SRH: Wonderful. SRH: Care at hospice was brilliant Happy with care at St Raphaels
2024/41		10/10/2024	MEDEX feedback August 2024:- No care concerns x 7 Hospice was "Just wonderful" St Raphael's provided Fantastic care. SRH: Care was unbelievable Very happy with the care Very grateful for the support from everyone Great support from the hopsice. So professional and bowled over by the support. Thank their lucky stars that pt admitted there. Care at St Raphael's was outstanding.
2024/42		10/10/2024	MEDEX feedback September 2024:- No care concerns x 5 Care at St Raphael's was outstanding, Care at the St Raphael's was excellent St Raphael's was really good St.Raphael's Hospice: Care was superb, best ever.

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2024/43	NS	14/10/2024	<p>We wanted to write to the co-chief executives to thank St Raphael's for the care you gave to our son , who died there on Thursday 3 October.</p> <p>We hope you'll be able to share our comments with colleagues at the hospice.</p> <p>We feel very fortunate that you were able to find space for him after his 4 weeks in Hospital. After the stress of that and the apprehension about coming to a hospice with our beloved son, we were amazed and so pleased to find we were given the family room with its kitchen and bathroom, and view out into the garden. All that made a massive difference to him and our experience over the next three weeks.</p> <p>The main thing we want to say is that your team of nurses and healthcare assistants are incredible. The expertise, dedication, care, support, advice, empathy, sensitivity, compassion and what often felt like love was beyond anything we could possibly have imagined. I wish we could thank everyone individually who worked with him; many we will never forget and always be grateful to.</p> <p>Our overriding wish for our son was that the very end of his life would be free from panic, distress or pain. Although the last few months of his life, including nearly all of his time at St Raphael's were miserable and upsetting for him - inevitably given how unwell he was and the nature of heart failure - you made the time at St Raphael's as bearable for him as anyone could, and your amazing staff made the very last part what we most wanted - peaceful and with all his family there with him.</p> <p>We have made a donation of £1,000 to St Raphael's and we will be asking guests at his funeral and reception to donate just to the hospice - your colleagues in fundraising have already supplied us with copy and links.</p> <p>The family are bereft and distraught at our loss but St Raphael's feels like it was some kind of bridge to help us through and perhaps over the trauma, and it is literally impossible to thank you enough for that.</p>
2024/44	MF	17/10/2024	<p>Dear Maura</p> <p>Thank you for arranging for me to spend some time with the community palliative care nursing team last week. please pass on my grateful thanks to the team who were so generous with their time and encouragement – Lorraine, Kate, Kate, Marilyn, Rebecca, Heather, Dr Busi, Dr Jenny and last but not least Tracy – it was lovely to put some faces to names I have been liaising with over the years.</p> <p>The day passed so quickly and I was fortunate to be able to join Lorraine on a first visit assessment – noting her compassion and empathy in addressing very sensitive themes with both the gentleman and his wife to assess their understanding and ensuring that they were prepared for what potentially could be a very short prognosis.</p> <p>I also spent time listening to Lorraine as she spoke with great care and understanding to a young lady whose husband had presented to A&E with a seizure overnight and had sadly passed away.</p> <p>I hold the palliative care nursing team in high regard for the guidance support they offer our patients and having benefitted personally from their all-encompassing support during each of my parents last weeks and days and remembering how I felt that a weight had been lifted from me once the community team were engaged.</p> <p>With grateful thanks</p>
2024/45	GT	18/10/2024	<p>Feedback from Volunteer Counsellor on leaving 'I am sad to be leaving so quickly after joining!! It was not my plan, but personal life changes have meant that I need to focus on my own work n Fridays now. My last day will be next week, on Friday 25th October.I am extremely grateful for having the opportunity to work here, for meeting the lovely people I have met and what I have learned!!With many thanks.</p>
2024/46	TC	24/10/2024	<p>Dear lorraine, A heartfelt thank you to you and everyone at St Raphael's for letting my husband have the peaceful death that we'd both wanted for him. The morning that he dies was the first time for ages that we'd been able to spend some quiet time alone and it was just what we needed. When I saw him after the nurses laid him out he looked like his old self, calm, unworried and almost with a smile on his face. I dread to think what might have happened if he hadn't come into St Raphael's for that very short but very important time. I really can't thank you enough. It was a miracle.</p>
2024/47	TC	18/11/2024	<p>I just wanted to let you know how you are all appreciated. I'm more grateful than I have words for. Everyone was so caring for my husband who pass in October 2024. I nhis last few days he was treated with compassion, respect and care by everyone who looked after him and my family during this very sad time, form our lovely nurse Avril and all teh staff from housekeepers, receptionist, you kept him pain free and safe. A thousand thanks ar enot enough. You are all living angels. Thanks always.</p>
2024/48	AR/TC/KW/GTR	02/12/2024	<p>CPCT CNSI just wanted to hand over for a lady who she went out to visit on Saturday and sent to A&E for possible drainage of her ascites.</p> <p>Whilst in A&E bloods were taken and this lady was found to be in multiple organ failure and her husband was informed that her prognosis was very short. I had a distressed phone call from her husband early Sunday morning as she was in A&E and in a corridor – he informed me that someone in A&E had referred her to hospital PCT and they would contact us.</p> <p>During this time one of the hospital consultants had spoken with our on call reg and had discussed this lady being admitted to IPU; CNSI also spoke with Hospital CNS who knew exactly who I was calling about and was so helpful and reassuring.</p> <p>Due to the communication being so quick and effective this lady was admitted to the IPU by 12pm Sunday afternoon and her family are all so relieved she is in the hospice as she has 2 young children.</p> <p>I just wanted to feed back how well the joint working and communication worked.</p>
2024/49	SJW	04/12/2024	<p>Just a note to say one of your volunteers - Abdelbasit Mohammed knocked on my door regarding the lottery. He is a fantastic advocate for you and I don't think I've ever met someone so happy, positive and enthusiastic for their work. Because of him, I have bought a star dedicated in memory to my father. Please thank him for raising such a great charity within the community</p>
2024/50	NS	17/12/2024	<p>Nick was at an HUK fundraiser with a number of their big trust and corporate supporters, one of which is the National Gardens Scheme – their Chair and Vice Chair attended, and the latter spoke of how her friend and fellow Trustee was looked after at home by St Raphael's in the last twelve months. She said that after the hospital had failed to relieve her pain, St Raphaels very swiftly got this under control (and she said it was a doctor) giving effective pain management and that this had enabled her friend to die as she had hoped to at home, in peace and in dignity. Coming after Nick had done a slot on the tough year we have endured and the loss of experienced colleagues, it was a very powerful personal note on the difference the team make and the importance of getting a fair funding settlement as soon as possible.</p>

Clinical Risk Control Register												
Risk Category	Activity	Top Risk(s)	Initial Likelihood	Initial Severity	Initial Risk Rating	Prevention Controls - reducing likelihood	Mitigation Controls - reducing severity	Final Likelihood	Final Severity	Final Risk Rating	Responsibility?	Last / next review
1	Reduced clinical workforce with loss of 0.6 WTE consultant cover	Reduced clinical capacity - specifically risk of loss of Specialist registrar position due to insufficient availability of consultant supervision which would lead to significant decrease in clinical capacity, morale and reputational damage.	5	3	15	Current consultants GTR and NC can provide telephone support/emergency on site visits if required for ad hoc days with no consultant presence on a short term/ interim basis (on call payment for SRH consultants now agreed. Could approach colleagues in Princess Alice Hospice, St Helier and Epsom Hospital to enquire about capacity to provide emergency either telephone support or on site cover at time of need. Advertise for replacement - RCP approved JD to maximise attractiveness of post. Exploration of joint site post/ NHS contract ongoing but currently no opportunity	Specialty Doctor one day a week contract now extended for a further six months (Sept 2025). Could offer increased sessions to current staff grade doctors (this would help provide clinical cover but would not address need for clinical supervision).	5	2	10	CD/ NC	Jan 25/April 25
2	Reduced clinical workforce / hours	Reduced responsiveness to existing caseloads Management of expectations Lower staff morale Reduced staff retention Reputational damage Reduced referrals	5	3	15	Clear messaging to internal and external stakeholders Review of operational guidelines following a period of existing guidelines and reduced staffing model. Regular staff meetings / open door policy	Manage staffing levels across a 7 day service Collaborative working with external colleagues to promote efficiency and reduce risk of patient outliers Prioritise the support that we are responsible for delivering and reduce the amount that we pick up due to a lack of provision within the community.	5	2	10	CD	Jan 25/April 25
3	IT PAS System Failure / Cloud Access Down	Inability to access contemporaneous clinical records or run business continuity reports	5	3	15	IT System Management Controls	<ul style="list-style-type: none"> Contactable team OOH (not formal contract) Back up resource -outsourced at times of AL 2 x HSCN routers and lines to support fail over Hard copy daily print outs to provide basic continuity EMIS mobile has been rolled out for the IPU, medical team and community team in case of system failure. Medical team can access our EMIS tenant from Princess Alice Hospice IT system. In an emergency our neighbouring Hospices would allow us access to our EMIS system from either their sites or through remote access. 2 x virtual tokens that can be used on the COWs (when tethered with mobile data) to allow remote access from the cloud to IPU NHS data access - should the physical routers or hardware fail. If any site wide issues in gaining access, we can request to visit any of our neighbouring hospices to gain remote access. 2 x Cisco firewalls configured for high availability. 	4	2	8	IT/CD	Jan 25/April 25
3	Insufficient Nursing Resource on the Inpatient Unit.	<ul style="list-style-type: none"> Unable to admit Impact on patients, families and reputation Impact on community team offer of admission 	3	3	9	<ul style="list-style-type: none"> Bank and Agency Nurses available Staff adapting/flexing shifts to cover IPU Monitoring of staffing capacity monthly/weekly/daily Alignment with Agenda for Change pay scales implemented Crisis cover payments in place Active recruitment ongoing 	<ul style="list-style-type: none"> IPU admissions can be reduced to meet staffing capacity Majority of patients are cared for in the community Nursing Associates are being upskilled Acuity score used to help guide admissions v staffing levels All Leave policies amended with improved leave entitlements Utilisation of 10 hour shifts to provide better cover 	2	3	6	CD/IPU Clinical Lead	Jan 25/April 25
4	Infection spread within hospice	<ul style="list-style-type: none"> Inability to provide full clinical service impacting on both patients, their families and staff. May impact on external stakeholders. May impact reputational damage and potential funding streams 	4	2	8	<ul style="list-style-type: none"> Attention to and compliance with governmental guidance Implementation and maintenance of CLIN52 COVID policy Implementation and maintenance of CLIN08 Infection Control policy IPC Lead in post - overseeing the link nurses on the IPU and Community Team and close working with SWL infection control leads. 	<ul style="list-style-type: none"> Implementation and maintenance of CLIN52 COVID policy Implementation and maintenance of CLIN08 Infection Control policy PPE regular supply available Contingency planning clarified for any identified cases within the Hospice - as per governmental guidance Single room nursing. Increased telephone contact FFP3 mask fit testing ongoing Refresher PPE training and advice and support from PHE Facility for staff to work from home 	3	2	6	CD	Jan 25/April 25

Risk Category	Activity	Top Risk(s)	Initial Likelihood	Initial Severity	Initial Risk Rating	Prevention Controls - reducing likelihood	Mitigation Controls - reducing severity	Final Likelihood	Final Severity	Final Risk Rating	Responsibility?	Last / next review
5	Breaches of confidentiality involving person identifiable data (PID), including data loss	<ul style="list-style-type: none"> Reputational damage Litigation Fines from ICO Service user distress and safety risk 	3	3	9	<ul style="list-style-type: none"> Protecting Confidential Information Policy All personnel and volunteers trained on Information Governance on induction and annual mandatory training. Data User Agreements in place DPO, ISO, Caldicott Guardian & SIRO in place Suite of Information Security and Governance policy in place Test Phishing emails via IT Dept 3rd party contract. Secure PID communication email channel in place through NHS Net. Regular organisational sweeps in all departments Caldicott Guardian attends regular training and presents at associated fora. Maintenance of shared network drive to ensure file security. IT policy in place to restrict USB storage devices from being used. no local workstations store data, all data is accessed on centralised SAN. 	<ul style="list-style-type: none"> All personnel and volunteers trained on Information Governance on induction and annual mandatory training. Proactive checking in areas such as photocopier/clear desks. Established link with Capsticks solicitor who provides ad hoc advice on data access issues Annual - Information Governance Check list audit / Clinical Record documentation audit 	2	2	4	IT/CD	Jan 25/April 25
7	Extended bed occupancy	<ul style="list-style-type: none"> Delay to discharge due to limited availability of CHC funded beds in the community and patient/family reluctance to transfer. Limits our processing of requests for admission. Potential effect on reputation, income generation and staff morale. Does fluctuate but more of an issue in the autumn/winter. 	3	2	6	<ul style="list-style-type: none"> Maintain relationships with Care Homes/ Sutton and Merton PLACE that have CHC funding. Provision of information to patient and family 	<ul style="list-style-type: none"> Staff proficiency in completing fast track. Screen referrals for potential impact. Dual planning with Hospital requesting admission. Consideration of CHC funded IPU beds in future. Expertise in discussion with patients and family members re discharge planning. 	2	2	4	CD/IPU MDT	Jan 25/April 25
8	Clinical Incidents	<ul style="list-style-type: none"> Serious or moderate harm to patient Safety Risk of complaints from patients/families Reputational damage / litigation 	2	3	6	<ul style="list-style-type: none"> Low threshold to reporting Culture embraces reporting of all incidents related to clinical care Hierarchy of investigation Outputs- Learning informs improved procedures and processes Report to Clinical Quality & Governance Committee supports transparency Embrace of the Patient Safety Incident Response Framework (PSIRF) and Plan in OP01 in support of patient safety and learning from incidents 	<ul style="list-style-type: none"> Continued staff training and awareness of new techniques and products. 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 across all departments. Annual clinical audit / QI / research / data monitoring program 	2	2	4	CD & Director of QI	Jan 25/April 25
9	Clinical Complaints	<ul style="list-style-type: none"> Local press coverage Potential for public concern Elements of public expectation not being met Loss of confidence in the service Reputational damage 	3	2	6	<ul style="list-style-type: none"> Organisational policy supporting values, behaviours and practices Education and training re communication Adherence to OP05 Feedback and Complaints policy Reported at Clinical Quality and Governance Committee All complaints discussed at hospice team meetings for awareness and learning across the organisation 	<ul style="list-style-type: none"> Reporting culture of any concerns- no blame but responsibility Use of investigative tools for significant incidents. Feedback to complainants regarding change/improvement in practice. All complaints both verbal and written treated with the same level of scrutiny Scoping to establish all clinical staff access to communication skills training Training on care delivery Information shared re: Duty of Candour and scope of the policy Complainants (both verbal and written) are offered the opportunity to meet and discuss concerns with Clinical Director, and maybe offered opportunity to join HUG to help with SRH future learning Complaints documented and register maintained Annual review by EXEC 	2	2	4	CD	Jan 25/April 25
10	Lone working	<ul style="list-style-type: none"> 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 	3	2	6	<ul style="list-style-type: none"> OP17 Lone worker Policy Community staff are 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. 	<ul style="list-style-type: none"> 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. If there is perceived or hx of risk staff work in pairs and alert is added to the EPR. Lone Worker Risk assessment and EMIS template updated 	2	1	2	CD/MDT	Jan 25/April 25

The axis for Likelihood should be from 1. Very Low – 2. Low – 3. Medium – 4. High – 5. Very High
 The axis for Severity should be from 1. Light – 2. Serious – 3. Major – 4. Catastrophic – 5. Multi Catastrophic
 Key
 Over 13 = red
 8-13 = amber
 7 or under = green

ITEM 06

Clinical Quality and Governance Report

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Aim

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

Recommendation

The report be noted.

