Meeting: Trust Board in Public

Date of Meeting: 04 November 2021

Item Number: 20

Title of Report: Interim Safe Staffing Report Acute Hospital Sites

Executive Director Lead: Deputy Chief Executive RCHT / Dual Director of Nursing, Midwifery and Allied Health Care Professionals

Author and Job Title: Bernadette George, Director of Integrated Governance

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Purpose of the Report:

Approve ☐ **Discuss** ☒ **Note** ☐ **Endorse** ☐

Consultation:

March nursing template reviews March 2021. Considered for assurance by Quality Assurance Committee on 26 October 2021.

Key Risks (please tick one or more):

Clinical ☒ **Financial** ☒ **People** ☒
Reputational ☒ **Legal / Regulatory** ☒

Impact Assessment:

The COVID – 19 Pandemic restrictions including the impact on ward environments due to social distancing requirements

The Trusts continued commitment to increasing our International Nursing recruitment programme and our Wheal Vor educational support worker programme will have a positive impact on the equality and diversity of our acute hospital sites.

Recommendation(s):

The Board is recommended to:

- **note** the temporary ward changes undertaken and establishment increases due to the COVID – 19 Pandemic;
- **note** the changes to enhance ward leadership in relation to Ward Leaders supervisory to shift times; this has been impacted on due to staffing issues and sustained operational pressures;
- **note** the limitations of the interim Shelford Safer Nursing Tool outputs in March 2021 and the remedial actions taken to correct this to ensure data accuracy for the October 2021 collection period to ensure a full and comprehensive review can take place in October and November 2021.

Title: Safe Staffing Report

1. Situation / Executive Summary

1.1 Delivering high quality care to patients requires nursing and care staff to have the right skills, in the right place, at the right time. There is a plethora of evidence and research that states getting this right links to improved patient outcomes, decreased length of stay, improves patient experience and staff job satisfaction**.**

1.2 During the COVID – 19 Pandemic special dispensations were given as regards safe staff reporting and expectations of flexibility. Nursing and Medical leaders nationally and locally recognised that there would be a requirement for health and care professionals to be flexible in what they do including working in unfamiliar circumstances or surroundings or working in clinical areas outside of their usual practice for the benefit of patients, individuals and the population as a whole. They noted the need to abide to the basic principles of professional practice at the same time taking into account of the realities of a very abnormal Pandemic situation and to use professional judgement to assess risk and making sure people receive safe care, informed by the values and principles set out in their professional standards.

1.3 The purpose of this report is to provide an update on safe staffing requirements during the COVID – 19 Pandemic and report the outputs of the interim safe staffing requirements and template reviews undertaken during March 2021 pending a full safe staffing establishment review during October and November 2021.

2. Background

Safe staffing can be assessed using the following principles:

- Staff to bed ratio: this is simple to use, allows benchmarking but assumes that the base staffing levels are accurate and reflect patient need. However, it is insensitive to changes in workload and environment;

- Utilising an evidence based safe staffing tool to inform decision making. Evidenced based tools have been utilised by adopting the Shelford Acuity

Tool to capture patient's acuity within the Acute Hospital Sites. This was completed in March 2021;

- In addition, there will always be an element of professional clinical judgement to determine staffing levels. This practice is comparable with other Trusts. Within this judgement are the consideration of patient outcomes and risk / acuity of need. However, key to the staffing risk assessments are the numbers required to deliver safe and high-quality care;

- It is also acknowledged that the ward situation can change due to the increase in acuity and the number of patients requiring enhanced care in acute hospital health settings.

- CHPPD (Care Hours per patient per day**)**. The hours of Registered Nurses / Midwives and Support Workers available divided by the total number of inpatients is calculated on a monthly basis.

- Planned versus Actual Numbers. Each Acute Hospital Ward has a Ward Leader and the support of a Clinical Matron that provides leadership, management and support. Each ward is also supported by a team of specialists / therapists who have an important impact on the safety, quality and effectiveness of care. Some Care Groups have practice educators to support staff and care in practice. This is not consistent across the Trust.

    - The Ward Leader (Band 7) – support given to the ward clinically as required;

    - Clinical Matron;

    - Specialists such as medics, occupational therapists, physiotherapists and psychologists etc;

    - On a twice daily basis a meeting is held at to review nurse staffing across the Acute Hospital wards and is chaired by a Head Of Nursing on a rotational basis;

    - During the COVID – 19 Pandemic the Interim Deputy Director of Nursing, Midwifery and Allied Health Professionals for the Acute Hospitals joined the meetings; where each afternoon, this included

a review of staffing across the entire care system; staff re-allocated according to the relevant care organisations' needs including supporting the independent Care Home sector for critical shifts.

- Staffing has remained a considerable challenge during the COVID – 19 Pandemic period particularly through the wave one and wave two peaks and a safest care approach adopted to manage risk across the whole acute site.

- Therapy staffing is reviewed each day and throughout the day by the inpatient therapy manager and staffing flexed to best meet the needs of the hospital sites. As therapies is an integrated service staffing across the acute and community hospitals / services this is more collaborative, during the Pandemic we have also been looking at supporting the care home sector during this daily review. During the initial phase of the Pandemic, a large number of therapy staff were re-deployed to support the community service response who then subsequently returned. Some staff remain re-deployed to support the D2A service. The AHP Workforce Toolkit submission has been completed during this period for RCHT and CPFT. A review of the AHP workforce structure has been commissioned for the interim Associate Director of Therapies and will report in the early part of 2022.

3. Assessment & Findings

3.1 Ward Changes Due to COVID -19 Pandemic

There have been a number of temporary ward changes and reconfigurations due to the COVID – 19 Pandemic within some Care Groups in order to keep green, amber, red/blue pathways and areas. These are as follows:

Urgent, Emergency and Trauma Care Group:

- Trauma Wards had a reduction in bed numbers to support phase 4 Intensive Care surge from 56 to 32 and the setting up of the Trauma Assessment Area to mitigate and support the Trauma emergency pathway. An increase in registered nurse establishment overnight to

support British Orthopaedic Peer Review recommendations was undertaken in the earlier part of year.

- Same Day Assessment Area (SDMA) shift reduction from 1900-0230 from full night shift;

- The Emergency Department Resuscitation bays expansion is now fully funded and the establishment increased accordingly on a substantive basis. A Shelford Safer Nursing Care tool specifically for Emergency Departments has now been released and will be undertaken in November 2021 by the new Deputy Head Of Nursing for the Emergency Department so a full review of staffing against acuity, dependency, activity and professional judgment can be undertaken.

Specialist Medicine Care Group:

- Wheal Prosper Ward (infection prevention and control ward / isolation ward) designated red ward for COVID -19 positive / red patients. Temporary increase in establishment in place to support ward changes; an additional HCA on the night shift.

- Wellington Ward (respiratory and non- invasive ventilation High Dependency Area (NIV)) reduction in 2 bed numbers to support social distancing and intermittent switch to COVID -19 positive patients' additional capacity including NIV. Temporary increase in establishment to support additional NIV patients; an additional registered nurse on each shift.

- Roskear Ward (cardiology ward) reduction in 2 bed numbers to support social distancing and additional COVID -19 positive patients as required;

- Temporary switch of Surgical Assessment Lounge (SAL) from General Surgery Care Group to Specialist Medicine Care Group to create additional medical beds with reduction in bed numbers due to social distancing from 28 to 21.

General Surgery and Cancer Care Group:

- Temporary switch of Surgical Assessment Lounge (SAL) from General Surgery Care Group to Specialist Medicine Care Group to create an additional 21 medical beds.

Specialist Surgery Care Group:

- Temporary ward relocation from Wheal Coates to Kynance Ward to support the use of Wheal Coates for potential Intensive Care Unit surge of COVID -19 patients. No increase or decrease in bed numbers.

Maternity Services:

- Enhanced triage line to support pregnant women.
- Midwife to birth ratio in April 2021 was 1:28.
- A full Birthrate plus review had already been commissioned by the Dual Director of Nursing, Midwifery and Allied Health Care Professionals to commence in January 2021; in line with the ongoing 5 year staffing plan.

Anaesthetics and Critical Care Group:

In addition to substantive Critical Care staff, personnel from non-essential areas were allocated to augment critical care services as required. The following actions were taken to identify additional staff with transferrable skills.

In April 2020 – Critical Care commenced Trust wide COVID - 19 upskilling to enable previous and non - Critical Care nurses to obtain the skills required to support the Pandemic response (categorised in the attachment above). Approximately 120 RN/HCA/runners were trained and added to a central spreadsheet. The RNs were categorised as either CAT A or B dependant on their skill set, and this was uploaded to the Trust central roster to enable easy identification and weekly reports to be pulled denoting their work hours and location ‘ghost rota’.

During the initial surges – staff from the spreadsheet were released by Cornwall Partnership Foundation Trust and the Trusts acute sites on secondment followed by support from the staff from the ‘ghost’ rota to flex staffing numbers daily. This ensured that we had a core group of competence upskilled nurses and the ability to flex to acuity whilst maintaining staff safety within the Trust. It was recognised during this period that there may be a requirement to temporarily change the established nurse: patient ratios as defined in the national GPICSv2.

The above changes in all Care Groups remains fluid and reviewed under the Trusts Incident Command Centre in response to the current operational context and requirements under COVID -19 as wards continue to switch between amber and red wards as required and where temporary ward increases may be required in line with our surge plans.

3.2 The Shelford Safer Nursing Acuity Tool Date Collection Process

The Shelford Safer Nursing Acuity Tool was used to undertake the data collection process during March 2021. A large number of anomalies have been identified including the disproportionate and higher application of level 2 and level 3 patients during the review process across the surgical and medical wards.

The full classification of the Shelford Safer Nursing Acuity Tool is in Appendix One.

Staff have incorrectly applied level 3 and level 4 safe and supportive care for dependent patients requiring Enhanced Supervision to these categories when level 1a and 1b should be applied. Across Pendennis, St Mawes and Theatre Direct Wards staff have incorrectly categorised level 2 surgical patients for ITU step down when the majority should be level 1b and across Lowen Ward level 2 should only be used for stem cell transplantation patients. Other than the agreed template changes in March 2021 there are no other substantive changes proposed as a result of this review due to the inconsistent application of the tool and the current COVID -19 operational position.

For the October 2021 Shelford Safer Nursing Acuity Tool data collection process a weekly validation process has been put in place with the Heads of Nursing to correct this to ensure data accuracy.

3.3 March 2021 Registered Band 5 and Non-Registered Nurse Vacancy Position

Table 1 Band 5 Trust Wide Vacancy Position

Care Group & Corporate	Substantive FTE	Vacancy Gap FTE	% Vacancy Gap
Anaesthetics Critical Care & Theatres	156.54	**7.02**	**4.3%**
Clinical Support	11.62	**-7.35**	**-172.1%**

Corporate	12.53	**-1.23**	**-10.9%**
General Surgery & Cancer	77.96	**15.83**	**16.9%**
Specialist Medicine	92.61	**41.26**	**30.8%**
Specialist Services & Surgery	72.34	**10.94**	**13.1%**
St Michaels	38.85	**10.50**	**21.3%**
Urgent Emergency & Trauma	159.72	**46.75**	**22.6%**
West Cornwall Hospital	48.06	**7.15**	**13.0%**
Women Children & Sexual Health	86.15	**11.97**	**12.2%**
Trust Totals	**756.38**	**142.84**	**15.9%**

Table 2 Trust Wide Band 2 Health Care Assistant Vacancy

Care Group & Corporate	Substantive FTE	Vacancy Gap FTE	% Vacancy Gap
Anaesthetics Critical Care & Theatres	8.56	**-2.70**	**-46.1%**
General Surgery & Cancer	38.58	**-2.28**	**-6.3%**
Specialist Medicine	78.93	**12.19**	**13.4%**
Specialist Services & Surgery	43.11	**8.93**	**17.2%**
St Michaels Hospital	17.79	**1.49**	**7.7%**
Urgent Emergency & Trauma	137.33	**37.89**	**21.6%**
West Cornwall Hospital	36.92	**3.26**	**8.1%**
Women Children & Sexual Health	25.38	**-6.87**	**-37.1%**
Trust Totals	**387.20**	**51.91**	**11.8%**

Table 3 Trust Wide Band 1- 4 Vacancy

Care Group & Corporate	Substantive FTE	Vacancy Gap FTE	% Vacancy Gap
Anaesthetics Critical Care & Theatres	33.98	**-7.60**	**-28.8%**
Clinical Support	18.24	**-17.64**	**-2940.0%**
Corporate	12.90	**-2.38**	**-22.6%**
General Surgery & Cancer	83.21	**4.91**	**5.6%**
Specialist Medicine	125.87	**3.22**	**2.5%**
Specialist Services & Surgery	83.30	**8.08**	**8.8%**
St Michaels Hospital	34.84	**0.50**	**1.4%**
Urgent Emergency & Trauma	221.45	**27.32**	**11.0%**

West Cornwall Hospital	53.03	**2.47**	**4.5%**
Women Children & Sexual Health	101.80	**0.42**	**0.4%**
Trust Totals	**768.62**	**19.30**	**2.4%**

Recruitment to un-registered posts continues via the generic advertisement process and the Trust maintained its commitment to zero healthcare assistant vacancies in line with the Chief Nursing Officers commitments.

The Wheal Vor Ward 'intermediate care' additional capacity and educational / developmental programme will further aid recruitment for support workers. This comes on line on the 11 November 2021.

Domestic registered nurse recruitment remains challenging and has decreased during the COVID – 19 Pandemic, but targeted recruitment as wave 2 finishes will step up including preceptorship events in addition to the 153 WTE Winter Funding and Strand B Plus International Nursing pipeline commitments that the Trust has signed up to during 2021 /2022. The Trust is also part of the pilot for the Vanguard retention programme.

3.4 Enhanced Care Requirements

Historically in the Trust enhanced care requirements for level 3 and level 4 enhanced and supportive care in the Urgent, Emergency Care and Trauma Care Group and Specialist Medicine Care Group has been funded through the use of a substantive budget in both Care Groups against the allocation of temporary Kernoflex Health Care Assistant workers. Template reviews were undertaken during March 2021 with the relevant Head of Nursing and Financial Business Partner to correct this and substantiate these toward establishment numbers and actively recruit into the following areas:

- Trauma Wards;
- Kerensa Ward (Elderly Care);
- Tintagel Ward (Elderly Care and Neurology);
- Acute Medical Unit (Acute Medicine);
- Roskear Ward (Cardiology);
- West Cornwall (Med 1 and Med 2 Ward)

The full impact of these changes will be reported through the outputs of the October 2021 establishment review.

3.5 Ward Leaders Supervisory to Shift

There is disparity across the Acute Hospital Sites in relation to funded supervisory to shift times for Ward Leaders. The following Care Group areas currently fund Ward Leaders 100% supervisory to shift where daily staffing requirements allow. The remaining Care Group areas fund Ward Leaders 60% supervisory to shift times where daily staffing allows:

- Specialist Surgery Care Group

During template reviews in March 2021 supervisory to shift times to 100% were increased in the following Care Groups where daily staffing allows:

- Urgent, Emergency and Trauma Care Group
- Specialist Medicine Care Group

General Surgery and Cancer Care Group, Women and Children's and West Cornwall and St Michaels are reviewing current funding to fund from April 2022. This will be reviewed against progress during the October and November 2021 establishment review process.

3.6 NHSI / E Submission Fill Rates

Acute Trusts are required to collate and report staffing fill rates for external data submissions to NHSI/E every month. Fill rates are calculated by comparing planned against actual hours worked for both registered nurses and health care assistants and reported in the monthly Integrated Performance Report to the Trust Board. March's 2021 fill rate is outlined below.

