

St Helena
For the people you love

Quality Account

2025 - 2026

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Sarah Beer	Media and Stories Lead
Laura Brisley	Facilities and Health & Safety Manager
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Nicky Coombes	Hospice in the Home Matron
Julie Eke	Lead Counsellor
Mandy Gowers	Director of Finance and Asset Management
Alison Gray	Director of Care
Samina Haig-Earle	Hospice Senior Sister
Jenni Homewood	Complementary Therapies Team Lead
Fran Hyde	Chair of the Board of Trustees
Tim Leeson	Spirituality Lead
Shani Levy	Associate Director of Community Development
Wendy Marcon	Volunteer Services Manager
Kath Oakley	Consultant and Clinical Medicines Management
Christine Parsons	Executive PA
Vickie Peters	Safe Harbour Project Manager
Susan Ryan	Lead Counsellor
Sarah Samuels	Clinical Quality Lead
Nicola Smeeth	Specialist Physiotherapist and Falls Lead
Kirsty Smith	Hospice Matron
Mandy Summons	Head of Hospice Education
Emma Tempest	Medical Director
David Traynier	Head of Quality & Compliance
Caroline Vergo	Infection Prevention & Control Consultant

The husband of ... wanted to express his immense gratitude that he got to hold [him] in his arms as he died...

Statement on Quality

1.1 CEO Statement



St Helena has supported people to receive excellent end of life care in our community for 41 years. The Care Quality Commission (CQC) recognises us as providing outstanding care, and we remain committed to delivering high quality, compassionate support for the people of North East Essex over the long term.

During 2025-26, we had to address a financial deficit created by the national underfunding of hospices and the failure of the NHS to fully commission for the palliative care needs of the population. Like many hospices, we needed to reduce services to secure our long term sustainability. For St Helena, this meant reducing care costs by £1.6 million, closing some inpatient beds, and reducing clinical staff by 25 roles. This was a very difficult period for everyone involved and has resulted in a smaller but financially sustainable service. We now operate eight inpatient beds alongside eight 'virtual' hospice beds, enabling people to receive intensive specialist-led care at home. We have also restricted our referral criteria to people with specialist palliative care needs, meaning those whose needs cannot be met by NHS primary and community services. We continue to campaign alongside hospices across the country for fair NHS funding for palliative care and remain keen to grow services so we can support more people as soon as this becomes affordable.

Despite these challenges, our colleagues have continued to deliver an excellent service for local people. During the year, we cared for 3,545 people with life limiting conditions and supported 933 family members. Of these, 212 people were admitted to the Specialist Palliative Care Virtual Ward and 202 to our inpatient hospice beds. Our SinglePoint nursing service answered more than 38,000 calls, and our rapid response team carried out over 4,500 visits to people in crisis. Our clinical nurse specialist team cared for 1,450 people in their own homes, while the rehabilitation team delivered 3,475 contacts for over 400 people.

Our counselling and emotional support team continued to care for patients and their families, while also providing bereavement support for adults and children across the community. This included group support, individual counselling, and newly launched bereavement cafés, which have been very well attended.

The care and support team provided personal care to 253 people at home in the last weeks of life through our 'home ward' service, alongside offering a night sitting service for those at the end of life.

St Helena continues to play a key role in the Compassionate City network, promoting death literacy and

compassion across our community. We launched a Care Choices service in which volunteers support people to consider their priorities for the last phase of life and record their advance care plans. The Safe Harbour service was also awarded a further three years of funding to continue reaching communities that have historically been underserved by hospice services.

We are grateful to our spiritual care and complementary therapy teams, whose holistic support for people at the end of life and their families is deeply valued by those they care for.

This year also saw a change in leadership, with Kate Heslegrave and I appointed as Co-CEOs in December 2025. This shared leadership approach has supported continuity while strengthening senior leadership capacity as St Helena moves forward with a focus on affordable growth in 2026-27.

We would like to thank all our colleagues, including our volunteers, for the determination and compassion they have shown in serving our community over the past year. Kate and I feel honoured to be part of such a committed and creative organisation, and we look forward to leading St Helena into the future.