Report

Clinical Services

Psychological Support Services

- Service has experienced ongoing pressures with a reduction in staff hours and increased complexity of referrals received.
- Cecilie Sasu left SRH on November 26, 2024, and Diana Bromboszcz has integrated Cecilie's responsibilities into her role as Psychological Lead. Due to service restraints and limited resources, service provision has been adjusted accordingly.
- Ali Lutz increased her counselling hours to 3 working days since the end of October in the light of Cecile's planned departure, which helped to cover clinical service provision for patients and their families. She is thriving in her position despite some challenges which the service is working through, and she has been supported by the team.
- The role of a Clinical Supervisor to support bereavement service and supervise students on placement was advertised, but recruitment has not been successful to date. The role is being looked at and will possibly be remodelled to increase the likelihood of filling the vacancy whilst meeting the needs of the service. Changes to the team will be agreed upon and finalised in due course.
- Diana continues to supervise students on placement and coordinate bereavement services. The waiting list has been reduced to appropriate standards, and students are supported and continue their placements successfully providing bereavement counselling.
- Discussions and meetings took place to support HMP High Down in upskilling its staff. DB agreed to a training day for HMP High Down staff.

Social Work

- Social work team remains busy – there appears to be an increase in younger patients with more complex social needs, experiencing financial hardship and limited support networks.

Their work continues with:

- Supporting with End-of-life planning to enable their wishes to be put in place
- Supporting younger patients with young children, how to manage the difficult conversations in an age-appropriate way
- Legacy letters, memory making and memory boxes
- Supporting parents with children and liaising with schools
- Continued joint working with other SW professionals - re a lone Patient with young children – very limited support network or family in UK – family member identified - plan in place for the children's future - Patient RIP
- Supporting patients to get their affairs in order – e.g. getting the other partner upskilled re paying bills – in some cases ensuring they can access finances post bereavement
- Ensuring patients and families have access to financial benefits they are entitled too, also end of life grants which make a lot of difference for families at end of life - referring to specialist agencies and charities when relevant.
- Supporting families with debt built up whilst unwell e.g. Supported family going through the repossession process
- Support re visas and immigration issues

- Burial costs supporting families to access grants/benefits to cover funeral costs – seeing an increase in families not being able to afford funeral costs

Wellbeing Services and Compassionate Neighbours

- October marked black history month with appropriate art and music sessions. The art displays in the Wellbeing Centre draw lots of compliments.
- In November attendees celebrated Diwali which coincided with bonfire night, so also enjoyed painting fireworks and marking the festival of light.
- December was of course dominated by Christmas. Visits from two primary school choirs who came to sing carols to attendees and volunteers and a third school performed their nativity at the WB Christmas party. The inter-generational interaction was a joy to see.
- The party itself was very well attended and enjoyed by all, including Sutton’s Deputy Mayor. Live music from a local band Vinyl Matters added to the fun as did a buffet spread.
- Numbers remain steady (and good). In the new year a new drive to recruit men for the men’s den and to push the Living Well sessions will be a priority.

In terms of reaching out into the community recent talks / visits include the following:

- Wallington Wellbeing Fair
- Beddington Hindu temple
- A number of local GPs PPGs
- Merton Memory Hub

We intend to re-open the Compassionate Neighbours project to external referrals in the new year after successfully recruiting and training a new cohort of volunteers.

Complementary therapies

- Ana and Ginny have been recruiting and we have 2 new comp vols starting over the next few weeks as well as a regular volunteer returning from long term sick leave.

Inpatient Unit

- There have been a few starters and leavers during this quarter, which has meant a number of gaps in roles for periods of time. SSN Julie Ford and SSN Penny James have continued to jointly lead the IPU as senior band 6s and have stepped up particularly over the month of December whereby sickness has been extraordinarily high.
- We have successfully appointed to IPU Clinical Lead and Francis Quinon starts in the new role in early January.
- Fire doors have now been fitted on the IPU single rooms and the facilities team have been refreshing areas in need of repair.
- The infection control annual audit was undertaken in October, led by Sara Mosalam, our Infection Prevention and Control Lead – areas for address have been highlighted with the facilities team who are working through the areas for attention, to ensure we remain safe and compliant.
- We continue to support a number of nursing students and medical trainees whose interest in palliative care is always encouraging and feedback from them is consistently positive.

- Due to our more frequent applications for CHC funding (when patients are longer stay and unable to be placed elsewhere) we have put forward a bid to SWL CHC to request a standardised funding agreement. We are waiting for a meeting to discuss this further.

Community Palliative Care Team (CPCT)

- There have been 2 resignations within the CPCT over the last quarter. Both were for geographical reasons but one was precipitated by the redundancies last summer. However, one member of staff has now withdrawn her resignation. We have successfully recruited to the second post (paramedic) and there will be a small gap between the CNS leaving and the new starter commencing.
- One CNS has returned to work (Dec) after prolonged absence on reduced hours 30 hrs per week
- One of the CNSs who left last summer has now returned on the bank and supports the Hospice Point of Contact once a week on average.
- Unfortunately there has also been a large amount of sickness due to physical and emotional issues (97.5 hrs absence in Nov. in one week)-significantly impacted routine visiting capacity
- Staff have however still managed to attend educational events such as Advanced Communication Skills training, Advanced symptom Management conference, Human Rights in Palliative Care session as well as others.
- The CPCT has also focused on networking with other services and providers to strengthen shared working, share educational opportunities and disseminate best practice, whilst improving communication and coordination of care involved.
- EMIS sharing has now been activated for Sutton / Merton across all services.
- Activity below helps to demonstrate the additional work that the CPCT undertake alongside their usual caseload management:
(see table below)

<u>Activity for CPCT(Oct - mid December) as follows:</u>
<ul style="list-style-type: none"> • 32 joint visits (Sept – Nov) recorded by either CPCT or Medical Team across September, October and November 2024 : 27 of which included Hospice staff and 5 included one Hospice staff and an external HCP
<ul style="list-style-type: none"> • 22 calls regarding ‘Unregistered patients’ (data up to 27.12.24) mostly from LAS / DNAs/ Urgent care , mostly OOH requesting advice . Large % known to MEolCT or SPCH
<ul style="list-style-type: none"> • 14 fast track applications completed

<u>Impact due to cessation of H@H – recorded across the month of November</u>
<ul style="list-style-type: none"> • There was a total of 26 identified episodes when it was felt that H@H input would have been of benefit (Sutton 12/Merton 10/Wandsworth 4). Two patients were identified on 2 different occasions due to change in condition – therefore a total of 24 individuals
<ul style="list-style-type: none"> • Rationale for H@H Support was: ‘respite or carer crisis’ 14/ CNS or SP support 6/Preferred Place of Death (PPD) support 5/avoidance of hospital admission 1
<ul style="list-style-type: none"> • The classified Phase of Illness for these patients was: Deteriorating 14/ Unstable 7/Dying 4/ Stable 1
<ul style="list-style-type: none"> • The work therefore taken on by the CPCT included the following: Required a F2F visit by CNS or SP 4/ Required a virtual assessment by CNS or SP 1/ Increased emotional support needs for patient and/or those important to them 7 (phone calls or F2F conversations)/Increased telephone calls for triage 9/ Unmet care needs meaning liaising with care agencies or being unable to support 3/ declined referrals and therefore signposting or referring to other services 2.

Education/Training

- In October the education team facilitated an Advanced Communications Refresher- this was a one-day course aimed at staff who had completed the Advanced Communications Skills Training in the past. It was attended by internal staff. Due to the excellent feedback, we plan to repeat the course in 2025 and hope to offer places to colleagues in the wider community.
- Several staff attended Equality, diversity & inclusion training in October. This day is in addition to mandatory training and gives staff the opportunity to discuss EDI topics with colleagues, supported by an experienced trainer.
- Advanced Communication Skills Training was held in November and was attended by our own staff and colleagues from the Sutton and Merton. This two-day course offers the opportunity to reflect complex and challenging conversations and develop skills in a supported environment. The feedback from attendees was excellent and two further courses are planned for 2025.
- A Medicines Management study day for the community palliative care team took place in December. This annual study day gives staff the opportunity to refresh their knowledge around medication issues and to come together to discuss changes in process and best practice.
- During this time, the education team supported clinical staff with revalidation, manual handling training and professional development.

Medical Team

Changes to medical team.

- Dr Jenny Strawson left us at the end of November to start work at Woking Hospice.
- The post is currently being advertised on NHS jobs, SRH website and to the upcoming CCT qualifiers. We have had a few enquiries but no applicants yet that would be suitable for the role. In the interim, Dr Collins and Dr Tamura-Rose have kindly agreed to cover 'on call' on their days off when we have no consultant in the Hospice.
- Our new SpR, Shahlaa Walsh joined us in October and is part time, working three days a week. Dr Tamura-Rose continues to provide 2 PAs to Epsom Hospital Palliative Care team due to a temporary reduction in their consultant provision (from May 2024 to January 2025).
- We have extended Dr Roughley's one day a week contract for a further 6 months until the end of September to help manage the shortfall in medical team hours. We are managing to maintain service provision with the current workforce but will obviously be monitoring the situation going forward.
- Psychiatry trainees – Our two trainees have now come to the end of their placement with us, and we hope to attract future trainees to replace them as we have found their input really valuable (They jointly presented a poster in November at the RCP study day)

Research

- We have completed recruitment of 20 patients to the CHELseall study into hydration at the end of life. Recruitment to the POST survey (into opinion about terminology) remains open and ongoing.

Education Attended

- Dr Tamura Rose attended the Hospice UK Conference in November alongside three other colleagues – time was useful for both learning and networking. Dr Collins has commenced a Masters in Medical Leadership, City of London University.

Office Space

- The consultants are to be moving from their current office space to facilitate provision of an outpatient room, allowing more efficient use of medical and community team capacity. The junior doctors have now moved into the CPCT office.

CQC and Organisational Assurance

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

Much has changed since our last inspection, and we are keen to showcase all the developments we have made.

A depository for evidence of excellence is included as an Agenda item for the CQ&G Sub.

We expect our KLOE work will support our evidence base to demonstrate compliance. Achieving an 'Outstanding' rating at our next inspection and maintaining it in the future remains our ambition.

Governance Meetings

The Hospice's 'Governance' meetings feed into the work of all the sub-committees of the Hospice's Board of Trustees. Presently, there are 6 clinically focused forums that currently feed into the CQ&G Committee.

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

The Staff Consultative Group is suspended and the Training & Development Committee feeds into the HR Committee.

Governance Meetings - Clinical	Date last held	Date of Last Minutes Reviewed at CQ&G Sub	Next meeting
Clinical Audit and Activity Data	Apr'24	Apr'24	Feb'25
Clinical HODs	Oct'24	Dec'24	Jan'25
Medical Business	Nov'24	Nov'24	Jan'25
Drugs & Therapeutics	Aug'24	Aug'24	Feb'25
Outcome Measurement Group	Dec'22 (no min)	May'22	Pended
Infection Control	Nov'24	Nov'24	Feb'25
Prescribers	Nov'24	Nov'24	Mar'25

Incidents / Accidents / Near Misses

- DATIX incident reporting was implemented in November 2021. Each incident is reviewed by the line manager (HOD) and all incidents receive final approval from a member of the Executive team. Clinical review has been incorporated into the business of the Clinical Heads of Department Meeting that meets every 6 weeks. Those that are non-clinical are reviewed at H&S Committee. Representatives are expected to cascade review information back to their teams and an incident feedback facility is programmed into the DATIX report for the reporter. Data is presented later in this report and remains to note how engagement with the system continues to be healthy, from both clinical and non-clinical departments.
- An annual report for incidents has been included as a future planning priority in 2023/24's Quality Account and is part of the Management Plan objectives for 2024/25 to demonstrate the range of incidents / accidents recorded across the Hospice and to provide a useful reference point for the learning taken.
- Quarterly submission to Hospice UK's Quality Metrics project began in July 2017 and are on-going with the latest submission made in January 2025. The submission categories cover pressure sores, patient medication incidents and incidents of patient falls.

Quality Account

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

EMIS

Implementation of the new EMIS system commenced in May 2023.

The project team includes Clinical Admin (Kelly & Dawn) who provide users with additional practical support, along with John Groom, Heather Siddall, Tracy Christmas, Alex Rudkin and Dr Gaby Tamura-Rose. The departure for Dr Strawson is a loss in many ways not least among which has been her pivotal role in the architecture and tweaking of the EMIS system's configuration. However, her expertise has been shared with clinical admin and John remains with the same knowledge. Reporting knowledge is primarily held by both John Groom and Alex Rudkin. Both Dr Gaby and Tracy C have stepped into the group that meets only periodically now as the system is embedded. Discussion has very recently commenced regarding use of the system to support electronic prescribing in the community with intent to improve the efficiency and effectiveness of community prescribing to the benefit of staff and patients.

EMIS facilitates the data capture that supports the care planned and delivered alongside the data output that feeds into SWLICB activity review meetings.

Design and rollout of EMIS mobile has been effected. This provides both connectivity contingency and facilitate community engagement.

Data sharing was also implemented in December 2023 and shared record access is now in place with all GP practices in Sutton & Merton. Engagement of the community hubs Sutton and CLCH (Merton/Wandsworth) was finally achieved in December 2024 which concludes the data sharing objectives for the system.

Prompted by Carrie's query at October 2024's CQ&G on a quantification of potential impact on first visit responsiveness from the Community Team following the reduced staffing, the below shows data based on comparative periods of September & October 2023 and 2024.