	Registered Nurses Average Fill Rate	**Healthcare Support Assistants Average Fill Rate**
March 2021	**Day**	**Day**
March 2021	87%	81%

3.7 Registered Nurse Ratios

Analysis of ward splits for registered and non -registered staff there are 11 areas that show less than a 50% RN ratio. This is below RCN national standards (65:35) but needs to be noted with caution due to development of Band 4 Nurse Associate roles and having a larger establishment of HCA's due to dependency rather than acuity. This will be reviewed in the October and November 2021 full review.

3.8 Nurse Apprenticeships and Nurse Associate Roles

As part of the March 2021 template reviews a baseline assessment was undertaken in relation to apprenticeship and Nurse Associate roles in the funded manpower limit for each area and capacity and demand for the next 2 years.

There remains variance across the ward areas but agreements were made increase Nurse Associate training in Critical Care, General Surgery and Cancer and Specialist Medicine where training numbers are historically low. This will be reviewed again in October 2021 and a business case submitted as part of the operational planning process for 2022/2023 for the whole Trust backfill requirements for the forthcoming year as currently this is funded through the nurse vacancy position Trust wide and a clearer workforce strategy for demand is required going forward.

4. Risk

Pledge	Principal Risk	Score
Brilliant Care BC 1.1: Provide care that is safe and avoids harm *Risk ID 7013*	There is a risk that the Trust will not be able to deliver high quality, harm free, compassionate care to patients. This is due to; ongoing recruitment challenges and the use of temporary staff.	16 ↔

Recruitment remains one of our greatest challenges and a continued focus on Healthcare Support Assistants and the domestic and delivery of the International band 5 pipeline will be critical over the coming months to close the current vacancy gap.

Gaps in workforce could impact and provide a poor patient experience and impact on staff resilience and morale

Any future substantive establishment changes out of the October and November 2021 review could have a financial impact which will need to be picked up as part of the 2022/2023 operational planning process.

4. Accountability

4.1 The Dual Director of Nursing, Midwifery and Allied Health Care Professionals / Deputy Chief Executive RCHT; Executive Lead for Nurse Safe Staffing

4.2 Director Of Integrated Governance and Interim Deputy DoN for the Acute Hospital site is responsible for the operational delivery of the safe staffing requirements and has nursing workforce in their portfolio.

5. Recommendations

- **note** the temporary ward changes undertaken and establishment increases due to the COVID – 19 Pandemic;
- **note** the changes to enhance ward leadership in relation to Ward Leaders supervisory to shift times; this has been impacted on due to staffing issues and sustained operational pressures;
- **note** the limitations of the interim Shelford Safer Nursing Tool outputs in March 2021 and the remedial actions taken to correct this to ensure data accuracy for the October 2021 collection period to ensure a full and comprehensive review can take place in October and November 2021.

Meeting: Trust Board in Public

Date of Meeting: 04 November 2021

Item Number: 21

Title of Report: Annual Learning from Patient Safety Incidents, Complaints and Claims 2020/21

Executive Director Lead: Berni George, Director of Integrated Governance

Author and Job Title: Dr Richenda Tisdale, Deputy Director of Integrated Governance

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Purpose of the Report:

Approve ☐ **Discuss** ☐ **Note** ☒ **Endorse** ☐

Receive and note the information contained in this report as part of its Board assurance arrangements relating to the quality and safety of the Trust's services.

Consultation:

Considered by Incident Review and Learning Group and by Quality Assurance Committee in May 2021

Key Risks (please tick one or more):

Clinical ☒ **Financial** ☐ **People** ☐

Reputational ☒ **Legal / Regulatory** ☐

Impact Assessment:

It is acknowledged that some patient groups experience greater health inequalities and may also experience difficulties raising concerns about the healthcare they receive. Actions are planned through our Patient Engagement team to ensure that consideration is given to addressing these issues and ensuring that all patients are able to engage in patient safety incident investigations under the Trust's Patient Safety Incident response Plan which is currently being drawn up.

There are no direct environmental impacts arising.

Recommendation(s):

The Board **is recommended to:**

- **receive** and **note** the findings of the report and the priorities identified from this review form the basis of the Trust PSIRP for the twelve month period from 1 January 2021, as part of its Board assurance arrangements relating to the quality and safety of the Trust's services

1. Purpose

This paper provides a thematic review and analysis of the patient safety incidents reported at the Royal Cornwall Hospitals Trust (RCHT) during the twelve months from 1 April 2020. The information is triangulated with data from claims and complaints for the same period.

Analysis permits comparison with previous years, specifically the annual report from the previous year, which provides assurance as to whether learning is being embedded from incidents and appropriate action taken to prevent recurrence.

2. Background and Links to Previous Papers

This 2nd annual report will also inform the patient safety investigations, harm reduction and quality improvement projects for the coming twelve months. This will include the production of the paused Trust's Patient Safety Incident Response Plan (PSIRP) as one of the early adopters working with NHS England Improvement (NHS I) to finalise the National Patient Safety Incident Response Framework (PSIRF).

This work aligns with the Trust strategic aim around 'Brilliant care' –always providing safe, effective and compassionate care, where we listen and learn to provide an excellent patient experience.

3. Executive Summary

3.1 Summary of Serious Incidents (SIs)

A serious incident is categorised as an event in health care where the potential for learning is so great, or the consequences to patients, families, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

The number of serious incidents declared at the Trust has fallen year on year for the last four years. 85 Serious incidents were declared during 2020/21.

As early adopters of NHS England and Improvement's Patient Safety Incident Response Framework (PSIRF), fewer patient safety incidents will be investigated as SIs, with the resource focused in areas in which the greatest improvements in patient safety can be realised. Other forms of investigation, which utilise systems-based learning will be given greater emphasis under the new framework, including after action reviews and hot debriefs.

As part of the evolution towards PSIRF, the Trust has investigated falls which resulted in moderate harm or above, cohorted, via detailed local investigations led by a multi-disciplinary falls team. The investigation reports and the learning from them are presented at IRLG. Some of these incidents would previously have been investigated as SIs.

	2017/18	2018/19	2019/20	2020/21
Number of Serious Incidents	195	178	105	85

Table 1: number of Serious Incidents declared at Royal Cornwall Hospitals Trust per annum

3.2 Serious Incidents by Care Group

One third of the SIs (34%) declared during the period relate to the Urgent, Emergency and Trauma (UET) Care Group. This is consistent with the proportion (35%) of SIs reported in the previous year. UET treat a high volume of patients, often with high acuity, and it is perhaps unsurprising that they are involved in the largest proportion of incidents. There remains a strong correlation between escalation status of the hospital which remains challenging and serious incidents occurring.

Women, Children and Sexual Health Care Group(WCSH) reported the second highest number of SIs by Care group during 2019/20, and this year reported half that number, with 12 SIs, of which 11 SIs were declared in obstetrics. This represents a significant improvement in patient safety in the Care Group and reflects the impact of the Trust Maternity Improvement Plan and changes made as a result of the incident investigations undertaken and changes made in maternity and obstetric care over the last year.

Care Group –number of SIs during the period	2019/20	2020/21
Urgent Emergency and trauma (UET)	37	30
Women, Children and Sexual Health (WC&SH)	25	12
Specialist Medicine (SM)	13	15
General Surgery and Cancer (GS&C)	10	10
Specialist Surgery (SS)	8	7
West Cornwall Hospital (WCH)	4	1
Anaesthetics, Critical Care and Theatre (ACCT)	2	1
Clinical Support Services (CSST)	2	2
Corporate	2	0
Estates	1	2
St Michael's Hospital (SMH)	1	1
Kernow Health CIC 111		4
Total	105	85

Table 1: number of Serious Incidents declared at RCHT per Care Group

3.3 Serious Incidents by Category

The most common categories of SI have been consistent for the last few years, with clinical assessment, falls, pressure ulcers, obstetric incidents and pressure ulcers all featuring prominently.

Serious Incidents	2017/18	2018/19	2019/20	2020/21
Clinical Assessment	53	39	30	26
Falls	29	31	17	13
Labour and Delivery	10	11	16	8
Pressure Ulcers	5	9	6	1
Venous Thromboembolism	11	15	5	7
Medication	11	8	5	4
Surgery/Theatre	15	10	2	4
Other	54	52	24	11
Total	**198**	**175**	105	85

Table 2: number of Serious Incidents declared at RCHT per annum by category

This table demonstrates that there has been a decrease in the number of SIs declared in the most common categories of Serious Incident, with the exception of VTE which rose from 5 SIs last year to 8 this year, and Surgery and Theatre where the number of SIs had shown a promising reduction in 2019/20, but where a number of Never Events and other SIs were reported in this twelve months. These are discussed in more detail below.

Surgery and Theatre

In response to a series of Never Events reported at the Trust during 2020, a number of which related to the implementation of the Steps to Safer Surgery and WHO checklists, the Trust has created a robust integrated improvement plan and made a number of key changes to safety in these areas. This improvement plan including the Dermatology Quality improvement plan will continue through 2021 / 2022 will continue to ensure the changes made are embedded and sustained in practice.

A Safer Surgery Group has been set up to provide oversight of the implementation of the Steps to Safer Surgery, to undertake and action learning from audits of WHO checklist in all interventional areas and to ensure that Local Safety Standards for Invasive Procedures (LocSSIPs) are compliant with the National Safety Standards for Invasive Procedures (NatSSIPs) framework.

Venous Thromboembolism (VTE)

A working group has been set up in the latter part of 2021 to undertake a Quality Improvement project designed to improve compliance with VTE prophylaxis Trust wide. In the absence of an electronic forcing function through the electronic medication prescribing and administration which is awaiting a national solution fix, work will continue to establish and embed local system and processes and culture in relation to this patient safety issue.

3.4 Impact of PSIRF on the number of SIs declared and investigated.

As outlined above, the transition to NHSE's PSIRF means that falls which would previously have been investigated as an SI were instead investigated by a multi-disciplinary falls team with a report and action plan presented to the IRLG for sign off. This change was instituted in the third quarter of the year with the approval of the KCCG.

3.5 When do Serious Incidents occur at RCHT?

In the previous year, a correlation was noted between the number of SIs declared, and the times of greatest operational pressures. 2020/21 was a year unlike any other. Peaks in the number of SIs declared were seen in July and October, with the fewest SIs (1) declared in November 2020. The first wave of the pandemic hit the Trust in May of 2020, and the second wave in January and February of 2021.

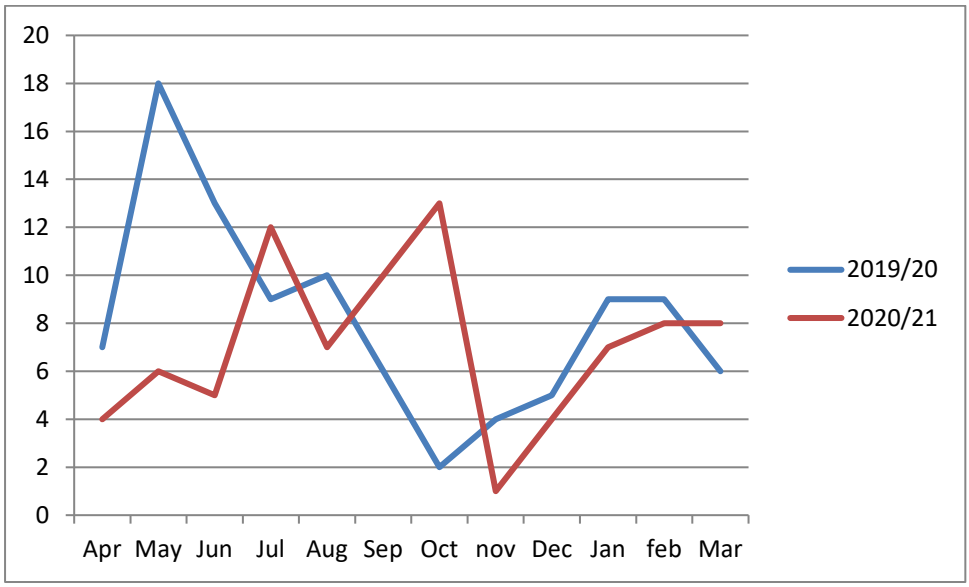

Figure 1: number of Serious Incidents declared by month during the years 2019/20 and 2020/21

3.6 Overall Patient Safety Incidents

Patient safety incidents are reported via Datix and uploaded to the National Reporting and Learning System (NRLS).

	2017/18	2018/19	2019/20	2020/21
No injury	8489	8450	8291	8480
Minor injury	1824	1892	2242	1655
Moderate injury/ RIDDOR reportable	289	289	269	344
Major injury/long term incapacity	48	26	22	13
Death/catastrophic	30	29	9	8
Total	10680	10686	10833	10455

Table 3: NRLS patient safety incidents for RCHT 2020/2021 per annum by harm category

It is reassuring to note that high levels of incident reporting has continued across the Trust during the pandemic, with more 'no harm' incidents reported this year than in the preceding twelve months. This is a good indicator that the Trust has an open reporting culture and staff are aware of the need to report all incidents. There has a been a reduction in significant harm patient safety incidents despite the operational challenges.

Moderate injury

The number of incidents categorised as moderate harm has increased by 28% from the previous year, from 269 to 344. Review of these incidents reveals that 84 of these were Covid-19 infection control incidents. These constitute the probable or definite hospital-acquired Covid-19 cases which are reported via the Datix incident system in accordance with national requirements.

All outbreaks of nosocomial Covid-19 infection at the Trust have been investigated by way of outbreak investigations by the Infection Prevention and Control team, and action taken where indicated to reduce the likelihood of further spread or future outbreaks.

With the exception of the Covid-19 incidents, the overall number of incidents in which moderate harm was deemed to occur was consistent with the previous year.

Major injury/long term incapacity

13 incidents were reported during the year as having resulted in major injury or long term incapacity. This was a reduction on the previous year and continues the downwards trend –reflecting improvements in patient safety.

Of these 13:

- 3 relate to failure to act on an abnormality noted on imaging
- 2 relate to delayed treatment
- 2 relate to suboptimal care of the deteriorating patient
- 1 is a recognised complication of a necessary surgical procedure
- 1 was an in-patient fall
- 1 was a failure to book an appointment for a patient
- 2 were missed or delayed diagnoses
- 1 failure to act on abnormal results

Death/catastrophic

8 incidents have been reported with the severity death/catastrophic harm, some of these incidents are still under investigations and the severity of harm is likely to be downgraded in a number of these, wherein the outcome for the patient may have been death, but there has not been harm caused by the Trust.

Type of incident	Number
Fall	1
Outpatient appointment not booked	1
Delay in angiography	1
Failure to observe patient and act on results of blood test in Emergency Department	1
Telephone advice given via 111 Kernow Health CIC	1
Delay in prescribing correct medication to an inpatient	1
Inadequate discharge information provided	1
Sudden unexpected death – under investigation	1

Table 4: Death / Catastrophic Harm incidents reported by category

3.7 Overall categories of patient safety incidents

	2017/18	2018/19	2019/20	2020/21
Pressure Ulcers	2128	2065	**2069**	**2581**
Falls	1431	1173	**1196**	**1540**
Clinical assessment	836	882	**1032**	**1242**
Discharge	755	682	**796**	**850**
Communication	525	667	**628**	**668**
Medication	1092	858	**572**	**1079**
Documentation	337	442	**461**	**491**
Transfer	368	327	**396**	**322**
Labour and Delivery	431	411	**373**	**588**
Admission	485	405	**349**	**518**

Other categories with increased numbers of incidents during this twelve month period were infection control, with 456 and surgery/theatre with 391.

4.0 Claims

The Trust was notified of 45 new claims during 2020/21 in comparison to 58 the year before. This may reflect that some law firms reduced their workload during the pandemic and the number of new claims filed during the coming year will provide a clearer indication as any trend.

