St Raphael's Hospice

Meeting of the Clinical Quality & Governance Committee

To be held at St Raphael's Hospice with video dial-in option

At 10:00am on Friday 1st April 2022

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

In attendance: Gail Linehan – Joint CEO (GL)
Nick Stevens – Joint CEO (NS)
Dr Jenny Strawson – Consultant (JS)
Rebecca Trower – Clinical Director (BT)
Alex Rudkin - Head of Quality and Improvement (AR)
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.	10.05-10.20	Review of minutes from 14th January 2022 Clinical Quality & Governance Committee meeting	Approval	Chair
		Actions List and update on matters arising	Discussion	
3.	10.20-10.35	Evidence of Excellent Practice Register	Discussion	
4.	10.35-10.55	Clinical Risk Register • Update on admissions refused due to staff capacity	Discussion	RT
5.	10.55-11.05	Clinical Quality & Governance Report	Discussion	RT/AR
6.	11.05-11.35	Clinical Quality & Governance Objectives - Extract from Management Plan 2022/23	Discussion	RT/AR
7.	11.35-11.45	Minutes of internal meetings • Benchmarking of Safeguarding referrals vs other local hospices • Update on staff vaccination	Discussion	
8.	11.45-11.55	Annual Review of Committee Terms of Reference	Discussion	
9.	11.55-12.00	Any Other Business & Date of next meeting	Discussion	Chair

Dates of future meetings:

- Friday 1st July 2022, 10am-12pm
- Friday 7th October 2022, 10am-12pm

St Raphael's Hospice

Minutes of a Meeting of the Clinical Quality & Governance Committee

Held using Zoom Video Conferencing

At 10:00 on Friday 14th January 2022

Members: Dr Carrie Chill – Board Advisor & Committee member (CC)
Alan Cogbill – Trustee & Committee member (AC)
Dr Eva Kalmus – Co-opted Committee member (EK)
Norman McWhinney – Board Chair & Committee member (NM)
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In attendance: Gail Linehan – Joint CEO (GL)
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Rebecca Trower – Clinical Director (BT)
Anna Machin (Clerk – AM)

Actions arising

Agenda item	Action	Responsible	Timeline	Ref.
5. Clinical Risk Register	Provide update on data showing number of instances when Admission refused based on staff capacity, including due to Covid-19	Rebecca Trower	1st April meeting	2022/14/01-01
7. CAP 2021/22	Bring together document to frame progress outlined in CAP	Rebecca Trower	1st April meeting	2022/14/01-02
6. Minutes of meetings	Benchmark level of Safeguarding referrals vs. other local Hospices	Rebecca Trower, with colleagues	1st April meeting	2022/14/01-03
	Take forward arranging Safeguarding Link Trustee visit	Rebecca Trower, Joy Tweed	By 1st April meeting	2022/14/01-04
	Provide update on conversations regarding staff vaccination	Rebecca Trower	1st April meeting	2022/14/01-05

1. **Welcome and apologies for absence**

   Dr Carrie Chill took the Chair. Apologies were received and accepted from Alex Rudkin.

2. **Review of minutes from last meeting**

   The minutes of the 29th October 2021 meeting were reviewed and approved as an accurate record of proceedings subject to one correction.

3. Action list from previous meetings

Committee members reviewed the matters arising:

- 21/05/14-02 – Ensure HR Committee consider position on staff contracts and vaccination – this will be a standing item in the Report for each meeting.
- 21/07/16-01 – Explore option to recruit agency nurse for night shifts – the Hospice continues to conduct outreach.
- 21/07/16-04 – Update on equality and diversity Working Group on patient behaviour towards staff – this meeting has not been held due to the pressures of Covid-19 but is a priority to plan.
- 21/07/16-07 - Consider further ways to help inform patients of Hospice support compared to other services – the Information Booklet has not yet been printed.
- 21/10/20-01 – Share FAQs from drop-in sessions on Agenda for Change with all staff – this was not circulated as there was strong attendance at face-to-face meetings.
- 21/09/29-02 – Update Clinical Risk Register – the suggested change has been made.
- 21/10/29-03 – Update on support for younger patients – this will be presented at a meeting later in the year.

4. Evidence of Excellent Practice Register

The Committee noted the range of good practice examples of staff and volunteers going above and beyond, including the decision to keep existing patients in the Hospice during the Christmas period so that they could be visited by families, swift issuing of the death certificate for a Muslim patient to enable the funeral to be organised quickly, and responsive service across the Hospice and Community teams. The Committee and colleagues discussed the process sitting behind the complex decision-making on patients moving on from the Hospice into nursing homes. This is guided by the Multi-Disciplinary Team (MDT), and knowledge of the patient and family.

5. Clinical Risk Register

Rebecca Trower highlighted that the highest priority risk related to staff absence caused by Covid-19. The number of bank staff, including registered nurses, has increased in the last 2-3 months. Certain staff will retire, or reduce hours, in coming months. A Band 7 Ward Sister post is being advertised for internal recruitment as part of providing more job opportunities for existing staff. Feedback from student nurses has been strong.

The IT system failure risk has been reduced down due to efforts by the IT and data teams on business continuity and securing back-up staff cover.

The prior challenges relating to the communication of the move to the Agenda for Change have not translated into more negative staff survey results. It was agreed that the residual risk would be raised in order to keep monitoring this area.

The Committee requested an update on the impact of the Omicron variant. The levels of staff absence have not compared to the wave of Delta in the previous winter. Staff went above and beyond over the Christmas to provide cover, and the bed occupancy was reviewed and flexed frequently based on staffing levels. Staff worked between the Ward and Community teams as needed, and the benefits were shown of having a First, Second and at times Third On-Call rota in collaboration with other local Hospices.

The Committee asked for an update at the next meeting on the data showing instances when Admission is denied based on insufficient staffing capacity due to Covid-19, which could be captured through Datix or the Capacity Tracker.

6. Clinical Quality & Governance Report

Rebecca Trower shared key highlights from the Report:

- The Covid-19 policies continue to be reviewed rigorously, in line with the latest guidance and staff undertake regular testing. The Wellbeing Centre activities have been moved online during the current wave.
- Community have been working in locality teams for six months so a review of progress against original goals will be held. There is a focus on providing training for HCAs to undertake new tasks. The £60k CCG funding to support weekend provision will be used to fund a substantive post, and if the funding is not continued, this will be managed through natural attrition.
- Safeguarding referrals made by the Hospice are being upheld by the Local Authority (LA) which shows sound decision-making and the outcomes of staff training.

The Committee asked for an update on Datix implementation. It was confirmed that the system has been well received and sped up the process of logging information, and the roll-out was accompanied by a bespoke training video.

The Committee asked for further contextual information to the two main complaints. The main learning for the first complaint related to the challenge in finding appropriate nursing home accommodation for younger patients. The Committee and colleagues discussed the potential benefits and risks associated with acting to either provide provision on-site, or support the attraction of funding to enable better local provision in care homes, with it in mind that the Hospice's primary purpose is palliative end of life care.

With the second complaint, it was not supported by other members of the family, and it was in many ways a symptom of the range of different services supporting the family. It demonstrates the need for more capacity and coordination in the health system, and also practically shows the importance of close working with District Nurses. In both cases, a staff member from St Raphael's visited the family.

7. Clinical Action Plan (CAP) 2021/22

The Committee noted the extent of progress on actions in the CAP in the face of Covid-19. It is still a goal to introduce Schwartz Rounds, review the Hospice at Home service, and introduce a new assessment tool to support patients' carers. For several of the objectives, they relate to ongoing improvement in provision rather than a specific 'SMART' goal. It was agreed that a document would be brought together to frame the CAP priorities, and differentiate between ongoing work, in-year targets and stretch targets.

8. Minutes of meetings and other documents

The Committee discussed the content of the Safeguarding Audit Report, and received assurance on the strong Safeguarding culture, training and internal awareness on how to access the relevant policies. 100% of concerns have been reported to the CCG, primarily through the Community team, and these primarily relate to areas including hoarding, abuse, self-neglect and fire risk. The Committee requested that the level of referrals should be benchmarked compared to other local Hospices.

Rebecca Trower raised a small number of staff have not yet been vaccinated due to specific medical reasons. It will be mandatory for all patient-facing staff to be vaccinated from 1st April 2022. Conversations have been initiated with these staff members, and the Hospice is ensuring sensitivity, privacy impact assessments, and potential approaches to redeployment of staff if needed, depending on the outcome of the relevant risk assessments. The Committee reflected the mature approach being taken to these conversations and asked for an update at the next meeting.

9. Any Other Business and Dates of future meetings

There were no items raised under Any Other Business. The date of the next meeting was confirmed as Friday 1st April from 10am-12pm, which is due to be held in person, dependent on the Covid-19 guidance at the time.

The meeting ended at 11.50am.

Approved………………………………….. Date………………………………………..

ITEM 04 ACTION LIST

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

Reference	Lead	Description	Target Date for Completion	Comments
21/07/16-04	R Trower	Share update on equality & diversity Working Group on patient behaviour towards staff	April 2022	All members engaged and in process of 1st meeting set up (BD-S, MB, CC, SM, RT)
21/10/29-03	Dr J Strawson	Provide update on paediatric palliative trainee post and support for younger patients	Meeting during 2022	
22/01/14-02	R Trower	Bring together document to frame progress outlined in CAP	April 2022	Incorporated into main Management Plan
22/01/14-03	R Trower with colleagues	Benchmark level of Safeguarding referrals vs. other local Hospices	April 2022	Canvassed for feedback
22/01/14-04	R Trower, J Tweed	Take forward arranging Safeguarding Link Trustee visit	April 2022	Complete
22/01/14-05	R Trower	Provide update on conversations regarding staff vaccination	April 2022	Complete

Ref No.	Recorded By	Date	EXAMPLES OF EXCELLENT PRACTICE - Description	Link to evidence	PT Id	KLOE	Key Staff	Related System
2022/01	MF/AR	24/01/2022	Please see below from Medical Examiners received today. “We just received highly positive feedback from Maureen Gage's family which they wanted to pass onto you: We spoke with daughter Claire and son Colin. The reported the care in the last 2 weeks has been "OUTSTANDING". The care at the hospice has "blown us away" with the compassion shown - not only to Maureen but also to the family as a whole. They expressed "absolute satisfaction" for the entire process, including the ME call. They felt all the literature, pamphlets provided were incredibly helpful. "Every single staff member has been outstanding" and they specifically commended: Dr Strawson Dr Fletcher Dr Jovy The family have made a donation to the hospice and we encouraged them to also email/feedback to the hospice directly, as they were so impressed with the care and the service.”	N:\Care Quality Commission\Excellence in Practice\Evidence of excellence copy\Medical Examiners family feedback 24-01-2022.msg	15467	C, R, E , W		
2022/02	RT	27/01/2022	Patient died on the IPU. Staff Nurse CV cut a lock of hair and placed with wedding ring in a decorative box to give to the husband. Placed a yellow rose on the pillow of the deceased for the husband when he viewed the body.		16471	C		
2022/03	TC	14/02/2022	The events commenced Sunday morning with an OOH call taken by Julie Ford which was then escalated to the community team CNS’s ,Becky Lucas and Kate Weldon . The wider working with our IPU, hospital collegues in the RMHS , SHH and the oncall hospice Dr really demonstrated effective communication and collbrative working to reach the best possible outcome for the patient . Drs from both the RMHS and SHH A/ E (Dr Alena and Sister Val) compared and discussed imaging to exclude any new fractures . CNS, Becky Lucas cordinated and communication between all parties to allow a smooth transfer for the patient .		229	C,R,E	RL, JF, on call dr	
2022/04	RT	28/02/2022	A two year old visits her grandmlother on the Hospice Ward and received a lovely surprise on her birthday	Evidence of excellence copy\FW patient in room 1.msg	18598	C	Housekeeping	

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

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

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

ITEM 05

Clinical Quality and Governance Report

Contents

Aim....1
Recommendation....1
Report....2
Update on Organisational Response to the Covid 19 Pandemic....2
Clinical Services....2
Medical Team....3
Education/Training....4
Capacity Tracker....5
Governance meetings....5
Clinical Audit, Monitoring and Research....6
Data Dashboards....7
Quality Account....7
CQC and Organisational Assurance....7
Clinical Action Plan 2021/22....8
Audit/Research 2021/22....10
Clinical Risk Management....29
Clinical Complaints....33
Complaints Overview....38
Records – Access Requests....39
Notifications....39
Clinical Commissioning Group (CCG) Data....39

Aim

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

Recommendation

The report be noted.

Report

Update on Organisational Response to the Covid 19 Pandemic

Covid has now become part of 'Business as Usual' – government guidance returns the onus to the individual provider on most counts and so we have once again reviewed our response to remain as safe as possible whilst giving consideration to the unique needs of our patient group.
Mask wearing away from the clinical area is optional and testing is now only mandatory on a regular basis for those in clinical situations or who have a presence in the hospice building.

A number of staff are still being affected by the Omnicron variant and we continue to have dips in our staffing levels at times but managing workload by using creative approaches is now second nature.

Our Service level agreement with the Infection Prevention and Control (IPC) team from St Helier Hospital becomes formal from 1 April and over the next twelve months we will be training one of our senior members of clinical staff in IPC so that we can manage IPC inhouse again from 2023.

We are gradually returning some of our services to their pre-Covid form through the reintroduction of some of our volunteers and recommencing services such as complementary therapies.

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

Clinical Services

Our **Psychological Support Team** is due to expand following a compelling presentation from Steve Molyneux, Psychological Support Lead. There is an increasing demand for counselling for our service users and the current PSS Team are beyond capacity. The service is an essential part of specialist palliative care and the invaluable support that the team provides will now be more responsive with a 0.6WTE counsellor added to the team. The role will include experience in Post Traumatic Stress Disorder, now more prevalent due to the effects of Covid on bereavement and late diagnosis. The bereavement group is now being run independently by Sr Anne and is proving a popular group.

Our **Wellbeing** attendance numbers continue to rise and the Living Well programme remains popular – with consistently positive feedback. Engaging with social prescribers has increased our referrals and our numbers are currently evenly divided between those already known to our service and those who have engaged with us from other referral sources. Sheila's team are working in collaboration with a number of other local groups and services to promote a unified community service. There has been interest in accessing the service from people outside of the SRH catchment area and we are looking at working with other hospices in order to increase efficiency and promote Wellbeing earlier on in disease trajectories. The Men's Den is currently under construction – the building looks amazing. Our next focus is develop the Men's Den in a way that meets the needs of the 'missing men' in our community – there is documented evidence that men are less likely than women to seek emotional support. We are hoping that our 'Den' will encourage men to meet together and support one another in ways that they find comfortable, such as through social interaction.
We have appointed a new complementary therapist – Laura Janowski. Laura is an experienced and incredibly enthusiastic therapist and will be working one day a week to recommence our CT service,

overseeing the return of previous volunteers as well as recruiting new therapists. CT has always been a popular service and we are aiming to offer treatments across the week as the service builds. Jane Gauld, one of our CPCT CNS', will also be offering manual lymphatic drainage to service users on a monthly basis.