No. of Days between referral in September & October 2023 & 2024 and 1st seen	No of referrals in 2024	% of referrals in 2024	No of referrals in 2023	% of referrals in 2023
No. of referrals receiving service	106		95	
0-7 days*	44	42%	28	29%
8 - 14 days*	19	18%	36	38%
15-21 days*	20	19%	15	16%
22- 31 days*	13	12%	7	7%
32+ days*	10	9%	9	9%
Range in days*	Same Day-59 days		Same Day – 60 days	
Average No of Days* between Referral and 1st Visit	14 days		14 days	
Median No of Days* between Referral and 1st Visit	11 days		12 days	
Mode No of Day*s between Referral and 1st Visit	1 day		Bi-modal 7 & 12 days	

*Days includes weekends

The Community Team have been applauded for the attention they give to responsiveness and their application to maintain turnaround of HPOC assessment and CPCT visit in such responsive fashion. For the post redundancy period in 2024 the team have been adjusting to their new staffing level and have been adding response slots to diaries. Tracy Christmas's gut feeling is that they have improved further since Sep/Oct 2024.

Clinical Audit, Quality Improvement, Monitoring and Research

Proactive audit of the prescription charts remains a weekly undertaking for our clinical Pharmacist and results are routinely shared via the Live Care system and reported to the D&TC. The management of controlled drugs (CDs) audit is an annual audit undertaken by the Ashton's Pharmacist and our Clinical Director who is our Accountable Officer for CDs.

Review of progress with the clinical audit program and opportunity to feedback results is provided via the Clinical Audit and Activity Data forum (CAAD). Its next meeting is scheduled for February 2025. A Clinical Audit and Quality Improvement Project Presentation Forum that provides platform for project leads to present results of their project to a wider audience was last held in November 2024 with presentations delivered on CSCI Audit; Fast Track on the IPU and IPU Admissions Audit (presentations included in papers). The forum usually occupies a lunch-time slot and is open to the clinical teams and those with an interest in topic.

Progress of the Audit/Research Programme 2024/25 - spanning clinical audit, quality improvement, research and data monitoring - is set out from page 12. At the start of 2024/25 we set out 25 substantive projects for pursuit that expanded to 27. New topics in 2024/25 include Abstral prescribing on the IPU, Use of CSCIs and Fast Track patients – a review.

Ownership is delegated across the clinical team and Quality office and the medical team projects have had Dr Strawson as medical audit and research overseer from April 2024 to the end of November 2024. That has since been transferred to Shahlaa Walsh, SPR.

Data Dashboards

The population of clinical data dashboards that inform the service areas of the IPU, Well-being Centre, Community and Psychological Support Services teams is expected to be re-commenced in 2025/26 subject to priorities highlighted at the CAAD meetings. An index of tracked data that has been periodically presented and communicated to the clinical team is held.

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

Clinical Quality & Governance Management Plan Objectives 2024/25

Summary

DATE	Number	Complete / on-going	Into 25/26	Pended
27-09-2024	28	3 / 21	1	3
10-01-2025	28	8 / 16	1	3

Goals Completed

Ref	Goal
3.1	Develop provision for psychiatry trainee support for Hospice Dr GTR approached several Psychiatry trainees interested in visiting the Hospice as part of their “special interest”
3.2	Produce and maintain an audit/monitoring/research project schedule 2024/25
3.3	Maintain student bereavement counsellor placements at 8
3.4	Maintain delivery of Trauma Specific Work (EMDR).
3.5	Develop the Bereavement Pathway Project
3.6	Evaluate the Patient Safety Incident Response Framework and position the Hospice accordingly
3.7	Support the design, implementation, training, use, integrity and output of the EMIS system Ensure input templates are fit for purpose
3.8	Maintain an establishment that services the safe delivery of care for a 10 bed IPU

Audit / QI /Research 2024/25

Overview

27 projects scheduled in 2024/2025

2024/25 Listing

Project Ref.	Title	HQIP Prioritisation	Lead	Status
2024/25-01	IPU & Community - VOICES survey of bereaved next of kin 3-6months post bereavement	• Priority 2 Internal 'must do' audit	Quality Office - J Cope / A Rudkin	Ongoing – Last published in November 2024. Report for Oct 23 – Mar 24 drafted for publication in January 2025
2024/25-02	IPU - Patient Satisfaction	• Priority 2 Internal 'must do' audit	IPU - R Wallis Quality Office - J Cope / A Rudkin	Ongoing - 2024 report for publication in Mar 2025
2024/25-03	IPU – Infection Control: Environment & Hand-washing Audit	Priority 1 External 'must do' audit	IPU - S Leech Community - J Smith Quality Office - J Cope / A Rudkin	Ongoing - Quarterly production of graphical compliance for IPU display across Handwashing, Staff, Environment and Sharps.
2024/25-04	IPU - Medicines Management Audit	• Priority 2 Internal 'must do' audit	Ashton's Clinical Pharmacist	Ongoing Last published in January 2025
2024/25-05	IPU - Re- Audit against Audit NICE Guidance NG31 Care of Dying Adults at the End of Life	Priority 1 External 'must do' audit	Dr Naomi Collins	Presented in February 2024 following report in January 2024. Data collection for March - June 2024 started in August 2024
2024/25-06	IPU: Patient Handling / Pressure Areas	• Priority 2 Internal 'must do' audit	Rebecca Wallis	Last reported in March 2024 and presented in May 2024

Project Ref.	Title	HQIP Prioritisation	Lead	Status
2024/25-07	IPU: Mouthcare Audit	• Priority 2 Internal 'must do' audit	Rebecca Wallis	Last reported in January 2024 and presented in May 2024
2024/25-08	Controlled Drugs Annual Audit	Priority 1 External 'must do' audit	R Trower	Ongoing Last published in January 2024
2024/25-09	Fast Track Patients – a review	• Priority 3 Specialty Priority	Dr A Akhtar/J Giles	Published in August 2024
2024/25-10	DNACPR	• Priority 4 Clinician interest audit	Dr B Da Silva	Data collection started in November 2024
2024/25 – 11	Prescribing Abstral on the IPU	• Priority 3 Specialty Priority	Dr S Ainley	Published and presented at D&TC in August 2024
2024/25-12	Outcome measures (Step 2- CSNAT)	• Priority 2 Internal 'must do' audit	Implementation Group Dr NC / TC	Nov 22 - Apr 23 data pilot summary last reported in July 2023. Pended to 2025/26 for IPU initially
2024/25-13	Psychological Support Services Questionnaire	• Priority 4 Clinician interest audit	Psychological services SM	Jan-Jun 2024 rpt published in November 2024
2024/25-14	Activity Monitoring Data UCR NOK CPCT Responsiveness Sharing Information Safeguarding Referrals Referrals to RIP Active Caseloads Daily Activity Data - capacity tracker Referrals by Postcode PPOD	• Priority 3 Specialty Priority	Quality Office+ CAAD	Pended in 2024/25

Project Ref.	Title	HQIP Prioritisation	Lead	Status
2024/25-15	IPU & Community & Psychological Support Services - Activity Data Dashboards Development	• Priority 2 Internal 'must do' audit	Quality Office + CAAD	Ongoing
2024/25-16	Incidents	• Priority 2 Internal 'must do' audit	Quality Office + CHODs	Ongoing NEW annual report expected pre-June 2025
2024/25-17	Falls	• Priority 2 Internal 'must do' audit	Quality Office + CHODs Mtg	Ongoing - April 2023 - March 2024 chart last produced in May 2024
2024/25-18	Complaints	• Priority 2 Internal 'must do' audit	Quality Office + Exec	Ongoing - 2023 complaints review held and reported in May 2024
2024/25-19	Safeguarding Documentation	• Priority 3 Specialty Priority	Elisa Lunn Quality Office	2023 annual report published in May 2024 2024 annual report for publication in February 2025
2024/25-20	Clinical Records Documentation	• Priority 2 Internal 'must do' audit	R Trower	Last Reported in Dec 2022. Re-audit in 2024/2025
2024/25-21	Referral to the IPU Re-Audit	• Priority 3 Specialty Priority	Dr J Strawson	Last reported in May 2024
2024/25-22	Caldicott - IG Sweep	• Priority 2 Internal 'must do' audit	Dr G Tamura-Rose	Annual Data collection Last undertaken in January 2023. Tool revised in May 2024.
2024/25 - 23	Advance Care Planning Re-audit	• Priority 2 Internal 'must do' audit	Dr G Tamura-Rose Tracy Christmas	Data collection underway in July 2024
2024/25 - 24	Audit of the use of CSCIs - indication for use, communication, supported via documentation	• Priority 3 Specialty Priority	Dr J Strawson	Report published in October 2024

Project Ref.	Title	HQIP Prioritisation	Lead	Status
2024/25-25	IPU Admission Audit	• Priority 4 Clinician interest audit	Dr G Tamura-Rose	Report published in October 2024
2024/25-26	CHELsea II examining hydration at the end of life - led by Surrey University Clinical Trials Unit : cluster randomised trial until Oct 2024	Research participation	Dr N Collins	Complete : 20 patients recruited as at 03-09-2024.
2024/25-27	Patient 'label' research project - the PhD project for a Pall Care SpR in Our Ladies Hospice in Ireland, Dr Any Taylor. Prof Andrew Davies is the overall Principal Investigator and Dr Charlotte Leach, Pall Care Consultant at Royal Surrey County Hospital, is UK lead.	Research participation	Dr N Collins	Data collection started in November 2023 (whole project nationally to recruit 383 patients across 7 sites).
2024/25-28	Psychological support via virtual platform, (Lancaster Univ - PHD project)	Research participation	Med Team	Agreed as Site only - not recruiting patients just advertising service
2024/25-29	Iron replacement in palliative care patients	Research participation	Med Team	Questionnaire submitted
2024/25-30	Injectable medications in the community - Cambridge University survey	Research participation	Med Team	Survey submitted 2024

Clinical Risk Management

Clinical Unexpected Incidents

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

2024	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2024	2023	2022	2021	2020
Admissions to IPU	21	16	18	19	19	19	16	15	16	22	15	15	211	207	207	138	195
Discharges	4	1	4	3	4	2	0	1	3	5	2	4	33				
RIPS on IPU	13	13	13	12	17	14	15	14	13	20	10	15	169				
Beds	10	10	10	10	10	10	10	10	10	10	10	10					
Bed Occupied Days	237	237	229	238	256	247	264	230	265	225	205	233					
Bed Available Days	310	290	310	300	310	300	310	310	300	310	300	310					
Bed Occupancy (10 beds)	76.45%	81.72%	73.87%	79.33%	82.58%	82.33%	85.16%	74.19%	88.33%	72.58%	66.13%	75.16%					
CD Medication Incident	3	0	0	3	4	2	1	3	2	1	1	1	20	42	29	35	15
CD Medication Near Miss	0	0	0	0	1	0	0	0	0	1	0	0	2	1	1	2	1
Non-CD Medication Incident	1	2	1	0	0	1	0	1	0	1	1	1	9	22	21	7	4
Non-CD Medication Near Miss	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3		
Pressure Sore on Admission	4	4	1	3	6	3	3	3	2	3	0	2	32	30	22	16	19
Pressure Sore during Admission	3	0	1	0	1	3	5	5	6	1	2	0	27	16	17	6	4
Moisture Associated Skin Damage ON Admission	0	0	0	0	0	0	0	0	1	0	1	0	2	1	1		
Moisture Associated Skin Damage DURING Admission	0	0	0	0	0	2	0	0	0	0	0	0	2	1	0		
Sharps/Splash	0	0	0	0	0	0	0	0	0	0	0	0	0	3	3		
Infection (Near Miss)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3		
Infection	0	0	0	1	0	0	0	0	0	0	0	0	1	3	6		
Unexpected Transfer	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
Near Miss(non-medication & non-IG)	0	0	0	0	0	0	0	0	0	0	0	0	0	0		1	1
Staffing	0	0	0	1	0	0	0	0	1	0	0	0	2	0	9		

2024	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2024	2023	2022	2021	2020
Behaviour (staff) : non-complaint	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1		
IG	0	1	0	0	1	1	4	1	0	0	0	0	8	15	16	4	3
IG near miss	0	0	0	0	0	0	0	0	0	0	0	0	0	3	4	5	1
Manual Handling	1	0	0	0	0	0	0	0	0	0	0	0	1		1	2	1
Slips, trips, falls	2	2	3	4	5	2	4	3	2	4	1	0	32	14	21	19	20
Falls near miss	0	0	0	0	0	0	0	0	0	0	0	0		6			
Verbal Violence (Pt)	0	1	0	0	0	0	0	0	0	0	0	0	1	1			1
Verbal Violence (Rel)	0	0	0	0	1	0	0	0	0	0	0	1	1				
Physical Violence (Pt)	0	0	0	0	0	0	1	0	0	0	0	0	1	2	3		
Physical Violence (Rel)	0	0	0	0	0	0	0	0	0	0	0	1	1				
Bump	0	0	0	0	0	1	0	0	0	0	0	0	1				
Burn/Scald	0	0	0	0	0	0	0	0	1	0	0	0	1	1	1		
Equipment	0	0	0	0	0	0	0	0	1	0	0	0	1	2	1		
Equipment (near miss)	0	0	0	0	0	0	0	0	0	0	0	0		2	1		
Doctor On Call	0	0	0	0	0	0	0	0	0	0	0	0		1			
EXEC Out of Hours Call	0	0	1	5	2	2	5	1	2	2	1	0	21	5	2		
OTHER - Admin/Property/Documentation/OOH	2	1	2	1	3	0	2	0	1	1	2	0	15	11	12	12	14
MAD Alerts (re SRH)	0	0	0	0	0	0	0	0	0	0	0	0		2			
* Incidents reported to Community – non-SRH	3	0	0	0	0	0	0	0	0	0	0	0	3	7	25	2	8
* MAD Alerts (incl. in Community: non-SRH)	0	0	0	0	0	0	0	0	0	0	0	0	0	3	12		
Total 2024 *excluded	16	11	9	18	24	17	25	17	19	14	9	6	185				
Total 2023 *excluded	26	8	31	7	24	12	4	15	20	13	23	9		192			
Total 2022 *excluded	8	12	15	10	15	19	18	16	13	24	16	14			180		
Total 2021 *excluded	3	2	7	8	21	13	3	1	19	9	11	12				109	
Total 2020 *excluded	7	6	7	6	11	15	5	5	4	3	8	8					85

Incident Key

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

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

<i>Clinical Significance</i>	Jan	Feb	Mar	Jan-Mar	Apr	May	Jun	Apr-Jun	Jul	Aug	Sep	Jul-Sep	Oct	Nov	Dec	Oct-Dec	2024	2023	2022	2021	2020
Admissions to IPU	21	16	18	55	19	19	19	57	16	15	16	47	22	15	15	52	211	207	207	138	193
Bed Occupied Days	237	237	229		238	256	247		264	230	265		225	205	233						
Bed Available Days	310	290	310		300	310	300		300	310	300		310	300	310						
Bed Occupancy	76.45%	81.72%	73.87%		79.33%	82.58%	82.33%		85.16%	74.19%	88.33%		72.58%	66.11%	75.16%						
Fall No Harm	2	2	3	7	4	5	1	10	1	2	2	5	3	1	0	4	26	11	15	12	14
Fall Low Harm	0	0	0	0	0	0	1	1	3	1	0	4	1	0	0	1	6	3	6	7	6
Fall Moderate Harm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Med Level 0	0	1	0	1	3	3	0	6	0	0	0	0	1	1	0	2	9	32	4	20	9
Med Level 1	4	1	1	6	0	2	3	5	1	4	2	7	2	1	2	5	23	34	49	20	10
Med Level 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Med Level 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Minor (No Harm or Low Harm)	3	3	3	9	8	7	4	19	12	2	6	20	3	3	2	8	56	62	65	25	15
Moderate (Moderate Harm)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	6
Serious (serious Harm)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Pressure Sores	7	4	2	13	3	7	8	18	8	8	9	25	4	3	2	9	65	50	40	22	23
Totals 2024	16	11	9	36	18	24	17	59	25	17	19	61	14	9	6	27	185				
Totals 2023	26	8	31	65	7	24	12	43	4	15	20	39	13	23	9	45		192			
Totals 2022	8	12	15	35	10	15	19	44	18	16	13	47	24	16	14	54			180		
Totals 2021	3	2	7	12	8	21	13	42	3	1	19	23	9	11	12	32				109	
Totals 2020	7	6	7	20	6	11	15	32	5	5	4	14	3	8	8	19					85

Clinical Complaints

- There have been 0 clinical complaints received in and between September and December 2024.