These claims related to incidents dating back as far as 2005 and as such do not clearly triangulate with the patient safety incidents reported in the twelve month period.

14 (31%) of the claims notified had been the subject of a Trust SI investigation, and 13 (29%) of the claims had also been brought as complaints against the Trust.

General Surgery and Cancer were notified of the largest number of claims during this period with 12 across the year, followed by UET who were notified of ten.

Care Group	Number of claims notified in 2020/21
General Surgery & Cancer	12
Urgent, Emergency and Trauma	10
Specialist Services Surgery	7
St Michael's Hospital (orthopaedics)	7
Specialty Medicine	5
Clinical Support Services	3
Anaesthetics and theatre	3

Table 5: Claims per Care Group for RCHT 2020/2021

Category of allegation	Number
Delayed Diagnosis	14
Incorrect clinical treatment	8
Inadequate consent	7
Never Event	3
VTE	2
Medication	2
Slip/fall	1
other	8

Table 6: Claims per category

Seven claims include an allegation of inadequate consent as part of the claim against the Trust. 6 of these related to alleged inadequate consent and breast reconstruction and concern the practice of one consultant who no longer works for the Trust.

5. Inquests

Over the course of the year, the Trust provided reports in 275 cases. The 2020/21 figures are at variance to previous trends due to changes introduced by the Coroner and the impact of COVID 19. Representatives of the Trust attended and gave evidence in 17 cases of which 8 had been investigated as part of the complaints process and 1 case had been investigated as a Serious Incident and a complaint. 3 cases were concerns raised about discharge decisions.

	18/19	19/20	20/21
Total number of inquest cases	414	425	275
Total number of inquests attended in 2020/21	44	35	17
SI inquests heard in 2020/21	9	8	0
Complaint inquests heard in 2020/21	5	11	8
Claim inquests heard in 2020/21	0	0	0
SI and Complaint inquests heard in 2020/21	2	0	1
Complaint and Claim heard in 2020/21	1	0	0
SI Claim inquest heard in 2020/21	1	0	0

Table 11: Breakdown of Inquest cases at RCHT over three years

Reports on Action to prevent Future Deaths (PFD reports) or Regulation 28 reports are issued by the coroner in circumstances where there is a risk that future deaths will occur and that, in the coroner's opinion, action should be taken to prevent those circumstances happening again. One PFD reports has been issued over the year in relation to lack of a specialist nurse Parkinson's service. The Trust has now recruited to this post.

6.0 Complaints

The number of informal and formal complaints received at the Trust fell during this twelve month period, which may reflect both lower levels of activity in the Trust and also recognition on the part of patients and their relatives that the NHS was facing a time of unprecedented pressure.

The top 5 themes for complaints during this period were the same as in the previous three years. A full breakdown of the complaints was provided to QAC in April 2021 in the Annual Complaints report.

Subjects	2019/20	2020/21	% +/-
Communication	516	**370**	-28%
Clinical Treatment	592	**332**	-43%
Patient Care	414	**235**	-43%
Admissions and Discharges	211	**147**	-30%
Values and Behaviours (Staff)	209	**109**	-48%

Table 7: Top 5 Subjects of Formal Complaints in 2020/2021

7.0 Conclusion

Whilst the pandemic has impacted on the provision of all aspects of care in the Trust over the last twelve months, the Trust has continued to build on the pledges made in the Brilliant Care strategy to provide safe care and minimise avoidable harm.

Robust action is being taken in response to the areas identified as requiring further focus, including the implementation of surgical procedures and prevention of hospital acquired thrombosis time.

The ten areas identified during review of incidents at the Trust in preparation of the Trust's PSIRP remain priority areas for the Trust to focus resource in order to deliver the greatest improvement to patient safety. These ten areas are set out in the table below. The incident types accord strongly with patient safety incidents, particularly those which have resulted in moderate harm or above, and also with complaints seen at the Trust.

It is recommended that these areas form the basis for the Trust PSIRP which will be set out in detail in the next quarter for sign off by Kernow CCG and NHS England / Improvement following the pause in Covid-19.

	Incident type	Specialty
1	Clinical assessment – suboptimal recognition of the deteriorating patient	Medical
2	In patient falls- witnessed and unwitnessed	Trust wide

3	Labour and Delivery	Obstetrics
4	Discharges	Trust wide
5	Medication	Trust wide
6	Development and or deterioration of Pressure Ulcers	System wide – RCHT and CFT
7	Hospital-acquired venous thromboembolism	Trust wide
8	Clinical Assessment Front Door	Emergency Department
9	Infection prevention and control – Hospital acquired infection	Trust wide
10	Safety culture during procedures	All areas in which procedures are undertaken

Table 8: ten incident types identified as priority areas for the RCHT Patient Safety Incident response Plan (PSIRP)

8.0 Areas of risk

There is a risk to patient safety if we fail to identify or act upon incidents arising around the Trust. Unmitigated patient safety risks pose a risk to the reputation and performance of the Trust.

9.0 Link to Trust objectives and Corporate/Board Assurance Framework Risks

Strategic Aim: Brilliant Care: Always providing safe, effective and compassionate care, where we listen and learn to provide an excellent patient experience and reduce avoidable harm.

- BC 1.1: Provide care that is safe and avoids harm
- BC 1.4: Provide clinically effective care, which minimises delay and the amount of time people spend in our care

10.0 Governance

The KCCG and NHS England/Improvement will both review and sign off the Trust PSIRP as early adopters of this scheme.

IRLG reports quarterly to QAC with details of the patient safety incidents and learning arising from the investigation of these.

11.0 Responsibility

The Director of Integrated Governance

12.0 Recommendations

- **receive** and **note** the findings of the report and the priorities identified from this review form the basis of the Trust PSIRP for the twelve month period from 1 January 2021, as part of its Board assurance arrangements relating to the quality and safety of the Trust's services

Name and Title of author: Richenda Tisdale – Deputy Director of Integrated Governance and Bernadette George, Director of Integrated Governance

May 2021

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Royal Cornwall Hospitals NHS Trust

Meeting: Board in Public

Date of Meeting: 04 November 2021

Item Number: 22

Title of Report: End of Life Care Annual Report 2021/21

Executive Director Lead: Dual Director for Nursing, Midwifery and AHPs

Author and Job Title: Sue Adams Lead Practitioner EOL; Liz Thomas Lead Practitioner EOL; Louise Dickinson Deputy Director of Nursing Midwifery and AHPS

Email Address: suzanne.adams4@nhs.net

Purpose of the Report:

Approve ☐ **Discuss** ☐ **Note** ☒ **Endorse** ☐

This report provides an overview of the progress to date of the SPEOL Care Team against the EOL Care Strategy, the EOL Group, the EOL work plan for 2020/2021, the CQC Action Plan and how these have supported local and national priorities.

Consultation:

Quarterly reports have been presented to the Quality Assurance Committee throughout 2020/2021. The Report has been discussed and approved at the SPEOL Governance Meeting. The Report will be presented at the End of Life Care (EOL) Group meeting in May 2021.

Key Risks (please tick one or more):

Clinical ☒ **Financial** ☐ **People** ☐

Reputational ☒ **Legal / Regulatory** ☐

Impact Assessment:

No potential negative impacts have been identified by this report but equality and diversity will continue to be considered through the review of incidents and complaints.

Recommendation(s):

The Board **is recommended to:**

- **note** the End of Life Care Report for 2020/21

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Royal Cornwall Hospitals
NHS Trust

Specialist Palliative and End of Life Care
Annual Report 2020/2021

1. Executive Summary

Royal Cornwall Hospital Trust places significant value on the importance of delivering excellent care to all of those patients and their families at, or approaching End of Life (EOL). This includes not only those receiving acute care, but just as importantly those who require care at the end of their lives, something that has never been more important than over the last year where the impact of COVID-19 has presented consistent challenges to delivering high quality EOL care. This report provides an overview of the activity of the Specialist Palliative and End of Life (SPEOL) Care Team, End of Life Care Working Group, the EOL work plan for 2020/2021, the CQC Action Plan and how these have supported local and national priorities.

During the most recent CQC report issued in February 2020 EOL care was reviewed as a core service. The overall rating awarded for EOL was 'Good' this being an improvement in four out of the five key domains, with RCHT now rated as 'Good' across all domains for EOL care. The recommendations made by the CQC form part of the overall Trust CQC Action Plan which has scrutiny at the Quality Assurance Committee.

The team has provided a seven day service on all but one occasion throughout the COVID – 19 Pandemic despite the constraints of sickness and staff shielding.

The SPEOLC Team had a total of 809 in-patient referrals in the reported year compared to 1111 in the previous year which is a decrease of 27%. This is thought to be due to the COVID – 19 Pandemic; particularly in the first wave, when reduced hospital admissions in general were noted. In the last year there were 33.5% of referrals made with a non-malignant diagnosis compared to 35% of patients in the previous year.

Despite the Pandemic, the SPEOLC Team continues to undertake quality improvement initiatives. Trust staff have continued to support patients in delivering 'Rainbow Days' 'with badges awarded to those staff supporting patients and families in achieving 'wish fulfilment' at End of Life. The team was recognised nationally once again for this piece of work having been shortlisted for five Patient Experience (PENNA) awards and winning in two of the categories.

The Integrated Consultant Team of Cornwall Hospice Care and RCHT employed Consultants have provided 24/7 telephone support to the acute hospital throughout this period. This service was redeployed from in reach face to face consultant support in the hospital to support teams and services closer to patients' home, as part of the county strategy. Following a formal SLA, on-site face to face consultant input recommenced mid-February 2021. This will continue to be monitored and evaluated during 2021 in response to the CQC recommendations to consider increasing medical staffing capacity and as part of a system wide reconfiguration of services.

The SPEOLC Team recognises the need for continued commitment to embedding past QI projects to ensure ongoing success, whilst fulfilling the current work plan and progressing new initiatives. The team remain enthusiastic and committed to improving the quality and delivery of care to patients and families at EOL.

2. Introduction

The SPEOLC Team continues to provide a nurse-led service across the Trust with medical support provided by Consultants in Palliative Medicine from the Integrated Service. The focus remains on the delivery of high quality, person centred care. This includes patients and families referred directly to the service, but also ensuring high quality EOL care is experienced across the Trust by working closely with other areas to support those patients and families who may be in the last year of life. Established quality improvement initiatives aim to support staff in delivering holistic, compassionate care, taking into account the needs and preferences of each individual patient and their family requiring support at this difficult time.

This report provides an overview of the progress to date of the SPEOL Care Team against the EOL Care Strategy, the EOL Group, the EOL work plan for 2020/2021, the CQC Action Plan and how these have supported local and national priorities.

3. Specialist Palliative and End of Life Care Team (SPEOLC)

3.1. Aims *of the SPEOLC Team*

The aim of the SPEOLC Team is to promote the best achievable quality of life for adult patients and their families facing cancer and other life-threatening illness that are not responsive to curative treatment. This may be offered at any point in the disease trajectory, from maximising potential for rehabilitation to supporting in the dying process.

The SPEOLC Team aims to achieve a high standard of care through:

- Providing safe, effective and responsive support to patients and families;

- Providing the 5 key areas of care that the evidence suggests are important to patients with advanced incurable illnesses – good symptom control, timely information sharing about their illness and how it will affect them in the future, reduced family burden and distress, plans and preferences for the future listened to and adhered to, alongside coordinated care across care settings;

- Offering advice, support and information for healthcare professionals involved in the palliative care of people with cancer or other advanced incurable illness;

- Ensuring that patients experience care that is coordinated and integrated across all settings, with robust handover arrangements and communication between generalist and specialist healthcare professionals;

- Ensuring patients are involved as much as they wish to be in making decisions about their care, with inclusion of their family, carers and those important to them;

- Providing training and opportunities for ongoing learning in palliative and end of life care for healthcare professionals involved in supporting and caring for patients with end of life care need;

- Supporting ongoing quality improvement in specialist palliative and end of life care; to support evidence based practice and ongoing evaluation of patient outcomes in specialist palliative and end of life care;

- Directing the RCHT Strategy for end of life care, through ongoing quality improvement initiatives, supporting evidence based practice and development of an annual work plan for specialist palliative and end of life care;

- Referring to national guidelines, policies and strategies to develop and improve services offered, including: Ambitions for Palliative and End of Life Care (2015), NICE Guideline for the Care of the Dying Adult in the Last Days of Life (2015), NICE Quality Standard End of Life Care for Adults (2011), One Chance to Get it Right (2014).

3.2. Operational Policy and SPEOLC Team Members

The SPEOLC Team operates a seven day face to face service from 08. 00 am until 16.00 pm. Consultant level advice is provided available during these working hours (08.00-16.00) and outside of working hours (16.00-.08.00) to all of the staff working at RCHT. This is provided through the Consultant Led Cornwall Hospice Care 24/7 advice line.

The RCHT SPEOLC Team comprises:

- Consultants in Palliative Medicine as part of an integrated service working across care settings, employed by varying organisations;

- Lead Practitioner End of Life Band 8A (0.8 WTE) job share;

- Clinical Nurse Specialist End of Life Band 7 (0.4 WTE);

- Clinical Nurse Specialist Band 7 Palliative & End of Life Care (0.6 WTE);

- Specialist Nurses Band 6 (4.0 WTE);

- Palliative Occupational Therapist (0.8 WTE);

- Administrative support 1.0 WTE Band 4 job share.

The extended team includes physiotherapists, dieticians and speech and language therapists.

The SPEOLC Team have an Operational Policy for 2021/2022 and a team work plan for 2021/2022; Appendix 1. The service supports a SPEOLC multi-disciplinary team (MDT) meeting weekly.

The team sits within the Corporate Nursing Directorate; the Director of Nursing, Midwifery and Allied Health Professionals is the Executive lead for the integrated service.

The Consultants in Palliative Medicine are employed by varying organisations but as an Integrated Team are under the Executive Leadership of the Medical Director of Cornwall Partnership NHS Foundation Trust.

3.3. Clinical Activity

The SPEOLC Team had a total of 809 in-patient referrals in the reported year compared to 1111 in the previous year which is a decrease of 27%. It is thought that this was due to the COVID -19 Pandemic which saw a reduction in admissions for a period of time across the Trust particularly in the first wave.

The team also provides support for patients with non-malignant conditions. Of the total number of patients referred to the Team, 33.5 % had a non-malignant diagnosis which compares to 35% in the previous year.

The SPEOL Team Key Performance Indicator (KPI) is the time to see referrals. All urgent referrals should be seen within 24 hours of referral. Non-urgent referrals are expected to be seen within 48 hours from referral. The patients who were not reviewed within 48 hours are those who were referred on a Friday but due to lone working at the weekend may not be seen, as urgent cases are prioritised. This may also occur if the team needs to suspend weekend working due to sickness.

	SPEOL Referral Compliance	
	Urgent within 24 hours	Non urgent within 48 hours
Apr-20	100	100
May-20	100	100
Jun-20	100	98.5
Jul-20	100	98.2
Sep-20	94.1	90.3
Oct-20	100	100
Nov-20	100	100
Dec-20	100	100
Jan-20	100	100
Feb-20	100	100
Mar-20	100	100
Year to date	99.5%	98.8%

3.4. Multidisciplinary Team (MDT) Meetings

Weekly MDT meetings are normally held with extended team members to ensure the benefits of a multi – disciplinary review of individual patient cases and to ensure patients and their families have a holistic approach to their care. Due to the COVID -19 Pandemic attendance figures for 2020/2021 were low due to redeployment of extended team members and services working differently. A summary of personnel attendance is detailed below.