Dr. Karen Chumbley, Co-Chief Executive Officer

...It gave me so much comfort to know that she died so peacefully. Had she been able to thank you herself she would. She would have been so grateful...

1.2 Statement from the Board of Trustees



The Board of Trustees is accountable to all stakeholders for the quality of care provided by St Helena Hospice, and this accountability remains a central focus of the Board's work.

Since the last report, Mark Jarman-Howe stepped down after 12 successful years as Chief Executive Officer. Following an interim period and a robust recruitment process, the Board of Trustees appointed Karen Chumbley and Kate Heslegrave as Co-Chief Executives. Karen and Kate took up their posts in December 2025.

The Board currently comprises nine trustees, including a Chair, Deputy Chair and Treasurer. We continue to strengthen our governance approach by ensuring that key operational areas of St Helena, including People and Clinical services, have direct links to individual trustees. A structured annual programme of Board meetings ensures each of these areas receives dedicated focus. Link trustees bring forward key developments, risks and achievements, while also highlighting the people delivering this work. This approach supports a well-informed

Board with a broad and balanced understanding of the organisation. Trustees have also actively supported a range of fundraising events and meetings, helping them to engage with and better understand teams across St Helena.

The service changes outlined in last year's statement were implemented over the summer of 2025. Managing this period of consultation, while maintaining day to day operations and ensuring that care for patients and families continued without compromise, proved challenging and demanding for everyone involved. This work, which was essential to securing the future and financial sustainability of St Helena, has now been completed. We now focus on refreshing and renewing our organisational strategy.

The external operating environment continues to present challenges. A complex geopolitical climate has increased costs, including fuel prices. More locally, changes in commissioning arrangements and moves towards closer integration of health and social care across Essex continue to evolve. The Board monitors these developments closely.

The Board acknowledges and thanks all staff and volunteers for their continued dedication and commitment in supporting the people of North East Essex. We fully endorse this Quality Account.

Fran Hyde, Chair of the Board of Trustees, St Helena Hospice

thank you for all your care and support, you gave to us all, during a really hard time... [he] was in his element with his milk, ice cream, and Guinness!

1.3 Executive Summary



In 2025–26, St Helena Hospice continued to provide high-quality, compassionate care for people facing incurable illness and bereavement across north east Essex, despite a challenging financial and system context. The organisation has adapted to a smaller, more sustainable operating model while maintaining excellent care, strong outcomes and positive feedback from patients and families.

Looking ahead, St Helena Hospice is focused on delivering sustainable growth and strengthening services through three key priorities for 2026–27. Alongside this, the organisation continues to demonstrate strong performance across its inpatient, community and specialist services.

Priorities for 2026–27

During 2026–27, St Helena Hospice will focus on three key areas to support sustainable development and improve outcomes for patients and families.

Extending our offer in a realistic and sustainable way
St Helena Hospice will continue to develop services in line with available resources to ensure long-term sustainability. This includes completing refurbishment of the inpatient unit, launching a new bereavement model, expanding outpatient services and growing collaborative working within

neighbourhoods. The organisation will also pilot developments such as the Care Choices service and explore opportunities to introduce paid-for services where appropriate.

Supporting carers to support those they care for
Recognising the essential role of carers, St Helena Hospice will strengthen support for those caring for people with incurable illness. This includes relaunching carers' groups, improving support for family administration of medication and developing training opportunities to help carers feel more confident and supported.

Supporting and developing our expert workforce
St Helena Hospice will continue to invest in its workforce, recognising the importance of staff wellbeing, education and professional development. This includes embedding the Synergy learning platform, strengthening Hospice Education and supporting career development across the clinical workforce.

Positive outcomes and achievements

Across all services, St Helena Hospice has continued to deliver high-quality care and achieve positive outcomes for patients and families.

High-quality inpatient care

The inpatient unit has maintained strong performance despite operating with reduced bed capacity. Bed occupancy averaged 88%, exceeding the organisation's target, and patients continued to receive high standards of care with a short average wait for admission. The team also successfully reintroduced respite care during the year, providing additional flexibility and support for patients and families.