Complaints Overview

2024 - Complaints	CPCT / H@H Care	CPCT / H@H Comms	IPU Care	IPU Comms	IPU Care & Comms	Bereavement Comms	Reception Comms	Volunteer Services Comms	Fundraising /Shop Comms	HR	Total	Merton	Sutton	Other	UPHELD in Whole or Part
January		1							1		2		1		2
February											0				
March								1			1				1
April											0				
May									2		2				2
June									2		2				2
July									3		3				2
August									3		3				2
September									1		1				1
October											0				
November									4		4				4
December									1		1				1
2024	0	1	0	0	0	0	0	1	17	0	19	0	1	0	17
2023	1	4	1	4	0	1	1	0	10	0	22	3	9	0	20
2022	3	0	2	3	0	0	0	0	0	0	8	1	7	0	6
2021	4	5	1	1	1	0	0	1	0	0	13	6	6	0	12
2020	4	1	2	3	1	1	0	0	1	2	15	6	6	0	14

Clinical Complaints: September - December 2024

ID	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASS	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE
			None reported between September and December 2024			

Records – Access Requests

Between January and December 2024, we have had 4 SAR, 1 access to health records request and 4 sharing requests.

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

Notifications

Between January and December 2024, there have been 30 serious injury notifications made to the CQC all concerning pressure sores grade 3 or 4, Deep Tissue Injury or Unstageable. Of the 30, 20 (67%) were reportable PUs on Admission.

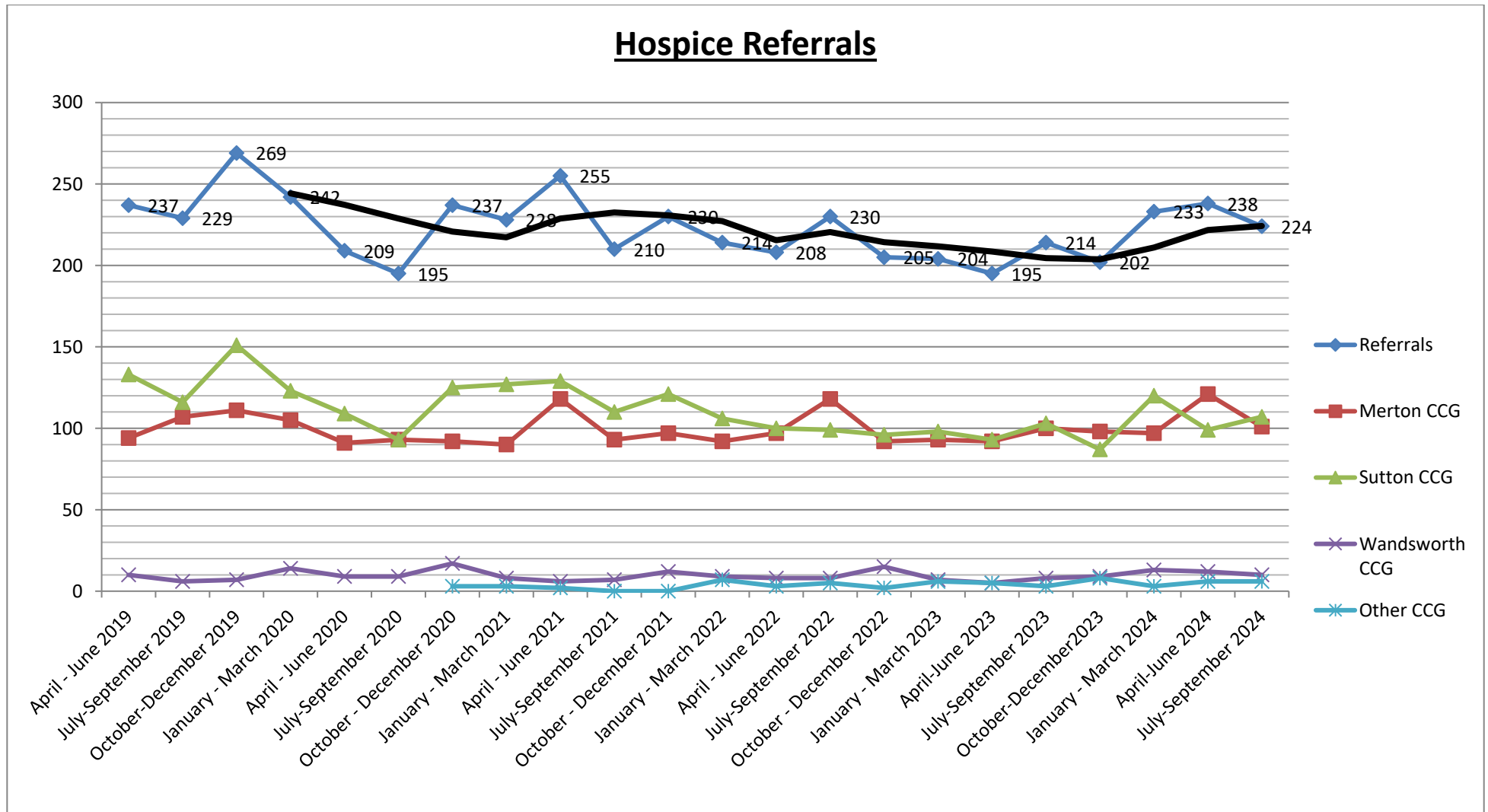
Between January and December 2024 there have been 8 safeguarding notifications made to the CQC: 3 concerning patient self-neglect, 2 concerning abuse/aggressive behaviour, 2 concerning financial matters and 1 concerning care provider neglect. All were reported to the local safeguarding teams. Of the 8, 7 have been triggered by report from the Community Team and 1 by the Inpatient Unit Team.

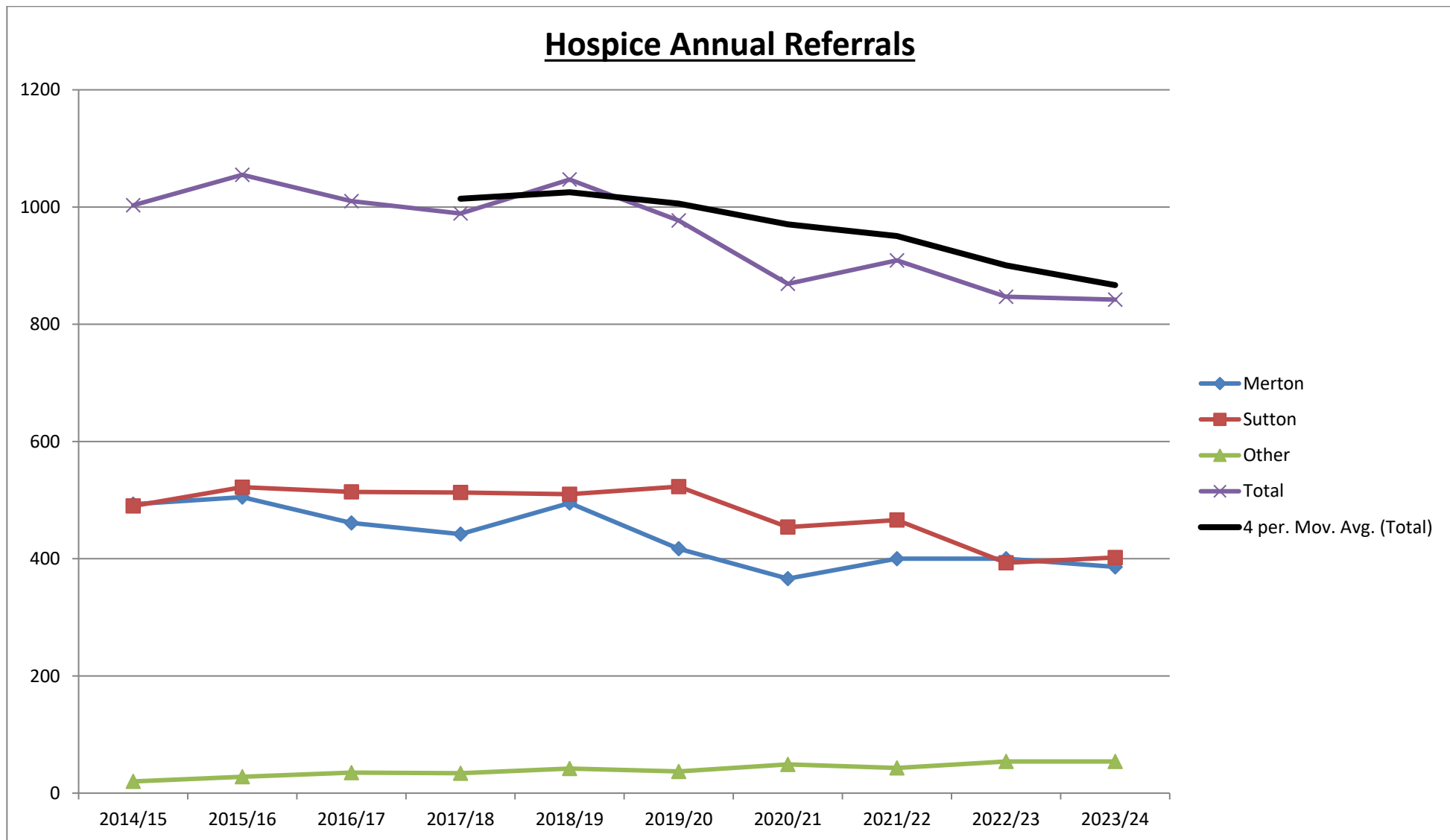
	Serious Injury	Safeguarding
2024	30	8
2023	21	13
2022	9	21
2021	10	19

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

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

Review of the last 6/12 of IPU admissions

St Raphael's Hospice

October 2024

Background to Audit

- STRH noticing increasingly *complex* referrals to our CPCT and IPU
- Recent funding/financial challenges necessitating more scrutiny over cost spending
- Clinical team more mindful of identifying supportive payments for either non-specialist “long-stay” patients, or “nursing heavy” SPC patients on IPU

Significance

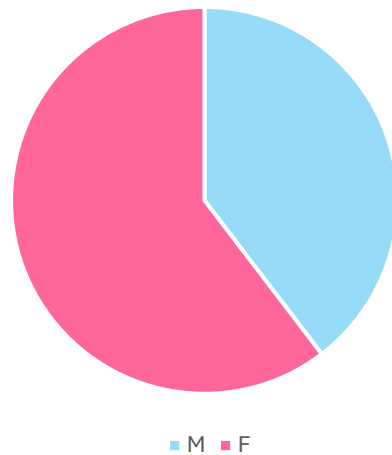
“Hospices are our ITUs in the community”

Hospice UK November 2021

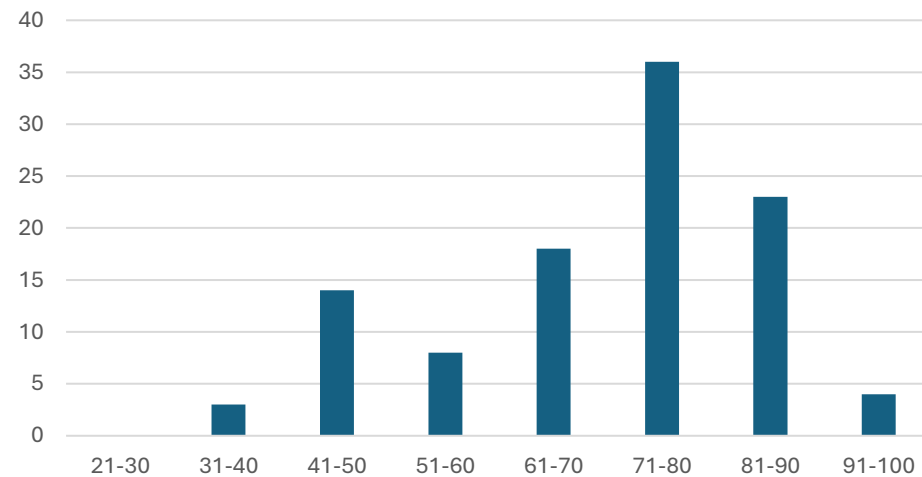
Statistics

- 106 patients admitted between May and October 2024

Sex distribution of 106 inpatients



Age distribution of 106 inpatients



CLIN01 Admissions Policy

To be considered for admission to the Hospice, a patient must fulfil the Hospice referral criteria which includes being assessed as experiencing *complex/distressing symptoms* related to a life limiting illness and consenting to referral for Hospice services.

There are 3 types of admission at STRH – planned, urgent and emergency admissions.