Summary of attendance by Role	Total number of meetings	Total number	Percentage
Consultants	51	15	39
Nursing Specialist Palliative	51	51	100
MDT co-ordinator	51	44	86
Occupational Therapist	51	17	33
Pastoral Care Team	51	19	37
Physiotherapist	51	12	23
Visitors**	51	0	15

** visitors included – other CNS, OT Technical Instructor, CQC Inspector, student nurses, medical students, Staff Nurses, Community Palliative Care Nurse.

4. End of Life Group

The RCHT EOL Group continues to meet bi-monthly having moved to a virtual format. The purpose of the EOL Group is to:

- Support and promote improvements to EOL care across the Trust by local quality improvement initiatives and the implementation of relevant national guidance. An example of this would be the Pet Passport. An initiative which supports patients to access visits from much loved pets at EOL;

- Support initiatives to increase the options and choices available to patients who may be in the last year of life for their future care. An example of this would be ongoing work to improve EOL discharge processes;

- Establish and support the patient's wishes and preferences regarding their immediate priorities of care at EOL (including their preferred place of care) as far as this is realistically feasible. An example of this would be regular group attendance from Trudy Rayment, Continuing Healthcare Operational Manager;

- Support patients to be involved as far as they wish in the planning and recording of their preferences for future care via system wide Advance Care Planning processes and documentation. An example of this would be representation of group members on the Coordinate my Care (CMC) training and education work stream (CMC is an electronic Advance care planning platform which is planned for roll out in the coming year);

- Promote and enable communication of relevant clinical and social information across settings of care to improve service delivery. An example of this would be the syringe driver review group and the cross setting MDTs which have been developed to enable a smooth transition of care across settings;

- Ensure best practice in the provision of care, including specifically provision of high quality EOL Care in acute hospitals in the last few days of life. An example of this would be the virtual headsets for patients at EOL, an initiative that was showcased at the RCHT Den;

- Scrutinise EOL related incidents to identify opportunities for learning and improving practice. An example of this would be the rise in incidents relating to falls in patients at EOL and the collaboration by the SPEOL Care Team with Paul Cadger, Falls Improvement Practitioner;

- Review feedback from patients and relatives / carers on the quality of care and treatment with a view to continually improving care. An example of this would be feedback to the group on the Medical examiner initiative and the impact of this upon bereaved families;

- Review EOL data to identify any areas for concern or opportunities for improvement An example of this would be the EOL electronic dashboard;

- Review and update the EOL risk register where indicated.

The group has membership from medical, nursing, therapy, chaplaincy, bereavement services, SPEOLC team, Information Services and the Patient Experience Team. COVID-19 has impacted upon the group in terms of representation by the Palliative Care Consultants and Healthwatch etc. There are plans to refresh the group membership as a Q1 action for this coming year. The Group Chair is the Director of Nursing Midwifery and AHPs and the Deputy Chair is the Deputy Director of Nursing Midwifery and AHPs.

The End of Life Group is accountable to the Quality Assurance Committee and reports quarterly to this Board.

5. Care Quality Commission (CQC)

The most recent CQC report in February 2020 awarded improved ratings in four of the five domains resulting in an overall rating of 'Good' awarded to the Trust:

Ratings for Royal Cornwall Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
End of life care	Good ↑ Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019	Good ↑ Dec 2019	Good ↑ Dec 2019	Good ↑ Dec 2019

The CQC inspection for EOL care is based upon the 'One Chance to Get it Right' national guidance document as well as the NICE guidelines and quality standards for EOL care. The inspection includes all care provided to patients who are approaching the end of their life and following death, it also includes care for relatives and those people close to patients. During this inspection SPEOLC Service and ward areas were reviewed. In addition the onward care team, the Cove Cancer Centre, the mortuary, chaplaincy service and bereavement office were inspected. Interviews included those with Specialist Palliative Care Consultants, Specialist Nurses, Registered Nurses, Health Care Assistants, Chaplains, the Bereavement Team, the Patient Experience Team, the End of Life Executive Lead, administrators, the Mortuary Manager, volunteer staff, junior doctors and patients and their families.

5.1. Areas of outstanding practice:

Four areas of outstanding practice were identified by the CQC, these were:

- The public facing Advance Care Planning web page supported improving public knowledge about making decisions if they were diagnosed with a life limiting illness;

- Valuing patient experience- Recognising acts of compassionate at EOL via the `Rainbow Days` scheme & proactively promoting learning from patient experience;

- Regular reflective sessions- a joint initiative with occupational health. Open to all staff these monthly sessions support staff across the trust with their own emotional wellbeing;

- System wide working- joint working on the education passport (Cornwall & IOS EOL learning path). Providing education sessions to a set standard and increasing understanding for all staff across the system

5.2. Summary of positive feedback:

- The service had enough staff with the key knowledge and skills. Staff assessed risks to patients, acted on them and managed medicines well;

- The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service. Staff were working towards keeping good records and audit;

- Staff provided suitable care and treatment for patients at EOL. Managers monitored the effectiveness of the service and staff competency;

- Staff worked well together and supported patients to make decisions. Key services were available seven days a week;

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs, providing emotional support to patients, families and carers;

- The service made it easy for people to give feedback;

- Staff had the skills, knowledge and experience to lead the service, ran services well, were developing information systems and supported staff to develop their skills;

- Specialist end of life staff understood the service's vision and values. Most staff felt respected, supported and valued. Staff were clear about their roles and accountabilities;

- The service engaged well with patients and the community to plan. All staff were committed to improving services continually.

5.3. Areas of concern identified were:

- Documentation did not always provide assurance that suitable, individualised care was provided for patients at the end of their life;

- End of life documentation was not always fully completed;

- Audits did not provide assurance all patients near to the end of their lives received suitable, individualised care;

- Staff did not always document mental capacity assessments;

- Palliative Care Consultants felt their workload was unsustainable;

- Palliative Care Consultants felt frustrated when they did not have the time to provide expert advice and support to add further pace and quality to improvement projects.

5.4. Areas identified where improvements should take place were:

- Continue with creating systems which provide assurance that patients at the end of their life receive suitable, personalised care;

- Continue to embed improvements for accurate completion of treatment escalation plans, ensuring assessment of decision making is documented;

- Consider increasing capacity for medical staff to work within contracted hours while effectively supporting SPEOL team leads with developing the service;

- Continue with plans to increase the medical staffing levels in line with national guidance;

- Document all risks to providing good quality end of life care to patients on the service's risk register and escalate risks as required;

- Provide side rooms to end of life patients when they choose this option.

The ‘should do’ actions and areas of concern identified by the CQC have informed the End of Life work plan which is monitored by the End of Life Group and there is additional scrutiny from the CQC scrutiny group and the Quality Assurance Committee.

6. End of Life Care Work Plan

The Specialist Palliative and End of Life work plan 2020/2021 continued to focus on the key issues, specifically education, audit, learning from incidents and complaints, co-design and documentation.

Achievements:

6.1. Education

- Weekly virtual EOL session to support mandatory training for clinical staff;
- Monthly virtual EOL session included in senior medical staff mandatory training;
- EOL session included in junior doctor mandatory training;
- EOL sessions delivered on the F1 and F2 staff education rota;
- Over 50 daily COVID-19 EOL refresher education sessions were delivered during the first wave;
- Virtual face to face education sessions have been delivered to RCHT staff to support those staff undertaking the Cornwall and IOS EOL learning path. These sessions cover topics relating to symptom management, breaking bad news and personal care at EOL. In March 2021 the Specialist Palliative and EOL care lead was invited to present this project at Hospice UK. The learning path was shortlisted for a PENNA award;
- Bespoke education sessions have been delivered upon request to a variety of audiences. Amongst these are EOL study days for student nurses, preceptees, junior doctors, Kerensa Ward staff, and sessions for pharmacy, anaesthetics etc.
- During the first wave of the pandemic, weekly reflective debrief sessions ran across the Trust to provide staff with the opportunity to debrief and access emotional support;
- Specific debrief sessions were supported for Critical Care and Lowen Ward.
- A SPEOL Care Newsletter is produced quarterly providing a platform to update staff on key developments within SPEOL care both locally and nationally;

- Quarterly SPEOL Link Practitioner meetings are held at the COVE Cancer Centre for registered and unregistered nurse and AHPs within the Trust. This provides an opportunity for training and education and the dissemination of clinical updates regularly hosting guest speakers. The last meeting was held in July 2020 .Meetings were then suspended due to the COVID-19 Pandemic. There are plans to recommence in July 2021;

- Registered nurse verification of expected adult death has commenced across RCHT. The Joint SPEOL Lead is delivering virtual education sessions to support this initiative;

- Three members of the SPEOL Team Lead have undertaken the Co-ordinate my Care train the trainers programme to support education of trust staff using the Advance care planning platform;

- The integrated consultant palliative medicine team set up and delivered online education meetings twice a month for the medical and nursing staff in the acute hospital, community and hospices (specialist palliative care staff). This has been sustained and enabled integrated learning between teams employed by varying organisations, and is now integral to the system across Cornwall;

- The Palliative Care Consultants continued to support the full delivery of the University of Exeter (4th and 5th year) palliative care curriculum throughout the Covid pandemic, including providing significant extra input to replace sessions unable to be provided by community or hospital services during the pandemic. This was recognised by the Dean of the Medical School in Truro ‘as having been of an excellent standard throughout the pandemic’.

6.2. Audit

- Team members were delighted to receive the results of an independent audit commissioned by the Trust. Audit South West Assurance published the results of their independent audit into EOL care at RCHT awarding their highest possible result of ‘Significant assurance’ in the governance of EOL care planning;

- The National Audit of Care at End of Life (NACEL) for was suspended during this year in response to COVID 19. An action plan developed following the second round audit in 2019 has been monitored by the EOL group. The audit results illustrate that despite improvements in recording there remain ongoing challenges in compliance with EOL care planning. Priority areas include:

    1. Communication;

    2. Nutrition / Hydration;

3. Symptom Control;

4. Spiritual / Psychological Support;

5. Support to families.

Results revealed that a plan of care for supporting patients to eat if able is not routinely than average scores. The assessment of spiritual and psychological care was not routinely documented in the majority of care plans with less than half of the families surveyed believing their loved one had received care for their emotional needs;

Symptom management achieved a high score which was echoed by the quality survey with the vast majority of families believing that RCHT provided effective symptom relief and peace and privacy being the right place for their loved one to be cared for at end of life;

An action plan was formulated which included education and ward support in relation to completion of the EOL care plan and ongoing audit;

- The development of processes to support EOL care planning form part of the CQC action plan. The EOL care plan is now supported by a Formic electronic audit tool;

- An audit proposal was developed to audit Care Groups individually on a rotating three monthly basis with 60 EOL care plans audited. A further 10 patients without an EOL care plan were reviewed and one ward undertaking an after death analysis of care providing an opportunity for staff to feedback of their impressions of care;

- The Specialist Medicine Care Group was audited between Oct / Nov / Dec 2020. A report has been produced for the Care Group and is scheduled to be presented at the Care Group learning event. The audit results demonstrated good uptake in initiating the EOL care plan with the junior doctors demonstrating good completion of the medical review section. There were opportunities for improvement identified in the initial nursing review section which contains the holistic care section;

- A significant number of examples of good practice were identified with 21 members of staff commended in the report demonstrating that the care group contains excellent clinical role models. This initial audit provides a baseline upon which care groups can action plan for improvement;

- An audit of wards within the Urgent Emergency and Trauma Care Group is now underway;

- A COVID - 19 electronic prescribing bundle (a joint initiative with the integrated palliative medicine consultant team) was initiated in the first wave of COVID- 19. The aim of the bundle was to provide symptom relief for patients with uncertain recovery. An electronic audit of prescribing for 24 patients with COVID-19 demonstrated that the bundle was prescribed safely with patients receiving symptom control in line with COVID-19 prescribing guidelines;

- There is an ongoing audit of the Trust's EPMA EOL anticipatory prescribing bundles. The data for a 1000 prescriptions is being reviewed by the Joint Specialist Palliative and EOL Care Lead, a junior pharmacist and F1 doctor. Preliminary results have been discussed at the EOL governance meeting with all but 20 of 1000 patients prescribed opiates appropriate to their renal function;

- The Joint Lead for Specialist Palliative and EOL care and the Lead Research Nurse have submitted a feasibility assessment for the MABEL (Morphine And BrEathLessness) study. This study will compare the effectiveness and cost effectiveness of low dose oral modified release morphine versus placebo on patient-reported worst breathlessness in patients with chronic breathlessness;

- Syringe driver audit - results of a spot check audit of syringe drivers highlighted that a number of the pumps did not have the keypads locked or have four hourly checks as per policy; actions from the results from the audit were circulated to all ward leaders for highlighting at the daily ward Safety Briefing. The syringe driver checklist has been amended to include a prompt to check the keypad is locked. The Medical Devices Officer now highlights the issues raised in the audit during training sessions. A Trust Wide Safety Briefing was issued in November 2020. A further spot check audit will be undertaken from March to May 2021.

6.3. Learning from incidents and complaints

- The SPEOL Team receives any incidents or complaints that relate to Palliative or EOL Care;

- A standard operating procedure is in place to support the teams in responding to EOL related incidents;

- A prompt sheet has been developed for the patient experience team to support the triage of complaints. This followed a review of all Q4 complaints and is based upon the NICE Quality standards (NQS) for End of life (NQS 13 & 144);

- The learning from incidents and complaints is incorporated into mandatory training/education sessions;

- Learning related to the themes arising from incidents/complaints is shared with staff in a quarterly SPEOL newsletter; alongside the development of actions for sharing across the Trust;

- The End of Life Group review incidents and complaints identifying areas for improvement. Themes over the last year have related to:

    - EOL transfer and discharge delays remain a feature of incidents and complaints as patients fail to achieve their preferred place of care, one of the proxy markers for quality in EOL care. The Joint SPEOL lead continues to work with the Continuing Healthcare team and other system partners to improve discharge processes. A business case has been submitted for a Trusted nurse assessor post for EOL transfer and discharge;

    - Communication often features in EOL complaints. The Joint SPEOL Lead supports communication education sessions for both nursing and medical staff;

    - There has been an increase in the frequency of falls in EOL patients. The Joint SPEOL Lead has worked with the Falls Improvement Practitioner to support ward based education with regards symptom management at EOL;

    - Visiting has featured regularly in incidents and complaints, with families feeling the impact of separation from loved ones. The SPEOL Team has supported virtual visiting with the provision of iPads and support with training;

    - Syringe driver errors have emerged as a theme. This relates to unlocked boxes, setting up the device, recording and monitoring and recording. The joint SPEOL Lead issued a syringe driver Safety Brief and updated the syringe driver checklist;

    - Patient property has emerged as a theme in incidents and complaints. There has been a process running throughout COVID-19 to support families and this has been largely well received. Recent changes in national guidance, lower infection rates and better understanding of the virus dictate a revision of current processes. The Joint SPEOL Lead has worked with the Complaints Manager to update the process;

- Feedback from the questionnaire for patients and their families regarding the Palliative Care service continues to be evaluated with positive results; no specific changes have been required.

