Lincolnshire Community Health Services NHS Trust

Risk Feeding Policy

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Ratified by:	LCHS Trust Board
Date ratified:	14th November 2017
Name of originator / author:	Angela Shimada, Jennifer Whiley (adapted with permissions from Heart of England NHS Trust FAR Policy)
Name of responsible committee / Individual	Effective Practice Assurance Group
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Target audience:	All Clinical Staff
Distributed via	Website

Risk Feeding Policy

Version Control Sheet

Version	Section / Para / Appendix	Version / Description of Amendments	Date	Author / Amended by
1		New Policy	November 17	
2				
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Contents

Summary

The aim of this policy is to provide documentation and guidance for all professionals working with patients for who risk feeding is a management option.

1.0 Introduction

1.1 Purpose

Patients who are deemed to have an unsafe swallow and at risk of aspiration are not always placed Nil By Mouth (NBM). Publications from the Royal College of Physicians and British Society of Gastroenterology (2010) highlight the increasing evidence-base which suggests that non-oral feeding is not always clinically or psychologically beneficial nor ethically sound in patients who are towards the end of their life.

In cases where non-oral nutrition is appropriate, every adult patient has the right to decide about their own treatment, and it may be that a decision is made to continue with oral intake, accepting of aspiration and choking risks. This is known at Lincolnshire Community Health Services and United Lincolnshire Hospitals Trust as risk feeding and may apply to any patient with dysphagia at any stage of their life.
The introduction of the Mental Capacity Act (2005) has led to improvements in the care and management of patients who are proven not to have capacity to make their own decisions. In cases where patients are unable to make decisions such as those related to their nutrition and hydration, decisions are made on behalf of the patient. The decision will take into consideration the patient's previous beliefs and wishes, views of the family, clinical evidence-base and quality of life. In some cases, a decision is made against non-oral nutrition and hydration. Good practice in decision-making towards end of life is evidenced in the GMC (2010) publication Treatment and Care Towards End of Life.

1.2 Context

Anecdotal evidence suggests that decisions to feed at risk are being made regularly. However there are often issues with these decisions including them not being made in a timely manner, relevant people not being involved (i.e family/patient/professionals) and/or the decision not being appropriately documented.

1.3 Objectives

Provide a clear pathway for risk feeding to guide professionals through risk feeding decision making process thereby fostering consistency, efficiency and improved communication.

1.4 Scope

1.4.1 Any registered member of staff who has a role with patients where risk feeding decisions are considered.

1.5 Compliance

1.5.1 This policy complies with the legislation, standards, guidelines, codes of conduct, and any other relevant document listed in the Referenced Documents' section.

2.0 Roles and Responsibilities

The multidisciplinary team plays a key role in the assessment, management and decision-making with patients who are being fed at risk. Professionals who most often take key roles are outlined below.

2.1 Speech and Language Therapist

The SLT has an advisory and educating role. SLT may be the first professionals to indicate that risk feeding is a possibility for a patient once they have assessed their swallow. The SLT must inform the medical team if they feel that the patient is not appropriate for risk feeding and the reasons why this is the case (for example, if they feel that risk feeding would be too distressing for the patient).

Members of the SLT team are responsible for:

1. Assessing the patient's swallow function in accordance with professional guidelines set out by the Royal College of Speech and Language Therapy and the Lincolnshire Community Health Services Dysphagia policy.

2. Evaluating the risk of aspiration that the patient is placed at by oral intake.

3. Assessing the benefits/disadvantages of compensatory strategies for reducing the risk of aspiration.

4. Identifying the need for further assessment, which may include instrumental techniques

5. Forming an opinion based on clinical evidence, regarding prognosis for swallow recovery.

6. Communicating these findings to the multi-disciplinary team (MDT).

7. Contributing to discussions with the patient, family and MDT regarding non-oral feeding, where appropriate.

8. Facilitating more effective discussions between the MDT and patients who have impaired communication skills.

9. Assessing or facilitating communication to aid decisions regarding mental capacity where appropriate.

10. Making recommendations to reduce the risk of aspiration if possible once a decision to risk feed has been made.

SLTs may not be involved with all patients who are being risk fed. On occasion the MDT may complete the whole process of risk feeding themselves, eg. Patients who have fluctuating responsiveness and therefore SLT unable to assess, patients who have capacity and have chosen to risk feed, patients who intermittently refuse oral intake, patients nearing the end of their lives where there is no distress involving eating and drinking.