Patients may be admitted to the IPU for the following reasons:-

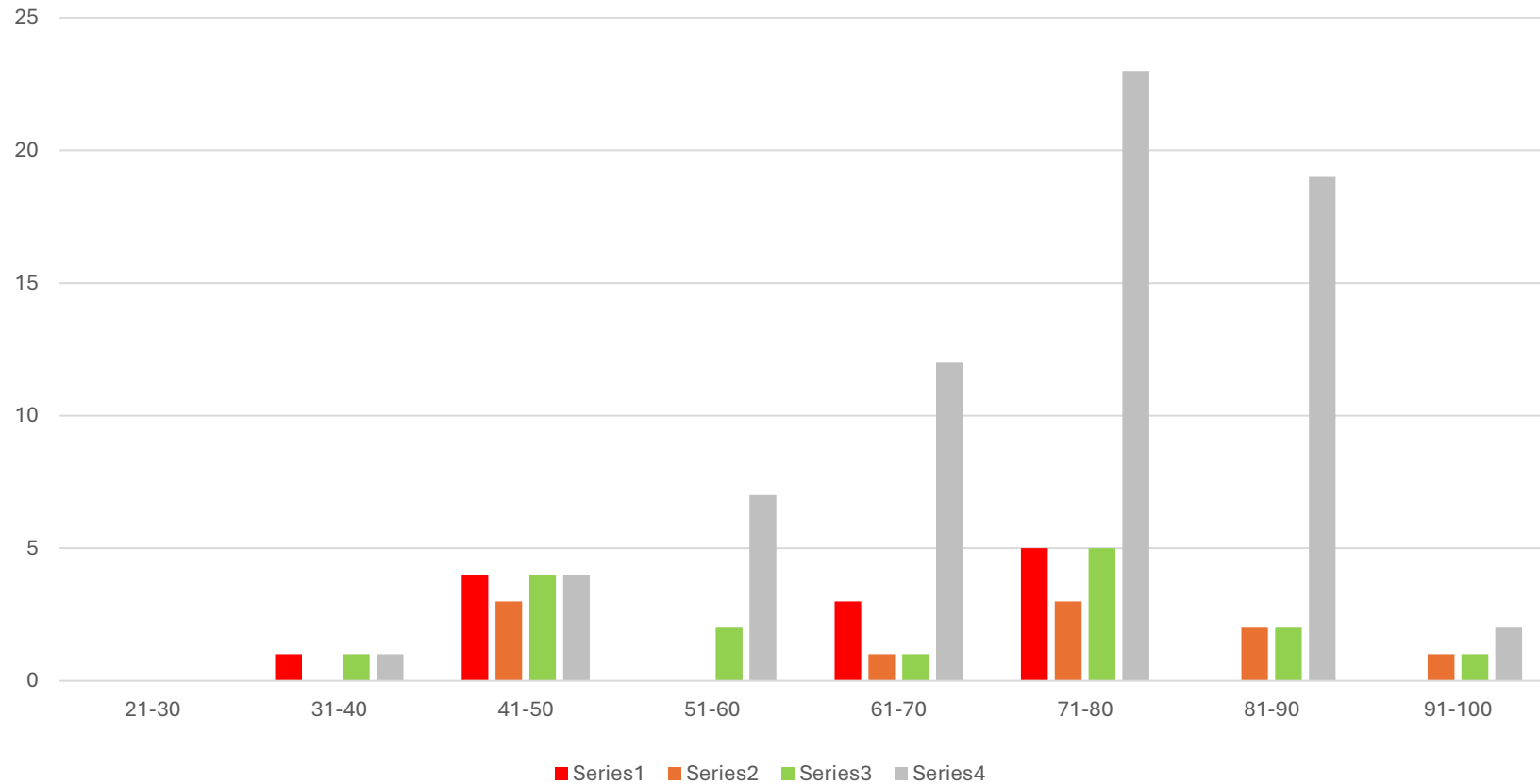
- i. Symptom Control:** for symptoms which have not resolved despite the intervention of the primary health care team, hospital specialists or the CPCT.
- ii. Continuing Terminal Care:** for patients who are thought to be in the last few days to (short) weeks of life, are no longer able to remain at home and require specialist palliative care.
- iii. EOLC:** to support PPD.

The *Hospice is unable to accept patients for long term care* and this should be made clear to patients and those important to them when Hospice admission is being discussed.

Length of Stay (LOS)

- LOS 1-85 days
- Average LOS 16.9 days (12.8 last financial year)
- 39/106, 37% patients stayed 14 or more days
- LOS categories;
 - WHITE: 0-13 days 68
 - GREEN: 14-20 days 16
 - AMBER: 21-28 days 10
 - RED: >29 days 13

Distribution of LOS according to age of patient



Current practice

After 14 days*, if patient's POI is either “stable/deteriorating” ie minimal to no SPC input and nursing care only, MDT: *Could this patient's care be met in an alternative location?*

If the answer is no, then CHC funding applied for

*or sooner if a SPC patient demonstrating exceptional nursing needs e.g. complex trachy care, behavioural challenges needing 1:1 support etc

Summary

8 inpatients received CHC funding for part of their IPU stay

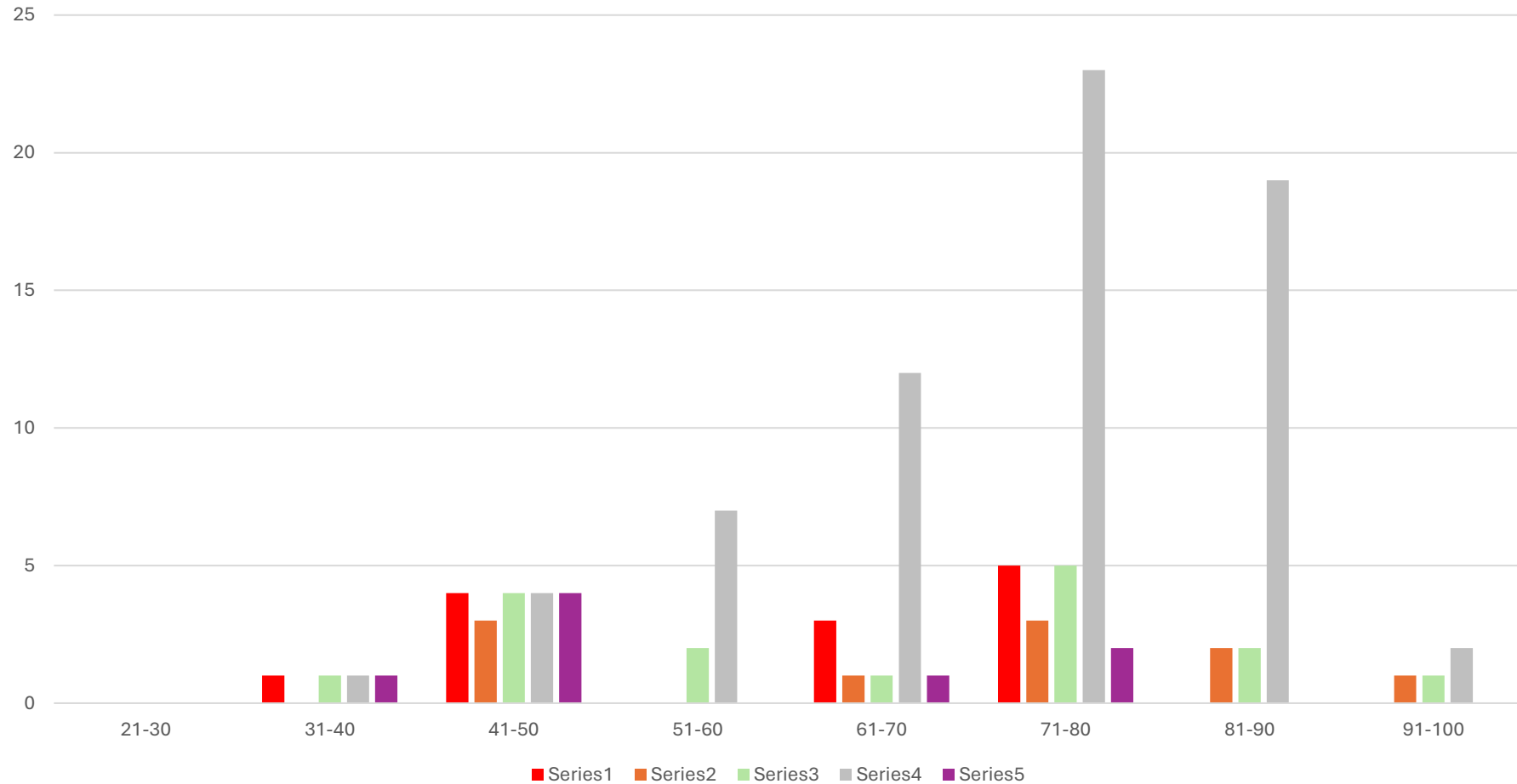
= 7.5% of total inpatients over 6/12 period

= 20.5% of all “long-stay” patients

Breakdown of 8 patients

Age	LOS	D/C destination	PPD	No. days CHC funded	Reason for CHC funding application
72	85	RIP STRH	STRH	22 / 85	Adm from home, behaviourally challenging, under DOLs, required 1:1 nursing care, complex pain control from ischaemic limb
47	63	RIP STRH	STRH	28 / 63	Young patient adm from home for symptom control, young children, wife still working
77	56	NH	STRH	22 / 56	Adm from bedsit w no accessible bathroom, delays in NH placement, resulted in OOA T/F
43	53	RIP STRH	STRH	47 / 53	Young patient adm from home, 2x CSCIs in situ, young child and wife needing lots of psychosocial support
69	40	RIP STRH	STRH	20 / 40	Extensive wound care and pain control, lived alone, T/F from hospital for EOLC , NH discussed but PPD STRH and patient at risk of sudden deterioration
48	31	RIP STRH	STRH	15 / 31	Young patient with complex breast wound care, no family, T/F from hospital for EOLC
45	23	RIP STRH	STRH	3 / 23	Young patient living with Down's Syndrome, struggled with change and facing own mortality, strong family preference for care at STRH, T/F for hospital for EOLC
34	14	RIP STRH	STRH	12 / 14	Young patient with met testicular Ca and brain mets, adm from home in crisis, living with ex-partner, falls risk, parents high psychosocial requirement

CHC funded beds on background of LOS age spread



What if?

If STRH IPU didn't exist....

- These patients would have either stayed in, or ended up in hospital
- Inappropriate use of acute hospital beds – impact upon rest of population given recurrent business continuity incidents
- More expensive to NHS than STRH IPU stay
- Failure to meet PPD
- Complex grief for those people important to them – impact upon GP and mental health services and their future approach to EOLC

Additional observed challenges

- Placement of patients who smoke
- Placement of patients whose family/those people important to them fail to engage with the D/C process
- Prognostic uncertainty

Next steps...

- More robust/standardised process, for;
 - Identification of appropriate patients
 - Timings of funding requests
 - Standardised funding tariff agreements
- *Across all SWL hospices*

Any Questions?

Meeting: Clinical HODs Meeting			
Date: 21.10.2024		Time: 13.30	
Chair : Rebecca Trower		Minutes: Lynn Jackson	
Present:			
Apologies:			
Agenda item	Discussion	Actions & by whom	Anticipated date for completion
Review of previous minutes			
Matters Arising			
Topic			
Infection Prevention			
Medical Devices	Ceiling hoist training on going		
Medicine Management	CPCT- 5 th December 2025 dates for IPU & CPCT		

<p>Incidents & Accidents/RCA's</p>	<p><u>September 2024</u> IPU Admissions = IPU Discharges = IPU RIPs = IPU Occupancy = %</p> <p>Pressure ulcers (incl. MASD) during admission (n=6), pressure ulcers (incl. MASD) on admission (n=3), patient falls (n=2), CD medication incidents (n=2) and ooh access/network disruption/staffing (n= 2) constitute 79% of reported clinical incident numbers in September of 2024 (n=15) c.f. 86% in August and 79% in July 2024.</p> <p>Of the 2 patient falls, both attributed to the same patient. Of the 2 CD incidents, 2 were associated with either missing drugs or drug counts incorrect. There were no incidents associated with medium or severe harm.</p> <p>PSIRF (Patient Safety Incident Response Framework) and – PSIRP (Patient Safety Incident Response Plan) amendments have been drafted to policy OP01 and reviewed by CD. Expected roll out for comment across clinical HoDs in November 2024 and, once finalised, copied to SWLICB for their information.</p> <p>In summary, the PSIRF seeks to support a systems approach to incident reporting and move incident reporting cultures within the NHS away from blame to learning cultures. It is primarily aimed at the secondary care sector and has not been implemented into primary care as yet. It is incorporated into the NHS standard contract for providers and its embrace by smaller organisations should be proportionate. To this extent, we have tried to complement the learning based culture at SRH with essential elements of PSIRF by making adjustments to our OP01 Incident and Near Miss Reporting Policy and incorporating the PSIRP into its appendices. Essentially these changes reflect upon the tools that should be used to reflect/investigate patient safety incidents and being more explicit about expectation of such reflection/investigation proportionate to the incident and its harm.</p>		
<p>Complaints & Compliments</p>			

Health & Safety	Fire Door replacement on the IPU expected to complete in October 2024. Capitol House RA re-assessment complete.		
New Policies/ Guidelines			
Documentation/ EMIS			
Audit/Research			
Education/Training Reflective Forums	CPCT teaching underway Clinical visits Adv Comms refresher & ACST RMH Update- £100 discounted price NHS England funding City St George's MSc ACP- teaching request Bluestream HUK- Becca, Anna, Gaby Teaching session on pleural & Peritoneal drains MH ongoing		
Recruitment/	CPCT – x2 resignation		

Staffing			
CQC/PIR			
AOB			
RT	Discussion on the Assisted Dying Bill		



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Date next meeting: Dec 2, 2024 1:30 PM

Jan 13, 2025 1:30 PM

Meeting ID: 856 3859 2795

Passcode: 976968

Minutes of Doctors Business Meeting 4/11/24

In attendance	Ambreen Akhtar	Speciality Dr	AA
	Naomi Collins	Consultant	NC
	Jenny Strawson	Consultant	JS
	Shahlaa Walsh	SpR	SW
Apologies			
	Gaby Tamura-Rose	Consultant	GTR
	Busi Da Silva	Specialty Dr	BDS
	Rayah Ahmed	GPVTS	RA
	ChristopherRoughley	Specialty Dr	CR
Minutes of the last meeting			
	No comments for the minutes of the last meeting.		AA
Team wellbeing			
	Went round the group and all shared, thank you 😊		
Rota / staffing			
	Welcome to SW her first medical team meeting! she has taken the task of circulating the medical team rota.		AA
	SW will be flexible with her SPA time sometimes might take half day every other week or 1 whole day depending on her other meetings.		SW
Clinical challenges			
	Two patients on the ward requiring significant time for their needs and discussion around equity of care for other patients and how it effect the whole medical and nursing team.		JS/AA
Drug Issues/ Budget			
	Taken forward the discussion from the last MBM Shahlaa will discuss with the SGH team whether WFI could be added to the PRN Charts.		SW
	Adrenaline Inj in short supply (since meeting supply now available meeting with Ashtons) Ongoing plan to use tranexamic acid inj as first line for controlling tumour bleeds.		JS
	Check with community pharmacy before ordering oral haloperidol availability.		JS
Infection control			
	Recent admission to the in-patient unit, who was tested for Covid infection because of her symptoms but that is not in the current infection control policy as now covid infection is being treated a respirtory tract infection and wearing mask is individual responsibility. Ensure all the time there is regular supply of FP3 mask.		JS

Minutes of Doctors Business Meeting 4/11/24

	Ongoing discussions around room swapping rooms _ consultants to take current resident doctors' room and Consultant room to become out-patient clinic. Resident doctors' room will be using the H@H office in the community. Hot desk being available in the consulting room and out-patient clinic room as well.	JS
Education	SW has organised study day for SPR's on 3 rd Dec 2024 offered to provide link for Busi/Ambreen as well. CR facilitating and examining for ECEPC in Nov 24. Jenny reminded about the upcoming face to face meeting on 12 th Dec with the RMH working group for pain interventions in palliative care patients.	SW/JS
Datix	Reminder to use the word "to" for writing ranges. Rewrite the drug chart if its crossed 50%. Write "mcg" in micrograms. Avoid writing 0.5mg when writing Lorazepam and haloperidol prescriptions.	JS
Audit & Research	Chelsea II completed – thank you all. SW to have meeting with JS as she would be the lead for audit and research from Dec onwards.	SW/JS
Deep Dive	Nothing discussed	
AOB	Jenny's leaving dinner on 18 th Nov 2024. NC reminded the team that discussions have started around Hospice strategy going forwards for the next five years. Everybody participation would be appreciated -a questionnaire has been sent around please take some time to complete it.	AA NC
Date of next meeting	4/12/24 to be confirm.	