The **IPU** is looking bright and welcoming in the recent sunshine - 'snaggings' from the refurb are almost complete and we are aiming to produce a short video with the help of a VR director who has offered his services free of charge. This will mean that patients and families as well as healthcare professionals will have a better idea of the environment without having to visit.
The unit is consistently busy – we have managed to increase our capacity to 9 beds on occasion over the past quarter and continue to review this, with staff numbers in mind. Recruitment remains challenging and we are looking at various opportunities that may increase applications such as information stands during study days and strengthening links with Roehampton university.
As part of EVE, we are focusing on our excellence strand for the IPU and have begun working towards a revised model to ensure that we remain responsive to the needs of our community. Becca Wallis (CNS in CPCT) has been successfully appointed as IPU sister for a 12 month secondment. Becca is currently working towards a degree in Advanced Clinical Practice, and will be overseeing the day to day management of the ward as well as leading the IPU nurses in developing their clinical skills. Ultimately we would like to upskill the team so that they become more adept in nurse led assessment and nurse led admissions for patients with less complex needs.
This means that Tracey Young is freed up to focus on the leading on projects, taking on IPC over the longer term and ensuring we demonstrate excellence in our clinical standards and audit. Her title has changed to Clinical Standards and Project Lead. Both Becca and Tracey will start their new roles in May and both are looking forward to the new opportunities this will bring.

The **CPCT**'s new model of three locality teams has been running for more than nine months and a formal review was undertaken at the beginning of March. The new model has proved to be successful with the team feeling less overwhelmed through having smaller caseloads shared by a few, rather than one team caseload. The locality leads undertake regular caseload reviews with medical input. The admissions meeting structure has changed slightly to include an extra meeting in the afternoons. This means that patients needing transfer from the acute sector can now be admitted the following day, allowing time for arrangement of transport, discharge information, medications etc.
Karen Fall, who has worked as a CNS in the CPCT for a number of years has now retired – Karen has been a hugely valuable member of the team and will be very much missed but has agreed to return and work on the bank should we need her. We have just appointed two new CNS' who will start with us at the end of May/early June. One will be a band 7 and the other is a band 6 training post. We are really looking forward to them joining us and they have a wealth of experience to offer.

The Hospice@Home team model has also been reviewed and we have decided to continue with the current remit. The service is very popular with consistent positive feedback from those they come into contact with. We have a couple of vacancies and are due to interview to fill these posts shortly.

Medical Team

The Medical On call collaboration continues to work well, with the consultants across all 3 sites meeting every 2 months to discuss any problems arising. Dr Strawson has recently completed a work diary to monitor the number of hours spent by the first on call medical team reviewing patients by phone and face to face over the 48 hour weekend on call period.

The consultant team have started to actively partake in the executive on call alongside their clinical duties. NC has completed her first week and there is now a spreadsheet to log calls alongside the Datix ststem.

As part of our endeavours to engage with other key local end of life care providers we invited Dr Eva Kalmus who presented on her GeriPal project and Dr Maryem George who presented on her role as a GP working for Sutton Health and Care to the community team during our morning meeting. The consultant team have also continued to support Merton end of life care team who are able to ring us directly by mobile phone for clinical advice and we have invited both Sutton and Merton EOL teams to attend our regular community case load reviews.

The medical team continue to support education across the team regularly delivering teaching to The Wellbeing Centre as part of the living well program, as part of our Monday medical teaching with Princess Alice and Woking and Sam Beare hospices and weekly journal club. Dr Collins as lead for education continues to organise and facilitate medical students from SGH for one day placements on Tuesdays and Thursdays – their feedback has been consistently positive. Unfortunately, our first face to face GP Masterclass was cancelled in March due to the low number of bookings, but we are hopeful for a full turn out for September. Our Physician Associate Jovy Giles presented her poster presentation on the role of the PA in hospices at the Palliative Care Congress in Telford on 24th and 25th of March which was very well received. The consultant team have offered to act as examiners/supervisors for candidates doing the European certificate in Palliative Care at Princess Alice and will shadow the next exam in June.

The consultants are actively involved in education and clinical supervision of several trainees: Dr Clingan Palliative Medicine ST5, Dr Woods ST7 paediatric palliative medicine, Dr Tina Jeong ST2 GP trainee. The consultant team have also taken the lead on supervising Dr Kris Ray, our recently recruited volunteer Consultant Psychiatrist– it has been great learning from each other and recognising some of the parallels between the specialities and the challenges faced. Dr Strawson and Dr Tamura-Rose are trained medical appraisers and ensure all of the medical team are supported with their yearly appraisal and revalidation. It’s a busy time as many of the team’s appraisals fall in March and April!

As April approaches we have completed and presented back the results of this year’s audit program at the audit presentation day, with just a few audits ongoing, in particular the yearly end of life care audit. We recently completed an audit looking at referrals to the IPU which has highlighted the effect of reduced bed occupancy on access to the hospice IPU, especially for patients referred from hospital. Looking forward to next year the plan is to focus on a few key areas that will really make a difference to the service.

Education/Training

Our Palliative Care Educators have now returned to their Education roles, having handed IPC over at long last. Their annual calendar looks busy and exciting – they are spending time teaching both inhouse and externally, as well as strengthening links with the local universities. We have nursing placements from both St Georges and Roehampton University and we are currently exploring a preceptorship programme, which would allow us to recruit newly qualified staff as soon as their training is complete. There have also been inhouse study days held over the last quarter – the Healthcare Assistants from

both the IPU and the H@H team recently attend a full day's training on a number of topics with really positive feedback.

Capacity Tracker

We continue to contribute our inputs into the NHS capacity Tracker which is aligned to the HUK grant from Treasury. Submissions will no longer be required following 31st March 2022.

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 8 clinically focused forums that currently feed into the CQ&G Sub.
The Health & Safety Committee feeds into the F&R Sub.
The Staff Consultative Group (suspended) and the Education, Training & Development Committee feed into the HR Sub.

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

Incidents / Accidents / Near Misses

- DATIX incident reporting was implemented in November 2021. Each incident is reviewed by the line manager (HoD) and all incidents receive final approval either from the Joint CEOs (IG), the Clinical Director (Clinical), the Head of Income Generation (Retail and Fundraising) or the Head of Quality and Improvement. Clinical review has been incorporated into the business of the Clinical Heads of Department Meeting that meets every 6 weeks. Those that are non-clinical are reviewed at H&S Committee. Representatives are expected to cascade review information back to their teams and an incident feedback facility is programmed into the DATIX report for the reporter. Data is presented later in this report but it is noticeable how engagement from the non-clinical area of Retail has increased since the introduction of the electronic report format.

- Quarterly submission to Hospice UK's Quality Metrics project began in July 2017 and are on-going with the latest submission delivered in January 2022. The submission categories cover pressure sores, patient medication incidents and incidents of patient falls.

- All falls are reviewed at meetings of the Falls Group. Its last meeting took place in December 2021 and its next meeting is scheduled for July 2023. The Falls Policy was last reviewed and re-published in October 2020.

Clinical Audit, Monitoring and Research

Proactive audit of the prescription charts remains a weekly undertaking for our clinical Pharmacist and results are routinely shared via the Live Care system and reported to the D&TC.

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 last meeting was held in January 2022. A Clinical Audit and Quality Improvement Project Presentation Forum has been established and commenced in March 2022. It occupies a lunch-time slot (12.45-2pm) and is open to the clinical teams and those with an interest in topic. It provides a platform for project leads to present results of their project to a wider audience.

The Audit/Research Programme 2021/2022 with timeline is set out from page 10. It itemises 24 projects spanning, clinical audit, quality improvement and data monitoring. Ownership is delegated across the clinical team and Quality office and the medical team projects have Dr Tamura-Rose as audit overseer.
Planning for 2022/23 is well underway and we have an ambitious and healthy program lined up.

Data Dashboards

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

Report Reference	Title	Lead	Created	Function	Primary Aud.	Exec / CCG Interest	Freq.	Resp.	Is Data Presented ?
20/001	CMC Monitoring	BG	Jan-20	To improve CMC data capture	CPCT	Yes	Weekly	AR	Yes
20/002	NoK Details	SM	Jan-20	To improve NoK data capture	Psy / Qual / Donor Support	No	Monthly	AR	Yes
20/003	Community Team Visit Responsiveness	LB	Jan-20	To support responsiveness evidence	CPCT	Yes	Quarterly	AR	Yes
20/004	Sharing Information Consent	TC	2018	To monitor and improve Sharing Information Consent data capture	CPCT	No	Monthly	AR	Yes
20/005	Safeguarding Monitoring	RW	Feb-20	To highlight patients with safeguarding concerns and track follow up	CPCT	No	Monthly	JL	No
20/006	Referrals Monitoring	JO'G	Mar-20	To monitor and improve Referrals data capture	CPCT	No	Monthly	AR	Yes
20/007	Referral to RIP Monitoring	JO'G	Mar-20	To monitor time between referral and death	CPCT	No	Monthly	AR	Yes
20/008	Active Caseloads	NS/GL	May-20	To monitor active caseload levels	Exec	Yes	Weekly	AR	Yes
20/009	Daily Activity Data - capacity tracker support	NS/GL	May-20	To monitor activity recorded on Crosscare	Exec	Yes	Daily	AR	Yes
20/010	Referrals by Postcode	DN	Jun-20	To monitor referrals by postcode	Fundraising & Exec	Yes	Monthly	AR	Yes
21/001	PPoD vs Actual PoD Monitoring	RT	Apr21	To monitor PPoD achievement rates	Exec	Yes	Quarterly	AR	Yes
21/002	IPU Waiting Times / Re4quests for Admission	RT	Feb-22	To demonstrate the servicing of admission requests and profile waiting times for admission	Exec	Yes	Quarterly	AR	Yes

Quality Account

The Hospice last submitted its **Quality Account** for 2020/2021 to the NHS Choices web site in June 2021 and is available on the Hospice's website at https://www.straphaels.org.uk/Handlers/Download.ashx?IDMF=a1a6bf91-8067-44e8-b3e1-aaeca9a274b6lt.

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

CQC and Organisational Assurance

The CQC last inspected the Hospice in November 2019 and awarded a Good rating. The report is available via the Hospice website.
An expanded working party periodically populates and keeps under review the Key Lines of Enquiry self-assessment documentation.
The CQC have published Temporary Monitoring Arrangement KLOEs that underpin their support calls that are expected more frequently than previously as part of their relationship building and assessment program. Last submission to support the latest telephone monitoring call was on 23rd February 2021 and was included in the papers for the February CQ&G Sub-committee meeting.

The self-assessment against the KLOEs will support our preparation for an inspection. We understand now that the CQC have abandoned the requirement for completion of a Provider Information Return with inspection methodology expected to embrace unannounced inspection. Allied to the workings of this group has been the creation of a depository for evidence of excellence that is included as an Agenda item for the CQ&G Sub. We hope our KLOE work will support our evidence base to achieve an 'Outstanding' rating at our next inspection and maintain it in the future.
The last TMA telephone catch up was held by Gail and Becca with Renae Clews, our CQC Relationship Manager, in March 2022.

Clinical Action Plan 2021/22

Summary

DATE	100% completion	75%-99% completion	50%-75% completion	25%-49% completion	1%-24% completion
23-Mar-21	0	4	3	2	11
23-Apr-21	0	4	4	2	10
09-Jul-21	0	6	3	7	4
13-Jul-21	0	6	5	7	2
22-Oct-21	3	5	6	4	2
13-Dec-21	6	8	3	2	1
24-Jan-22	15	4	0	1	0
25-Mar-22	18	1	0	1	0

Goals Completed

Ref	Goal
CAP01	Review suitability of staff support / clinical supervision/reflection mechanisms : consideration of Schwartz rounds
CAP02	Rotation of IPU staff across 24 hours Provide adequate competent staffing across days and nights
CAP03	Increase counselling support for post bereavement care from 6 student counsellors to 8
CAP05	To maintain CNS Development posts
CAP06	To include the audit of clinical risk assessment that supports individualised care planning in the clinical audit program
CAP07	Implementation, training and embedding of Step 1 (Phase of Illness & Karnofsky) of the Outcome Assessment and Complexity Collaborative (OACC)
CAP08	Incorporation of basic and advanced communication skills training for clinical staff into the mandatory training programme and delivering it
CAP10	To ensure there is participation in the planning and auditing of clinical practice across all clinical teams (IPU / Medical / Community / Psychological Support) in line with the Hospice's Clinical Audit program.
CAP11	To complete VOED (Verification of Expected Death) documentation in the Community
CAP12	Review of the CPCT service model

Ref	Goal
CAP13	Successful embedding of the new wellbeing model
CAP14	To increase community profile - GSFs - Nursing Home MDTs - GP Master Class - Foundation in Palliative Care for Community Nurses - Specialist OPD (Heart failure/ COPD/ Renal) To integrate Hospice into Acute Sector Site Specific Clinics to support fellow HCPs with approrpriate referral to Hospice Services
CAP15	Identification and allocation of clinical lead for the Medical Team Designated areas of responsibility clarified for Consultants
CAP16	To demonstrate the impact of the Physician Associate position
CAP17	To review the palliative intervention offer (Paracentesis) - Bladder scanner use - Ultrasound course access
CAP18	To increase SRH collaborations with other Hospices / HCPs
CAP19	To review the reach and delivery of services provided by the Hospice @ Home service
CAP20	To increase identification of carers needs and provision of support

75% Complete

Ref	Goal
CAP09	Implementation of Datix to manage Incident/complaint/complements. Incident reporting implemented in Nov’21. Plan to implement Feedback module Q1 2022/23.

25% Complete

Ref	Goal
CAP04	Increase establishment of Band 5 nurses on the IPU to facilitate secondment to other clinical departments to support staff development and a ‘One Team’ approach. Recruitment of RGNs to the IPU remains a challenge.