2.2 The Medical Team

The medical team should, where appropriate, be involved with:

- Identifying the need for a comfort/risk feeding decision
- Discussions with the patient, family and MDT
- Making onward referrals where necessary
- Agreeing the final decision regarding risk feeding
- Completing documentation
- Considering the future management of patients who are being risk fed (for example, management of potential aspiration events, dehydration, malnutrition)
- Communicating decisions with GP regarding future management of patients who are being risk fed (for example, re-admission to hospital as a result of chest infections)

Medics should refer to GMC and RCP guidelines for further details.

2.3 Nursing Staff

Trained nurses are likely to be involved in decision-making but are also key at the point of delivery. Nursing staff involved with patients who are being risk fed should be aware of these guidelines, the risk pathway and associated documentation. Any changes in the patient's response and comfort during oral intake should be documented and reported to an appropriate member of the MDT.

2.4 The Multidisciplinary Team

Risk feeding decisions should be decided as an MDT with the consultant/GP having the ultimate responsibility for the patient's care. If the consultant/GP is not immediately available and in situations where all those involved are in agreement it should then be documented by a responsible clinician who has been involved in the making of the decision. If delegated the Consultant/GP must be informed at the earliest opportunity.

2.5 Other members of the MDT

May include: Dietitians, Specialist Palliative Care Team, Clinical Nurse Specialists (eg. Parkinson's Disease, palliative care), physiotherapists and pharmacists.

3.0 Definitions

Swallowing: The entire act of deglutition from placement of food in the mouth through the oral and pharyngeal stages of the swallow until the material enters the oesophagus through the cricopharyngeal juncture (Logemann, 2011).

Dysphagia: Eating and drinking disorders which may occur in the oral, pharyngeal and oesophageal stages of deglutition (RCSLT, 2006).

Aspiration: The entry of food and fluid into the airway beyond the level of the vocal folds.

Non-oral feeding: The provision of nutrition via enteral or parenteral means, for example Naso-Gastric Tube (NGT), Total Parenteral Nutrition (TPN), Percutaneous Endoscopic Gastrostomy (PEG), Radiologically Inserted Gastrostomy (RIG).

Artificial Hydration: The provision of hydration via enteral or parenteral means, for example intra-venous access, sub-cutaneous access, nasogastric tube.

Risk feeding: A decision made to provide a patient with oral intake (hydration and/or nutrition) despite a high risk of aspiration. This may be made by the patient or in their best interests if they lack capacity (please see section on Legal Issues: Capacity).

4.0 Risk Feeding Pathway

4.1 The pathway is intended to guide health professionals through the Risk Feeding decision-making process thereby fostering consistency, efficiency and improved communication.

It is accepted that this pathway is not exhaustive and other considerations may be taken into account in order to put the patient at the centre of the decision-making process.

As with any other medical decision you must consider reviewing and/or repeating this pathway if a change in circumstance arises (for example if a patient's capacity or clinical presentation changes).

Refer to appendix one for the pathway.

4.2 Risk Flow Proforma

A proforma has been developed to provide a clear and efficient way of recording the decision that has been made. This should be completed and kept at the front of the medical notes behind any DNACPR form (see Appendix Two).

If it is agreed not to use this form the decision must be clearly documented in the medical notes. Information should include:

- The final feeding decision
- The rationale/reason for the decision
- Those involved in the decision-making
- Any reason that the patient was not involved (e.g. their capacity to make feeding decisions at the time)
- Those who have been informed of the decision but not directly involved (e.g. the patient's discharge destination, GP, community healthcare professionals).

If the risk feeding decision is cancelled, mark the decision through with 2 parallel lines, and write the word 'cancelled'. Record the date, time, your name and the reason for cancellation of the decision. File the cancellation form in the correspondence section of the medical notes.

4.2.1 Completing the risk feeding proforma

These are the guidelines for completing the Risk Feeding Proforma Form for use across all providers in Lincolnshire, section by section.

There are also brief guidance notes available on the back of the form.