Fast Track Audit on IPU

By Dr Ambreen Akhtar and Jovy Giles





Aims



01

To assess the FT application approval rate from the Inpatient Unit



03

To understand the timings surrounding fast track approval



02

How this translates into discharges for our patients



04

To discharge in line with national & hospice standards



Methodology

- ❖ Retrospective data collection for patients admitted between 1st November 2023 – 30th April 2024 who had FT applications sent for each patient.
- ❖ Data collected by reviewing:
 - EMIS notes
 - EMIS data filters
 - Email history srh.inpatientunit@nhs.net



Standards

Developed by Department of Health and Social Care

- National Framework 193 MDT (at least 2 professionals from different healthcare professions or 1 healthcare professional and 1 person responsible for assessing care needs).
 - Decision after undertaking 'Decision support tool' or 'Fast track pathway tool' for those with primary healthcare need and rapidly deteriorating condition.
- National Framework 98:
 - For those with a primary health need arising from a rapidly deteriorating condition and where that condition may be entering a terminal phase, a Fast Track Pathway tool should be used.
- National Framework 182:
 - ICB response < 48 hours
 - Overall assessment and decision making not to exceed 28 days from date of receipt of checklist





Current Practice

Our fast track application is in line with CLIN07 paragraph 2.1.5 & guidance from DH&SC

- FT appropriateness are assessed by MDT & FT Tool completed by medical team.

Daisy Wilson (2021) Fast-track hospital end-of-life discharge pathway: 'Is it actually fast?' National clinical audit. BMJ Supportive & Palliative Care. Available at <https://spcare.bmj.com/content/14/1/90>

- Sample size 347 FT applications from 12 sites 1st March 2019 – 31st March 2019 (31 days)

Key takeaways:

- Demonstrated approval rate of 93.1% of first applications
- 70.8% approval for re-submitted applications following initial rejection.
- Response rates of <48 hours was met in 27.6% of cases (therefore 72.4% exceeded 48 hours)
- The average days between FT approval & discharge was 3 (range 1-5 days).
- MDT decision re: FT submission was completed in 6.5% of cases





Results



- + There were 19 patients admitted to the IPU during 1st November 2023 – 30th April 2024 who had FT applications completed. 1 patient was excluded as they did not have a date of application approval recorded. 100% of FT applications were agreed in MDT prior to submission.

ICB response target is within 48 hours of receipt of application

15/18 were responded to within the same working day (<12 hours)

13/18 were approved on the same day as they were received (<12 hours)

2/18 were approved the next day (<24 hours)

1/18 was approved within 2 days (<48 hours)

2/18 were rejected the same day (<12 hours)

100% of applications were responded to within the 48-hour target





Results



+

Rejected FT applications

The resubmission approval rate has been quoted previously by BMJ SPC article as 70.8%

- 2/2 rejected FT applications were re submitted
- 100% of re submitted applications were approved and were on the same day (<12 hours)

+





Results

+

Days between FT approval & discharge:

16/18 FT approved patients were discharged from the IPU

2/18 approved applications were discharged from IPU on the same day

7/18 patients were discharged within 1-7 days (1 waited 2 days, 3 waited 5 days, 1 waited 6 days, 2 waited 7 days)

3/18 patients were discharged within 8-14 days (2 waited 8 days, 1 waited 13 days)

4/18 patients were discharged after waiting 15 days or more (1 waited 15 days, 1 waited 19 days, 1 waited 42 days, 1 waited 35+ pending days)

2/18 patients were unsafe to be discharged and died in the care of the hospice (RIP 5 & 7 days after approval of FT)

+





Results



+ Days between FT approval & death

Deaths: 4/7 within 7 days:

1 patient died in 2 days

1 patient died in 3 days

1 patient died in 5 days

1 patient died in 7 days

1/7 between 7 - 14 days

1 patient died on day 12.

2/7 after > 15 days:

1 patient died on day 18.

1 patient died on day 22.

Survivors:

5 patients alive & under care.

6 patients discharged from care (as their care is now outside the catchment area).





Discussion

Approval rate of IPU FT from first application is 88.9% (16/19), which is lower than that of the BMJ SPC article, however, is similar (93.1%). 2 IPU FT applications were rejected, however were both approved on resubmission; therefore, this is higher than the resubmission rate for BMJ SPC article (70.8%).

100% of FT applications during this period were responded to within the ICB target of 48 hours, with the majority being responded to within the same working day (83.3%), 11.1% responded to within 24 hours, and 5.6% within 48 hours.





Discussion

16/18 (88.9%) patients with FT approval were discharged from the hospice IPU.

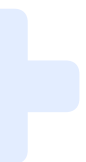
2 patients were discharged on the same day as FT approval (11.1%).

38.9 % of patients were discharged within 1 week of FT approval (therefore 50% of patients with FT approval were discharged from the IPU within 1 week).

16.7% of patients were discharged between 8-14 days, therefore 2/3rd (66.7%) of patients with FT approval were discharged within 2 weeks.

Roughly 1/5th (22.2%) of patients with FT approval waited more than 15 days after FT approval to be discharged from IPU. Factors contributing to this included lack of bed availability in nursing homes, as well as the fluctuating conditions of our palliative patient cohort.

2/18 patients (11.1%) were unable to be discharged from the IPU, so died in the care of the hospice despite FT approval. This illustrates the nuanced care planning we are able to deliver on the IPU, as well as evidencing our dual planning aims when prognostication is difficult.





Discussion

7/18 (38.9%) with FT approval died, 2 of whom were not discharged from the hospice as previously discussed. Of those discharged, 57.1% (4/7) died within 1 week, 14.2% (1/7) died between 7-14 days, and 28.5% (2/7) died after 15 or more days.

The average number of days between FT approval & death was 9.85 days. This shows we were appropriately applying for FT care for these patients with short prognoses.

- 5 surviving patients are currently alive and under our care.
- 6 patients were discharged to continue their care outside our catchment area.
- This reflects our commitment to accommodating patients' preferred place of care and death, including being near family out of area.

Conclusions

- FT pathway has been a successful tool to aid discharge for those patients where the hospice is no longer the most appropriate place of ongoing care.
- The high approval rates are in line with other audit results, and overall, our data has shown a fantastic response from ICB/CHC which allows us to facilitate rapid discharges within 1 week for half of our patient's eligible for FT.



Recommended Actions

+

1

Continue to apply for FT funding approval for our patients using the recommended template from ICB FT training.

2

Continue with dual planning FT applications for our IPU cohort.

3

Ensure date of FT approval is recorded on EMIS notes



**MINUTES OF THE
INFECTION CONTROL COMMITTEE**

**Held at 1pm on 12th November 2024
at St Bede's Conference Centre and via Zoom**

Attendance

(Dr JS) Dr J Stephenson, Consultant
Microbiologist -ESTH, SSAH (Chair)

(AR) A Rudkin – Director of Quality and
Improvement

(JC) J Cope – Quality Support (Minutes)

(TC) T Christmas – Community Team Manager

(CF) C Foster - IPU IC Link RN

(RT) R Trower – Clinical Director

(SM) Sara Mosalam – Infection Control
Lead

(PM) Peter Morris – Facilities Manager

(Dr GT-R) Gabrielle Tamura-Rose –
Consultant in Palliative Care

Apologies

(PD-P) P Di-Palma – Housekeeping

(AD) A Durrant – IPU rep

(MP) M Prior – Clinical Nurse Specialist

(Dr NC) Dr N Collins – Palliative Care
Consultant

(MS) M Sorrell – Community rep

(MF) M Flint – Palliative Care Educator

(JF) J Ford – Staff Nurse

ITEM 1: Welcome

Action

Dr JS extended welcome to all present. AR welcomed PM to the meeting. He has succeeded Steve Cresswell in the role of Facilities Manager.

ITEM 2: Apologies

Apologies as listed above

ITEM 3: Minutes of the last meeting held on 11 June 2024

3.1 These were accepted as an accurate record. Dr JS commended JC for taking and drafting the minutes.

ITEM 4: Matters Arising

4.1 Nil raised

ITEM 5: COVID-19 Update

- 5.1 **Staffing:** Currently minimal impact. Dr JS reported that in Epsom and St Helier Trust, there are few cases these days. SM told the meeting that the Hospice had one case in recent weeks which was two weeks ago.
- 5.2 **Testing :** SM advised that the LFT stock has been checked and replacements ordered for expired stock, so that stock will last until April 2025 before re-ordering. SM advised that the testing guidelines have been updated. LFT testing is only used if symptomatic.
- 5.3 **PPE :** SM informed the meeting that the standard for staff Fit testing is for review every two years for each staff member. There have been 8 new staff members; 4 were tested in the last two weeks; the others are scheduled for testing next month.
- 5.4 **POLICY :** SM has updated CLIN52 Managing COVID to include a section for how staff should prepare for overseas travel. Dr GT-R referred to a recent case of an IPU patient with COVID and asked whether that was handled in strict accordance with the wording of the relevant policy. SM responded that testing is only carried out in cases where the patients are immune-compromised. In those cases, the hospice contacts the agency to arrange a test for the patient in question. The testing kits are for staff members who have symptoms. Dr JS advised offering tests on a case-by-case basis. In the acute trusts there are LFT test kits which are used on occasion even though that service is not officially offered. Dr GT-R said that the patient who received a test stabilised and was discharged to a nursing home. Dr GT-R will seek to make suitable caveat explicit in the existing policy and will liaise with SM.

ITEM 6: IPC training/ education

- 6.1 SM informed the meeting that there has been no training in the past three months. SM and RT confirmed that only Bluestream training is being carried out currently.

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

- 7.1 There have been no new incidents. AR commended staff for their diligence. AR added that the monthly IC audits provide assurance and support aspects for improvement. Quarterly graphical reporting produced by JC reflects the data. SM observed that there has been an improvement in compliance although some items are still in action. Dr JS observed that the reporting shows a good use of audit. Set out below are the figures for the 3rd quarter (July September) of 2024 with available figures for the 2nd quarter 2024 (April-June) 2024 also included. This is followed by a written summary specifically for the 3rd quarter of 2024.

SM/JC

IPC Criterion	Apr-Jun 2024	Jul-Sep 2024
Staff Hand Hygiene	91%	98%
St Bede's Environmental	99%	NA
Wellbeing Centre Environmental	100%	98%
Men's Den Environmental	100%	100%
IPU Environmental	100%	90%
IPU Staff Spot Check	99%	97%
Sharps	95%	89%
Urinary Catheter Insertion	86%	97%
Waste Management	90%	81%
Mattress Cover	100%	100%
Mattress	91%	100%

- 7.2.1 Overall compliance for staff hand hygiene is 98%. Overall compliance is improved due to perfect compliance with hands being cleaned before patient contact and alcohol gel at point of care no longer being an audit criterion (it had the lowest compliance of all the criteria when it was still an audited criterion in April – June).
- 7.2.2 The Men's Den Environmental Audit maintained perfect compliance. The Wellbeing Centre Environmental audit showed a 98% compliance. The area of lowest compliance was the Wellbeing reception room with 92% compliance.
- 7.2.3 The Sharps Audit showed 89% compliance overall. Areas for improvement include keeping sharps' trays clean and tidy and making sure that sharps bins do not contain items other than sharps, ensuring bins are free from protruding sharps, and that the temporary closure mechanism is not in use.
- 7.2.4 IPU staff spot checks showed a 97% compliance. The only instances of non-compliance were single instances of staff members not being compliant regarding being bare below elbows, keeping nails short and free of polish, and not wearing jewellery.
- 7.2.5 The IPU Environmental Audit showed an overall compliance of 90%. The areas which brought down the overall compliance were: desks and surfaces being clean and free of dust (33% compliance), access to handwashing facilities and gel (67%), and carpets and floors being clean and free of stains (67%). The other 12 criteria all achieved 100% compliance.
- 7.2.6 Waste Management showed 81% overall compliance. Areas where compliance was not achieved were the area outside the bin area being clean and tidy, the bins, and waste bags not being overfilled, and the clinical waste bags being cabled, labelled and tied correctly.
- 7.2.7 The Urinary Catheter Insertion audit shows overall compliance of 97%. The one criterion that reduces overall compliance is the standard that the draining bag be dated and changed by day 8. This has achieved 88% compliance whereas the other criteria show perfect compliance.
- 7.2.8 The Mattress and Mattress Cover audit shows perfect compliance, but

the data cohort was just one mattress and mattress cover audited in July.

ITEM 8 : Alert Organisms Surveillance

- 8.1 Dr JS reported that COVID cases have reduced. Cold and Flu outbreaks occur seasonally. Alert Organisms encompass C-Diff and other multi-resistant organisms. In October, an investigation by Public Health Authorities found a risk of *Burkholderia stabilis* bacteria that contaminates ultrasound gel and may lead to infection if the affected gel is used on high-risk patients. NHS Supply Chain has now suspended supply of the non-sterile ultrasound gel.

ITEM 9 : Water Assessment and testing update

- 9.1 AR again welcomed PM to the meeting. PM has succeeded Steve Cresswell as Facilities Manager. There has been a robust flushing routine implemented by Facilities. There have been no new outbreaks of *Legionella* in the water. Water safety is a standing item at the H&S Committee.

ITEM 10 : Any Other Business

- 10.1 SM informed the annual report will be sent out at the end of the month.