Audit/Research 2021/22

Overview in March 2022

24 projects scheduled in 2021/2022 :

2021/22 Listing

Project Ref.	Title	**Lead**	Status	Report Link	Results
2021/22-01	Community - Carer & relative questionnaires for the Hospice @ Home Service	H@H Quality Office	Ongoing		2021 report under draft in March/April 2022
2021/22-02	IPU & Community - VOICES survey of bereaved next of kin 3-6months post bereavement	Clinical HoDs Quality Office	Ongoing - Latest Report for Apr-Sep 20 published 20-12-2021	N:\Clinical\Clinical Governance\Clinical Audit\Audit Report Library\2021\VOICES 2020 Report JCAR 20-12-2021 v1.0.pdf	For full results - see report April - September 2020. Responding to the Friends & Family question, of the 53 who did record an answer, 40 (75%) rated the hospice as 'Very Good' (c.f. 82% in 2019/20), 8 (15%) rated the hospice as 'Good' (c.f. 13% in 2019/20), 3 (6%) rated it as 'neither good nor poor' (c.f. 0% in 2019/20). 1 (2%) rated it as 'Poor' (c.f. 0% in 2019/20), none (0% c.f. 2% in 2019/20) rated it as 'Very Poor,' and 1 (2%) did not know the answer to this question (c.f. 4% in 2019/20).
2021/22-03	IPU - Patient Satisfaction	TY/Volunteers Quality Office	Re-start December 2021		May 2022 report planned / real-time contemporaneous dashboard
2021/22-04	IPU – Infection Control : Environment & Hand-washing Audit	IPU - S Dunmall Community - J Smith Quality Office	Ongoing	N:\Infection Control\Weekly spot checks\Spot Check Data\Graphs	Results are consistently very good.
2021/22-05	IPU - Medicines Management Audit	Ashton's Clinical Pharmacist	Ongoing	N:\Clinical\Clinical Governance\Clinical Audit\Audit Report Library\2021	Medicines Management Reports

Project Ref.	Title	**Lead**	Status	Report Link	Results
2021/22-06	Non-pharmacological intervention Audit (ISR Recs 2-5) - prevalence / effectiveness monitoring	IPU based : TC/TY/JS	Pended for discussion for 2022/23		
2021/22-08	IPU - Re- Audit against Audit NICE Guidance NG31 Care of Dying Adults at the End of Life	Dr Busi Da Silva	Data Collection Phase		Expected in April/May 2022
2021/22-09	Controlled Drugs Annual Audit	R Trower	Ongoing	Data submission project undertaken by CDAO	
2021/22-10	IPU - Re-audit of Discharge letter to include medication recording on Discharge from IPU corroboration with the EPR 'Medication Module'	Dr AA	Data collection complete Report in Jan2022.	N:\Clinical\Clinical Governance\Clinical Audit\Audit Report Library\2021\IPU Discharge Correspondence Re-audit Sept 2021.pdf	Results We are meeting all the standards set out by the SIGN discharge document template except for documenting whether a copy has been given to the patient. (https://www.sign.ac.uk/media/1066/sign128.pdf) This is consistent with our performance back in 2019, however of note, we only discharged 10 patients in that 3 month period. We are, however, as a result of the recommendations from the last audit, now routinely including a section/heading for Action required by the GP. We have incorporated within the Medication Changes section, separate headings for started and stopped. And despite this not being a requirement from the SIGN guidelines, as per our previous recommendations, we now include a review of ACP discussions held whilst on the IPU (DNA CPR status, PPC/D, CMC).

Project Ref.	Title	**Lead**	Status	Report Link	Results
					Recommendations ● In practice, patients do receive a copy of their discharge summary, however this is not captured on the current discharge summary template. The template will require updating to capture this in future. ● The default position should be that all patients receive a copy of their discharge summary. The medical team may wish to consider writing the letter as if directly addressing the patient i.e 'Dear John, You were admitted to the IPU for management of your shoulder pain.' This may allow the information contained within it to be accessible to both the patient and the clinical teams involved in care. (https://blogs.bmj.com/bmj/2018/01/18/writing-letters-directly-to-patients-puts-patients-at-the-centre-of-their-care/) ● There may be rare occasions when sensitive information may need to be communicated to the patient's GP and the medical team may be concerned about sharing this information with the patient and those important to them – consider if contacting the GP by telephone to discuss this may be a better means of communicating this. ● The consultant team have now moved away from routine review of all discharge summaries to avoid delays and as the letters have been found to be of a high standard. ● It may be worth noting that the SIGN website states that the guidance requires updating, therefore there is a need for us to keep abreast of any changes that may result after this review. ● Future audits may wish to explore/survey the opinion of our external healthcare professional

Project Ref.	Title	**Lead**	Status	Report Link	Results
					colleagues (GPs, DNs, secondary care) eg do they have any suggestions for what they would like to see included/omitted from our correspondence to them/how useful do they even find our discharge summaries.
2021/22-12	OACC measures (Step 1 - Phase of Illness + Karnofsky performance status; Phase 2 - iPOS)	OACC Task & Finish Group JS - IPU GT-R - Community	Policy Published. Training delivered Aug / Sep 2021 Into Practice Oct 21 Data Collection Tool for Dec 21		Audit in April/May 2022
2021/22-13	IPU : Patient Handling / Pressure Areas / Mouthcare	IPU - TY, PJ	Aug / Sep ' 21 Audit Data Gathered Oct'21 Database design and entry		Report under draft – expected April 2022

Project Ref.	Title	**Lead**	Status	Report Link	Results
2021/22-14	IPU - Mortality and Morbidity Meeting Audit	Dr AA	Published	N:\Clinical\Clinical Governance\Clinical Audit\Audit Report Library\2021\IPU Mortality & Morbidity Meeting Audit November 2021.pdf	**May to July 2021** This audit demonstrates that the IPU mortality meetings provide an opportunity for the IPU MDT to reflect on all deaths and consider our approach when there are challenges or family concerns have been voiced. - The meeting also promotes team reflection on good practice and areas of excellence. - The most common challenges were around discharge planning, complex symptom control, and communication with families around the above topics as well as around the side effects of medication. - Areas of excellence identified were: strong MDT working and support of families, provision of spiritual and psycho social support, meeting PPD and medical out of hours support for admitting patients in order to achieve this. - Documentation was adequate. - We are not currently highlighting/identifying achievement of PPC/D as excellent in all cases where arguably this should be seen as a positive achievement

Project Ref.	Title	**Lead**	Status	Report Link	Results
2021/22-15	Discharge Planning	Med Team Dr JS	Published	N:\Clinical\Clinical Governance\Clinical Audit\Audit Report Library\2021\IPU Discharge Planning Audit Report August 2021.pdf	**April to May 2021** These results show that the standards for assessing for and initiating discharge conversations are currently being met. Most patients had discharge discussions less than 72 hours into their stay in line with standard 2.1.2. The tentative dates (of 7-10 days post admission) suggested in 2.1.2 were met in only half of the discharges. These dates were not recorded in the electronic record for any of the patients as the policy states, so this could be a contributing factor to why they were not met. Discharge planning is started in appropriate patients with only a small percentage having to be stopped due to deterioration, and the patients who were discharged also survived on average for a month afterwards, with no failed discharges. Most patients were stable at discharge, with suitable reasoning for discharging the unstable patients, which must contribute to the success of discharges. The commonest discharge destination was home, and commonest place of death was the hospice. PPD was successfully met in 89% of cases, showing the strength of advanced care planning in the hospice. In half of the completed discharges, patients experienced delays to their leaving. The main cause of these were patient illness, then followed by administrative issues including medications not being ready, transport not being ordered in time, and care not being in place. In just over a third of patients where discharge was discussed there was patient or relative distress recorded. 3 of these complaints were about relatives not being properly informed about changes to discharge which is a failure to meet

Project Ref.	Title	**Lead**	Status	Report Link	Results
					standard 2.1.13 on these occasions. Patients who experienced distress/ concerns were associated with longer hospice stays than the rest of the patients. This may be because patients get used to a certain level of care, which is suggested by the fact that 3 of the concerns were about the patient not wanting to leave the care of St Raphael's and worried about coping. Concerns were only raised on one occasion that was associated with early mention of discharge, despite the majority of patients having these discussions early. This indicates that early discussion of discharge is unlikely to be a major cause of additional patient/ relative distress. Consider explicitly documenting that the patient has been assessed for discharge suitability in the Crosscare notes, and if suitable then recording the tentative dates in line with the discharge policy. Reiterate the importance of informing relatives to staff, as was the greatest cause of relative distress during discharge, and be aware that for patients with longer admissions discharge is associated with more patient distress so these discharges may require more time and support.

Project Ref.	Title	**Lead**	Status	Report Link	Results
2021/22-16	Referral to PS triggers	Psychological services SM	Pended for discussion for 2022/23		
2021/22-17	Bereavement Questionnaire	Psychological services SM	Pended for 2022/23		
2021/22-18	Non-medical Prescribing Activity Comparative : FP10.	Community KH	Not yet started		
2021/22-19	Advance Care Planning -(timelines)	Community Dr G T-R TC	Data Collection Phase		May 2022 report expected.
2021/22-20	Activity Monitoring Data CMC / NoK /CPCT Responsiveness / Sharing Information/ SafeguardingReferrals/ Referrals to RIP/ Active CaseloadsDaily Activity Data - capacity tracker /Referrals by Postcode/ et al	Quality Office+ CAAD	Ongoing		

Project Ref.	Title	**Lead**	Status	Report Link	Results
2021/22-21	IPU & Community & Psychological Support Services - Activity Data Dashboards Development	Quality Office + CAAD	Ongoing	N:\CCGs\Data - KPI Submissions\April 2020 Onwards	IPU & Community Dashboards developed
2021/22-22	Incidents	Quality Office + Incident Review Mtg	Ongoing		
2021/22-23	Falls	Quality Office + Falls Mtg	Ongoing		
2021/22-24	Complaints	Quality Office + Exec	Ongoing		
2021/22-25	IV & Paracentesis	Jenny & Jovy	Data Collected Report expected Jan 2022	N:\Clinical\Clinical Governance\Clinical Audit\Audit Report Library\2021\IV + Paracentesis - Asessment v2 as at 31-01-2022 .pdf	Conclusions Paracentesis: Discussions with local hospices reveal that many units are doing fewer and fewer ascitic drains. This is likely due to the improved accessibility to ambulatory units, the advances with permanent indwelling PleurX drains, the change in gold standard approach with USS guidance requiring USS equipment and staff training and a risk averse culture growing within medicine. This can set up a cycle of clinician unease, as fewer opportunities to perform the skill means confidence in the procedure can wane overtime. This is somewhat counteracted by the presence of rotating specialist trainees who are likely to be competent in the procedure and need to maintain competence in procedural skills via DOPs assessment. Going forward with trainees moving to dual training in acute medicine alongside palliative medicine we may see a change in the trainee skill set with more trainees competent in focused ultrasound skills for

Project Ref.	Title	**Lead**	Status	Report Link	Results
					example. With the advances in SIM mannequins on the market including those for practising ascitic drainage, investing in this equipment may allow clinicians to maintain procedural competence even if clinical cases are infrequent - this does however come at a notable cost. While paracentesis may not have been appropriate in the cases identified due to a short prognosis, the ability to use USS to aid in diagnosis may have at least helped in the clinical assessment of these cases. IV therapy: The case studies identify that in those who may have benefited from IV fluids, all were offered SC fluids, 2 of whom declined this intervention preferring oral hydration. Altering medication also helped to alleviate blood pressure related problems in one case. Of those who might benefit from IV antibiotics, one was transferred to hospital where she received IV antibiotics but subsequently died a few weeks later, and 2 were given oral antibiotics as an alternative (one patient died a week later from their lung cancer and one went on to be discharged to a NH and died a month later). One patient's one-off pyrexia was managed conservatively without antibiotics and never returned following management of opioid toxicity; the patient continues to be managed in a NH. It is hard to know if IV intervention would have made any meaningful difference to these patients, however without it there was no suggestion from the clinical record that their symptoms were uncontrolled or that quality of life was harmed by the omission of these interventions. The potential harm/distress to patients of hospital transfer in the last days/weeks of life, especially for those whose preferred place of death is home or the hospice, needs to be considered, alongside the potential

Project Ref.	Title	**Lead**	Status	Report Link	Results
					distress from IV line placement and potential side effects from antibiotics. The important role of antibiotic stewardship in clinical cases where antibiotics are unlikely to change prognosis or symptom control must also be taken into consideration. It is possible that having the means to easily access IV interventions may dissuade clinicians from weighing up the true benefit and risk of such interventions. This can be seen occasionally in the acute sector with practices including continuing IV therapy up to the point of cannula failure, or trialling IV antibiotics 48 hours in those identified as dying, whereas the most helpful option is possibly an honest, sensitive discussions about the limitations of such interventions in the last weeks of life, unless of course these interventions may offer symptom control of comfort. In those who may gain benefit from acute interventions, such as those presenting with serious infection outside of the last weeks of life, it is worth considering whether transfer to the acute sector would be more suitable in terms of access to staff with the right skill set, investigations and interventions (especially given there are no medical staff present overnight). IV treatment of hypercalcaemia: The case study identified was in someone with life threatening hypercalcaemia in the last weeks of life. While IV fluids and bisphosphonate will have helped to reduce high calcium (max effect day 4-7) it is unclear how much symptom control benefit this would have offered in the context of dying. In this patient symptoms were managed with a CSCI with antiemetic and analgesia, and SC fluids. An alternative drug option would be to give SC Denosumab, but note the peak effect is at day 10

Project Ref.	Title	**Lead**	Status	Report Link	Results
					compared to 4-7 days with zoledronic acid. Denosumab can also be given in patients with renal failure. There is a significant cost implication however with Denosumab. Recommended Actions - Continue to assess and recognise patients who may benefit from IV therapy or paracentesis and to communicate with them and those important to them, the alternative management options available in the community, the hospice IPU, or the option for transfer to the acute sector, whilst communicating the uncertainty around reversibility. - Continue to consider the potential advantages to future patients if resources allow hospice staff to be trained in the delivery of IV therapies +- USS and paracentesis, especially for those who may benefit but would find the hospital environment distressing. This consideration is caveated by our recognition that the acute sector is best placed to assess and monitor the acutely unwell who experience potentially reversible acute medical problems. - To ensure ACP discussions include the management of acute deterioration and interventions offered by the hospice IPU versus hospital. - Consider if the skills/resources of Spire St Anthony's may be utilised for the benefit of patients, such as bedside USS for diagnosis of ascites and paracentesis and if the cost is not prohibitive.