Box	Issue	Guidance
1.	Patient Details	Full name, Date of Birth and NHS number will all be entered. An addressograph label may be used providing it contains all 3 identifiers
2.	Date of decision	Enter the date that the risk feeding decision was discussed and made.
3.	Location	Enter the location where the decision was discussed and made.
4.	Reason for risk feeding decision	Tick appropriate box (or boxes) and specify why this decision was made.
5.	Capacity Assessment	The MDT is responsible for conducting a decision specific capacity assessment to establish a method of nutrition. Ensure that Trust Capacity Paperwork has been completed and inserted into the medical notes All records documenting the decision have been documented in patient Medical notes Ensure the patient has been involved with the decision making process
6.	Record of Discussion	The medical team are responsible for making decisions around advanced planning in relation to chest infections and further hospital admissions. These should be clearly documented in the medical notes, discussed with the patient/family/carers/significant others and detailed in the EDD. Has consideration been made for use of antibiotics to treat future chest infections? If the patient develops an aspiration pneumonia will this be treated at home or will the patient be readmitted to hospital?
7.	Risk Reducing Recommendations	If appropriate a speech and language therapist can make risk reducing recommendations to include modified diet, fluids and strategies to reduce the risk of aspiration. These should be documented here.
8.	Team Members Involved in the Decision	Write down all the names of the team members involved in the decision making process. A consultant/GP must sign the document as they have overall responsibility for the risk feeding decision.

4.3 Future Treatment

Once a risk feeding decision has been made, it is often beneficial to discuss the potential of future complications and how these may be managed. Any decisions/guidance should be clearly documented in the medical notes. Examples include whether or not a patient should be actively treated in the event of a chest infection; should the patient be re-admitted to hospital with subsequent chest infections.

4.4 Discharge from hospital

It is essential that any risk feeding decisions are communicated effectively to the patient's primary carers and health professionals who will be involved in their care upon discharge from hospital.

Some of the benefits of this include: consistency in the management of nutrition and hydration from hospital to home; support to those who are involved in feeding at the point of delivery and; avoidance of inappropriate hospital re-admission.

Information for patient/relatives/carers/other health care professionals is available in appendix three.

5.0 Legal issues

5.1 Capacity

You must work on the assumption that every adult patient has the capacity to make an informed decision about their oral feeding. If a patient's capacity to make decisions is impaired, the patient must be provided with all the appropriate help and support to maximise their ability to participate in the decision-making process (MCA 2005).

Please see the MCA Code of Practice (2007), GMC Guidelines (2010:12-24) and LCHS and ULHT policies on MCA for additional information and advice on decision-making with patients who lack capacity.

It is the role of the multidisciplinary team to clearly document decisions made about a patient's capacity in relation to their ability to make an informed risk feeding decision.

In situations where the patient lacks capacity then a Best Interest Decision needs to be made.

5.2 Emergency Procedures

In the event of difficulties leading to a life-threatening situation, a positive duty to act arises and health professionals are then required to do whatever would be reasonably expected of them in the circumstances. The MDT should follow Health and Safety guidelines, ensure they are adequately prepared for such an event and be familiar with emergency procedures for choking.

Health professionals need to be aware of a patient's DNACPR status prior to feeding as this will determine the course of emergency treatment a patient will receive. In the event of a choking incident, a patient will always receive emergency treatment (as directed by the medic on the scene) for choking and/or respiratory arrest. If this progresses to a cardiac event, the DNACPR procedure should be followed.

6.0 Competence

6.1 Speech & Language Therapy

All SLTs who are involved with risk feeding decision-making must have completed their dysphagia training (in-house or an appropriate post graduate dysphagia course). SLTs working within their first year of dysphagia training must discuss risk feeding decisions with a senior colleague.

6.2 Medical and Other Clinicians

Risk feeding decisions are the ultimate responsibility of the consultant/GP in charge of the patient's care. If the consultant/GP is not immediately available, this responsibility may be delegated to the multidisciplinary team and documented by a responsible clinician. If delegated the Consultant/GP must be informed at the earliest opportunity.

Any clinician accepting this responsibility must be aware of the risk feeding guidelines including the pathway for decision-making and the MCA Code of Practise, and feel competent to apply the content to the complex and critical situation.