6.4. Documentation & Co-design

- A care plan has been developed to support the administration of subcutaneous as required dosing at EOL;

- A comprehensive EOL care plan based upon best practice guidance supported by a symptom assessment chart is in use across the Trust;

- Syringe driver prescribing and administration documentation is under review;

- Advance care planning documentation for information and recording is available across the Trust;

- A 'Standards for care after death' checklist was developed with the bereavement office and launched across the Trust;

- The SPEOL Care Team has worked with system partners to develop countywide anticipatory prescribing guidance to support prescribing for patients with renal dysfunction at EOL. The established anticipatory prescribing guidance is not suitable for patients with impaired renal function. An alternate version was created to support these patients to support prescribing for these patients across the system;

- The SPEOL Care Team has joined with system partners to undertake a review of the processes supporting EOL syringe driver prescribing and administration. This has included the development of a new community combined prescribing and administration chart for EOL medication. This will be prescribed within RCHT at the point of patient discharge. EOL prescribing guidance has been developed to support decision making in relation to prescribing whilst and electronic protocol supporting EPMA syringe driver prescribing is due for pilot;

- The joint SPEOL Lead has worked with the Mortality Review Group to incorporate EOL questions to the mortality review tool. In future, reviewers will be asked to comment on the initiation of EOL care planning, anticipatory prescribing and communication;

- An appendix to the current Bereavement Policy has been developed to provide guidance for registered nurse verification of Expected Adult Death. This is supported by a competence framework and a procedural flow chart. The current paperwork for verification of death is being reviewed by the Joint SPEOL Lead supported by the Resuscitation Group;

- The Advance Care Plan (ACP) Steering Group has received presentations on shared decision making and Co-ordinate my Care, an electronic platform for recording wishes and preferences for end of life. The group will continue to work to support the Co-ordinate my Care rollout with a view to revisiting the current terms of reference;

- In response to a request from the respiratory team during the COVID-19 Pandemic, the consultant team adapted guidance on withdrawal of NIV at end of life for use in RCHT which was rapidly approved available to the team on the respiratory wards;

- The consultant team continued to be integral to the Improving Access project which is a joint initiative with Harbour Housing (homeless housing charity) and St Austell Community Health (primary care) seeking to improve support at end of life for those with substance or alcohol dependence or in vulnerable housing.

7. Quality Improvements

In addition to the Quality Improvement projects identified in the previous section, the following have also been progressed:

7.1. Butterfly Cornwall

`Butterfly Cornwall` was launched in December 2018 supported by funding from Macmillan. A project nurse was appointed to roll out the scheme over a 12 month period. The scheme has now been rolled out to all adult inpatient areas and continues to evolve;

`Butterfly Cornwall` is a scheme to improve the way patients and their loved ones spend their last days together. The yellow butterfly emblem has been adopted by RCHT to use for patients approaching end of life. Sadly, many people will be in hospital at the end of their life and the scheme acts to enhance the quality of life at that time. The aim of the scheme is for all staff to provide equitable care and compassion for patients who die in our care along with their family and loved ones. The scheme helps staff provide extra support when required such as offering refreshments, providing comfort bags, keeping noise down and minimising unnecessary interventions such as maintenance and domestic services around the bed space. Pastoral care can be provided by our chaplaincy team for patients and relatives throughout the day and night if needed.

The scheme includes:

- Butterfly emblems, magnets and dignity clips (to be used with the patient/relative's consent);
- Open visiting;
- Snack boxes via helpdesk and hot & cold drinks from the ward;
- Comfort Bags for relatives (which includes a drink, shampoo/shower gel, toothbrush and toothpaste, a comb, hand wipes, pen and paper and information about the location of showers and support services);
- Butterfly Belongings Bags for patient possessions after death;
- Pet visits;
- Parking permits;

- Tea/coffee vouchers;

- Single use fleece / knitted blankets;

- Pet Passports` introduced in 2020.

- **Wedding Boxes** – For patients, who wish to get married at the end of their life, the chaplaincy team can help arrange a special license and we provide a memory box including a guest book/wedding album, bunting, confetti, a picture frame, candle and a disposable camera;

- **Rainbow Days** – adding colour to someone's last days by making the moments matter (meeting special wishes for comfort care for example a special meal, a haircut, a manicure, massage, arranging a special journey);

- **Redecoration of dedicated side rooms** - for end of life patients throughout the Trust. Wellington, Grenville, Eden. Phoenix and Pendennis Wards all now have redecorated side rooms. Work was temporarily suspended due to the COVID -19 Pandemic but will recommence in 2021.

The scheme is delivered through a programme of short education sessions that take place on the ward and cover the principles of what Butterfly Cornwall is trying to achieve, effective communication, completion of the Priorities for Care documentation (the EOL care plan), symptom management and anticipatory prescribing. Education is provided for all staff who work in the clinical areas including Mitie colleagues (ward hosts, domestics and porters etc.), ward clerks, healthcare assistants, therapists, doctors of all levels and registered nurses.

In order for the scheme to be successful in an area, 50% of the ward staff are required to complete the training and a plan of how the scheme will embed with the team is required. Senior nurses in each area are being trained to provide cascade training to support completion of the training with the rest of the team and all new members of staff. Every member of staff who completes training receives a Butterfly pin badge to wear on their uniform along with a certificate. The scheme has been rolled out to 23 clinical areas to date. Funding for a further twelve months has been secured via an application to Macmillan. The additional funding with provide the opportunity to further embed the project and ensure this is sustained. Recruitment to this post is currently suspended due to COVID-19. The principles of the scheme have now also been adopted by Cornwall Foundation Trust. The scheme now additionally has its own fund with monies raised via fundraising events and public donations. Money raised will go to support end of life improvement initiatives within RCHT example of which are listed below:

- The `Butterfly Cornwall` Fund has supported `Care after Death Boxes` for all wards containing National Guidance to support staff who may be unsure of the process;

- The `Butterfly Cornwall` Fund will purchase Advance Care Planning key fobs and wallet cards to support the role out of ACP;

- Seeded paper butterflies on cards along with LED candles have been purchased from the fund and will be given to relatives attending `Remember a Loved One` services once they recommence in 2021.

- Butterfly Cornwall is utilising its funding to develop `Memory Boxes` for all wards which include handprint kits, writing paper etc. and Birthday Boxes for patients approaching End of Life;

- The SPEOL Team have been supporting a business case for a `Butterfly Companion` Volunteer Coordinator to work alongside Voluntary Services Lead in recruiting and supporting volunteer `Butterfly Companions` who will provide support to patients approaching end of life across the trust. The business case has been submitted for consideration.

7.2. Bereavement Support Group

This group is open to all that have experienced bereavement including staff. It is held quarterly at the Cove Cancer Centre jointly with the SPEOLC team, Chaplaincy Team and RCHT Volunteers if needed. The group has been temporarily suspended during the COVID – 19 Pandemic. However virtual Bereavement Support Groups held locally are circulated trust wide to ensure sign posting for support.

7.3. `Remember a Loved One` Services

This is a new initiative to enable those that have lost a loved one to attend a remembrance service within RCHT. This service was an initiative set up jointly by the SPEOLT and the Chaplaincy Team. The services will be held quarterly in the hospital chapel. Services have been suspended during the pandemic. The Chaplaincy Team plan to hold a virtual service during ‘Dying Matters’ week May 2021.

7.4. `See it My Way`

The Joint Lead Practitioner has worked with the Patient Experience Team to develop `See it my Way` an initiative to use patient, carer and staff stories to improve care.

The stories will be filmed and shared Trust wide for learning via a live virtual event which allows for questions and shared perspectives. The initiative focuses on a theme of ‘living with a life limiting condition’. The first event is planned for April 2021 as part of `Experience of Care` week and will focus on End of Life care with the theme of experiences of loss of a loved one during the COVID-19 Pandemic. A short film produced from the event will be circulated trust wide during `Dying Matters` week in May. This will be a yearly event led by the Patient Experience Team.

8. EOL Strategy

The current End of Life Strategy expires this year. A new EOL Strategy has been drafted incorporating outstanding actions and identifying new priorities. The current strategy was informed following a gap analysis against the 'Ambitions for palliative and end of life care: a national framework for local action 2015-2020'. The key priorities for attention have been prioritised into year 1, year 2 and year 3 and can be found in appendix 2 of the report. The implementation of the strategy is on target with two key areas of activity outstanding that still require progressing:

- Embedding the advance care planning processes- This will be influenced by the implementation of Coordinate my Care across the system;

- The implementation of a programme of TEP education-A new TEP Lead is due to be appointed this year providing a valuable opportunity to build upon previous progress.

9. Partnership working with Cornwall Hospice Care

Palliative Care Consultant cover has been provided via and integrated model. This was adopted with agreement between RCHT, CFT and Cornwall Hospice Care to mitigate the risks of lone working and to enable annual leave and study leave cover, alongside providing a platform for the integration of the specialist palliative medicine consultant team. A formal SLA for this service was signed by all organisations in February 2021.

Over the last year Palliative Care Consultant cover was provided via telephone support whilst they focused on enabling care closer to home as requested, ensuring a safe place for patients with symptom control and dying care needs to be cared for in the hospice and to ensure consistent 24/7 consultant telephone advice to all care settings.

A return to an on-site presence was welcomed in mid-February of this year with the extended team working well to evaluate a new model of working which sees four PA's currently offered for inpatient reviews.

The out of hours provision of specialist palliative care for all care settings including the acute hospital is provided by Cornwall Hospice Care from 4pm to 8am on weekdays and the weekends. It also provides palliative medicine consultant support to the nurse led team at RCHT during usual working hours for the team when on site consultant support is not available.

There is recognition of CQC recommendations to address medical staffing capacity and support ongoing service development. New ways of working are under consideration as part of a system wide review of Palliative and End of Life Care provision.

10. Activity during COVID - 19 Pandemic

- During the COVID -19 outbreak the SPEOL Care Team has worked alongside system partners to support a coordinated EOL response. As a member of the EOL cell the Joint SPEOL Lead developed a spreadsheet to record EOL initiatives in response to COVID- 19 across the system. The provided a valuable overview of resources and potential gaps;

- A leaflet for families separated by hospitalisation was developed by the EOL CNS, this was approved by the EOL Cell and the COVID-19 Incident Command and Control and distributed to South West Ambulance Service Trust, Emergency Department and Out of Hours service;

- Memento cards were created for patients to record messages for their loved ones; these have been distributed to CFT Community Hospitals also;

- COVID specific bereavement cards were developed which have been distributed to Cornwall Foundation Trust community hospitals in addition to RCHT bereavement office;

- The SPEOLC Team delivered over fifty one hour sessions on COVID-19 and EOL care to RCHT frontline clinical staff;

- Changes were made to the operational delivery of the team. A standard operating procedure was developed incorporating the daily Nervecentre review of virtual wards to identify patients not for escalation to Critical Care demonstrating NEWS scores above 5;

- Daily Virtual COVID-19 catch up sessions were offered to all red pathway wards to provide rapid access to advice and support;

- Daily routine red pathway ward visits took place to identify patients with palliative care needs and provide support and guidance;

- An EPMA COVID-19 symptom management bundle was developed in collaboration with the respiratory and pharmacy. This provided support for symptom management in those patients with uncertain recovery and was reviewed and updated as needed throughout the year in line with national guidance;

- A COVID-19 symptom observation chart was developed to support the assessment and management of symptoms;

- Two SPEOL newsletters focused on EOL COVID-19 management and staff experience;

- A COVID-19 decision support tool was developed and presented to the Medications Practice Committee to support junior doctors navigate the array of guidance related to managing patients with Covid-19.

11. Future Developments

The SPEOL Care Team remains committed to continued improvements in patient experience. Many of the actions and initiatives of recent years have received praise and recognition from the CQC.

The team recognises that the impact of the past year dictates that these projects require revising and revitalizing to ensure that these continue to be delivered with enthusiasm and to be fully embedded across the Trust.

An event to mark Dying Matters Week will offer Trust staff the opportunity to learn about the importance of digital legacy and protecting our virtual presence and those of our families after death.

The SPEOL Care Team is working with the bereavement office team to prepare for the third round of the NACEL audit, currently consenting families for participation in the Quality Survey and identifying patients for audit

The current End of Life Strategy expires this year. A new EOL Strategy is in draft and will carry forward outstanding actions and identifying new priorities. The current strategy was informed following a gap analysis of current service provision against the 'Ambitions for palliative & end of life care: a national framework for local action 2015-2020' due for revision this year. The new RCHT strategy will be informed by national guidance i.e. the Ambitions document, the NICE End of life care for adults: service delivery (NG142), the recent CQC report, and the NACEL audit report.

The End of Life Care Working Group will continue to meet bi-monthly and will oversee the work plan for 2020/21, NACEL audit actions, EOL incidents and complaints and the EOL Strategy to ensure continued attention to patient experience and quality improvement initiatives in end of life care.

Representatives from the RCHT will continue support the Cornwall and IOS End of Life Strategy group to support partnership working and also the Cornwall and IOS End of Life Education Group to promote shared learning and quality outcomes for care across settings for patients with end of life care needs

Appendix 1 Annual Work Plan 2020/2021

EOL team workplan 2021/22		Action to be completed by														
		Action complete														
		Action delayed														
		Lead	Status	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Status Update/Comments
1	Education and Training															
1.1	Continue to provide End of Life training on the mandatory training programme for clinical staff.	SA														
1.2	Continue to provide End of Life training on the Corporate Induction programme.	SA														
1.3	Continue to provide monthly reflective debrief session to emotionally support staff	SA														
1.4	Plan & deliver Dying Matters week events.	SA/LT														
1.5	Deliver quarterly Link Nurse forum.	LT														
1.6	Continue to increase The availabilty of communication skills training across the trust for those staff regularly dealing with distrss at End of Life.	SA														
1.7	Support Registered nurse verification of extected adult death training	SA														
1.8	Support the continued delivery of the Cornwall & IOS EOL learning path	SA														
1.9	Continue to develop and deliver a programme of face to face/virtual education reflecting key areas of care in EOL for all staff delivering EOL care across the trust.	SA														
1.1.1	Continue to support junior doctor medical training.	SA/LT														
1.1.2	Ensure RCHT representation at the Cornwall & IOS education group	SA														
1.1.3	Produce and circulate quarterly SPEOL newsletter	SA														
1.1.4	Support the RCHT Rainbow day programme across the trust.	LT														
1.1.5	Support Co-ordinate my care electronic ACP training	SA														
1.1.6	Support roll out of `Butterfly Huddles` across the trust as part of safety huddle.	LT														
1.1.7	Support the delivery of Butterfly Cornwall scheme across the Trust.	LT														

2	**Datix/complaints**															
2.1	Ensure EOL incidents and complaints are handled according to the SPEOL service SOP.	SA														
2.2	Attend local resolution meetings where required.	SA/LT														
2.3	Review Datix incidents and complaints and identify any themes for improvement.	SA														
2.4	Produce a bi-monthly summary for pesentation and review at the Governance & End of Life Group meeting.	SA														
2.5	Feedback learning from incidents and complaints into education sessions	SA														
2.6	Review and maintain the EOL risk register	LT/SA														
2.7	Include key learning points in the quarterly newsletter.	SA														
2.8	Attend ward sister/Charge nurse meetings every 2 months to share the learning from incidents and complaints	LT/SA														
3	**Research and Audit**															
3.1	Continue to support opportunities for palliative care research-MABEL study	SA/LT														
3.2	Support the electronic care group audit for monitoring compliance with EOL care plan	SA														
3.3	Complete data collection for the National Audit for Care at the End of Life 2021	SA														
3.4	Review patient feedback from the Palliative EOL care team questionnaire and present findings at the EOL group meeting.	LT														
3.5	Support re-commencement of the Bereavement questionnaire feedback at the governance and EOL group meeting to identify learning.	SA/LT														
3.6	Support ongoing audit of EOL pescribing/symptom management.	SA/LT														
3.7	Complete CSCI audit biannually and report findings to senior nurses group & SPEOL team to inform ongoing training & education	LT														
3.8	Ensure representation at the MROC	SA														
3.9	Facilitate pilot of the I-POS once IT systems in place to support data collection	LT														
3.1.0	Support ward areas to complete the rotational After death audit	SA														
4	**Documentation**															
4.1	Continue to support ward staff in completing the End of life care plan & symptom assessment chart.	SA/LT														
4.3	Review and update all policies	SA/LT														
4.4	Ensure all electronic resources, are reviewed and updated including the SPEOL webpage, EOL shelf & ACP webpage.	SA/LT														
4.5	Support the implementation of Advance care planning documentation and processes across the trust	SA/LT														
4.6	Rollout the electronic mechanisms for advance care planning activity (CMC)	SA/LT														