Project Ref.	Title	**Lead**	Status	Report Link	Results
2021/22-26	Safeguarding Documentation	Rebecca Wallis	Published	N:\Clinical\Clinical Governance\Clinical Audit\Audit Report Library\2021\Safeguarding Audit Report Jan 2020 - May 2021 v2 issued 12-12-2021.pdf	**1.0 Conclusions** 1.1. All safeguarding events raised to the LA were raised with the CQC – 100% compliance. 1.2. 70% of patients had documentation as to whether consent was gained or not from them before the safeguarding concern was raised to the local authority. 1.3. 30% had no documentation on consent or capacity. 1.4. Of that 70%, half of the patients did not consent to the referral and 86% of those patients had a clear rationale for why not and why the safeguarding referral was still being raised. **2.0 Areas for Improvement / Actions** 2.1 Documenting the capacity of a patient when making a safeguarding referral to the local authority. 2.2 Documenting the rationale for making a best interest decision when the patient had not provided or been able to provide explicit consent. 2.3 Update current safeguarding flow chart and training to highlight importance of documenting consent and whether or not the safeguarding referral is being made in best interests. **3.0 Auditor Comments / Discussion** 3.1 In the majority of patients, consent or the rationale for raising the concern without consent, was documented in the referral form sent to the local authority as there are clear prompts. This may reflect what is now needed within the hospice documentation system (Crosscare). 3.2 Of 15% that were not followed up, 100% either died or were moved to a place of safety before safeguarding team acted.
2021/22-27	Admissions Clerking	Jovy Giles	Report under draft	N:\Clinical\Clinical Governance\Clinical	**Conclusions**

Project Ref.	Title	**Lead**	Status	Report Link	Results
				Audit\Audit Report Library\2021\Timing of Inpatient Admissions Audit pub'd 15-11-2021.pptx	While only 64% of patients arrived before 3pm, 96% did arrive by 6pm with only one very late admission at 00.45 during the audit period. With a drive for 24/7 access to specialist palliative care as the gold standard, the hospice service may need to adapt ways of working to allow for this. The average time taken to admit a patient to the IPU averages at 1 hour 30 minutes, highlighting the complexities of this patient group and the time and care they and those important to them need. Having adequate staffing levels within both the medical and nursing team are essential for providing excellent and safe care. Given that the admission clerking is for many patients, and those important to them, their first impression of the hospice IPU, getting this part right and allowing the time needed, may make all the difference. **Recommended Actions** • As an organisation we may wish to consider whether use of a private ambulance service is justified and if this could be presented to the CCG with a request for funding. If this is not possible then liaising directly with the LAS end of life lead, to discuss options for prioritising end of life patient transfers may be helpful. • If patients are safe to arrive by means of their own transport or an accessible taxi this should be considered. • To try and facilitate patients arriving before 3pm, once a decision to admit has been made and the patient has agreed, an ambulance should be called as soon as possible. Extending this audit to look at any factors causing delays in requesting ambulances could be considered.

Project Ref.	Title	**Lead**	Status	Report Link	Results
					• Considering if there are adequate numbers of both nursing and medical team members for clerking new patients, should be part of the decision-making process during the admissions meeting. • Communicating with hospital teams around the importance of a discharge letter, but that a TTO may not be needed, may avoid unnecessary delays. The audit picked up that 2 hospitals out of area routinely send the full paper copy notes with the patient. This could be considered with our local hospital (SHH) to ensure full information is received, with a system in place for re-delivery of the notes one week after admission. • If hospital transfers are delayed, a hospice policy decision should be made about the appropriateness of delaying transfer until the following day. If prognosis is short this may not be suitable and the distress to patient and family must also be considered. • Clerking community patients at home may be considered when an ambulance transfer is delayed. The importance of handover of the management plan to the nursing team must be prioritised in these cases. • Considering the role of nurse led admissions for patients with lower complexity is something other hospices are moving towards and may be worth consideration within our organisation. This would require significant investment in the training of the nursing workforce (physical assessment, nurse prescribing). • A re audit following our recent on-call collaboration with PAH may be helpful once the service has embedded, we may wish to include how

Project Ref.	Title	**Lead**	Status	Report Link	Results
					often the medical team stay late and if time is offered back in lieu on these occasions. If this is a regular occurrence, changing medical shift patterns to allow one doctor to start, for example, at 11 am and finish at 7pm may better meet the needs of the service, but this would need to be considered alongside staff preferences, the needs of trainees, other hospice activities and home life and responsibilities. The regulations set out by the 2016 junior doctor contract would also need considering.
2021/22-29	Adjuvant Methadone	J Strawson	Deferred for consideration as part of 2022/23 plan		
2021/22-30	DNACPR documentation	J Strawson	Complete	N:\Clinical\Clinical Governance\Clinical Audit\Audit Report Library\2021\DNACPR Documentation Audit Report December 2021.pdf	**Conclusions** This audit demonstrates evidence of good practice with regards to documentation of DNACPR decisions and discussions with patients and those important to them as part of wider conversations around advance care planning. 100% of case-note entries were compliant with case law relating to DNACPR with regards to documentation of involvement of patient, this is a significant improvement on previous hospice audits which showed only 71% compliance (2017) and 86% compliance (2018) with this standard. The clinical team show an understanding of the medicolegal requirements including when a patient with capacity is not involved in the decision making process and clear documentation of why (i.e high risk of psychological harm). Recommended Actions This audit will be presented to the clinical team with education around how to complete the paper copy of the DNACPR as this area requires improvement.

Project Ref.	Title	**Lead**	Status	Report Link	Results
					The IPU team should ensure the hard copy DNACPR is properly filed within the patient's paper notes, to ensure the form can be easily found when needed. This audit can be included in the community education program for practitioners undergoing their DNACPR decisions competencies. If DNACPR forms are completed by the hospice CPCT these where possible should be scanned onto the EPR for reference. A larger audit of the full Advance Care Planning process is currently underway A repeat audit can be considered with more patients, as no patients who lacked capacity were captured by this small snapshot audit.
2021/22-31	Clinical Records Documentation	R Trower	Complete	N:\Clinical\Clinical Governance\Clinical Audit\Audit Report Library\2021\Record Keeping Audit December 2021.pdf	Summary of results 1.Consent for records to shared – specific, clear and easily visible 100% 2.Report/record decisions made and rationale for those decisions 100% 3.Demonstrate patient involvement in decision making where possible 100% All patients were able to actively participate in decision-making. Two records gave specific detail about those who were to be included in the sharing of information, demonstrating individualised care. 4.Are records objective? 100% Any opinions provided by the patient or family were surrounded by speech marks. All were to add value/context to the issue described. 5.Do records contain jargon or meaningless phrases or irrelevant speculation? No – 100% 6.Is third-party information relevant and appropriate? 100% 7.Are they succinct? Some were more wordy than others – tended to be down to the style of the inputter but 90% added value to the record. One

Project Ref.	Title	**Lead**	Status	Report Link	Results
					record was unnecessarily wordy which could make identifying relevant detail more time-consuming. 8.Comments: All records were informative and demonstrated compassion and sensitivity. Occasional spelling errors and one record described incorrect gender. There were some records whereby the surnames of HCPs were not included – this could make identification of those involved in the patient's care more difficult to identify over time and therefore should be addressed. Discussion The majority of records were succinct and easy to follow although there were times when the narrative became unnecessarily lengthy ('I said… she said etc'). The records demonstrated individualised care with attention to detail where relevant - such as the area of consent and precisely who was/wasn't to be informed. There are a number of abbreviations in the text but this has now become commonplace and those used are widely recognisable such as HCP, TC, FU etc. On occasion the notes referred to a colleague in a familiar way rather than using the full name. This needs to be addressed but is easy to rectify. Conclusion and Action Plan Results are positive with very few areas for improvement or focus. However, this is a very small sample and does not necessarily bear out all the issues for consideration. The results will be shared at CHODS as well as the Clinical Quality and Governance Committee. Managers will cascade to their teams. Staff will be reminded to use full names when referring to colleagues in the clinical record. The Records Management Policy is due for review in 2022 – in the meantime, the Clinical Director will

Project Ref.	Title	**Lead**	Status	Report Link	Results
					explore accessing an external education provider to deliver a half day workshop for staff on Clinical Record Keeping and Management as part of a wider initiative/refresher to include GDPR, Caldicott and Record Keeping. This will dovetail with the introduction of a new EPR system for SRH, scheduled for Spring 2022

Clinical Risk Management

Clinical Unexpected Incidents

Overview of incident data for January – December 2022 is shown below:-

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	22	21	20	19
Admissions to IPU	12	18											0	138	195	212
Beds	8	9														
Bed Occupied Days	203	216														
Bed Available Days	248	252														
Bed Occupancy (variable beds)	81.85%	85.71%!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!				
Bed Occupancy (10 beds)	65.48%	77.14%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%				
CD Medication Incident	0	3											3	35	15	23
CD Medication Near Miss	2	0											2	2	1	1
Adverse Reaction (Opioid Toxicity)	0	0											0	0	0	1
Adverse Reaction	0	0											0	0	0	0
Non-CD Medication Incident	2	2											4	7	4	12
Non-CD Medication Near Miss	0	1											1	0	0	1
Pressure Sore on Admission	1	0											1	16	19	16
Pressure Sore during Admission	0	2											2	6	4	3
Sharps	0	0											0	0	0	0
Infection (Near Miss)	1	0											1	0	0	0

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	22	21	20	19
Infection	0	0											0	0	0	0
Readm <7days	0	0											0	0	0	1
Unexpected Transfer	0	0											0	0	0	0
Near Miss(non-medication & non-IG)	0	0											0	1	1	1
PE	0	0											0	0	0	0
Staffing	0	0											0	0	0	1
IG	1	3											4	4	3	0
IG near miss	0	0											0	5	1	0
Manual Handling	0	0											0	2	1	5
Slips, trips, falls	0	0											0	19	20	21
Verbal Violence	0	0											0	0	1	0
Bump	0	0											0	0	0	0
Other - Admin/property/Documentation/Clinical	0	2											2	12	14	12
* Incidents reported to Community – non-SRH	1	2											3	2	8	12
* MAD Alerts (incl. in Community:non-SRH)	0	1											1			
Total 2022 *excluded	7	13	0	0	0	0	0	0	0	0	0	0	**20**			
Total 2021 *excluded	3	2	7	8	21	13	3	1	19	9	11	12		**109**		
Total 2020 *excluded	**7**	**6**	**7**	**6**	**11**	**15**	**5**	**5**	**4**	**3**	**8**	**8**			**85**	
Total 2019 *excluded	**1**	**14**	**13**	**7**	**8**	**7**	**6**	**6**	**5**	**16**	**10**	**6**				**99**

Reporting via DATIX commenced on 15th November 2021.

Incident Key

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

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

Clinical Significance	Jan	Feb	Mar	Jan-Mar	Apr	May	Jun	Apr-Jun	Jul	Aug	Sep	Jul-Sep	Oct	Nov	Dec	Oct-Dec	2022	2021	2020	2019	2018	2017
Admissions to IPU	12	18																138	193	212	211	214
Bed Occupied Days	203	216																				
Bed Available Days	248	252																				
Bed Occupancy	81.85%	85.71%																				
Fall No Harm																	0	9	14	15	21	
Fall Low Harm																	0	6	6	6	10	
Fall Moderate Harm																	0	0	0	0	1	
Med Level 0	2	1															3	13	9	13	6	
Med Level 1	2	5															7	18	10	21	37	
Med Level 2																	0	0	0	3	10	
Med Level 3																	0	0	0	0	3	
Minor	2	5															7	14	15	19	38	
Moderate																	0	3	6	2	21	
Serious																	0	0	1	1	3	
Pressure Sores	1	2															3	13	23	19	27	
Totals 2022	7	13															20					
Totals 2021	3	2	7	12	8	21	13	42	3	1	19	22	9	11	12	32		109				
Totals 2020	7	6	7	20	6	11	15	32	5	5	4	14	3	8	8	19			85			
Total 2019	1	14	13	28	7	8	7	22	6	6	5	17	16	10	6	32				99		
Total 2018	21	14	11	46	10	18	24	52	15	8	13	36	16	17	9	42					176	
Total 2017	13	11	19	43	15	15	17	47	12	2	16	30	16	15	12	43						163

Clinical Complaints

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

ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASS	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE	STATUS
2022/01	SURVEY	Son	28/01/2022	VOICES survey content reflected the son's rating of Poor for the care received by his mother from the Hospice CPCT with qualifying comment that 1.He felt her pain control poor ; 2. It was very difficult to get information about likely course of his mother's condition ; 3. Nobody could make his mother comfortable in the air bed at home. His overall experience of our service was rated as Very Poor and he explained that his mother was in great distress in the final few weeks of her life because a) clinicians put her in a hospital bed with an air mattress and she was extremely uncomfortable in it. Not one of the many professionals who visited his mother could make her even vaguely comfortable in the wretched bed and b) his mother was in great pain associated with her dementia. The Hospice doctors too far too long to get his mother's pain under control with the result that his mother was in unnecessary pain for many of her final few days.	CPCT Care	Records reviewed by Clinical Director, Community Services Team Manager and Hospice Palliative Care Consultant Team. **Community Services Team Manager** reflected : From the notes, agitation and distress was an ongoing , complex symptom and difficult to get under control despite very regular input from our medical team/ CPCT . Patient's son phoned in at regular intervals in and out of hours and the situation appears to have been responded to promptly and appropriately . There was what could be considered a delay with the DNs' setting up the initial CSCI, however contributing factors adding to this could be the time the email was sent / received (late afternoon) and therefore it would be reasonable that the CSCI was set up the following	Upheld	Closed

ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASS	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE	STATUS
						day?. There were some good examples of collaborated working with the GP who the patient was well known too . Airbed – there is limited reference to this in the EPR . I note that on the 19th July that it was recommended the son reconsider replacing this as he had removed it as he felt his mum didn't like it. Son's feedback is very valuable and I'm sorry the situation was so distressing for him and his mum. It can be more challenging to manage irretractable symptoms in the community due to care pathways and delivery . A stepwise approach to medication appears to have been taken and doses escalated in line with requirements however I recognise it took a considerable time to manage the patient's agitation which must have been very distressing for her son . **Hospice Palliative Care Consultant Team** : Lead Consultant telephoned son and talked through his concerns. She offered to		

ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASS	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE	STATUS
						process his feedback through a formal complaint process and he was in agreement as he hopes this will help the hospice secure more funding from the CCG in the future for community resources. She offered further bereavement support as suggested by our Head of Psychological Support Services but he has declined this. Letter sent following the conversation advising that we are trying to find new ways of working in the community, during the day and overnight, to allow us to be more responsive to the needs of future patients and families. Alongside this, we continue to expand our education program so that we can teach all professionals working in the community about common symptoms experienced at the end of life, including the management of pain and agitation and the need to escalate or change medication if needed.		

ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASS	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE	STATUS
2022/02	WRITTEN	MP & Husband	15/02/2022	Complaint received from MP Siobhain McDonagh advocating a complaint sent to her from bereaved husband of patient (RIP 28/12/21) regarding end of life care at home from multiple providers. Wasn't explicitly critical of SRH but felt he and son were overwhelmed by the care needs of his wife at the end of her life.	Multi-agency care provision at home at EoL	Telephone call to patient's husband followed by letter of apology. Opportunity taken to explain SRH's remit and what was offered. Apology given for being unable to provide admission due to availability of beds.	Upheld	Closed
2022/03	ORAL	Wife	08/02/2022	Wife telephoned following receipt of a feedback questionnaire and wished to speak with a manager about her husband's care. She thought H @ H gave her a lot of support but would have liked a CNS to come in and see her husband when he was dying. She said that her husband had had a lot of secretions at the end and would have liked a CNS to come in. HCA explained that when a patient has secretions that we would phone the D/N to administer required i/v medication. Wife advised that she didn't want a counsellor, just someone to talk to about his care. She stated that she didn't want to make a complaint. Advised that a manager would call her.	Comm Care	Investigated by Community Team Manager: Patient died on the IPU as his family were distressed with his increased respiratory secretions . Secretions were an ongoing problem when he was seen by BG on the 16/08/21 and on the telephone contact (23/08/21) the wife reported that he was still symptomatic. Its probably here that a face to face should have been arranged but we gave worsening advice and arranged another telephone rv . He was admitted to IPU on 06/09/21 and died peacefully with family by bedside on 7/9/2021. Clinical Director telephoned wife who explained that she felt that her husband had been deteriorating and that she had needed someone to have that conversation with both him and her. She felt the GP had	Upheld	Closed

ID	TYPE	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASS	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE	STATUS
						neither the experience nor the desire to do that and she would have felt more supported had we provided a face to face visit when she had called the team about his secretions on the Friday before the bank holiday weekend. She spoke very highly of all the services involved including SRH and described the staff as 'wonderful'. She wanted to make it clear that she wasn't complaining but had just identified upon reflection that she would have felt more supported by a FtF visit. She was reassured that we would be reflecting upon this. Patient case discussed at the complex CPCT M+M on the 9th of March.		

Complaints Overview

2021 - Complaints	CPCT / H@H Care	CPCT / H@H Comms	IPU Care	IPU Comms	IPU Care & Comms	Bereavement Comms	Volunteer Services Comms	Fundraising /Shop Comms	HR	Total	Merton	Sutton	Other	UPHELD
January	1	0	0	0	0	0	0	0	**0**	**1**	**0**	**1**	**0**	**1**
February	2	0	0	0	0	0	0	0	0	**2**	**0**	**2**	**0**	**2**
March														
April														
May														
June														
July														
August														
September														
October														
November														
December														
2022	**3**									**3**	**0**	**3**	**0**	**3**
2021	**4**	**5**	**1**	**0**	**1**	**0**	**1**	**0**	**0**	**13**	**6**	**6**	**1**	**10**
2020	4	1	2	3	1	1		1	2	15	6	6	0	14
2019	0	0	3	3	0	1		2	2	14				9
2018	2	5	10	4	1	0		1	0	27				19

Records – Access Requests

- In 2022 (Jan, Feb 2022), there have been 2 access to health records request : 2 x Solicitor (Jan & Feb 2022),

	DSARs	Access To Health Records	Sharing
2022	0	2	0
2021	0	5	4
2020	0	3	4
2019	1	4	0

Notifications

There have been 2 serious injury notifications made in January and February 2022 to the CQC all concerning pressure sores grade 3 or above.

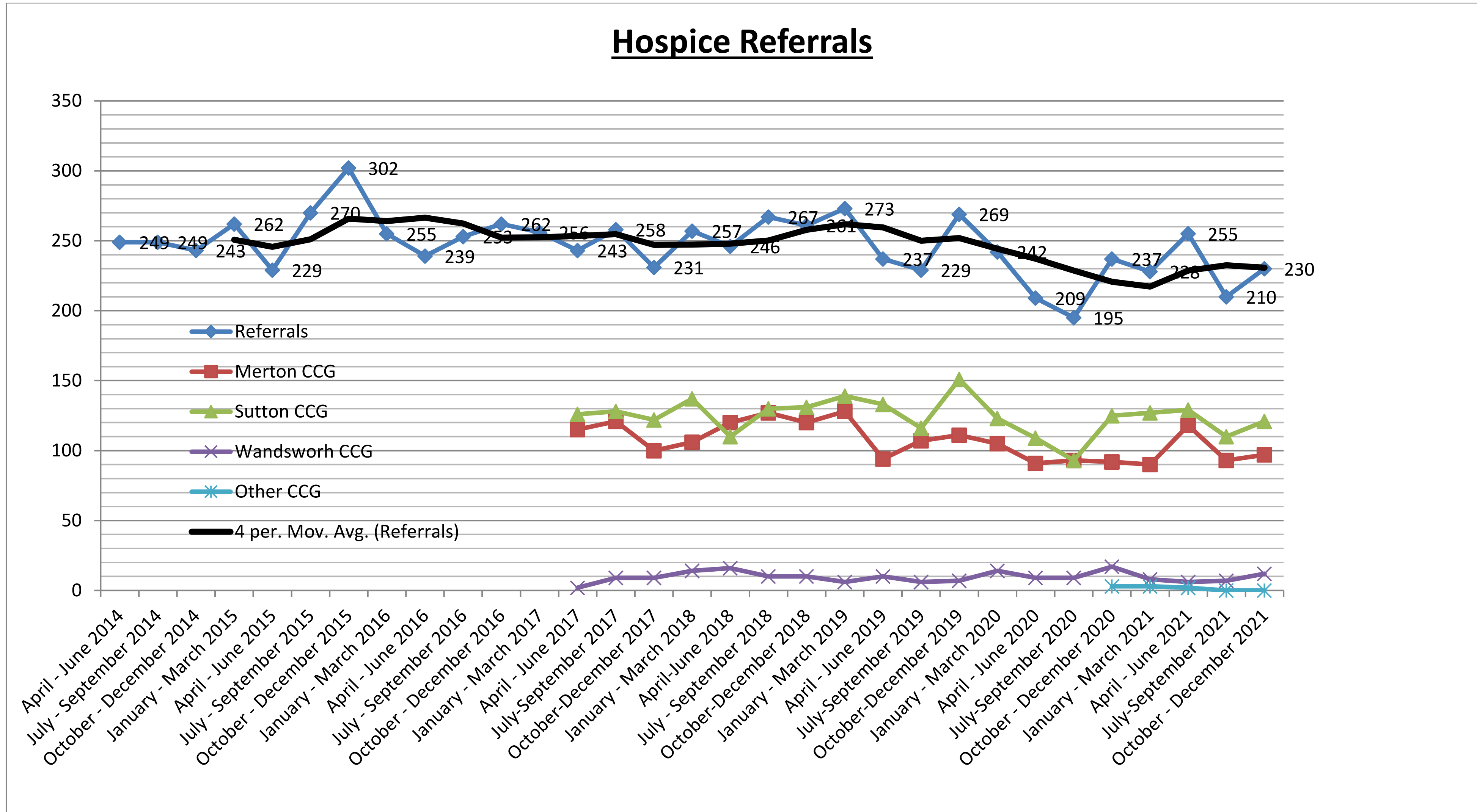
There have been 5 safeguarding notifications made to the CQC in 2022: 4 concerning individuals, 1 concerning POC. All 5 were reported to the local safeguarding teams.

	Serious Injury	Safeguarding
2022 (Jan-Feb)	2	5
2021	10	19

Clinical Commissioning Group (CCG) Data

Submission of Activity data for the preceding quarterly period is routinely supplied to the SWL CCG prior to our contract review meetings. The latest data period Q3 (Q3, October - December 2021) was submitted in February 2022. Next submission (Q4, January – March 2022) is due before our meeting in May 2022. A selection of graphical representations for some of the data items produced for the SWL CCG is included with papers.

Hospice Referrals



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

3. Clinical Quality & Governance

	Area of Development	***What will we do?***	***How will we know?***	***Lead(s)***	***Target Date***	***KLOE***	***RAG***	***Notes***
3.1	IPU : Move IPU towards a model of Excellence and a role model for other hospices	• Refine existing model to play to strengths, provide professional development opportunities and meet the needs of our patient group • Transition IPU Manager role to Clinical Standards and Project Lead. • Reintroduce IPU Sister role to incorporate advanced clinical skillset • Develop our Band 6 nurses in terms of succession planning	• Clinical Standards and Project Lead role embedded at 6 months with demonstrable evidence of robust clinical standards, audit, streamlined processes, projects underway. • IPU Sister role embedded at 6 months with demonstrable evidence of evolving staff culture of clinical enquiry • Band 6 nurses leading on specific areas of development and utilizing management skills effectively in the absence of senior nursing staff	TY/BW/RT				•

	Area of Development	*What will we do?*	*How will we know?*	*Lead(s)*	*Target Date*	*KLOE*	*RAG*	*Notes*
3.2	IPU : A more responsive and active IPU: Increase our admission capacity, providing more responsiveness and equity to our inpatient referral requests	• Open up 10 beds appropriately staffed • Review timings of admissions meeting to allow planning time for the acute sector • Streamline discharge process inc. allocated responsibility for completion of discharge process	• 10 beds open 90% of time as a minimum • Increase in number of accepted referrals from acute sector • Shorter LOS between discharge date set and actual discharge • Datix data demonstrates no increase in incidents/accidents that can be related to inadequate staffing numbers	TY/BW/Med	6 months (Oct 2022)			•
3.3	IPU : Increased Skillset of Registered Nurses	• Education and training for RNs re Adv Phys Ass/IV /Nurse led assessment, ECEPC etc • Sim training with PA and Ed Team	• Staff have passed competencies and can demonstrate Increased clinical input in patient assessment and procedures etc • Medical time on specific clinical tasks decreases in line with specific clinical tasks undertaken by nursing team. • Stable and satisfied workforce (HR evidence/staff survey)	BW / LB/ MF				•
3.4	IPU : Increased Skillset of Nursing Associates	• Education and training for NAs • Sim training with PA and Ed Team	• Nursing Associates successfully completed ECEPC • Nursing Associates successfully completed NA competencies •	BW / LB/ MF				•

	Area of Development	What will we do?	How will we know?	Lead(s)	Target Date	KLOE	RAG	Notes
3.5	IPU : Increased Skillset of HCAs	• Education and training including Care Certificate, phlebotomy skills, second checker competencies, pharmacy assistant roles etc • Train HCAs in audit and allocate specific areas	• HCAs have passed competencies and can demonstrate evidence of utilization of skills • Increase in audits undertaken and actions to improve practice • Stable and satisfied workforce (HR evidence/ staff survey)	LB/MF/TY				•

3.6	Outcomes	• Implement Step 2 of OACC – iPOS on the IPU and in the Community
		  • Policy / Documentation
		  • System / Capture
		  • Education
		  • Implementation
		  • Audit
		• Implement Step 3 of OACC - CSNAT
			• OMG Minutes
			• Start with IPU then Community
				OACC T&F Group IPU – TY; Community - TC	March 2023	Well-led Effective Responsive		•

3.7	IPU : New EPR system and Staff competency in digital care planning	• Introduce EMIS – collaborate with other users externally and refine to fit needs of SRH IPU • Transition from CMC to 'Better' (Urgent Care Plan)	• EPR is user friendly, information accessed and inputted is accurately reflective of patient care • UCP numbers are comparable to previous CMC records as a minimum	TY/Med Team /JG				•
3.8	IPU : Robust Infection Control practice across IPU	• Service Level Agreement with STHH IPC team for 12 months from 1 April 2022 • Clinical Standards and Project Lead to undertake formal IPC training with plan to lead on IPC in 12 months	• Infection rates remain low across the IPU • Staff feel confident and competent in managing infection prevention and control in line with mandatory training information and Infection control policies • Relevant audits are undertaken in a timely manner and reflect best practice	TY/StHH				•

	Area of Development	What will we do?	How will we know?	Lead(s)	Target Date	KLOE	RAG	Notes
3.9	Clinical : Reflection and Supervision	• To support clinical reflection and supervision through introduction of Schwartz rounds • Explore group HCA clinical supervision	• Introduce Schwartz Rounds • Introduce group HCA clinical supervision	RT / Med Team	TBA	Well-led Effective Safe Caring Responsive		•
3.10	Med Team : Training	• All core medical team trained in advanced communication skills	• Team completion of Advanced Communications Course	NC / Med Team				•
3.11	Community : Carer Admin of SC Meds	• Develop Policy • Establish training infrastructure	• CHoDS	GT-R/TC	Mar 2024	Well-led Effective Safe Caring Responsive		•
3.12	Complementary Therapy Service	• Re-establish the Service • Ensure Crosscare / information collection sources are designed to support service • Review Service Policy	• CHoDs	LJ/RT/AR/JG	May 2022	Well-led Effective Safe		•
3.13	IPU : Staffing	• To achieve full establishment of band 5 RGNs on the IPU that services rotation across days and nights	• Reduced agency usage • Increased occupancy • Secondment to other clinical areas	RT	TBA	Well-led Effective Safe		•
3.14	Community : Staffing	• To maintain CNS Development posts	• Staffing subject to vacancy	TC/RT	Annual			•

	Area of Development	***What will we do?***	***How will we know?***	***Lead(s)***	***Target Date***	***KLOE***	***RAG***	***Notes***
3.15	Psychological Support : Counselling for post - bereavement	• To maintain student counselling cohort of 8	• Continuation of reduced need for counselling by the Head of PS	SM	Annual	Well-led Effective Responsive		• We now have 8 volunteer Bereavement Counsellors – 4 are qualified and 4 are in their final year of training. • We are also due to go to advert for an additional 0.6 Counsellor post. • Added to this is the establishment of a rolling Bereavement Support Group. • This has allowed the Clinical Lead and core team to focus on patient work and the more complex cases.
3.16	Clinical Audit	• All clinical services to feed into and support the clinical audit program	• Clinical Audit Program & Timeline	CHoDS	May 2022	Well-led Effective		•
3.17	Clinical Audit	• Produce and maintain an audit/monitoring/research project schedule 2022/23	• CQ & G Minutes • Audit report library • Audit progress/results summary report	AR	Schedule of audits for coming year-May 2022	Well-led Effective Safe Caring Responsive		• N:\Clinical\Clinical Governance\Clinical Audit
3.18	Data Monitoring	• To provide data updates on a quarterly basis across all clinical services.	• CQ & G Minutes	AR	As per Index	Well-led Effective		• Data Monitoring Index

	Area of Development	What will we do?	How will we know?	Lead(s)	Target Date	KLOE	RAG	Notes
3.19	Outcomes	• Implement Step 2 of OACC – iPOS on the IPU and in the Community • Policy / Documentation • System / Capture • Education • Implementation • Audit • Implement Step 3 /4 of OACC - CSNAT / Dependency in 2023/24	• OMG Minutes	OACC T&F Group	March 2023	Well-led Effective Responsive		•
3.20	Risk Management – DATIX	• **Incident Management** • Adjust input screens to service experience and data needs • Establish reporting / output • **Feedback** • Adjust policy to support use of DATIX to capture complaints and feedback • Effect design changes to Feedback Module • Develop Complaints Feedback Training Video • Implement Feedback Module	• CQ&G Report • ChoDs Minutes	AR	May 2022 June 2022	Well-led Effective		•
3.21	Wellbeing – service users and attendances	• Engage with external groups including social prescribers • Collaborate with external groups to provide joint offers	• Crosscare Data	SP				•