Strong community services and responsive care

Hospice in the Home and SinglePoint services have continued to provide responsive, coordinated care in the community. SinglePoint managed over 38,000 calls and delivered more than 4,500 rapid response visits, with performance exceeding targets for response times. These services play a critical role in supporting patients to remain in their preferred place of care and avoiding unnecessary hospital admissions.

The primary care network clinical nurse specialist team has strengthened integration with local GP practices, increasing advance care planning and improving coordination of care. This has contributed to improved patient outcomes and reduced avoidable admissions.

Supporting people to stay at home

The Home Ward service has expanded its reach, delivering over 10,000 hours of care and supporting more people to be cared for at home at the end of life. This reflects St Helena Hospice's commitment to enabling patients to remain in their preferred place of care wherever possible.

Maintaining quality during service change

Across all clinical services, teams have adapted to a reduced staffing model while maintaining high standards of care. Strong multidisciplinary working, flexible approaches and ongoing monitoring of patient need have ensured that care quality has remained high.

Rehabilitation and holistic care

The rehabilitation team has continued to deliver specialist support across inpatient and community settings, helping patients maintain

independence, comfort and quality of life. The complementary therapies and wellbeing service has also demonstrated strong impact, with measurable improvements in patient wellbeing reported through outcome measures.

Emotional, psychological and spiritual support

The counselling and emotional support team has supported more than 1,200 people, while reducing waiting times over the course of the year despite increased demand. New initiatives such as bereavement cafés have improved access to early support within the community.

Spiritual care services have continued to provide valued support to patients, families and staff, including pastoral care, group activities and wellbeing initiatives.

Reducing inequalities and strengthening community engagement

Through the Safe Harbour service and wider compassionate communities work, St Helena Hospice has strengthened engagement with underserved communities. This has included targeted work with minority groups, improved access to advance care planning and development of more inclusive services.

The organisation has also continued to build its Compassionate Communities programme, supporting community-led approaches to end of life care and increasing awareness of death, dying and bereavement.

Education, partnership working and system impact

St Helena Hospice has continued to play a key role across the health and care system. This includes:

- Delivering education and training to health and care professionals
- Strengthening partnerships with other hospices and system partners
- Expanding the My Care Choices Register, now supporting thousands of people with advance care plans across a wider geographical area

These developments support improved coordination of care and better outcomes for patients across north east Essex and beyond.

Strong performance across quality and safety measures

Performance across key quality indicators remains strong. This includes high compliance with infection prevention standards, strong medicines management, and improvements in areas such as pressure ulcer prevention and falls reduction. Robust clinical audit processes and governance arrangements continue to support learning and continuous improvement.

Looking ahead

St Helena Hospice enters 2026–27 with a clear focus on sustainable growth, workforce development and strengthening support for patients and carers. While challenges remain within the wider health and care system, the organisation is well placed to build on its strengths and continue delivering high-quality, compassionate care for the community it serves.

2 Priorities for Improvement in 2026–27

Mum loved pink and butterflies, so it was truly comforting to see you had dressed her in her favourite pink cardigan and that she spent her final days in the Butterfly room...

In 2026, St Helena Hospice plans to launch a new three-year strategy alongside the first phase of affordable service growth. At the time of writing, the new strategic priorities have not yet been formally agreed by our Trustees.

At the end of 2025–26, the Senior Leadership Team agreed three key priorities that are expected to remain relevant within the future strategy. We will report progress against these priorities, alongside delivery of the new strategy, through our Quarterly Quality Reports during 2026–27.



2.1 Priority One

Extend our offer in a realistic and sustainable way
This includes completing the IPU renovation, launching a new bereavement model, developing opportunities for collaborative working within neighbourhoods, piloting the Care Choices service in Greenstead, growing paid-for services including respite and Forget Me Not bereavement support, and developing the outpatient offer.

2.2 Priority Two

Support carers to support those they care for
This includes relaunching carers' groups, increasing the provision of family administration of medication support, and developing a training offer for carers.