5	**Co-design/Partnership working**																
5.1	Support the systemwide adoption of the public facing EOL Charter.	SA/LT															
5.2	Work with data anlytics for ongoing review of the electronic EOL dashboard	SA															
5.3	Support the implementation of processes, documentation and guidance for the prescribing and administration of EOL medication.	SA/LT															
5.4	Ensure SPEOL representation at the Cornwall & IOS EOL strategy group	SA/LT															
5.5	Lead the RCHT Making a difference EOL group	LT															
5.6	Lead the care and transfer of the deceased task and finish group	SA															
5.7	Continue to support the RCHT TEP lead	SA															
5.1.1	Ensure attendance at the System wide care after death group.	SA															
5.1.2	Participate in the EOL fast-track transfer and discharge workstream	SA															
	Operational activity/patient care																
6.1	CNS review of urgent referrals within 24hrs	LT															
6.2	CNS review of non-urgent referrals within 48hrs of weekday working hours.	LT															
6.3	Weekly SPEOL multidisciplinary team caseload review meeting	LT															
6.4	Divide wards as part of quality improvement project to support clinical areas and link nurse development (SPEOLCT)	LT															

Appendix 2 End of Life Care Strategy Key Actions

End of Life Care Strategy 2018 - 2021 Action Plan				
	Priority 1	1 year		
	Priority 2	2 years		
	Priority 3	3 years		
No.	**Recommendation/Action**	**Priority**	**Progresss Update**	**RAG**
Personalised Care Planning				
1	Review compliance with EOLC planning.	1		
2	Embed the concept of Advance Care planning particularly with the non-malignant population.	3		
3	Focus education on Anticipatory Medication Guidelines to promote safer prescribing practice	2		
Education and Training				
4	Extend the education programme to incorporate communication skills and spirituality.	1		
5	Devise and introduce a TEP education programme for all staff.	1		
6	Increase the Sage and Thyme course capacity to fulfil the training needs of nursing staff and those regularly dealing with distress at End of Life.	1		
7	Develop a blended learning approach for End of Life Education cooperating with partners across the county	1		
8	Formalise junior doctor medical training	1		
Shared Records				
9	Support the introduction of an electronic shared record	2		
24/7 Access				
10	Introduce a 7 day SPEOL team service	1		
Evidence and Information				
11	An EOL dashboard will be introduced which captures the disease substrate for referral into the Specialist Palliative Care Service.	1		
12	Regular representation from Non-malignant Long Term Conditions or eldercare on will be evident at the End of Life Group meetings.	1		
13	A Mechanism needs to be identified which can capture and audit data relating to preferred place of care.	1		
14	We will reduce the number of Fast –track applications that are rejected on the grounds of lack of evidence.	1		
Co-design				
15	Working with Community Partners, update the End of Life discharge and transfer policy to address the issues that have been identified through the incident reporting system Datix and to provide seamless cross boundary End Of Life Care.	1		
16	There are inconsistencies in patients achieving their preferred place of care. A more focussed workforce and more detailed analysis of delays still requires completion.	2		
17	With Community partners provide a formal publicly available statement/commitment that enables patients and families to understand the care they should expect to receive at End of Life.	1		
18	In conjunction with the EOL Education sub-group establish a 'Compassionate Communities' project(s) across Cornwall	3		
19	Joint working with the Learning Disability team regarding provision for those patients with Learning Disabilities.	1		

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Royal Cornwall Hospitals NHS Trust

Meeting: Trust Board in Public

Date of Meeting: 04 November 2021

Item Number: 23

Title of Report: Flu Plan 2021

Executive Director Lead: Susan Bracefield, Chief Operating Officer

Author and Job Title: Anna Dalziel, Head of OH & Wellbeing

Email Address: anna.dalziel@nhs.net

Purpose of the Report:

Approve ☐ **Discuss** ☐ **Note** ☒ **Endorse** ☐

The purpose of this paper is to assure the Committee of the plans to increase the uptake of Flu vaccinations alongside the first season of COVID booster vaccines amongst staff at Royal Cornwall Hospitals Trust (RCHT) and to determine the commitment of resources to a wider system approach to the winter vaccination of our population.

Consultation:

This paper is the result of information and discussions that have taken place through the RCHT Flu Group, the Cornwall System Flu Group and the Southwest Regional Flu Meeting. Flu for both our colleagues is an annual programme of activity and is an effective way to reduce pressure on the health and social care (H&SC) system in winter months both through preventing illness that requires increased H&SC input and preventing sickness and absence in the H&SC workforce thus ensuring that we have enough resources to care for our population.

Executive Leadership Team approved the Flu Plan at its meeting on 20 October 2021. It was submitted to People and OD Committee for assurance at its 27 October 2021 meeting.

Key Risks (please tick one or more):

Clinical ☒ **Financial** ☐ **People** ☒

Reputational ☐ **Legal / Regulatory** ☒

Impact Assessment:

We are mindful that health inequalities make flu vaccination increasingly important – protecting our must vulnerable in the community helps us to reduce serious complications as a result of COVID-19. We are working hard to increase our peer vaccinators and also to provide multiple sites for colleagues and patients to book appointments at localities as well as in their workplace. Our communications and engagement will target those that might be more vulnerable to undertake vaccination as early as possible and as the campaign moves forward we will continue to monitor this.

Recommendation(s):

The Committee is recommended to:

- **Note** the Flu Vaccination Plan

Title: Flu vaccination programme 2021/22

1. Situation

1.1 This paper is presented as the annual flu activity plan for 21/22. It also describes how the vaccination programme links to the COVID booster programme that is taking place at the same time. It seeks to assure the committee of the Trust activity to promote and increase the uptake of Flu & COVID vaccinations this year and discuss the options for providing support to an increased uptake in winter vaccinations across our whole community.

This year the Occupational Health team will oversee the Flu Vaccination program for RCHT, CFT, KCCG and Kernow Health CIC. We will also be providing flu vaccinations for Adult Health and Social Care staff (approx. 2300 vaccinations).

1.2 This paper is supported by a Flu Action plan (Appendix 2) and the RCHT Flu Group, which now meets weekly, is informed by the Cornwall System Flu Group, the Cornwall Workforce Cell and the NHSE/I Southwest South Regional Flu Group. We receive good support from the system Infection Control Lead Nurse, and we are active in looking at a campaign that offers maximum effect for all of Cornwall and the Isles of Scilly and not just on front-line health care workers (FHCW)

Historically, our OH Nursing Team has provided 'Drop-in clinics' for colleagues across all of the sites that require vaccinations, but we will now be offering bookable appointments via the Tango 3 system that was implemented during the COVID mass vaccination work.

Therefore, an appointment system will run, and daily flu clinic offerings will be held to facilitate getting colleagues vaccinated in a safe and efficient way. The clinics be bookable via the Tango 3 system with Helpdesk operatives available to offer support.

We will continue to utilise peer vaccinators to increase the scope of the flu vaccination programme.

Bookable flu clinics will be offered in the postgraduate centre, the OH department and the satellite hospital sites from the last week in September.

We will also be using prescribers at the COVID mass vaccination site to administer the vaccine under PSD at a set number of clinics (3 in October – capacity of 1500 appointments) to help achieve the required throughput.

2. Background

2.1 Historically, flu vaccination uptake has been lower in Cornwall and the Isles of Scilly, both for our staff and for our community. Our staff uptake for 2020/21 was 60%, a figure higher than many previous years; however, this remains well below national targets.

2.2 Ensuring that our communications campaign is clear and visible in all areas and across multiple media sites will also be critical as we look to ensure that we use the personal responsibility of all to **'Boost your immunity this winter'** is at the heart of our campaign this year.

3. Risk

3.1 Winter months for Health & Social care staff are particularly challenging and we need to work together ass a system to ensure that we protect both staff and patients from the impact of flu and COVID both on the individual and prevent transmission to our patients.

4. Accountability

4.1 The Head of Occupational Health is responsible for the delivery of the flu vaccination programme and will work closely with COVID vaccination lead. The Chief operating officer maintains the Executive responsibility for this programme.

4.2 Weekly updates will be given to board and we will also provide weekly updates to NHSE/I and Public Health England.

5. Recommendations

5.1 The Committee is recommended to note the Flu Vaccination Plan.

Anna Dalziel, Head of OH & Wellbeing – Royal Cornwall Hospital Trust
Date**: 10.09.2021**

Meeting: Trust Board in Public

Date of Meeting: 04 November 2021

Item Number: 24

Title of Report: Controlled Drug Accountable Officer (CDAO) Annual Report 20-21

Executive Director Lead: Dr Gill Derrick, Deputy Medical Director

Author and Job Title: Michael Wilcock, Head of Prescribing Support Unit, Pharmacy

Email Address: mike.wilcock@nhs.net

Purpose of the Report:

Approve ☐ **Discuss** ☐ **Note** ☒ **Endorse** ☐

Summarise the annual activities of the CDAO The objective of this report is to provide the Board/Committee with assurance that the Trust meets the regulatory requirements for Accountable Officers (AO) which are set out in full in the Controlled Drugs (Supervision and Management of Use) Regulations 2006; www.opsi.gov.uk.The report also aims to highlight to significant events involving controlled drugs in 20-21 financial year.

Consultation:

This report has been discussed at Medication Practice Committee and Controlled Drug Assurance Group and minor amendments made. Considered by Executive Leadership Team on 20 October 2021 and Quality Assurance Committee on 26 October 2021.

Key Risks (please tick one or more):

Clinical ☒ **Financial** ☐ **People** ☐

Reputational ☒ **Legal / Regulatory** ☒

Impact Assessment:

An equality impact assessment has not been undertaken for this report.

Recommendation(s):

The Committee is recommended to:

- Receive and **note** the annual report from the Controlled Drugs Accountable Officer

Annual Controlled Drug Accountable Officer Report

(2020-21)

1.0 Introduction

Controlled drugs (CDs), such as morphine, diamorphine, methadone, amphetamines and cocaine, are subject to special legislative controls because there is a potential for them to be abused or diverted, causing possible harm.

There are legal controls in place governing all steps involved in getting CDs from the manufacturer to the patient. NHS Trusts are accountable for monitoring all aspects of the use and management of CDs by all healthcare professionals they employ or with whom they contract and a statutory duty to work together in local networks to share intelligence on CD issues where there are concerns.

1.1 The Controlled Drug Accountable Officer (CDAO)

The Controlled Drugs (Supervision of Management and Use) Regulations 2013 places a statutory responsibility on NHS Trusts to nominate a specific individual – an Accountable Officer - to be responsible for the monitoring of the safe use and management of CDs in their organisation.

The CDAO is the Deputy Medical Director for Royal Cornwall Hospitals NHS Trust. The chief pharmacist, Iain Davidson, and Prescribing Support pharmacist, Mike Wilcock, deputise for the CDAO. Dr Gillian Derrick is currently registered with the CQC as the CDAO for RCHT.

This report describes the activities undertaken by the CDAO with regard to strengthening of governance arrangements for management of CDs within Royal Cornwall Hospitals NHS Trust for the period April 2020-March 2021.

Consideration will need to be given to how the CDAO role will be fulfilled with the integration across the system with CFT and RCHT.

2.0 CD Local Intelligence Network (CDLIN)

- The CDLIN is run by the NHS England Area Team and is a Devon and Cornwall CDLIN
- The CDLIN is chaired by the Controlled Drugs Accountable Officer, and Medication Safety Officer for NHS England & NHS Improvement (South West) - Jon Hayhurst.

- The CDLIN is run as a joint Devon and Cornwall network, however due to the size of the group there is only one joint meeting each year and a local Cornwall meeting every 6 months.
- The CDLIN meetings are mandatory for the CDAO (or appropriate deputy).
- The CDAO has submitted an 'occurrence' report to CDLIN for each quarter. This report is a statutory requirement and outlines the main incidents and occurrences of concern within the Trust to ensure learning across the network. The occurrence report is also tabled and signed off at the Trust's Medication Practice Committee.
- The CDAO has attended both CDLIN meetings in 20-21.

3.0 Assurance Monitoring of Controlled Drug Usage within RCHT

3.1 Misappropriation of Controlled Drugs

3.1.1 CD variance reports

- The Trust uses electronic issue data as one way of monitoring inappropriate usage of controlled drugs.
- Monthly reports to the CDAO and deputies are compiled using data from the EPMA and Stock Control software package to report on variances in CD usage on each ward or clinical area.
- The system flags where there has been an increase in usage of a CD and produces a report, based on previous stock issue volumes to that clinical area.
- The deputy CDAO reviews this report on a monthly basis, sending a copy of the report to the clinical pharmacists and the senior nurses.
- The ward pharmacist responsible for that area then reviews the variance report and flags if there are any concerns to the deputy CDAO. Using RADAR data, they are able to see how many doses have been administered to patients that month and how much has been dispensed for discharge and thus if there is a discrepancy.
- The FP10 issue data is also reviewed on a monthly basis to identify any unusual prescribing.
- Significant concerns are then escalated to the CDAO and discussed at CDAG.

- Table 1 shows the number of variance reports issued each month, the percentage investigated and the number that required further investigation/monitoring.

  Table 1: Variance reports and investigation summary for 20-21 Table

Month	Number of Variance reports Issued	Percentage Responded to by Ward Pharmacist	Number triggering potential concerns/ enhanced monitoring	Areas not responded
Apr-20	54	100%	0	
May-20	67	100%	1	
Jun-20	59	100%	2	
Jul-20	62	100%	0	
Aug-20	54	100%	4	
Sep-20	71	100%	8	
Oct-20	58	100%	3	
Nov-20	51	100%	2	
Dec-20	52	100%	2	
Jan-21	58	100%	1	
Feb-21	43	100%	1	
Mar-21	56	98%	2	THEATRE DIRECT
Total	**685**	**99%**	**26**	

- During 20-21 685 variance reports were issued for RCHT wards and clinical areas (compared to 661 in 19-20). 99% of these variances were reviewed (compared to 82% in 19-20).

- 26 of the 685 total reports triggered the need for further investigation and additional monitoring. Two of these investigations led to a formal announcement to staff on the ward that there was suspicion of misappropriation - Cyclizine tabs (ED) and dihydrocodeine tabs (Kynance).

- The monthly report is mentioned at the daily pharmacy safety huddle and an email identifying variance reports yet to be completed is sent to named ward pharmacists. This approach, as well as having named uncompleted reports as a standing agenda item on the CDAG, has worked well in improving completion rates (from 82% to 99%).

3.1.2 Unaccounted for Losses

- A monthly log is kept of any losses on wards and in clinical areas that are unaccounted for and these are reported to the CDLIN as part of the return. This information is also shared with the CDAG. See Appendix 1.

- In 20-21 there were 46 instances of unaccounted for losses initially recorded across 53 areas. This compares to 91 instances in 19-20 and 63 in 18-19. Further analysis of the datixes suggest that in a small number of instances it is uncertain if there was actually a loss or not.

- There were 7 instances (across 4 clinical areas) of when FP10 prescription reconciliation records were not fully completed. This compares to 7 occasions in 19-20. One area flagged 4 times and this area was written to by the CDAO in her capacity as chair of the Medication Practice Committee.

  Table 1: most frequent drugs involved in unaccounted for losses

	Number of Instances of Unaccounted for Losses	**Percentage of overall Instances**
Pregabalin & Gabapentin (schedule 3)	9	23%
Oramorph liquid (schedule 5)	13	33%
Oxycodone (schedule 2)	10	25%
Weak opioid products (schedule 5)	4	10%
Other strong opioid (schedule 2)	3	8%
Benzodiazepine (schedule 4)	1	3%

- Many of the unaccounted for losses involve liquids and are likely due to ‘insensible’ losses when the liquid is repeatedly re-measured on the daily stock checks.