	Area of Development	***What will we do?***	***How will we know?***	***Lead(s)***	***Target Date***	***KLOE***	***RAG***	***Notes***
3.22	Wellbeing – Men's Den	• Launch a diversified offer to support male patients, carers, relatives and bereaved	• Crosscare Data	SP				•
3.23	Clinical : Diversify offer of Hospice service delivery to support patient choice	• Re-establish Outpatient service • Maintain diversified offer in Wellbeing/Living Well aligned to Social Prescribing	• Data extraction Cross Care • CQ&G minutes • User feedback	Med Team /Clin Dir/TC	June 22	Well-led Effective Safe Caring Responsive		• Outpatient room operational
3.24	Clinical : Access to/involvement with R&D	• Develop links and contacts to support development of local SW London Ethics Committee • Establish reflective forum for inclusion of all staff to present/ discuss clinical cases	• CQ & G Sub Minutes • CHoDs	GT-R/Med Team	Sept 22	Well-led Effective		• Work collaboratively with other local hospices & acute Pall Care Teams

	Area of Development	***What will we do?***	***How will we know?***	***Lead(s)***	***Target Date***	***KLOE***	***RAG***	***Notes***
3.25	Diversify and develop the psychological service delivery offer	• Increase team capacity (0.6 FTE post) • Offer service to a wider demographic • Offer extended service hours across 6 days • Offer new menu of services • Maintain virtual service provision • To have on-line service provision as an option post COVID • Maintain and support student counsellors	• Data Extraction • CQ & G Sub Minutes • QIC Minutes • User Feedback	SM	June 22	Well-led Effective Safe Caring Responsive		• JD and Advert produced for recruitment to new post first week of April 2022. • The new role will deliver services in house to children and young adults and also those patients and relatives with complex trauma (EMDR qualification and Child Counselling qualification desirable for the role). • The new role will also be providing services one evening each week and also on a Saturday (when need necessitates). The Volunteer Counsellors currently offer service provision on a Wednesday and Friday evening. • Menu of Services extended to include EMDR, Counselling to those under the age of 16, imbedded Bereavement Support Group. • Services now consistently delivered face to face, virtually and on the telephone. • Student and Volunteer Counsellors in regular and on-going fortnightly Clinical Supervision (in- house).

	Area of Development	What will we do?	How will we know?	Lead(s)	Target Date	KLOE	RAG	Notes
3.26	Verification of Expected Death (Community)	All Band 6 & band 7 community staff to be trained to complete VOED documentation	• Assessed as competent	TC	TBA	Well-led Effective Caring Responsive		
3.27	Community	Formalise Locality Team Lead Roles	• Job Descriptions finalised	TC	TBA	Well-led Effective Responsive		• JDs reviewed and updated to reflect role responsibilities
3.28	Community	Maintain the development of locality working	• Annual review agreed by team	TC	TBA	Well-led Effective Responsive		
	Policy / working model	Develop Policy for servicing the transition of young adults (referral & working model)	Transition of Young Adults Policy	TC / Med Team	TBA	Well-led Effective Caring Responsive Safe		
	Policy	Extend Referral Policy to capture self-referral for patients discharged from the Hospice clinical service	CLIN09 Referral Policy	TC / Med Team	TBA	Well-led Effective Caring Responsive Safe		
	Community Service Development	Develop policy / education for administration of s/c medication by the informal care giver at home.	Policy / Training	TC/Med Team	TBA	Well-led Effective Caring Responsive Safe		
	Service Review – H@H	To review the reach and delivery of services provided by the Hospice @ Home service	CHoDs	TC	TBA	Well-led Effective Caring Responsive Safe		

	Area of Development	***What will we do?***	***How will we know?***	***Lead(s)***	***Target Date***	***KLOE***	***RAG***	***Notes***
	Clinical : Digital Development	To support the transitioning of CMC to the Urgent Care Record	Policy	TC/Med Team	TBA			
	Communications	• To maintain a forum and system for the co-ordination compilation and review of clinical information material that supports patients, their families and carers and other HCPs is communicated effectively • Facilitate access to information material via the website and other agreed media that educate and inform patients, families and other healthcare professionals	• CQ&G Report • Production of Information leaflets • Website Accessibility	Information Material T&F Group	On going	Well-led Effective Caring Responsive Safe		• Forum established July 2020 • Development of clinical information progresses. • Information Material Index
	Clinical Activity : Daily data extraction to support inclusion in NHS Capacity Tracker- related to funding	• Review and revise training video to service data extraction for Xcare • Reduce reliance on one individual	• Nominated individuals can accurately extract daily data • Continued interface with Capacity Tracker across 365 days • Receipt of NHS funding associated with data entry	AR	Sep 2022	Well-led Effective Responsive		• Data extraction supports allocation of government funding.

St Raphael's
Your Local Hospice

MINUTES OF THE
OUTCOME MEASUREMENT GROUP

Held on 23rd November 2021
at St Bede's Conference Centre and via Zoom

Attendance		
	(AR) A Rudkin - Chair	(RT) R Trower – Clinical Director
	(JS) Medical Consultant Rep	(TY) T Young – IPU Manager
	(MF) M Flint – Practice Development Rep	

Apologies	(TC) T Christmas – Community Team Manager	(GT-R) G Tamura-Rose – Medical Consultant

		Action
ITEM 1: Minutes of the last meeting held on 8th September		
1.1	Accepted	
ITEM 2: Matters Arising		
2.1	ToR published 8th September 2021	
2.2	Crosscare – Review Topics exacts PoI and AKPS	
2.3	JS's teaching handout is laminated and provided to clinical teams.	
2.4	JS to send electronic copy to AR to append to CLINSOP08.	JS/AR
2.5	MF to liaise with JS in order to get copy of SCH information. Information / education update via handover / MDTs with intent to review additional educational need in the New Year.	MF
ITEM 3: Step 1 : PoI & AKPS : Feedback		
3.1	Tool earnestly implemented form 4th October 2021.	
3.2	Subjective variability of applying unstable/deteriorating across HCPs.	
3.3	Use of both tools positively encourages discussion	
3.4	AKPS requires 0-Dead category across Crosscare windows. Consider if applies to PoI.	JS/JG
3.5	Consider if PoI to be added to Care After Death window before Date of Death	JS/GT-R
3.6	Consider if complex dying needs to be another PoI category.	JS/GT-R/TC

ITEM 4: Step 2 : iPOS

4.1 Commence iPOS Clin SOP in New Year and plan for education roll out. Discuss at next meeting.

ITEM 5: Training

5.1 Covered at 2.5

ITEM 6: Any Other Business

6.1 Nil

ITEM 7: Future Dates

7.1 Dates of future meetings:

Date	Event	Venue/Time
26 January 2022 deferred to 2nd March 2022	**OMG Meeting**	St Bedes + Zoom / 15.45

St Raphael's
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MINUTES OF THE
DRUGS & THERAPEUTICS COMMITTEE
Held on 17th November 2021
in Training Room / Zoom

Attending

(Dr JS) Dr Jenny Strawson, Hospice Palliative Care Consultant (AR) Alex Rudkin – Head of Quality and Improvement / Mins / Chair (NC) Dr Naomi Collins - Hospice Palliative Care Consultant (KH) Kevin Hobson - CNS NMP	(HT) Hai To - Sutton CCG Care Home Pharmacist (TY) Tracey Young - IPU Manager (EL) E Lufadeju - Ashton's Pharmacist (Dr GT-R) Dr Gaby Tamura-Rose, Hospice Palliative Care Consultant,

ITEM 1: Welcome and Chairmanship

1.1 AR extended welcome. Meetings will be routinely be chaired by a consultant member of the medical team.

ITEM 2: Apologies for Absence

(JS) Jill Smith -CNS, NMP, (BG) Bernadette Griffin -CNS, NMP, (HH) Heather Howell - Advisory Committee Member, (LB) Laura Briant – Practice Educator, (TC) Tracy Christmas – Community Services Manager NMP, (GL) Gail Linehan – Joint CEO

ITEM 3: Minutes of the Last Meeting

Minutes of the last meeting held on 13th July 2021 were agreed.

ITEM 4: Matters Arising

a) Review of the Hospice's Diabetic Guidelines was completed and revision published on 1st November 2021.

b) Methadone guidance was published on 11th October 2021.

c) CLIN57 Community Guidance on Injectable Medications for Symptom Control at the EoL was last reviewed and published on 4th May 2021 and its flow chart last updated and published on 18th October 2021. A review of the adequacy of the IPU medication chart design will be led by the medical team. JS,GT-R,NC

d) Guidance on Keppra via CSCI was published on 8th October 2021. AR to send on copy to HT. HT advised that Keppra was not on the list of EoLC drugs held by community Pharmacists. GT-R advised that prescribing Keppra is increasing in popularity and HT remarked that the more it is used then the greater the likelihood AR

that it will be included in the list of EoLC drugs in community pharmacists.

e) Production of a leaflet on 'Just in Case' medications will be picked up in the Information Material meeting. AR to raise with Diamond. AR

f) Minor amendment has been incorporated into N:\Policy Manual\CLINSOP\CLINSOP09 Safe and Secure Management of NHS Prescription Stationery.pdf

g) ABI material supplied by MG at the last meeting has been circulated

ITEM 5: Pharmacy Update

Ashton's offer and availability to provide training as required such as 'Diabetes at the end of life (up to 3 training sessions per annum as part of our contract) remains. EL will circulate list of training topics available. Practice Development to arrange required training. EL LB
AR to send on copy of SRH Diabetes Policy. AR
EL visits the IPU on either Tuesdays or Wednesdays. She advised that she had been covering SRH for 4 weeks and there had been no major errors identified with nursing staff being extremely helpful. Whilst not an error she had noticed that indications for use have been missed and that she picked these up in person.
It was understood that all those that required access to Liveview had that access in place.
JS highlighted the issue being experienced sometimes with the supply of TTOs from Ashtons in so far as orders sometimes had items missing or damaged. With Ashton's 48 hour response period this raised the feasibility of a local Pharmacy contingency solution as our service to our patients was sometimes being compromised. This was an item that RT is exploring with Lesley Spencer, Ashton's Palliative Care Ambassador. RT

ITEM 6: Update on medication policy review

6.1 There have been 7 published updates/revisions to medication policy / guidance since the last meeting between July and 16 November 2021:-

Guidance for Prescribing and Administration of Continuous Subcutaneous Infusion Furosemide for Adults with End Stage Heart Failure in the Community.pdf v1.7 issued 22-07-2021 (logos updated)
CLIN21 Anaphylaxis Management Guidelines.pdf v2.6 issued 04-10-2021 (amendments throughout)
CLIN57a Flow Chart for Community prescribing at the end of life.pdf v2.0 issued 18-10-2021 (updated)
CLIN59 Prescribing Palliative Home Oxygen.pdf v1.1 issued 12-10-2021 (guideline reference update)
CLIN60 Subcutaneous (SC) Administration of Levetiracetam (Keppra).pdf v1.0 issued 08-10-2021 (NEW)
CLIN61 Prescribing Guidance for Methadone in Pain Management.pdf v1.0 issued 11-10-2021 (NEW)
CLIN24 Diabetic Management N:\Policy Manual\CLIN\CLIN24 Diabetic Management.pdf v7.0 issued 01-11-2021 (Revised – section 4 plus inclusion of Appendix 3)

6.2 Medication policy / guidance overdue for review are:-
CLIN18 Syringe Driver Policy (McKinley T34) IV Administration – T Young lead TY
CLIN26 Generic Drugs – M Flint Lead MF

ITEM 7: Serious Medication Incidents

7.1 There have been no serious medication incidents for review.

ITEM 8: Update on CAS/MHRA Alerts

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

8.2 There have been no alerts relevant.

ITEM 9: Any other business

9.1 JS questioned whether the Hospice could be a dispenser of stock medication in an emergency. HT will check with Sarah Taylor. HT

9.2 RT to share the costs of medication information that Ashton's supplies with the medical team in order to increase awareness of any cost differentials across medications and their preparations. RT

9.3 A new non-medical prescriber has been recruited – Lorraine Jeffreys – taking our NMP cohort to 5.

9.4 TY advised that the HCAs on the IPU had completed their competencies to service the CD waste 2nd checker function.

9.5 NC highlighted a nuance previously agreed with our CCG regarding Octreotide prescribing that afforded SRH facility to prescribe via FP10. JS will follow up this nuance (and any other) with GL to ensure suitable reference within policy/guidance. JS

ITEM 10: Future Dates

10.1 Dates of future meetings in 2022

Date	Event	Venue/Time
Wed, 9th March 2022	Drugs and Therapeutic Committee	St Bede's & Virtual 15.15

Prescribers Meeting 6th January 2022

Minutes

Present – Kevin Hobson, Jill Smith, Bernadette Griffin, Tracy Christmas, Kim Smith, Rachel Clingan

- **Previous meeting minutes**

Reviewed and agreed by team

- **MAAR charts (PRN authorisation for s/c injections V4 chart)**

New formatted charts are just awaiting approval! Tracy will send to all prescribers. They do look lot better!

- **Community Prescribing practices**

Team welcomed Kim Smith and congratulated on becoming NMP. We discussed how daunting in can be becoming a new prescriber!
Most prescribing activity still tends to be Fridays / weekends.
Reassured there is always a Dr. on call to check things out if unsure

- **Education for NMP's**

All agreed that that Healthcare Conference UK virtual conference for - Non Medical Prescribing in End of Life Care would suit the hospice team best. Places for whole team booked for Wed 9th Feb.