7.0 Application of the Guideline

All members of the multidisciplinary team who are involved in a comfort/risk feeding decision must be aware of and up to date with the ULHT/LCHS, GMC and RCP guidelines related to non-oral / withholding / withdrawing feeding.

8.0 Implementation, Monitoring and Review

Outline how the document will be disseminated to relevant staff and implemented within the Trust. Will any training be required? The policy will be highlighted through trust newsletters. SLT will provide awareness training for Matrons and Doctors for this to be disseminated.

Are there any costs associated with implementation of the policy? Implementation of the policy should save the trust money by reducing number of inappropriate hospital admissions. No additional costs

Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document? Ward audit can be implemented to ascertain whether documentation being used for risk feeding policy.

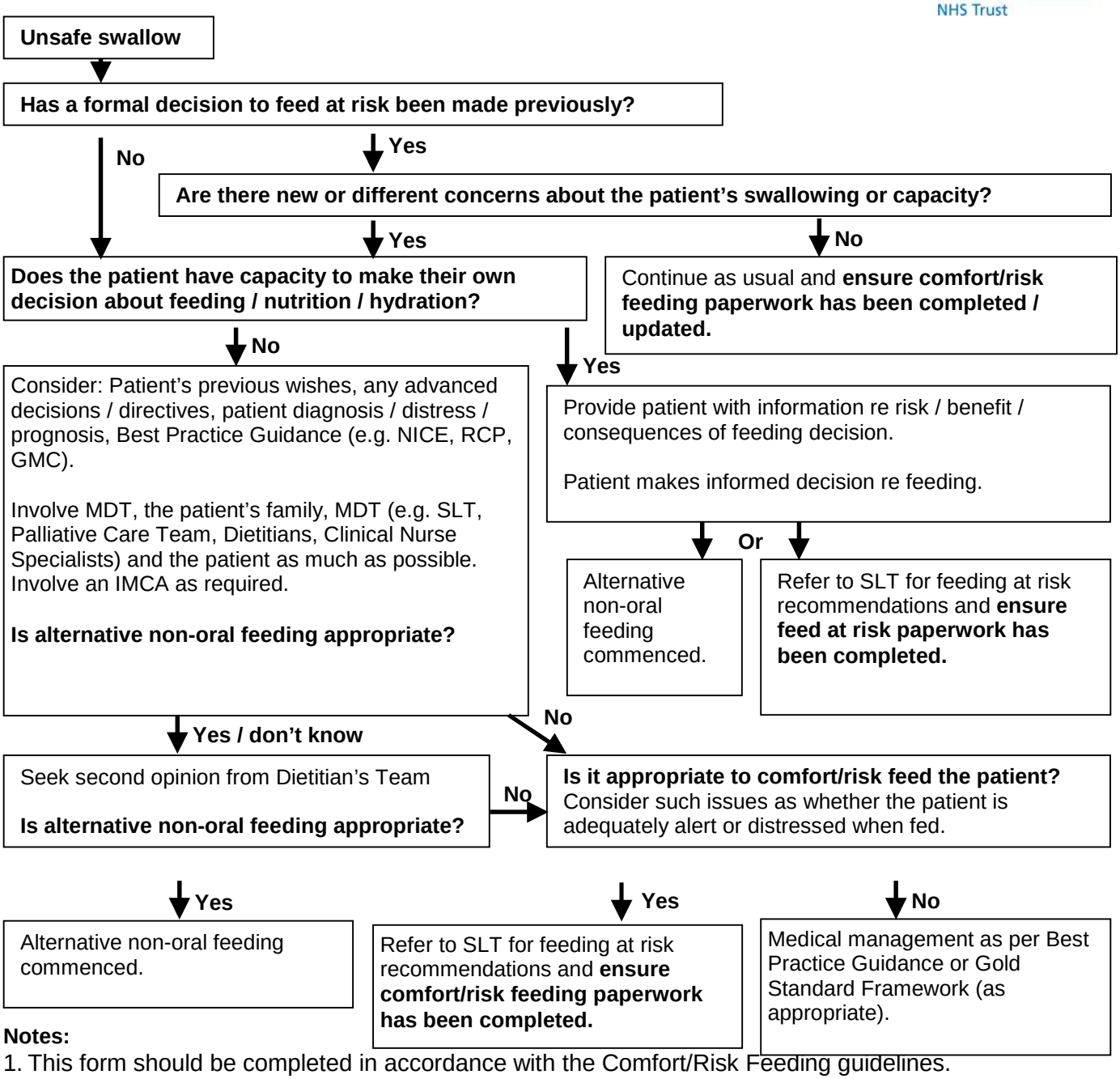
Monitoring Compliance

Minimum requirement to be monitored – monitoring against standards set out in policy	**Process for monitoring e.g. audit**	**Responsible individuals/ group/ committee**	**Frequency of monitoring/ audit/ reporting**	**Responsible individuals/ group/ committee for review of results and determining actions required**
ULHT Identify number of patients being risk fed on at least 2 wards on each hospital site, how many complying with standards set out in policy.	Audit	Nutritional Steering Group	Yearly	Nutritional Steering group

Appendix One – Risk Feeding Pathway

Comfort/Risk Feeding Pathway

Lincolnshire Community Health Services NHS Trust



Notes:

1. This form should be completed in accordance with the Comfort/Risk Feeding guidelines.
2. Comfort/Risk Feeding decisions are the ultimate responsibility of the consultant/GP in charge of the patient's care. If the consultant is not immediately available, this responsibility may be delegated to the multidisciplinary team and documented by a responsible clinician. If delegated the consultant must be informed at the earliest opportunity.
3. The Comfort/Risk Feeding decision will remain in place unless the patient's wishes change or oral feeding is no longer in their best interests. In the event, the decision-making process must be reviewed.
4. When Comfort/Risk Feeding decision is cancelled, mark the decision through with 2 parallel lines, and write the word 'cancelled'. Record the date, time, your name and the reason for cancellation of the decision. File the cancellation form in the correspondence section of the medical notes.