- Some of the losses are due to poor record keeping e.g. is it not clear whether patient’s own medicines have been given back to the patient on discharge.

- Gabapentin and pregabalin discrepancies may be a proxy for dispensing and administration errors. There are a wide range of strengths for both drugs and also the sound alike names increase the likelihood of the wrong drug being selected when dispensing or administering a dose. This may only be picked up when the reconciliations are wrong. Pharmacy has undertaken a review of the strengths stocked in the Trust and has not found any compelling indication that it would be safer to rationalise the various strengths, though further monitoring of datixes to continue.

- ED had the highest number of datixes for unaccounted losses (10) then St Joseph's ward (6) at St Michael's Hospital (SMH). Low levels of datixes were seen for other wards and departments but there are no obvious patterns in these incidents.

- There were 7 incidents recorded from SMH (compared to only one last year). This may reflect the change of activity (and therefore medicines usage) during the pandemic

- There were 3 incidents recorded in the year from WCH (same as the previous year).

- When CDs do go missing, the lack of a full audit trail makes investigation difficult as all nurses on that shift will have had access to the CD keys. Three wards implemented electronic drug cabinets in Feb 18. It is noticeable that the 3 areas which have electronic drug cabinets (Wellington, AMU1 and AMU2) had no instances of unaccounted for losses despite high usage of controlled drugs in those areas. ED only started to use their electronic drug cabinet for CDs after one of their incidents (oxycodone – see below).

- Concerns are investigated by the ward pharmacist, ward sister and may include the counter fraud officer or police. An area for improvement is ensuring the CDAO is fully aware when these investigations are running, what stage they are at and the outcome of them, even at the informal stages. Additional investigator and administration resource for the CDAO would be beneficial. The Counter Fraud Officer is invited to CDAG meetings at least twice a year.

- The majority of unaccounted for losses are small quantities and there is no specific pattern, though there were some significant datix incidents during 20-21 mentioned below.

- ED had a large quantity of cyclizine tablets (approximately 10 x100) go missing over a few months. This product was removed from the stock list and other

similar drugs have been monitored with no further loss so far. The other ED datixes for unaccounted losses had no obvious relationship to this significant incident of missing cyclizine tablets.

- Kynance had approximately 10x28 dihydrocodeine tablets go missing over 3 to 4 months. Increased surveillance was implemented, and eventually staff on the ward were told that misappropriation had been observed and no further loss has occurred.

- Oral oxycodone 5mg IR in ED - a page in the CD register had been removed. Local concise investigation (involving police) was unable to identify an individual. ED now utilises Omnicell to a much greater extent to store CDs and an action was taken to remove CDs from other storage areas in ED. This enabled a better audit trail. The ED Pharmacy team have carried out more stock checks and removed items that should not be held as stock.

- Diamorphine injection in ED - the entries in the CD register had been tampered with and the local concise investigation (also involving police) was unable to identify an individual.

- Both above events have led to discussion about use of electronic registers throughout the trust.

3.1.3 Illegal substances

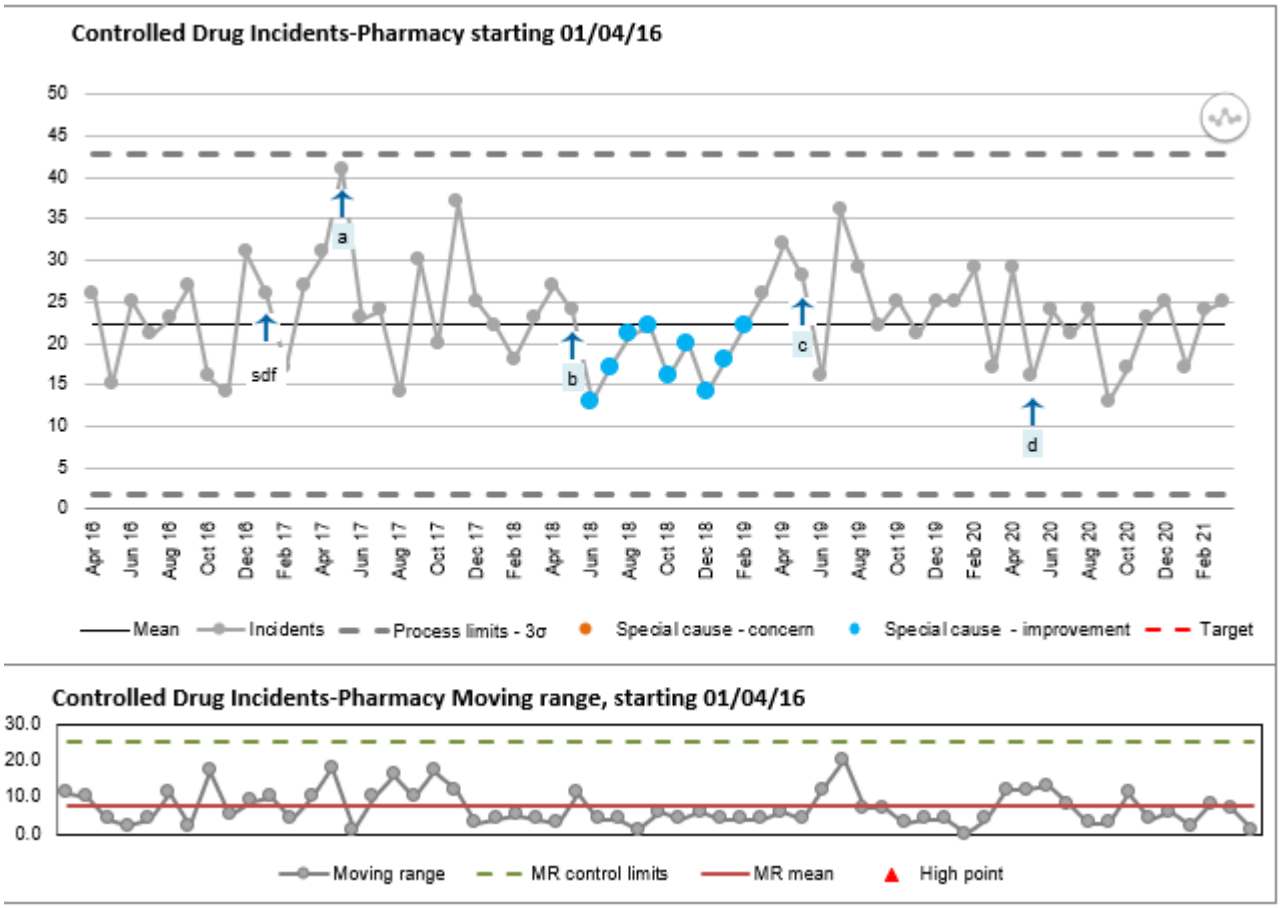
- During 20-21, a small number of incidents of patients bringing possible illegal substances with them into hospital led to the development of a policy for 'Use of Cannabidiol (CBD) Products Clinical Guideline' which covers the use of CBD oil in all inpatient areas within RCHT.

3.3 Review of CD Datix Incidents

- The Medication Safety Officer reviews all datixes related to medicines (CD and non-CD) and raises any concerns immediately within the 14 day review period. The CDAO deputies review all CD datixes as part of the quarterly CDLIN report which is then signed off by the CDAO on submission to the CDLIN and also tabled at the Medication Practice Committee.

- Where themes of incidents are picked up, the CDAO and deputies will refer these to the Medication Safety Group or other relevant groups for wider discussion, investigation and recommendations. They may also be highlighted in the regular Pharmacy Matters all user bulletins.

Graph 1: CD datix trend.



- In 20-21 the average number of Controlled drug incidents was 22/month compared to 25/month in 19-20 and 22 in 18-19. CD datixes account for approximately 20-25% of all reported medication incidents.
- The Statistical Process Control graph shows variation around the mean, all within the upper and lower process limits. There is a slight reduction in incident numbers seen in 20-21.
- There was a never event involving administration of an oral medicine via an intravenous (IV) route in the emergency department. Various actions were recommended (internal and external) following the investigation. This incident was noted in the CQC February 2021 report which commented that learning from the incident needed to be shared with other sites within the trust. Various trust-wide communications were sent out on this topic, and an incident summary is on the trust document library.

- Key themes and areas of concerns are similar to those described in last year's report and include:

	Theme	Action Taken
1.	Unaccounted for losses of liquids - particularly Oramorph and Oxycodone. Either due to insensible losses when measuring the volumes or forgetting to record Oramorph in the register.	Wards provided with bungs and purple oral syringes to measure volumes rather than measuring cups.
2.	Dispensing and administration errors of gabapentin and pregabalin - reflecting the similarity in name and the multiple different strengths available.	Agreed at that review that any rationalisation of different product strengths may introduce other areas of concern. To monitor closely.
3.	Opioid patches - not being removed when stopped, more than one patch applied and inappropriate prescribing of patches in the pain ladder.	A revised sticker is now in place for nursing notes to detail where the previous patch is located. Ongoing education to check for patches on admission and before applying another patch.
4.	Failure to accurately record in the CD register. This most frequently happens with Oramorph and medicines that have recently been required to be recorded - tramadol, gabapentin and pregabalin	Ongoing monitoring and feedback through the Pharmacy Matters bulletin and Safety Alerts. Further deployment of Omnicell electronic drug cabinets would be beneficial as it automates and digitalises this recording process.
5.	Prescribing too high doses of opioids in patients that are opioid naïve or require dose reductions for clinical reasons such as renal impairment.	Highlighted in Pharmacy Matters bulletins. Further Education at Grand Round by eg Pain Team, was not possible due to Covid issues being the main topic during 20-21

6.	A number of incidents of confirmed or suspected staff misappropriation of controlled drugs.	Serious incidents and investigations declared as necessary. Where confirmed, police and registering bodies notified and policies and SOPs reviewed.

3.4 Ward & Pharmacy Stock Balance Checks

- Wards and clinical areas complete CD stock checks at the end of every shift. Discrepancies are investigated and datixed if they cannot be resolved. This process is checked as part of the ward accreditation scheme.

- Theatres and signature checks, which was an issue raised in last year's report, are being audited every month in every theatre across Treliske and SMH. Two entries per theatre are checked and patient notes are recalled to confirm that drugs entered into CD register match up with the anaesthetic chart. This is reported back to the CQC scrutiny group. In addition, the lead OPs do random spot check to ensure that register entries are complete. There is a picture of how to complete a CD entry in the register on the front of each cupboard in theatres. There has been improvement towards the latter half of 20-21. There was also a presentation on how to complete a CD register played during CD Awareness week early in 2021.

- The pharmacy department performs daily and monthly checks on all their controlled drugs balances. The daily check consists of all the balances of the controlled drugs dispensed in the previous 24 hrs being reconciled.

- Where discrepancies are identified and can't be resolved, these are datixed and reported to the chief pharmacist and in turn, to the AO if appropriate.

- In May 2019 the department introduced a data collection form which clearly displays when checks have been completed. This report is summarised on the departmental Deviation database for approval by the Responsible Person/chief pharmacist.

- The level of checks is comprehensive and exceeds Royal Pharmaceutical Society standards. Due to unpredictable workload, there are infrequent days when the CD checks are not fully completed, however, these will generally be carried out the following day and thus the risk to good CD management is low.

Significant non-compliance with the required checks are escalated and acted upon by the senior pharmacy leadership team.

3.5 Safe Storage Audits on the Wards & Clinical Areas

3.5.1 Ward Six Monthly CD checks

- Each ward is scheduled to be audited for compliance with the CD policy and have their stock levels checked by the pharmacy department on a 6 monthly basis, as dictated by DoH guidance.
- These audit results are signed off by the ward pharmacist and communicated to the ward managers if appropriate and escalated to the chief pharmacist and CDAO if necessary.
- Table 2 shows performance for 19-20 and 20-21. The poor performance is 20-21 is due to pharmacy staff not visiting wards to the same extent during the pandemic.

Table 2: Performance of pharmacy 6 monthly clinical area audits;

Metric	19-20	20-21
Number of Areas to be audited	57	57
Number of Audits Carried Out (Most areas should have 2 audits/year but a theatre suite will have more as each anaesthetic room will need auditing)	96	42
Number of audits formally signed off by the ward pharmacist on Q-pulse	93	29
Number of wards that received 2 or more checks in the 12 month period	28	7 of which 3 fully closed off
Number of wards that received 1 check in the 12 month period	22	27 of which 23 fully closed off
Number of wards that received no 6 monthly checks	7	23

- In 20-21, 57 clinical areas were identified for audit. Most areas require 2 audits a year, but some areas have multiple CD cupboards to audit e.g. Tower theatres, so will require more. In the region of 130 audits are required each year.
- Only 42 audits were undertaken (compared to 96 in 19-20). These audits can be undertaken by pharmacy senior assistants, a pharmacy technician or a pharmacist. Those undertaken by an assistant or technician are then signed off by a pharmacist, 29 of these audits had been signed off by the ward pharmacist (compared to 93 in 19-20).
- 23 areas received no audit during the year. This is mainly due to impact of the pandemic
- A number of issues were noted with the audit process that will need to be rectified.
    - It is difficult to have a comprehensive overview of audit completion compliance with the Q-pulse audit tool. Though the Trust upgraded to a new version of Q-pulse, the improved reporting tool remains suboptimal. An assurance report for CD audits goes to the monthly pharmacy governance and also to CDAG.
    - Theatres need to be listed as individual areas (e.g., Theatre 1,2,3 etc) rather than grouped together. This will give assurance that all areas, rather than a sample, are being audited.
    - Steps need to be taken to ensure that the audit schedule includes all areas in the Trust that store controlled drugs.
- An investigation into a serious incident in the Emergency Department where records had been altered to potentially cover up misappropriation, has triggered a review of the audit questions and these will be implemented as part of the QI project.

3.5.2 Pharmacy Annual Safe and Secure Storage of Medicines Audit.

- Due to the pandemic and the restrictions placed on staff as regards visiting wards, there weas no Annual Safe and Secure Storage of Medicines Audit undertaken in 20/21, though it is scheduled for autumn of 2021.

3.5.3 Ward Accreditation Process – no data are available for this report

3.5.4 Quanta Audits

- Pharmacy undertakes a rapid audit when completing ward top-up. This audit asks if treatment doors, drug cupboards and fridges are locked and whether any medicines are left out on the side. The results are fed back to ward sisters and matrons. The question is not specific to controlled drug storage but gives some assurance that this standard is being frequently assessed and fed back to wards. See table 3 for current compliance figures.

  Table 3: Compliance with 'drug cupboards locked' question on weekly quanta audits across all wards.

	Mar	Feb	Jan	Dec	Nov	Oct	Sep	Aug	Jul	Jun	May	Apr
19-20	Nil audit	90%	86%	83%	90%	81%	87%	78%	100%	78%	85%	86%
20-21	74%	78%	82%	87%	90%	87%	77%	76%	77%	77%	70%	67%

- Compliance has dipped slightly (average 79% vs 86% 19-20). Pharmacy will re-focus on safe storage of medicines now that the COVID peaks have passed.

4.0 Policies and Procedures

- The Trust's 'Controlled Drugs policy' was updated in May 2020 and is available on the document library. Its review date is May 2023.
- The Ward, Theatre and Department Standard Operating Procedure for Controlled Drugs is frequently reviewed (most recently June 2021) and is available on the document library.
- Pharmacy also has a range of SOPs, work instructions and forms covering the handling of CDs. These documents are controlled on the Q-pulse system and are regularly reviewed.