Kim will probably go with the programme at St. Christopher's

- **Prescription safety**

Team aware of new system (CLIN SOP 09) re safe keeping of prescription pads
New Log book now being used and should be clearer.
Reminded that we need to check stock monthly (checking envelope seals not broken / tampered with) and recorded in back of Log book.
FP10 pads should be checked quarterly to ensure all prescription pages correspond with log book records (new envelopes and resealed)

AOB

Kim

- Heart Failure CNS Sue Langley is Cardio-Resp lead for Merton - also NMP and good resource/contact
- Kathy Welch CNS Resp team at SGH also useful contact / resource for advice
- Confirmed Merton community teams use Normal Saline as flush / diluent for s/c meds

Tracy

- Consider inviting other community NMP's to next meeting – D/N's Angela Redpath, Angel Searle, Janese

Next meeting tbc March 2022

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Meeting: **Clinical HODs Meeting**			
Date: 24.01.22		Time: 13.30	
Chair : Rebecca Trower - RT		Minutes: Lynn Jackson	
Present: TC, JS, LB, MF, SM, GTR, NC, AR, JF			
Apologies: TY			

Agenda item	**Discussion**	**Actions & by whom**	**Anticipated date for completion**
Review of previous minutes	Accurate		
Matters Arising			
Topic			
Infection Prevention	➢ **SHH Infection control Support** The SLA is more expensive than first thought. Cost to be reviewed in Budget meeting. February – March 2022, then new financial year April 22 – March 23 – negotiations to be had	RT/NS/GL	February 2022
Medical Devices	Mercel syringe drivers to be purchased. SOP to be written Mercel SD training = 3rd March 2022 –" Train the Trainer" **BARIATRIC EQUIPMENT** IPU has the following Bed, recliner chair & 1 large blood pressure cuff. New large hoist slings on order	TY/RT L/MF/TY	March 22 Ongoing
Medicine Management	Discharge/changes to TTOs are currently being delayed by Ashtons due to order time required– this has consequences upon IPU discharges as discussed by GTR as patients who are fit for discharge cannot be due to delay in medications from Ashton's. Possible use of local pharmacies for TTOs using FP10s discussed. This approach can be taken when needed and monitoring of frequency to be undertaken	RT, TY, NC, To discuss	Ongoing

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Your Local Hospice

Incidents & Accidents/RCA's	Datix has been launched 13.11.21. This is a new system to SRH & the training videos have been useful. AR informed the group that due to Datix being only 4 weeks old few statistics can be sought at present & an ongoing learning area. AR would like any feedback on the use of Datix TY - 2 patients were admitted with grade 3 pressure sores 1 incident of patient fall. Patient's son was with the patient at the time of the fall. Patient died within 24 hours of fall, coroners were made aware. Staff concerned	AR / IT TY/ Dr Tristan to contact medical examiner	Ongoing Ongoing
Complaints & Compliments	No complaints raised Compliments are to be stored in Excellence File for use as evidence for CQC	CPCT/IPU/AR	Ongoing
Health & Safety	1st April 2022 Government guidelines will apply with regards staff vaccination status. N.B This has since been reviewed and the likelihood is that vaccinations will not be mandatory but encouraged.	All staff /HR	Ongoing
New Policies/ Guidelines	Covid policy continues to be reviewed & amended as necessary in line with Government guidelines AR policy adjustments will be available from this week	AR/ HODS AR/ RT/ TY	Ongoing Ongoing
Documentation/ Crosscare	EPR systems are being reviewed to date: Care database, System 1 & EMIS Staff location system for ACC to be looked into Crosscare – M&M documentation – Care after death/Bereavement call has been amended	JG/RT RT/JG/JMcG JG/RW	Ongoing March 2022 Feb 2022
Audit/Research	AR Thanked the HODS for their completed audits 2023 audit programme to be discussed Excellent Feedback from CQ&G meeting has been received with regards Rebecca Wallis Safeguarding	AR/RT AR/RW	Ongoing

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	There has been interest amongst local hospices with regards to a research collaborative.	GTR	Onging
Education/Training Reflective Forums	GP Masterclass will take place on 2 different days during the year Face to face. Participants are to be charged for this training Education calendar 2022 is complete – monthly updates to be shared. • Mercel training • Train the trainer Fit testing • phlebotomy/IV have been booked Guildford Course - if SRH book in advance, we get 4 spaces for 3 Kate W/ Naomi S/ Kerry & Penny are to undertake the European Certificate in Essential Palliative Care course starting in April Talks between SM & Fundraising to take place with regards shop staff & some of the difficulties they face.	Education/Medical team MF Education/ Clinical staff Education SM/SJM	March/Sep 2022 Ongoing Ongoing Ongoing Ongoing Ongoing
Recruitment/ Staffing	IPU Band 7 – ward sister – advertised HCA advertised CPCT CNS band 7 – advertised SM – 2 volunteer counsellors have been recruited & 3 interviewed RoisinYin-Poole has been appointed & started as Hospice Neighbour lead Tuesday/Wednesday/Friday	RT/TY/HR	Ongoing
CQC/PIR	No known inspection date but likely to be over the coming months		
AOB			

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Your Local Hospice

CAP 2021/22	AR shared report which was discussed & amended as necessary Assisted Dying Leaflet is to be discussed further as to the place of the leaflet. TC liked the literature which she thought was impartial/useful & sensitive CPCT HS raised the possibility of a Photo shoot for one of our families. Deaf awareness course was discussed but CHODS concluded that the infrequency of use outweighed the cost Horizon Scanning presentation is to take place at Board meeting in February, looking at where hospices might be in 5 years time Review of admissions was discussed due to delays re transport bookings, TTOs etc. Following discussion, it was felt that the admission meeting should stay at the original time but that some admissions might be pre-booked for the following day, allowing more time for transport to be organised and TTOs/information to be provided. To be reviewed at next meeting	CHODS CHODS HS/ DN Board members IPU/CPCT/medical team/HPOC	Ongoing Ongoing 09.02.2022 Ongoing

Date next meeting: MONDAY 7th MARCH 2022

SAINT RAPHAEL'S HOSPICE

MINUTES OF THE MEDICAL BUSINESS MEETING
Held on 2nd March 2022

In attendance:	Jenny Strawson	Consultant (Chair)
	Naomi Collins	Consultant
	Gaby Tamura-Rose	Consultant
	Rachel Clingan	Registrar
	Will Ashley-Fenn	FY1 (shadowing)
	Pascale Evans	Clinical Admin (minutes)

ITEM 1: Apologies for Absence

1.1 Ambreen Akhtar; Busi Da Silva; Jovy Giles

ITEM 2: Minutes of the Last Meeting

2.1 Approved.

ITEM 3: Rota / staffing for the next three months

3.1 Will Ashley-Fenn from St Helier Hospital was shadowing the team for 3 days and attended the meeting.

3.2 GP trainee Tina Hyerim Jeong will join the team on Monday 7th March and will work with Jenny on the IPU to start with. Naomi will be her clinical supervisor.

ITEM 4: Clinical Challenges

4.1 Jovy had expressed concerns about time spent training staff, 2 days FIT testing in her case and how this may affect staffing on IPU. Feedback from the team was that Jovy and Gill had delivered excellent, very professional training on fit testing.

4.2 Ambreen has also been teaching mainly in the Wellbeing Centre on different topics and Gaby has offered to do the next session. Although it is not a major problem, it would be help to have a bigger pool of teachers to relieve pressure on the medical team.

4.3 The admission meetings need improving. A smaller group was suggested. Pros and cons of current versus new approach discussed. When the new ward sister is in post she might bring ideas/solutions. Shortage of beds due to on-going staffing issues have not helped but Band 5 nurses are being recruited.

4.4 Busi reported high levels of stress on the IPU during an on call visit because of a very symptomatic patient and only one RGN on shift (with Nursing associate and HCA team), the nursing team have fed back feeling very well supported by Busi.

4.5 Ambreen and Busi will feedback on the on call with Princess Alice at the next meeting.

ITEM 5: Infection Control

5.1 Infection control guidance remains the same.

ITEM 6: Education

6.1 Rachel and Jane Gauld facilitated Princess Alice Monday teaching on 28 January and their session was very well received.

6.2 Gaby will look at facilitating a session on the Caldicott Guardian.

6.3 Jovy will present her poster at the Palliative Care Congress in March on the role of the Physician Associate.

6.4 There are no takers at the moment for the GP Masterclass. It would be useful to meet the GPs face to face and find out if there was a better date/time for the class. The comms team are working to follow up invites.

ITEM 7: Audit

7.1 Auditing is going very well.

7.2 Need to focus priority audits in the next audit year (quality versus quantity), team asked to consider areas of interest.

ITEM 8: Any other business:

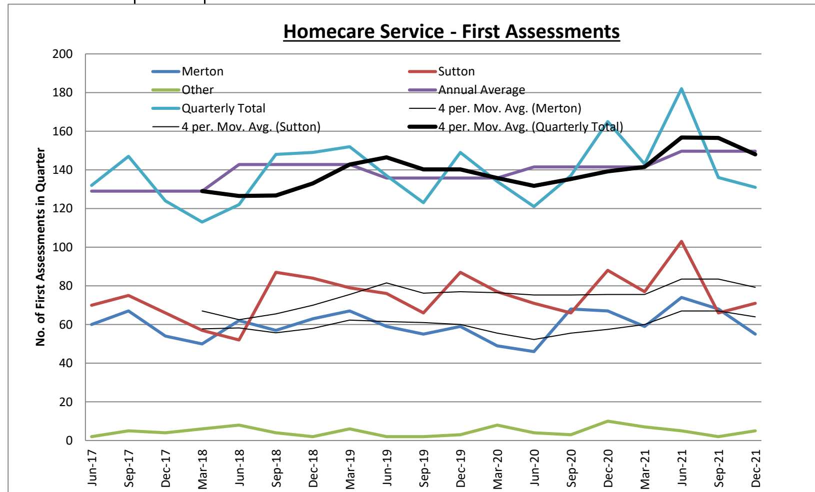
8.1 Gaby will not be able to attend the next 2 Drugs & Therapeutics meeting and requested for another team member to cover, Naomi or Jenny are happy to help.

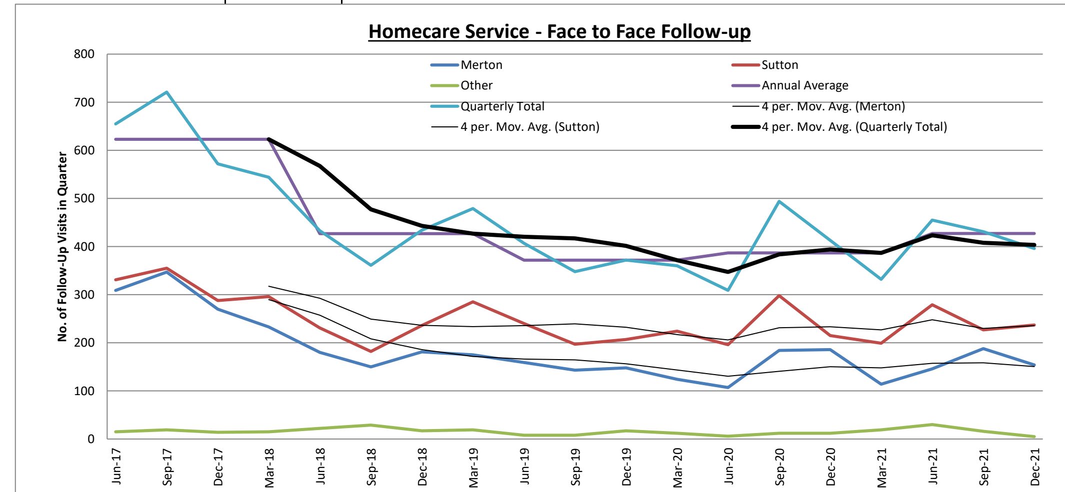
8.2 Dates of future meetings:

Date	Event	Venue/Time
06.04.2022	**Medical Business Meeting**	14.00 – 15.00 Training Room

Community Team					
Homecare Service - First Assessments					
	Merton	Sutton	Other	Annual Average	Quarterly Total
Jun-17	60	70	2	129	132
Sep-17	67	75	5	129	147
Dec-17	54	66	4	129	124
Mar-18	50	57	6	129	113
Jun-18	62	52	8	143	122
Sep-18	57	87	4	143	148
Dec-18	63	84	2	143	149
Mar-19	67	79	6	143	152
Jun-19	59	76	2	136	137
Sep-19	55	66	2	136	123
Dec-19	59	87	3	136	149
Mar-20	49	77	8	136	134
Jun-20	46	71	4	142	121
Sep-20	68	66	3	142	137
Dec-20	67	88	10	142	165
Mar-21	59	77	7	142	143
Jun-21	74	103	5	150	182
Sep-21	68	66	2	150	136
Dec-21	55	71	5	150	131

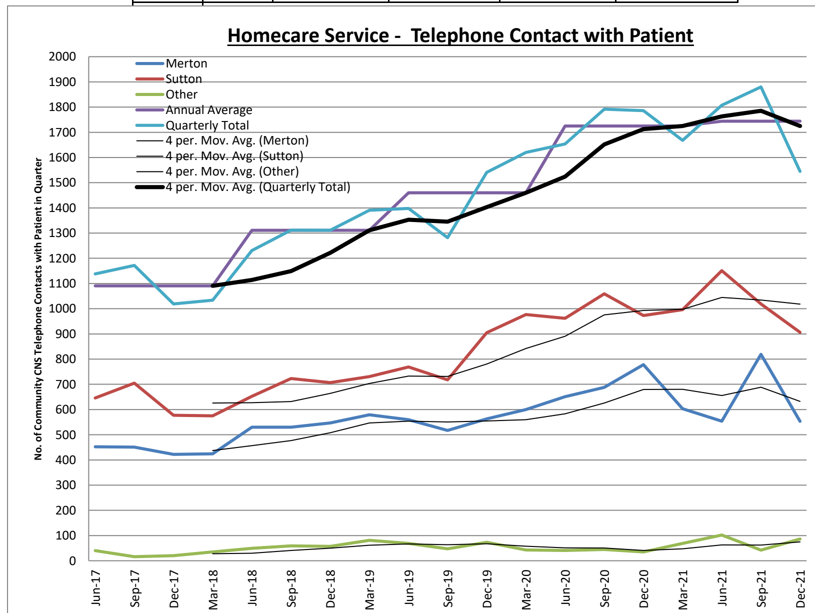
Community Team					
Homecare Service - Follow Up Visits					
	Merton	Sutton	Other	Annual Average	Quarterly Total
Jun-17	309	331	15	623	655
Sep-17	347	355	19	623	721
Dec-17	270	288	14	623	572
Mar-18	233	296	15	623	544
Jun-18	180	231	22	426.75	433
Sep-18	150	182	29	426.75	361
Dec-18	181	236	17	426.75	434
Mar-19	175	285	19	426.75	479
Jun-19	159	240	8	372	407
Sep-19	143	197	8	372	348
Dec-19	148	207	17	372	372
Mar-20	124	224	12	372	360
Jun-20	107	196	6	387	309
Sep-20	184	298	12	387	494
Dec-20	186	215	12	387	413
Mar-21	114	199	19	387	332
Jun-21	146	279	30	427	455
Sep-21	188	227	16	427	431
Dec-21	154	237	5	427	396