ITEM 11 : Date of next ICC meeting

Date	Event	Venue/Time
TBA	IP&C Meeting	TBA

Prescribers Meeting 19th November 2024

Minutes

Present – Kevin Hobson, Bev McDermott, Dr. Jenny Strawson, Katie White, Paula Coyne, Kim Smith, Tracy Christmas

Hospice and Community prescribing

Prescribing from hospice and community prescribers continues to be mainly Fridays and weekends to prevent delays in Pt's receiving medications.

Prescriptions written by community team so far this year –

Kate B - 2

Kevin - 3

Lorraine – 15

Katie – 23

Please ensure your personal log and computer log of all prescriptions is kept up to date. We also need log of any charts (PRN / CSCI) written or recommended.

Go to -

N Drive / Clinical / Nurse Independent Prescribers / Nurse Prescribing Data / Prescribing Log / CURRENT PRESCRIBING LOG

Merton community nurses have switched to Electronic Prescribing. They report the system as much more efficient, easy to use and faster.

Tracy will make enquiries re possibility of the hospice investing into the system.

SWL Medicines Optimisation Newsletter

The ICB publishes the newsletter monthly which covers Wandsworth, Sutton and Merton.

Latest issue reported –

- Home Enteral Feeding contract is held by Nutricia in SW London – all prescriptions to be sent to them
- ScriptSwitch reports are being sent to all G.P. practices re prescribing practices – responsibility of community teams to review (and planned webinars to explain)
- Update on medicines shortages
- Currently Antimicrobial Resistance Awareness week – guidance and tools available around prescribing antibiotics

We will send newsletter on to Kim and anyone else who would like to receive it.

Prescribing Competencies

RPS Competencies and Hospice Intention to Prescribe forms have to be renewed / completed by all NMP's before year is out.

Please ensure you are up to date

Speak to Kevin if you need help.

National Supply Shortages

Our Medicines suppliers – Ashtons – send us weekly updates about current shortages.

It seems an increasing problem since Brexit!

Haloperidol was not on this weeks list but was difficult to source in recent weeks.

Current drug shortages include Glycopyrronium for injection (we tend to prescribe Buscopan now),

Scopoderm patches (long term shortage) and Quetiapine.

As always, calls to different pharmacies can be helpful.

Education Update Day

We plan to have our Non Medical Prescribers update / education day on Wednesday 12th Feb 2025.

A packed informative programme will be planned!

But please forward any suggestions / ideas you would like to be included.

Flyers will be sent out soon.

AOB

Kim – highlighted need for Furosemide s/c policy is due to be reviewed. The renal team should take the lead on this.

Draught copies to be sent to hospice for comment?

We will aim to have next Meeting in March 2025 – please invite any other Prescribers you know that may benefit from attending

ST RAPHAEL'S HOSPICE CSCI USE WITHIN THE INPATIENT AND COMMUNITY SETTING JUNE 2024

Dr Jenny Strawson



Audit Aims:

To audit the clinical indication/rationale for starting a CSCI

To audit the medication prescribed via CSCI and clinical indication, as well as the diluent used

To audit the dose titration of medication and clinical reasoning behind this

To audit the clinical team's documentation around communication with patient and those important to them regarding starting or titrating a CSCI

1. Methodology

1. Retrospective EMIS reporting with cross checking within body of consultation notes and scanned drug charts/MAAR charts.
2. EMIS report created to identify all patients where the CSCI code was selected during EMIS documentation as part of the IPU nursing assessment, community assessment, or priorities at the end-of-life template, during the month of June in both the inpatient and community care setting.

1. Standards

Standards are primarily based on the Hospice's CLIN 18 syringe pump policy and CLIN 57 Community Guidance on Injectable Medications for Symptom Management at the End-of-Life policy.

1. The recommended indications for starting a CSCI are: patients unable to swallow oral medications encountered commonly in the dying phase of illness, those with absorption issues/uncontrolled vomiting/bowel obstruction, or patients with unstable escalating pain.

CLIN 18: 4.0 Indications for Use:

- nausea and vomiting
- dysphagia
- severe weakness
- confusion/delirium
- diminishing level of consciousness
- bowel obstruction
- uncontrolled pain
- when patients would otherwise require regular injections

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2. Titration of medication doses via CSCI is usually based on the patient's requirement for extra PRN doses over the last 24 hour period, and/or identified ongoing uncontrolled symptoms following clinical review. With regards to PRN doses of injectable medication, CLIN 57a states 'If ≥ 3 doses in 24hrs, titrate PRN dose, review effectiveness, and consider use of a syringe pump'.
 3. The hospice's recommended first line diluent is Water for Injection, following cost benefit analysis. 0.9% normal saline is recommended for patients experiencing site reactions or for drugs where only saline is compatible (although I note this is not specifically stated in the current policy).
 4. Documentation should capture important discussions with patients and those important to them around starting or titrating medication via CSCI.

RESULTS

21 patient records were identified where the CSCI codes had been selected during EMIS documentation. Codes currently in use include: *administration of medication via syringe driver, syringe driver commenced and management of syringe driver* (please note the preferred term is syringe pump, but the EMIS code uses the term syringe driver).

1 patient was excluded as they died in hospital before being cared for at SRH

(n=20) 5 patients were at home and 15 were on the IPU during this audit period.

Demographics: 9 male, 11 female, average age 72 (range 33 yrs to 88 yrs), AKPS range 10% to 50% at time CSCI started and POI Deteriorating (6) Unstable (11) Dying (3) stable (0). Time from starting CSCI to death - range from hours to 77 days (average number of days = 16.2 days, median 7 days (0,1 ,1,1,2,3,3,3,3,6,7,7,9,18, 23, 32, 32, 40, 56, 77)).

Diagnosis:

Cancer diagnosis: 16 (lung ca 2, glioblastoma 1, gastric ca 1, urothelial ca 1, pancreatic ca 3, breast ca 2, cervical ca 1, oesophageal cancer 1, bowel ca 3, CUP 1).

Non cancer diagnosis = 4 (ischaemic leg, spinocerebellar ataxia, COPD, heart and renal failure).

Were the standards met?

1. Reasons for starting CSCI clearly documented: 20/20

- unable to swallow oral medications at EOL: **10/20 (50%)**
- absorption issues/uncontrolled vomiting/bowel obstruction: **7/20 (35%)** : 3 (BO), 4 (severe nausea/vomiting)
- unstable escalating pain: **3/20 (15%)** (2 started in hospital for uncontrolled pain, 1 started on IPU for uncontrolled pain and toxicity on oral morphine/oxycodone switch to alfentanil)

2. Dose titration and clinical reasoning:

Starting dose in line with PRNs/previous regular oral medication taken/usual recommended starting dose:

- YES = 14 NO = 0 Unknown started in hospital = 6

Dose increased appropriately in line with multiple PRNs /or ongoing clinical symptoms requiring increase:

- YES = 14 /14 NO = 0 N/A No titration needed = 6

Titration in line with exact PRN dose given over 24 hours:

- YES = 4 NO = 10

Higher dose prescribed and clinical reasoning given = 4

- **Pt 741:** pt on IPU, indication severe terminal agitation, Levomepromazine 50mg given in PRNs, 100mg started, went on to require Phenobarbital despite this
- **Pt 746:** pt on IPU, 80mg Buscopan given PRN, 120mg started for BO/colicky pain, 2.5mg Midazolam given, 10mg started as dying and restless
- **Pt 901:** pt at home, decision to increase Alfentanil from 200mcg to 400mcg, as pt in pain and unable to call DNs for PRNs
- **Pt 1716:** pt at home, slightly higher doses added to CSCI, 4mg Oxycodone PRN, 5mg added to CSCI, 200mcg Glycopyrronium PRN, CSCI started at 600mcg which are the usual recommended starting doses.

Lower dose prescribed and clinical reasoning given = 6

- **Pt 966:** dose reduced despite multiple PRNs of Oxycodone, concern regarding toxicity
- **Pt 1143:** cautious titration of Alfentanil despite multiple Oxycodone PRNs due to history of toxicity, delirium, and pain felt only partially opioid responsive (ischaemic pain)
- **Pt 1236:** on call doctor f2f review, CSCI slightly lower doses of Morphine, Midazolam and Buscopan prescribed than PRNs given, actively dying and comfortable when reviewed.
- **Pt 1615:** slightly less Oxycodone and Midazolam in CSCI than PRNs given , decision to round down to 20mg oxycodone and 5mg midazolam (22.5mg oxycodone given in 24 hours and 7.5mg midazolam, perhaps a reflection of more cautious prescribing in the on call setting over a weekend).
- **Pt 1663:** Alfentanil increased from 12mg to 16mg, although 8mg in Alfentanil PRN approximate equivalent in Oxycodone given, Midazolam increased as anxiety distress may be contributing to total pain.
- **Pt 1777:** Oxycodone CSCI increased from 50mg to 75mg (30mg in PRN given, decision to increase by max of 50%), and later 7.5mg midazolam, 30mg oxycodone given PRN not added to CSCI as being used pre movement and remained comfortable at rest.

3. DILUENT PRESCRIBED

- WFI = 17
- Saline =1 (site reaction with Levomepromazine, 50 ml syringe used)
- WFI/or Saline prescribed via community MAAR unclear which one used: 2

Medication prescribed via CSCI :

- **Pain/dyspnoea - Opioid:** Morphine 9, Oxycodone 5, Alfentanil 5
- **Anti-emetic:** Haloperidol 3, Metoclopramide 1, Levomepromazine 5, Cyclizine 2
- **Agitation:** Midazolam 11, Levomepromazine 1, Phenobarbital 1(severe terminal agitation)
- **Secretions:** Hyoscine Butylbromide 6, Glycopyrronium 1
- **Seizures:** Levetiracetam 1, Midazolam 30mg (replacing Sodium Valproate, Levetiracetam, Clonazepam also agitated)
- **Other:** Clonazepam 1(ischaemic limb pain = 0.5mg)
- **2 pumps required:** 3 patients: Levetiracetam, incompatibility with Levomepromazine and Cyclizine*, Phenobarbital

4. DOCUMENTATION IN THE EPR:

- No documentation: 0
- Clearly documented conversation with patient and those important to them specifically around CSCI starting and/or dose changes on all occasions: 12/20 (60%)
- Clearly documented conversation with patient and those important to them specifically around CSCI starting and/or dose changes on most occasions: 8(40%).
- Documented signposting to written information on CSCI: 0
- Of those where documentation was unclear:
- 6: conversation implied as written in plan and family present during consultation but no explicit documentation of communication
- 1: patient 966, during a weekend, addition of low dose Midazolam not discussed with NOK, but discussed with patient, NOK felt this caused excessive drowsiness and asked for it to be removed on Monday with agreement from the patient, request was actioned by the clinical team
- 1: patient 84, pre-emptive conversation days prior to CSCI starting, but not documented on the day CSCI started

OTHER AUDIT OBSERVATIONS

- **Patient preference not to titrate CSCI:** patient 955 received several PRNs of Morphine and Levomepromazine but declined CSCI titration.
- **IPU drug chart CSCI prescription page:** varying practice, choice of diluent sometimes circled by the prescriber, sometimes not. The drug chart does state: Use WFI as standard, use 0.9% Saline for site reactions/drugs. Nurses to ensure appropriate diluent for each syringe pump prescription.

- **Provisional CSCI prescriptions (1 in community, 1 on IPU):**

-IPU patient: 975, CSCI Oxycodone CSCI already running, 4/6/24 (Tues) prescription for +/- Midazolam 5mg to 10mg, Hyoscine Butylbromide 60mg to 120mg and Haloperidol 1.5mg to 2.5mg in case needed overnight following identification of deterioration. Prescription not used, patient died 3 days later.

-Community patient:1866 already on Alfentanil CSCI 300micrograms, +/- Haloperidol, Midazolam and Glycopyrronium prescribed on MAAR chart on a Friday, patient died peacefully 2 days later - drugs not required.

CPCT MAAR CSCI CHARTS RANGES (N=5):

- Standard practice is to include a range in the community.
- Of the 5 patients identified in this audit, ranges were felt to be clinically appropriate and safe.
- **Pt 1716** Oxycodone 5mg to 10mg to 15mg, Midazolam 5mg to 10mg to 15mg, Haloperidol 1.5mg to 3mg, Glycopyrronium 400micrograms to 600micrograms to 800 micrograms.
- **Pt 901** Alfentanil 200micrograms to 400micrograms, Metoclopramide 30mg to 60mg.
- **Pt 1767** Oxycodone 10mg to 15mg to 20mg, Midazolam 15mg to 20mg to 25mg, Buscopan 60mg to 120mg, Levomepromazine 12.5mg to 25mg (pt had terminal agitation).
- **Pt 1866** Alfentanil 300micrograms to 500micrograms to 1mg Alfentanil, Haloperidol 1mg to 2mg to 3mg, Midazolam 5mg to 10mg to 15mg, Glycopyrronium 600micrograms to 1.2mg.
- **Pt 1450** chart handwritten in the house, no scan available.

DISCUSSION POINTS

- **First three audit standards met fully: Appropriate indications for starting CSCI in all patients audited, appropriate titration in line with PRNs and/ or following clinical review, first line diluent WFI used.**
- **Main areas for improvement:**
- Explicit Documentation around starting and titrating CSCI.
- EMIS template prompt uses the term 'Clinical management plan agreed' which may imply to the clinician that stating it has been discussed and agreed with pt/those important to them is not required.
- On the IPU alongside the medical team, the nursing team regularly discuss with patients and those important to them changes made to the CSCI at the time the CSCI is re-sited/replenished, so it is likely that patients and families were aware of changes, however this cannot be verified in the EPR documentation.
- No documented evidence of use of CSCI leaflet.
- Agreement from medical team on IPU CSCI prescribing, do we need to circle the diluent?

DISCUSSION POINTS

- **Provisional CSCI prescriptions** in 2/20 patients – one on IPU and one community, on both occasions these seemed appropriate
- You could question the need for provisional charts on the IPU but given no doctor is on site for the on-call period, a provisional prescription by a clinician who knows the patient well and has reviewed them face to face may be justified over an on call medical prescriber who may not have met the patient. Provisional prescriptions are used occasionally in the community setting, especially to cover weekend periods when availability of clinical staff is greatly reduced.
- **Clinical practice around combining Cyclizine and Levomepromazine?** Not usually recommended as Levomepromazine has similar action to cyclizine (H1 antagonist, anti-muscarinic) and compatibility data is low– thoughts?

CONCLUSION AND RECOMMENDED ACTIONS

- The results of this audit demonstrate prescribing practice in keeping with the hospice standards as set out in policy, with syringe pumps started for appropriate clinical reasons, at appropriate starting doses, with evidence of careful and considered titration of medication taking into account PRN requirements, clinical review, alongside the preferences of the patient and those important to them.
- The main area identified for improvement is around the consistent and explicit documentation on the EMIS EPR of communication had with patients and those important to them around starting and titrating syringe pumps, as well as documenting if the SRH written information leaflet on syringe pumps has been offered .