5. Clinical judgement can override a Comfort/Risk Feeding decision, e.g. if a patient is drowsy, refusing, distressed or if they are NBM for another reason (e.g. surgical / gastro).

Once completed, this form should be kept at the front of the medical notes behind any DNACPR forms.

Appendix Two

RISK FEEDING PROFORMA

These guidelines have been set out and agreed because this patient is at high risk of aspiration (food and fluids entering his/her lungs as a result of an impaired swallow) **but is to continue eating and drinking. THE ORIGINAL COPY STAYS WITH THE PATIENT.**

1. Patient Details (or affix addressograph)
Surname:……..
First Name(s):……
Date of Birth:…….
NHS no:…….

2. Date of risk feeding decision:……..

3. Location decision made:…….

4. Reason for risk feeding decision (tick all which apply):

- ☐ Palliative Care (state reason): _____
- ☐ Patient has declined artificial nutrition and hydratic
- ☐ Procedure risks outweigh benefits
- ☐ Other (state reason): _____

5. Capacity Assessment **(ensure that trust capacity assessment paperwork completed and inserted in medical notes)**
Based on the decision-specific capacity assessment (documented in medical notes)

- ☐ the patient has capacity in making a decision regarding nutritional management
- ☐ the patient does not have capacity in making a decision regarding nutritional management

If the patient lacks capacity has a best interests decision has been made by the MDT and authorised by a Consultant
YES NO Consultant/GP Signature:_____ GMC no._____

6. Record of discussion (tick boxes and provide further information below)

a) Has feeding with the associated risk of possible aspiration pneumonia been discussed with the patient/patient's family/Independent Mental Capacity Advocate (IMCA), as appropriate, at the earliest available opportunity? YES NO

If "yes", record content of discussion. If no, state why not discussed. A "no" response should not prevent initiation of comfort feeding or lead to a patient being left nil by mouth.

……

b) Has the decision to commence risk feeding been communicated to the patient/family/carers/ significant others. YES NO

If "yes", record name, relationship and content of discussion. If "no", state why not discussed.

……
……

c) Have decisions regarding treatment of future chest infections and hospital admissions discussed with patient/ family/carers/significant others and documented on the EDD.
YES NO

If yes, record name, relationship and content of discussion. If "no", state why not discussed.

……
……

7. Risk Reducing Recommendations (to be completed by a Speech and Language Therapist, as appropriate)
FLUIDS: DIET: STRATEGIES:
Name:……. Position……..Date:……..