2.3 Priority Three

Support and develop our expert workforce

We will continue and strengthen staff wellbeing initiatives, and embed and expand the Synergy education platform, growing Hospice Education, and developing delivery of the four pillars of practice within the senior nursing workforce.

2.4 Priorities for Improvement from 2025–26

In this section, we review our progress in delivering the goals we set for 2025–26, as outlined in our 2024–25 Quality Account. The full report is available at: https://www.sthelena.org.uk/about-us/governance.

2.4.1 2025–26 Priority One

What we wanted to achieve

We will remodel St Helena clinical services to ensure we continue delivering outstanding, population-based care within a challenging financial climate.

What we have achieved

The service was remodelled and reduced in size in September 2025 to remain financially sustainable in the long term. The service criteria changed to offer specialist palliative care only, and the number of open inpatient beds was reduced to eight.

Our specialist palliative care Virtual Ward almost doubled the number of people it supported from the previous year, caring for 212 people with complex needs in their own homes. Although smaller, the service is now affordable within our current budget and provided excellent holistic care to more than 3,500 people in our community with specialist palliative care needs this year.



2.4.2 2025–26 Priority Two

What we wanted to achieve

We will continue to address health inequalities and improve outcomes for the population we serve.

What we have achieved

This year we were delighted to be awarded three years of funding from the National Lottery for the Safe Harbour service, which reaches out to minority groups historically underserved by hospices. During the year, the team has strengthened links with the learning disability community and services, as well as with communities in more deprived areas, to improve access to advance care planning and hospice care.

This year also saw the launch of the Care Choices service, a volunteer-based initiative enabling advance care planning conversations. It supports people to identify their priorities at the end of life and helps enable effective care coordination.

Our service data shows that St Helena Hospice now provides proportionately more support to people living in more deprived areas, where palliative care needs are greater.

...his wife described his death as 'incredible' and expressed her gratitude to everyone involved in his care over the years.

This year has also seen improvements in key patient outcomes, including an increase in the achievement of preferred place of care from 67% to 72%. Ninety-two per cent of patients reported being treated with dignity and respect all or most of the time, and 96% said their symptoms were well managed. Additionally, 99% of family members and carers rated their experience as good or very good.

We did, however, see a higher percentage of patients die in hospital, which is likely to be linked to the reduction in our inpatient unit bed numbers.

2.4.3 2025–26 Priority Three

What we wanted to achieve

We will work in partnership with local health and care providers, as well as the wider community, to increase

access to advance care planning for people in the last years of life.

What we have achieved

There were more than 7,100 people with advance care plans recorded on the My Care Choices Register (MCCR) this year. During the year, the Care Choices service also began receiving referrals for residents of Greenstead in collaboration with Abbeyfield Surgery. The My Care Choices Register has now been launched across Suffolk.

The hospice education team delivered training to a wide range of system partners on advance care planning and frailty, and two of our clinical nurse specialist team continue to work within Primary Care Networks in Tendring.

Approximately 50% of people in our community accessed the My Care Choices Register at the end of life.

2.4.4 2025–26 Priority Four

What we wanted to achieve

We will expand Hospice Education and continue to strengthen our workforce through apprenticeship opportunities.

What we have achieved

Hospice Education spanned the three hospices across Suffolk and north east Essex in 2025–26.

A wide portfolio of education sessions has been delivered, alongside integrated nurse and healthcare assistant study days. The workforce development programme for frailty and end of life care was also completed this year, culminating in two highly successful frailty conferences.

The Synergy platform was launched, providing an excellent resource for sharing educational materials across the organisation.

Masterclasses were delivered for health and care professionals across Suffolk and north east Essex, including a series on the complex issue of assisted dying, which is currently being debated in Parliament.

Apprenticeships continue across the organisation, with growing interest in new opportunities from colleagues.



2.4.5 2025–26 Priority Five

What we wanted to achieve

We will remain actively engaged in collaborative work across the evolving health and care system.

What we have achieved

This year saw extensive collaboration across Suffolk and north east Essex, including the expansion of the My Care Choices Register, delivery of a collaborative frailty and end of life care workforce programme, integration of clinical nurse specialists within two Primary Care Networks, and the Hospice Education collaborative.