Recommended Actions

1. Communication of audit results with clinical teams to highlight the importance of clear documentation around communication with the patient and those important to them when starting and titrating syringe pumps. I would also recommend raising awareness within the clinical teams about the availability of the St Raphael's written information leaflet on syringe pumps and suggest this is routinely offered as part of communication around the use of syringe pumps.
2. Clinical team to discuss combination of Cyclizine and Levomepromazine via CSCI, as this is a rare combination of two antiemetics with similar receptor antagonism profile, whilst allowing for an individual approach with regards to refractory nausea and inter individual variation in response to anti-emetics.
3. Medical team to agree on prescribing practice with regards to diluent syringe pump prescription on the IPU -is circling of preferred diluent necessary or can this be left to nursing discretion, with WFI recommended first line.

St Raphael's Hospice
Meeting of the Clinical Quality & Governance Committee
Held at St Raphael's, London Road, Cheam, Sutton, SM3 9DX with video call access

At 10:00 on Friday 11th October 2024

Members: Dr Carrie Chill – Trustee & Committee member (CC)
 Alan Cogbill – Trustee & Committee member (AC)
 Bernard Marley - Trustee & Committee member (BM)
 Norman McWhinney – Board Chair & Committee member (NM) (apologies)

In attendance: Dr Jenny Strawson – Consultant (JS)
 Rebecca Trower – Joint CEO (RT)
 Alex Rudkin – Director of Quality and Governance (apologies)
 Jenny Wingate - Governance (JW)

Agenda item	Action	Responsible	Timeline	Ref.
3. Excellent Practice Register	Update on drains related risk	Rebecca Trower	Jan meeting	11.10.24/01
4. Restructure		Rebecca Trower	asap	11.10.24/0
	Analysis of impact of loss of Hospice at Home service – provide data	Rebecca Trower	Jan meeting	11.10.24/02
5. Risk register	Considering appropriate reporting on time from referral to first assessment in the community	Alex Rudkin	Jan meeting	11.10.24/03
	Add risk around absence of Director of Quality and Governance and need for succession planning/sharing of expertise	Rebecca Trower	Asap	11.10.24/04
	Add risk around consultant not always able to be onsite	Jenny Strawson	Asap	11.10.24/04

1. Welcome, apologies for absence and declarations of interest

The Chair welcomed Committee members to the meeting. Apologies were received from Norman McWhinney, Nick Stevens and Alex Rudkin who had been taken unwell. The meeting was confirmed as quorate.

2. Review of minutes from 12th July 2024 Clinical Quality & Governance Committee meeting, Actions List and update on matters arising

The minutes of the previous meetings were approved as an accurate record of proceedings – all actions have been completed. The Chair asked that a fresh actions log be created as all actions are now complete.

3. Evidence of Excellent Practice Register

The Chair spoke about how pleasing it was to see this register and the positive comments from users as well as clinical staff. Dr Jenny Strawson spoke about how evident it was that staff go to extra lengths without themselves recognising this was the case. An example was given of the effort a staff member went into ensuring that a son who was in the army overseas could get permission to come back at very short notice to see his mother before she died. This is a clear example of excellent practice but was not recognised by the staff member as going above and beyond.

The Committee looked at the Medical Examiners' feedback report which is a reasonably new method of feedback and is to be shared with staff. They welcomed the positive comments. There was a discussion about some specific issues arising as a result of the particular drains used at times when patients are transferred from hospital and the continued use of these when at the hospice. The Committee heard that an investigation was being conducted into one case due to concerns raised by the sister of the patient. They were pleased to hear that a process for managing risk had now been put in place and an update would be provided at the next meeting.

The Committee confirmed with Jenny that the learning is being captured so it can inform future management. Jenny confirmed this and that it had been an important case in considering how best to work across organisational boundaries.

Jenny was asked if the medical examiner process was working well and was helpful. She said there had been no negative feedback to date and that it was proving a useful and thorough benchmark. There are some logistical issues for GPs who do not have the same system, but it is positive in terms of building relationships.

4. St Raphael's Hospice restructure

Rebecca Trower reported on the restructure confirming that all those who had opted for voluntary redundancy had left. She said that it had been a difficult period, especially for those in the community team and that two community nurses had recently found jobs elsewhere, so now they are in an unfortunate position of needing to recruit to these positions. Rebecca reflected on whether anything could have been done to prevent this and whether there was some learning about how the difficult messages had been communicated and the level of transparency. Trustees suggested that there were always risks around staff leaving, and it was difficult to be able to anticipate the decisions that staff might take as a result of uncertainty. They heard that the two staff leaving were leaving to be closer to home and so this was not necessarily a negative step for them.

Nonetheless she emphasised how hard the community team were finding the changes, and that when the head of the team reduces her hours in November, this is also likely to have an impact.

The Committee asked whether departures might result in a risk that the team cannot function safely and appropriately. Rebecca responded that they are aware of this risk and are ensuring expectations are set at the right level amongst providers and the community and where necessary, are reminded about the other agencies that provide palliative care in the community.

The Committee discussed the challenges around this, noting that very often St Raphael's will be contacted following a lack of response from other agencies such as the emergency services. Nonetheless, Rebecca stated that referrals have levelled out recently and are manageable, but there may be a need to remodel in the new year.

Rebecca was asked what remodelling might look like – she explained that some scenario setting based on resource availability would be conducted, with the optimum scenario being that of the position prior to the reorganisation.

Rebecca reported on staffing in other teams as follows:

- In-patient unit – the physician associate role has ceased – this is currently manageable, but when the proposed reductions in staff grade and consultant hours are implemented there will be a need to monitor this closely. A candidate has recently been appointed to the IPU lead role.
- Psychological support team – there will be one leaver in this team and there will now be a sole lead with a counsellor taking on more hours and providing greater support to the counselling students. This is working well with the team flourishing. There is an advert out for a two day a week Facilitator/Supervisor role to oversee the students.
- Education team – there is a significant level of work to be completed for the number of hours in the team and this will need to be reviewed. Nonetheless the team has done some external training which has been well received, e.g. palliative care master class.
- Wellbeing team – despite changes, the team is working well, the therapy and compassionate neighbours work is continuing but at a reduced level. The hospice has submitted a 5 year £40k p.a. grant application for the Wellbeing team which all are hopeful about.
- Medical team – noted that Dr Jenny Strawson was leaving with interview of a possible candidate planned for 23rd October. The Committee were made aware that there will now be times during the week when a consultant is not on site and so there may be risks around consultant coverage. It was agreed that this risk should be added to the risk register.

The Committee considered the impact of the Hospice at Home service closing. They heard that there had been a small number of requests for support which had to be declined and that following closure, there had been some feedback via Voices about how positive the service was. In addition, following recent press coverage, a significant donation was made which further emphasises how important the press coverage has been.

Rebecca was asked whether she would recommend restarting the service should funding become available. She suggested that the priority would be the specialist community service followed by Hospice at Home.

She reported that since the closure, the clinical lead for end-of-life care for SW London had been in touch to ask if St Raphael's would be interested in setting up a CHC funded care provider as there were concerns about the capacity of current care providers. She suggested that at this stage, they would not have the capacity, but they could do some support to model practice which would bring in further funds. She will be following up to understand more and will report back.

The Committee suggested that it would be useful to have an analysis of the impact of the loss of the service by tracking requests that can't be met etc. This was agreed.

5. Clinical Risk Register

The Committee reviewed the risk register and noted risks where ratings had increased or decreased. They commented on specific risks as follows:

- Reduced responsiveness to existing case loads is the most heightened risk currently. The Committee asked how this was monitored, and it was explained that this was primarily through feedback from community team as well as times from referral to first assessment.. This is an area that Alex Rudkin would be asked to report on at the next meeting.
- Lower staff morale remains a key risk which has been discussed at length – effort continues to be made with ensuring there is regular contact with team members to check on their wellbeing
- It was agreed that it was important to ensure the CPCT keep to their role and remit as St Raphael's and ensure this was not extended without additional funding.
- Confirmation that the risk around IT system failure remains high but has been downgraded due to the work that has happened to mitigate against this. Disaster recovery plans are now being worked on for all teams and there is greater confidence all round.

The Committee discussed the nature of the risk register urging a level of caution around the use of numerical targets given the nature of the work and the environment. The Committee confirmed that they felt that the format was very clear and would be useful from an audit perspective. They suggested consideration should be given to whether a staffing risk related to the absence of Alex Rudkin should be added but also heard that actions were being taken to ensure that others were able to provide cover as needed. Rebecca added that there was also a need to ensure that data is being collated in the most effective manner, for example, making greater use of data from EMIS, or allocating document review tasks to more than one individual in the team.

6. Clinical Quality & Governance Report inc Clinical Action Plan

The Committee agreed that much of this had already been covered during the meeting. They noted that R Wallis had completed a number of actions prior to leaving, but there were some that needed reallocating, e.g. safeguarding audit. It was also noted that admissions and referral data had not been recently updated – this would be done for the next meeting.

The Committee were told there had been no new complaints since the last meeting. Whilst this could be possible, leaders did suggest that this raised an issue of how feedback is being requested, and will be kept under review. Jenny added that she thought there would be at least two when reporting next time and confirmed that there is strong oversight of these matters.

7. Minutes of internal meetings

Committee noted the minutes.

8. Annual review of Hospice's position in local healthcare ecosystem

Rebecca reported that the ICB chair and CFO would be coming to St Raphael's on 30th October and that a briefing paper is being prepared for them. She added that the Chair has been proactively engaged with the hospices and seems supportive.

The longer term strategy from the ICB in relation to hospices is still not clear, but the SWL hospices are now meeting regularly and shortly will be meeting with the continuing healthcare team at the ICB to discuss the rates to be paid for commissioned bed space at the IPU. Currently Merton are paying between £400 and £550 a night for patients who meet the fast track funding criteria, but this is not sustainable for Merton and there is a need to agree a standard rate that is acceptable for the ICBs and the hospices.

The Committee congratulated Rebecca and the press team on how much coverage they had achieved recently and were pleased to hear that a number of MPs are visiting the hospice and that Rebecca will be attending the Hospice UK conference. The Committee suggested that a St Raphael's representative might do a useful session on lessons learnt from the cyber attack at the conference at some point.

9. Safeguarding Update

It was noted that Alex would have been reporting on this, but that there were no instances of concern to report.

10. Any Other Business and Dates of future meetings

There were no further items of business raised. The Committee thanked the team for the quality of reports provided and thanked Jenny for her work at the hospice and wished her all the best.

The date of the next meeting was confirmed as 15th January 2025 from 10am-12pm.

The meeting ended at 11.50am

Approved.....

Date.....

DRAFT

St Raphael's Hospice
Meeting of the Clinical Quality & Governance Committee
To be held virtually
10am-12pm on Friday 17th January 2025

Members: Dr Carrie Chill – Trustee & Committee member (CC)
 Alan Cogbill – Trustee & Committee member (AC)
 Benard Marley – Trustee & Committee member (BM)
 Norman McWhinney – Board Chair & Committee member (NM)

In attendance: Nick Stevens – Joint CEO (NS – apologies)
 Rebecca Trower – Joint CEO (RT)
 Alex Rudkin – Director of Quality and Governance (AR)
 Dr Naomi Collins – Consultant (NC)
 Anna Machin – Governance (AM)

Item	Time	Description	Purpose	Lead
1.	10.00 – 10.05	Welcomes, apologies for absence and declarations of interest	Discussion	Chair
2.	10.05 – 10.15	Review of minutes from Clinical Quality & Governance Committee meeting held on 11 th October 2024	Approval	Chair
		Actions List and update on matters arising	Discussion	
3.	10.15 – 10.25	Evidence of Excellent Practice Register	Discussion	RT
4.	10.25 – 10.45	NHS consultation	Discussion	NS, RT, AR
5.	10.45 – 11.10	Clinical Risk Register	Discussion	RT
6.	11.10 – 11.25	Clinical Quality & Governance Report inc. Clinical Action Plan	Discussion	RT, AR
7.	11.25 – 11.30	Minutes of internal meetings	Discussion	AR
8.	11.45 – 11.55	Safeguarding Update (verbal update)	Discussion	AR
9.	11.55 – 12.00	Any Other Business & Date of next meeting	Discussion	Chair

Dates of future meetings: Friday 2nd May, 10am-12pm (In person meeting); Friday 11th July, 10am-12pm (Virtual meeting)

Actions log

Agenda item	Action	Responsible	Timeline	Ref.	Update
3. Excellent Practice Register	Update on drains related risk	Rebecca Trower	Jan meeting	11.10.24/01	Feedback and update 17.01.25
4. Restructure	Add risk around consultant onsite time to register	Rebecca Trower	asap	11.10.24/02	Added - complete
	Analysis of impact of loss of Hospice at Home service – provide data	Rebecca Trower	Jan meeting	11.10.24/03	Feedback and update 17.01.25
5. Risk register	Considering appropriate reporting on time from referral to first assessment in the community	Alex Rudkin	Jan meeting	11.10.24/04	Update to be given at meeting
5. Clinical Action Plan	Circulate Quality Account to Committee for comment by correspondence	Alex Rudkin	May/ June	19.04.24/01	Complete
	Place 2023/24 Quality Account on agenda of next meeting	Anna Machin, Alex Rudkin	July meeting	19.01.24/02	Complete
	Look at complaint in further detail, as agreed with Committee	Becca Trower	Update at July meeting	19.04.24/03	Complete
7. Safeguarding update	Place 2023/24 Safeguarding update on agenda of next meeting	Anna Machin, Alex Rudkin	July meeting	19.04.24/04	Complete
4. Clinical risk register	Take forward discussion on use of technology for note-taking to Hospice user group	Consultant team, Becca Trower	Spring 2024, by April 2024 meeting	19.01.24/01	Complete
	Reflect further on lone working communications to staff	Consultant team, Becca Trower	Spring 2024, by April 2024 meeting	19.01.24/02	Complete
5. Clinical Quality & Governance Report	Include Psycho-Social team survey report in April meeting pack	Alex Rudkin	For April 2024 meeting	19.01.24/03	Complete
	Consider further ways to streamline referral notes process	Consultant team, Becca Trower	Spring 2024, by April 2024 meeting	19.01.24/04	Complete
	Update on grant funding proposal	Consultant team, Becca Trower	For April 2024 meeting	19.01.24/05	Complete
	Update pages 16 and 18 in report on patient numbers	Alex Rudkin	Immediate	19.01.24/06	Complete

	Split out minor and major IG incidents in report	Alex Rudkin	Immediate	19.01.24/07	Complete
2. Review of Quality Account and Management Plan	Finalise Quality Account and circulate for final Committee review	Alex Rudkin	Immediate	17.06.24/01	Complete