5.0 Governance & Regulatory Structures for Controlled Drugs

- The CDAO quarterly report goes to the Medication Practice Committee (MPC) and the CDAG, both chaired by the Deputy Medical Director.
- The MPC in turn reports to the Clinical Effectiveness Group and ultimately to the Board.

- The Trust requires a Home Office Controlled Drug Licence to supply CDs to other legal entities (in addition to the wholesale dealer licence we already hold). The Trust was re-issued the licence following an annual return on 23 December 2020.
- The Home Office inspect premises every 3-5 years. A routine Home Office inspection took place on 7 November 2019 with no adverse findings and the recommendation to re-issue the licence.
- The Trust's wholesale dealer activity (WDA) which requires the Home Office Licence, also falls under the regulatory authority of the MHRA. RCHT is overdue its WDA inspection and we can expect a visit imminently.
- The supply of named patient controlled drugs to other legal entities (e.g. the supply of a CD to a patient being discharged from a community hospital), falls under the regulatory framework of the General Pharmaceutical Council. They have inspected within the last 3 years and raised no concerns.

6.0 Significant Events/ Incidents

6.1. Significant datix reports

All CD incidents are reported to the CDLIN. All CD incidents are graded from low to extreme following guidance set out by the CDLIN. The tables below show those graded as high or extreme events in 20-21. Two key themes for the year are safely prescribing opioids via syringe drive / Pump and misappropriation of medicines by Trust staff.

April-June 2020

Summary	Actions	Learning
On the evening of the 31/03/2020 a patient was given 2.5mg Diamorphine Subcutaneously. 1 x 5mg ampoule was removed from the CD cupboard to administer this, as documented by myself and the RN who administered the dose, which was witnessed to have been drawn up and disposed of appropriately. On looking through the book on 02/04/2020 at 20:20pm, it is apparent that the initial notation has been edited. "5mg given" has had a numeric 1 placed in front making it "15mg given", and the	Nurse in charge of current shift notified. Agreed datix to be done. Checked with staff member who checked medications 01/04/2020 @ 06:30am with myself that we remember 2 x vials remaining, which has been the case. Checked that medication has not been removed and placed in a different cupboard within the department. Checked EPMA history, named	I have checked the patients EPMA and RADAR also for evidence of any further administrations to the patient listed and to see if any further patients received Diamorphine and I cannot find no evidence of further administrations therefore I can only conclude that the two vials of Diamorphine were stolen from the CD cupboard. I have reviewed the ED nursing rota for the 2 days in question (and attached copies) There are a few

remaining vials were originally noted as "2" which has been crossed through and a numeric "0" has replaced this. There is no additional signature to supplement this change.	patient did not receive any further doses during their admission.	members of staff working that have not worked in ED prior to and following the incident date but that said after discussion with ED Matron this has not been the first time that we have had unaccounted controlled medication problems previously reported related to the CD Cupboard in Majors One and that there is a strong possibility that this is not an isolate incident. Fraud officer involved.
Patient prescribed Oxycodone 10mg. CD cupboard accessed to administer. CD book stated oxycodone 5mg tablets had been carried over from page number 31 and 20 tablets were present in cupboard. Entry in book was poorly written and did not contain date and staff signature so previous page accessed to check details. Page 31 and 32 found to have been removed from CD book. Page had been cleanly cut very close to centre spine of book.	Medication checked with two members of staff. CD book removed and kept by NIC. New book to be obtained from pharmacy in AM and full cupboard drug check to be repeated.	Investigated with Fraud Officer and police
Patient admitted with abdominal pain. Known to have chronic pancreatitis and recurrent admissions with abdo pain. Opiate naïve. Prescribed IV morphine and PO morphine PRN in ED (ED have investigated, see investigation tab). I was asked to review patient as she had dropped her oxygen sats. An ABG showed acute type 2 respiratory failure. Very drowsy and difficult to rouse. On review of EPMA had received 30mg of IV morphine and 70gmg of PO morphine in 5 hours. Given naloxone which improved drowsiness and blood gas; required multiple doses and an infusion.	When it was identified how much morphine this opioid-naïve patient had received, and this was related to her clinical condition, she was given naloxone, to good effect. Her type two respiratory failure improved with repeat doses of this. She required 4 doses in total over 6 hours, and was prescribed an infusion (although this was declined by the patient). She did not require an escalation of respiratory support above venturi-delivered oxygen therapy.	initial Iv access difficult so oral morphine,then IV. AMU response from Nurse involved was she gave morphine to control the pain - she escalated concerns at the amount required by patient to resolve pain and requested the F1 to review. He simply advised to continue giving the morphine.
I was asked for advice regarding supply of gabapentin, tramadol and oramorph for a patient on Wheal Fortune. When I looked into this further, the patient is breastfeeding her baby (23 days old at this point). When looking into her opioid consumption it appears that since baby's and her first admission on 10/5/20-13/5/20 (baby 4 days old as of 10/5/20) she had 500mg Pethidine in a 24 hour period, ~100mg of Morphine (as Oramorph 10mg/5mL) and an unknown amount of co-dydramol (as self-medicating as refused to give supply to nursing staff), patient and baby were then discharged. They were then readmitted on 26/5/20, at this point she was on Tramadol 100mg QDS + Oramorph 20mg hourly (with around 100mg daily being used), I can also see that the GP has supplied her with Tramadol 50mg 1-2	I was not happy with this TTO therefore went and spoke to team looking after patient (O&G reg), midwife and transitional care paediatric doctor. I looked through notes and wrote that I was unhappy with this patient being discharged home when pain meds are acutely being changed, as I am concerned mum will quickly use the oramorph supplied and then baby will begin withdrawing, or that baby will develop respiratory issues. I confirmed baby is well in itself and is meeting weight gain targets etc. I discussed this with the transitional care doctor who discussed this with her consultant,	Patient readmitted twice with chronic pain of unknown origin. Multi-professional approach. Staff should have been more mindful when considering medicines with a breastfeeding mother.

QDS PRN on the 15/5/20 and 20/5/20. She was seen by pain team 28/5/20 who started her on a titrating regime of gabapentin up to 600mg TDS and then to try and wean off of Morphine with a review on 24/6/20. When asked to look at the TTO I felt uncomfortable due to NAS risk in baby and also increased risk of respiratory depression and feeding issues.	and the decision was taken to admit Baby for NAS monitoring.	
Concerns over a number of months of potential dihydrocodiene misappropriation on the maternity wards. A counter fraud investigation had been launched and a midwife was found responsible and has admitted the misappropriation	midwife worked on kerowflex and since dismissed with referral to the NMC and police. Investigation ongoing.	Importance of completing the monthly variance reports and acting on concerns

July-Sept 2020

Summary	Actions	Learning
morphine sulphate infusion infused at wrong rate. 40mcgs/hr given instead of 20mcgs/hr for three hours.	Infusion rate and calculation was correctly prescribed by ANNP. Busy unit on shift. Both nurses followed policy for double checking. Correct amount in syringe. Started syringe dose on 40 mcgs at 2 mls instead of 20 mcgs and not 1 mls an hour. Both nurses realised error 3 hours after starting infusion. Once realised stopped infusion immediately Informed nurse in charge, consultant and mum informed. Duty of candour given to mum. Documented in baby's notes. Baby was not harmed. Fluids prescribed on A4 medication sheet not an A3 infusion sheet.	For speciality governance group to emphasis staff to double check dose with prescription. Follow policy. Prescribe using A3 fluid sheet.
Patient referred to palliative care and reviewed. On the end of life pathway documentation with a syringe driver in situ. Opioid naive patient having previously only required 15/500mg co-codamol. Prescription for the CSCi was 50mg oxycodone and 20mg midazolam - inappropriate doses in frail patient.	Reported to Incident review & learning group and to go to Medication Safety Group	All staff to be vigilant with dosing of opioids.

10mg Oromorph drawn up in purple oral syringe by Staff Nurse 1 and witnessed out of Omnicell by Staff Nurse 2. Upon Staff Nurse 1 going into patient to administer, Doctor was present doing examination. Staff Nurse 1 asked Doctor if he was happy to administer the medication to patient when he had finished. Doctor happy to and asks "Its 10mg right?" to which Staff Nurse 1 replied yes. Staff Nurse 1 signed oral Morphine order on EPMA. Doctor leaves cubical and says the Staff Nurse 1 "When you give a push which port of the cannula do you put it in?", Staff Nurse 1 replied "What do you mean?", Doctor replied "Do you disconnect the fluid or put it in the top port?", Staff Nurse 1 replies "That was Oromorph". Doctor admits to pushing IV.	Investigated as possible never event	Investigation concluded and reported to incident review and learning group. To go to Medication Safety Group

Oct-Dec 2020

No high or extreme grade incidents this quarter

Jan-March 2021

No high or extreme grade incidents this quarter

7.0 Training

Controlled drug training is part of the mandatory training for all staff at induction and refresher. Current compliance is approximately 90% as of June 2021 compared to >97% as of June 2020. There are currently recognised problems with staff being able to record some of their training on ESR. The ward SOP is covered at local induction and is signed off by the ward nurses.

Compliance in Medicines Management Awareness at 30 June 2021
Source: ESR

Care Group / Division	Required	Achieved	Compliance %
156 Anaesthetics Critical Care & Theatres	261	242	**92.72%**
156 Clinical Support	200	193	**96.50%**
156 Corporate	33	31	**93.94%**

156 General Surgery & Cancer	266	225	**84.59%**
156 Specialist Medicine	214	191	**89.25%**
156 Specialist Services & Surgery	209	197	**94.26%**
156 St Michaels Hospital	53	52	**98.11%**
156 Urgent Emergency & Trauma	394	326	**82.74%**
156 West Cornwall Hospital	151	139	**92.05%**
156 Women Children & Sexual Health	406	370	**91.13%**
Trust Total	**2187**	**1966**	**89.89%**
	4374	**3932**	**89.89%**

8.0 The Gosport Enquiry

The assurance report from the now completed Task and Finish Group was tabled at the RCHT Clinical Effectiveness Committee in May 2019. Surveillance reports are still being run (last one Sept 2020 - February 2021) and to be taken to the CDAG.

9.0 Response to Covid-19

During the pandemic, various initiatives and changes to practice were implemented. Those that involved controlled drugs included

- vial sharing where there was possible supply shortage of critical injectable medicines – a Covid 19 policy was developed that allowed vial sharing of alfentanil. This explained how to share the vial, storage, and documentation.
- destruction of controlled drugs on wards - there was more destruction occurring on the ward than prior to the pandemic to avoid bringing back CDs from red / amber ward to pharmacy.
- Various changes to the Trust CD policy including status of Oramorph changing from being treated as a Schedule 2 to a Schedule 5 drug but still within its legal status to ease transport and prescribing; changes to the requirement for wet signatures on prescriptions to avoid infection control risk and hasten speed of discharge; moving CD checks at the end of shift to once a day.
- end-of-life packs– these packs, prepared in the pharmacy department, were supplied to a lead GP surgery in the primary care networks across NHS Kernow CCG as well as the CATUs and Emergency Department. This was in response to concerns that there were challenges in how patients would

access palliative medicines during wave one of the pandemic. The packs contained a small supply of the controlled drug (fentanyl patch) and Oramorph along with other palliative care medicines. Although over 100 packs were distributed, it is believed that only a handful were ever supplied to patients. The remainder were collected by pharmacy department staff and disposed of safely. A similar arrangement was put in place during wave 2 though this time without the fentanyl patch.

10.0 Conclusions

- The Trust complies with the statutory requirements of attendance at the CDLIN and submission of occurrence reports.
- There is a comprehensive assurance framework for the management of controlled drugs in the organisation overseen by the CDAO (Deputy Medical Director) and the CDAG (ToR appendix 3).
- There has been improvement in completion rates of the variance audits and investigations undertaken though further improvement is required for the CD ward audits.
- There have been cases of misappropriation of abusable medicines within the Trust that did not result in identifying an individual. The resource required to investigate all potential instances and maintain a pan-organisation view is significant.
- Significant clinical incidents relate to prescribing and administration errors, in some cases requiring rescue medication, and the covert self-administration of patient's own opioids and sedatives, resulting in overdose. Prescribing via syringe driver / Pump is a particular risk.
- Monitoring continues to be in place to reduce the risk of spurious practice as per the Gosport review.

10.0 Recommendations

- Receive and **note** the annual report from the Controlled Drugs Accountable Officer

Dr Gillian Derrick- Deputy Medical Director and CDAO

Iain Davidson- Chief Pharmacist

Mike Wilcock - Head of Prescribing Support

October 2021

Appendix 1: Incidents of Unaccounted for Losses 20-21.

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Ward												
ED (and CDU)	4			1			3	2				
Anaesthetic rm												
CIU												
Constantine												
GLU								1				
CCU				1								2
Delivery Suite								1				
Eden (was Tolgus)												
Endoscopy												
Fistral/ Sennen							1					
Godolphin												
Grenville												
Harlyn												
ITU												
Kerenza												
Kynance			1		1		1					
Lowen												
AMU 1												
AMU 2												
Newlyn Unit							1					
NNU											1	
Oral and Facial surg unit												
Pharmacy	1							1	1			
Phoenix									1			
Pendennis (Poldark)												
Polgooth												
Polkerris												
Recovery (RCH)												1
Roskear		1	2									
SAL			1									
S Crofty												
SRU												
St Mawes (SRU before Dec 13)			1	1								
Theatres (Tower)												
Theatre Direct												
tintagel/ escalation											1	
Theatre (trelawny)							1					
Trauma 1&2											1	
Wellington												
Wheal Agar (gren)												
Wheal Rose												
Wheal Prosper												
Wheal Coates												
Wheal Fortune								1				
X-ray												
SMH												
St Josephs	3	1			1							1
St Michaels												
Anaesthetic rm (SMH)												
Thetares								1				
WCH												
Med 1 WCH				1	1		1					
Med 2 WCH												
WCH Recovery/Theatres												
WCH pharmacy												

Appendix 2

Updated Action Plan from 19-20 Annual Report

	Action	Who and by when	Update
1.	Support the implementation of Electronic Ward Stock cupboards across all inpatient wards to improve the safety of storage at ward level and improve the audit trail for the purposes of accountability.	Liam Bastian Pharmacy Digital Lead	Ongoing
2.	Pharmacy is to undertake a review of the strengths of gabapentin and pregabalin stocked in the Trust to try and reduce the risk of error	Ann Cardell – Medication Safety Officer	Complete. Agreed at that review that any rationalisation may introduce other problems. To monitor closely.
3.	Theatres need to be listed as individual areas (i.e. Theatre 1,2,3 etc) rather than grouped together. This will give assurance that all areas, rather than a sample, are being audited.	Alison Hill- Lead Pharmacist for Supply services.	Complete
4.	Support the resourcing and recruitment of investigator and admin support for the CDAO to maintain oversight of all ongoing concerns across the organisation.	Alison Hill- Lead Pharmacist for Supply services & Iain Davidson	Ongoing - requires rework of Q-pulse and recently implemented reporting module.
5.	Pharmacy to produce a monthly ward audit assurance report for CD audits. To come to the monthly pharmacy governance for oversight and CDAG	Mike Wilcock – Deputy CDAO	Complete

6	Pharmacy to address the assurance audits gaps in theatres, SAL and Theatre Direct.	Mike Wilcock- deputy CDAO Lorraine Moore – Lead Pharmacist, Theatres & Critical Care	Complete for both variance reports and completion of CD registers
7.	CDAO access to ward accreditation responses re CDs once data capture goes electronic.	Bernadette George- Safety and Quality Improvement Director March 2020	Not progressed- data not yet electronic
8.	Develop process to confidentially record investigations into suspicions of misappropriation, the investigation outcomes and sharing with CDLIN and employer networks	Dr Gillian Derrick- CDAO March 2020	Not progressed