8. Team members involved in this risk feeding decision
Name:……. Signature……..Position…….
Name:……. Signature……..Position…….
Name:……. Signature……..Position…….

If the risk feeding decision is cancelled, the form should be crossed though with 2 diagonal lines in black ball-point ink and the word "CANCELLED" written clearly between them, dated and signed by the healthcare professional with their name and professional registration number clearly identifiable.

Guidance Notes

This Risk Feeding Proforma is intended to be used countywide across Lincolnshire by all Healthcare Providers.
This form should be completed legibly in* black *ball point ink and used in accordance with the risk feeding policy.
All discussions relating to the decision to risk feed must be documented in the patient's clinical notes.
This form remains the property of the patient and it is transferrable to other healthcare settings. If the patient moves to a different location, the original copy of this form MUST go with the patient, but a black and white photocopy can be retained in the medical records. The clinical team responsible for the patient must ensure their professional colleagues receiving the patient are aware of the decision.

Box	Issue	Guidance
1.	t Details	Full name, Date of Birth and NHS number will all be entered. An addressograph label may be used providing it contains all 3 identifiers
2.	Date of decision	Enter the date that the risk feeding decision was discussed and made.
3.	Location	Enter the location where the decision was discussed and made.
4.	Reason for risk feeding decision	Tick appropriate box (or boxes) and specify why this decision was made.
5.	Capacity Assessment	The MDT is responsible for conducting a decision specific capacity assessment to establish a method of nutrition and hydration. Ensure that Trust Capacity Paperwork has been completed and inserted into the medical notes All records documenting the decision have been documented in patient medical Notes Ensure the patient has been involved with the decision making process
6.	Record of Discussion	The medical team are responsible for making decisions around advanced planning in relation to chest infections and further hospital admissions. These should be clearly documented in the medical notes, discussed with the patient/family/carer significant others and detailed in the EDD. Has consideration been made for use of antibiotics to treat future chest infections? If the patient develops an aspiration pneumonia will this be treated at home or will the patient be readmitted to hospital?
7.	Risk Reducing Recommendations	If appropriate a speech and language therapist can make risk reducing recommendations to include modified diet, fluids and strategies to reduce the risk of aspiration. These should be documented here.

8.	Team Members Involved in the Decision	Write down all the names of the team members involved in the decision making process. A consultant /GP must sign the document as they have overall responsibility for the risk feeding decision.

Appendix Three – Risk Feeding Advice for Patients / Carers / Relatives

Comfort/Risk Feeding

Information for Health Care Workers

This patient is being comfort/risk fed**.**

Dysphagia is a difficulty in swallowing. Difficulties in swallowing can put a person at increased risk of choking and chest infections because food and drink are aspirated onto the lungs instead of the stomach.

The term 'comfort/risk feeding' is used when a decision is made to allow a person to continue to eat and drink, accepting that they may suffer from choking episodes or repeated chest infections. This decision is usually made when alternative forms of nutrition are not appropriate and / or to help maintain a person's quality of life.

It has been agreed by the patient / family / hospital team (delete as appropriate) on _____ that they will continue to eat and drink, accepting the risk of aspiration. The patient should have a 'comfort/risk feeding' form inside their medical records.

In order to maintain comfort and ease whilst eating and drinking, the patient has been assessed by a Speech and Language Therapist (if involved) and the following recommendations have been made:

(SLT to insert feeding / consistency recommendations if involved)

When the patient is eating and drinking they may experience any of the following:

- Coughing
- Choking
- Colour change in their face
- A wet gurgly voice or breathing
- Shortness of breath after eating and drinking
- Recurrent chest infections / pneumonia
- High temperatures

If you observe any of the above symptoms then you may wish to stop and try again later.

There may be instances where food and drink and no longer accepted or tolerated by the patient or the patient's health deteriorates. It may be appropriate to take no further action, but this will need to be discussed with the patient's doctor.

The GP will be made aware of the 'Comfort/Risk Feeding' decision (via the EDD) and should be the point of contact for further management once the patient has been discharged from hospital.

Contact Details of Key Health Professional:

Name:

Profession:

Telephone number:

Please note:
Further Speech and Language Therapy involvement will be at the discretion of the Health Professionals involved but it unlikely to be significant benefit. Reasons for further involvement may be linked with significant improvement and / or significant change in medical condition (that are likely to affect swallow function).