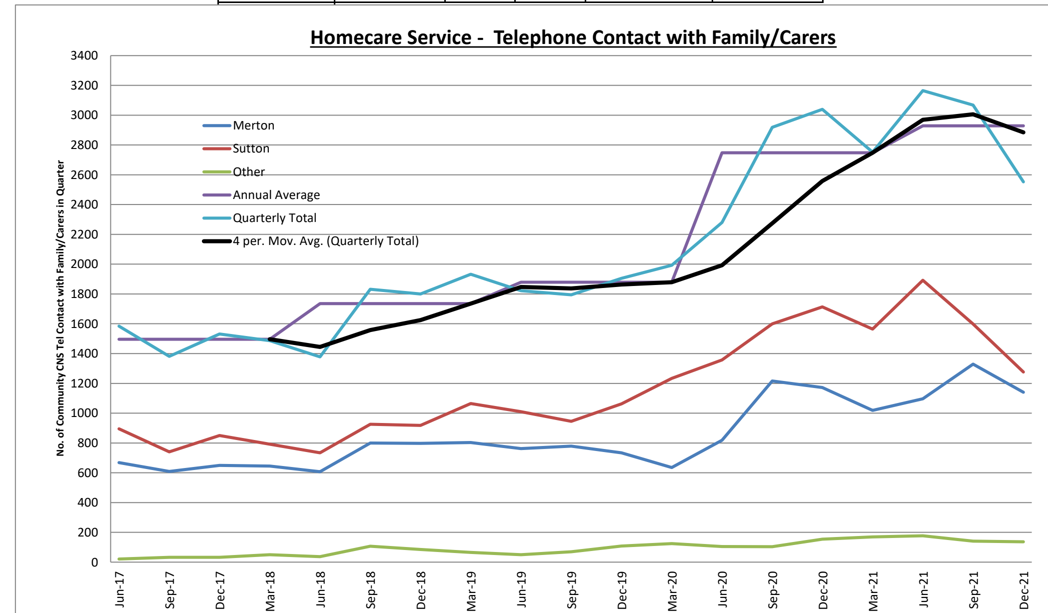




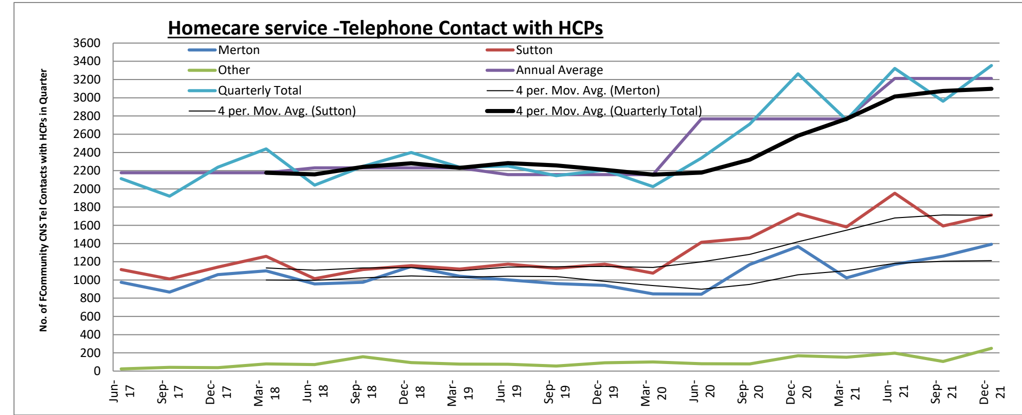
Community Team					
Homecare Service - Telephone Contact with Patient					
	Merton	Sutton	Other	Annual Average	Quarterly Total
Jun-17	452	646	40	1091	1138
Sep-17	451	705	16	1091	1172
Dec-17	422	577	20	1091	1019
Mar-18	424	575	35	1091	1034
Jun-18	530	652	49	1311	1231
Sep-18	530	723	59	1311	1312
Dec-18	547	707	57	1311	1311
Mar-19	579	731	81	1311	1391
Jun-19	560	769	69	1460	1398
Sep-19	517	718	47	1460	1282
Dec-19	563	905	73	1460	1541
Mar-20	600	977	43	1460	1620
Jun-20	651	962	41	1725	1654
Sep-20	688	1059	45	1725	1792
Dec-20	778	973	35	1725	1786
Mar-21	603	996	69	1725	1668
Jun-21	554	1151	102	1744	1807
Sep-21	819	1019	42	1744	1880
Dec-21	553	906	86	1744	1545

Community Team					
Homecare Service - Telephone Contact with Family/Carers					
	Merton	Sutton	Other	Annual Average	Quarterly Total
Jun-17	668	895	21	1496	1584
Sep-17	609	740	32	1496	1381
Dec-17	649	850	33	1496	1532
Mar-18	645	792	50	1496	1487
Jun-18	607	734	37	1736	1378
Sep-18	800	925	107	1736	1832
Dec-18	797	918	85	1736	1800
Mar-19	803	1065	65	1736	1933
Jun-19	762	1010	50	1879	1822
Sep-19	779	945	70	1879	1794
Dec-19	734	1063	108	1879	1905
Mar-20	635	1233	125	1879	1993
Jun-20	818	1357	105	2748	2280
Sep-20	1216	1599	104	2748	2919
Dec-20	1172	1713	154	2748	3039
Mar-21	1019	1564	169	2748	2752
Jun-21	1096	1892	177	2929	3165
Sep-21	1329	1598	141	2929	3068
Dec-21	1140	1276	137	2929	2553

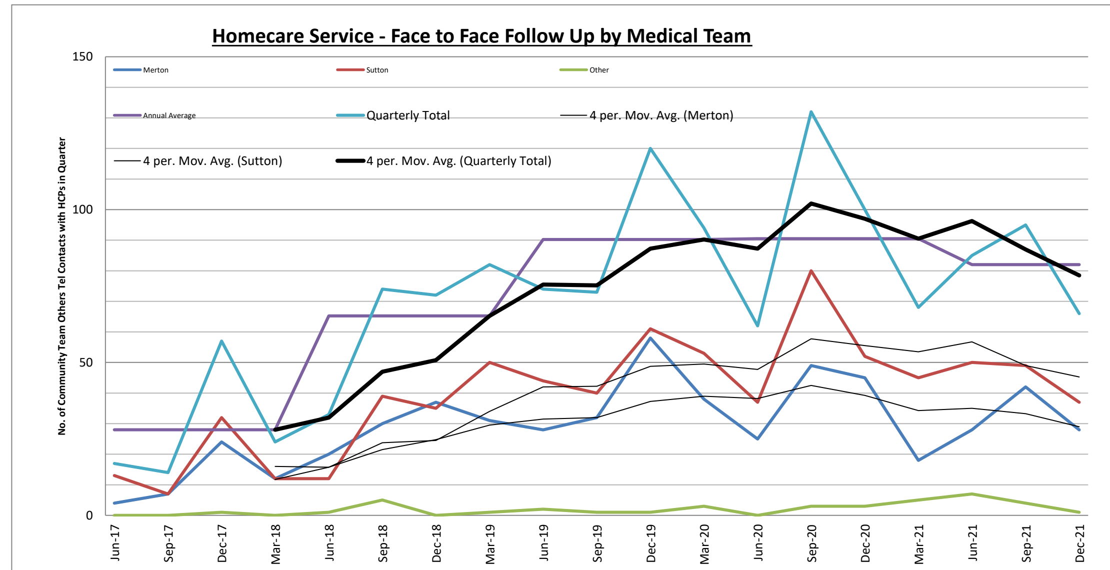




Community Team					
Homecare service - Telephone Contact with HCPs					
	Merton	Sutton	Other	Annual Average	Quarterly Total
Jun-17	974	1115	24	2177	2113
Sep-17	868	1011	41	2177	1920
Dec-17	1058	1142	37	2177	2237
Mar-18	1100	1260	79	2177	2439
Jun-18	956	1014	71	2231	2041
Sep-18	975	1115	157	2231	2247
Dec-18	1149	1157	93	2231	2399
Mar-19	1041	1119	77	2231	2237
Jun-19	1002	1173	76	2157	2251
Sep-19	961	1129	55	2157	2145
Dec-19	941	1173	92	2157	2206
Mar-20	848	1075	101	2157	2024
Jun-20	844	1414	81	2768	2339
Sep-20	1170	1462	79	2768	2711
Dec-20	1367	1727	169	2768	3263
Mar-21	1023	1582	152	2768	2757
Jun-21	1172	1952	197	3212	3321
Sep-21	1262	1593	106	3212	2961
Dec-21	1392	1712	250	3212	3354



Homecare Service					
Medical Team Face to Face Follow Ups					
	Merton	Sutton	Other	Annual Average	Quarterly Total
Jun-17	4	13	0	28	17
Sep-17	7	7	0	28	14
Dec-17	24	32	1	28	57
Mar-18	12	12	0	28	24
Jun-18	20	12	1	65	33
Sep-18	30	39	5	65	74
Dec-18	37	35	0	65	72
Mar-19	31	50	1	65	82
Jun-19	28	44	2	90	74
Sep-19	32	40	1	90	73
Dec-19	58	61	1	90	120
Mar-20	38	53	3	90	94
Jun-20	25	37	0	91	62
Sep-20	49	80	3	91	132
Dec-20	45	52	3	91	100
Mar-21	18	45	5	91	68
Jun-21	28	50	7	82	85
Sep-21	42	49	4	82	95
Dec-21	28	37	1	82	66



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Terms of Reference for Clinical Quality & Governance Committee

St Raphael's Hospice

Scope of Committee remit

1. The Board of St Raphael's Hospice is responsible for the strategic direction of the charity, and Board members hold collective legal liability for oversight of the charity. The Board are supported in their oversight of the clinical quality, governance and risk activities by the Clinical Quality & Governance Committee.
2. The Committee takes responsibility for providing assurance to the Hospice Board that the organisation has a robust framework for clinical governance that supports the delivery of safe and effective care and the management of clinical systems and processes. To achieve this, the Committee will ensure that quality is integral to the work of the Hospice and the systems and services that support that work, and that there is a robust programme that supports the monitoring of clinical performance across all clinical services. Committee members will contribute expertise, human resource capacity, and their professional perspectives to the development and successful operation of the Saint Raphael's Hospice clinical governance activities.
3. The charity's Scheme of Delegation outlines the key decision-making structure within the charity, including delegation from the Board to the Committee.
4. The Committee reports directly to the Board of St Raphael's Hospice.

Committee membership and composition

5. In line with the Articles of Association, the number of Committee members shall not be less than two, of whom at least one must be a Trustee of St Raphael's Hospice. It will be general practice for Committees to consist of at least three individuals, of whom two will be Trustees.
6. Additional suitable Committee members may be co-opted who, in the opinion of the Board and Committee, will bring additional relevant skills and expertise. Co-opted Committee members do not hold the same legal duties as the charity's Trustees, but are expected to uphold high standards of governance and adhere to the policies and procedures applicable to Board members.
7. At least one Committee member should have a Clinical background.
8. Committee members must be over 16 years in age, and must not be disqualified under the provisions of clause 5.6 of the Articles of Association and disqualification criteria set by the Charities Commission of England and Wales.
9. Appointments to the Clinical Quality & Governance Committee are made by the Trustees, for a period of three years. Following this first term, a Committee member may be appointed for up to two further terms of three years. This arrangement mirrors the term lengths for the St Raphael's Hospice Board of Trustees.
10. Committee members will receive no remuneration in relation to their role, and will adhere to the charity's expectations and procedures with regards to conflicts of interest and connected persons.

11. The Trustees will appoint a Chair of the Clinical Quality & Governance Committee, who shall be a Trustee. The Chairing of this Committee may rotate between each meeting, to leverage the respective expertise of Committee members.

~~11.~~12. The Safeguarding Link Trustee will be a member of the Clinical Quality & Governance Committee.

Role and responsibilities of the Committee

~~12.~~13. Subject to the provisions in the charity's Articles of Association, the members of the Clinical Quality & Governance Committee take delegated responsibility on behalf of the Board of Trustees for the following high-level areas:

- Receive assurance on the delivery of a work programme on an annual basis in accordance with Hospice's strategic objectives.
- Assure the quality and safety of any service development or re-design.
- To receive reports on progress against key clinical quality and governance objectives in the Hospice's annual Management Plan.
- Receive assurance that the key critical clinical systems and processes are robust, safe and effective. These systems will include, but are not limited to clinical leadership, staffing, competency, activity, learning/ education, incident management, complaints, audit, and effective. They will also encompass the Patient and Service User Experience, compliance with the CQC Fundamental standards of quality and safety, Electronic Patient Record (EPR), Research and Development and Medicines Management.
- Receive assurance that safe and effective person-centred care is being delivered and will do this by:
    - Receive reports on clinical quality across the Hospice.
    - Ensuring mechanisms are identified to enable all clinical teams to review performance in line with national benchmarking and evidence based practice and review/agree subsequent action plans.
    - Receive assurance that that new clinical systems are implemented within a framework of robust clinical governance, improve patient care and experience.
    - Receive and review minutes from the Hospice's internal Clinical Committees.
- Review the Provider Information Return.
- Conduct in-depth review of the Clinical Risk Register.
- Receive progress reports on the Clinical Action Plan.
- Receive Safeguarding Update reports.
- Review Clinical Key Performance Indicators (KPIs), data and information on Clinical Complaints.
- To review and approve/ recommend to the Board other related clinical reports or publications as agreed.
- To consider how the Hospice contributes and is part of the wider health and care system.
- Have delegated authority to review progress and take decisions within a framework approved by the Advisory Board and linked to the annual business cycle.
- Assisting the Board identify the Hospice's major risks in relation to clinical quality and governance, and developing appropriate approaches to risk management. This will include periodic reviews of the Hospice's corporate risk register and insurance cover.

Access

~~13.~~14. Individual Committee members or managers may raise concerns with the Committee Chair at any time.

Committee Meetings

~~14.~~15. The Committee will meet at least four times a year. The Committee Chair may call additional meetings if necessary.

~~15.~~16. In line with the St Raphael's Hospice Articles of Association, the quorum for Committee meetings will be two Committee members, of whom one must be a Trustee.

~~16.~~17. Meetings may be held in person, or by suitable electronic means such as video conference.

~~17.~~18. Meetings of the Committee will normally be attended by the Joint CEOs, Clinical Director and Head of Quality and Improvement. Consultants working at the Hospice may also be invited to attend or present.

~~18.~~19. Committee members may ask any attendees who are not members to withdraw to facilitate open discussion of particular matters.

~~19.~~20. Any votes will be undertaken in accordance with the provisions in the St Raphael's Hospice Articles of Association.

Reporting

~~20.~~21. Minutes will be taken of each meeting of the Committee, by the Secretary to the Committee or another individual agreed with the Committee, and circulated to Committee members.

~~21.~~22. Minutes of Committee meetings will be made available to the Board.

~~22.~~23. Minutes will be stored for at least 10 years.

Renewal

~~23.~~24. The Terms of Reference will be updated every three years.

Date of last approval: March 2021. Date of next renewal: March 2024.