Equality Analysis: Initial Assessment Form

Title: *of the function to which the Equality Analysis Initial Assessment applies*
Risk Feeding

Describe the function to which the Equality Analysis Initial Assessment applies:		
☐ Service delivery	☐ Service improvement	☐ Service change
☐ Policy	☐ Strategy	☐ Procedure/Guidance
☐ Board paper	☐ Committee / Forum paper	☐ Business care
☐ Other (please specify) ……		

Is this assessment for a new or existing function?	**New**
Name and designation of function Lead professional:	**Angela Shimada, Speech and Language Therapist**
Business Unit / Clinical Directorate:	**Speech and Language Therapist**

What are the intended outcomes of this function? (*Please include outline of function objectives and aims):*
To provide a clear pathway and rationale for clinicians working with patients who may require a risk feeding approach in both acute and community settings.

Who will be affected? Please describe in what manner they will be affected?

Patients / Service Users:	**Staff:**	**Wider Community:**
Patients who have dysphagia but are not appropriate for long term enteral feeding; patients who have dysphagia and refuse long term enteral feeding. The policy provides clear guidance on the decision making process for these patients	All clinical staff in both acute and community settings: provides clear guidance on process for consideration of risk feeding. Provides guidance on consideration of on-going treatment following risk feeding decision making e.g further treatment for chest infections, hospital admissions, treatment at home	

What impact is the function expected to have on people identifying with any of the protected characteristics (below), as articulated in the Equality Act 2010? (Please tick as appropriate)

	Positive	Neutral	Negative	**Please state the reason for your**

				response and the evidence used in your assessment.
Disability		X		
Sex		X		
Race		X		
Age		X		
Gender Reassignment		X		
Sexual Orientation		X		
Religion or Belief		X		
Pregnancy & Maternity		X		
Marriage & Civil Partnership		X		
Carers		X		
Other groups identified (please specify)	X			Health Professionals: will give clear guidance on patient recommendations

If the answer to the above question is a predicted negative impact for one or more of the protected characteristic groups, a full Equality Analysis must be completed. (The template is located on the Intranet)

Name of person/s who carried out the Equality Analysis Initial Assessment:	**Angela Shimada**
Date assessment completed:	**28/3/17**
Name of function owner:	**Angela Shimada**
Date assessment signed off by function owner:	**28/3/17**
Proposed review date (please place in your diary)	**March 2018**

As we have a duty to publicise the results of all Equality Analyses, please forward a copy of this completed document to tim.couchman@ulh.nhs.uk.

References

1. Chakladar E on behalf of the British Geriatrics Society (2012) Dysphagia Management for Older People Towards the End of Life
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19. Sherman FT (2003). Nutrition in advanced dementia. Tube feeding or hand feeding until death? Editorial. *Geriatrics* 58, 11: 10.
20. Skelly RH (2002). Are we using percutaneous endoscopic gastrostomy appropriately in the elderly? *Current Opinion in Clinical Nutrition and Metabolic Care*. 5(1) 35-42.

Signature Sheet

Names of people consulted about this policy:

Name	Job title	Department
Dr Adam Brown	Palliative Consultant	ULHT
Dr Abdul Elmarimi	Stroke Consultant	ULHT
Dr Katharine Collett	Palliative Consultant	ULHT
Dr Georgina Keenleyside	Palliative Consultant	ULHT
Dr Gillian Garden	Palliative Consultant	St Barnabus
Professor Jagdish Sharma	PD Consultant	ULHT
Dr Neal Parkes	Acting Medical Director	LCHS
Sarah Scrace	CTL SLT	LCHS
Janet O'Neill	CTL SLT	LCHS
Katherine Green	Lead Dietitian	ULHT
Kathryn Kelly	Site lead dietitian	ULHT
Jo Hagens	Palliative Nurse	ULHT
Nicola Hine	Sister	ULHT

Names of committees which have approved the policy	**Approved on**
ULHT Nutritional Steering Group	2016
ULHT Clinical Effective Steering Committee	2017
LCHS Adult govenrnance committee	2017
LCHS Community Hospital Governance	July 2017