In the latter part of the year, as NHS system configurations began to change, we formed the Essex Hospice Collaborative and look forward to further opportunities through this partnership in 2026–27.

We have also worked collaboratively on Compassionate Communities events, the End of Life Care Coalition, and across north east Essex within Primary Care Networks and the neighbourhoods programme.

Our medical team continues to work in an integrated way with the local hospital palliative medicine team. There is a weekly multidisciplinary team meeting between St Helena Hospice and hospital palliative care teams, alongside a daily integrated multidisciplinary team meeting with the community nursing team.

St Helena Care and Support has delivered a highly successful winter care model, and as a result, the additional 100 care hours per week for people with urgent care needs have been commissioned for a further year.

... At such a difficult and frightening time, I know my auntie felt safe, respected, and well looked after by all the caring and amazing staff. To do what you do every day with smiles on your faces; with such positivity and grace is truly astounding!

2.5 Mandatory Statements Relating to the Quality of the NHS Service Provided

2.5.1 Review of Services

During 2025–26, St Helena Hospice provided the following services:

- Inpatient services – eight specialist palliative care beds, supported by the hospice multidisciplinary team (MDT), which includes the nursing team, a specialist physiotherapist, a specialist occupational therapist, counsellors, and family support workers. This MDT also hosts the complementary therapies service for both inpatients and community patients, as well as the spiritual care lead and volunteers.
- Community services – comprising the SinglePoint service (24/7 advice, support and information), the community clinical nurse specialist (CNS) team, and the community night nursing service. The Hospice in the Home MDT includes the nursing team, a specialist physiotherapist, a specialist occupational therapist, counsellors, and family support workers.
- The medical team and Specialist Palliative Care Virtual Ward, supporting both MDTs.
- The rehabilitation team, comprising two specialist physiotherapists and two specialist occupational therapist, supporting both MDTs.
- The counselling and emotional support team (CEST), which provides psychological support for anyone over the age of five who is affected by incurable illness or bereavement. St Helena Hospice supports patients, families, and friends, and the team works across both MDTs. The bereavement service is open to referrals for adults and children, regardless of the cause of death.

- The compassionate communities programme, encompassing the Safe Harbour project and compassionate workplaces programme. [SS1.1]
- Hospice education in collaboration with St Elizabeth Hospice. St Nicholas Hospice chose not to continue; however, St Helena Hospice will welcome Farleigh Hospice in 2026–27.

2.5.2 Funding of Services



In 2025-26 our total income was £24,247,385 of which ~£4,665,000 was from our NHS grant for palliative care services.

Our diverse range of income streams includes commercial ventures, lottery services (through which we also support a range of other charities), High Street and online shops, and the valuable support we receive from our community through corporate partnerships, donations, gifts in Wills, and other fundraising activities.

Raising this money for the hospice means so much to me, as the care you all provided my mum and us as a family was truly remarkable...

2.5.3 Clinical Audit

2.5.3.1 National Audits

St Helena did not participate in any national audits during 2025–26.

2.5.3.2 Local Audits



ICRLDL Documentation [52-2526]

This audit examined how the Individualised Care Record for the Last Days of Life (ICRLDL) is used on the IPU. The ICRLDL is essential for delivering personalised care in the final days of life, supporting a dynamic, holistic approach. It ensures the patient and those close to them are informed of the prognosis, that nutritional needs are assessed, and that documentation is clear and concise.

The audit tool was based on the ICRLDL document provided by East Suffolk and North Essex NHS Foundation Trust (ESNEFT) and adapted by a St Helena Specialty Doctor to suit IPU use. A baseline audit was completed in 2016, with re-audits in 2019 and again this year The current audit was undertaken by a medical student under the supervision of a St Helena doctor.

Although there are no standardised guidelines for ICRLDL use, St Helena aims for 90% of anticipated deaths to involve the document. The audit found 93%

compliance, with generally high standards of documentation.

A further re-audit is planned for January 2027.

Hospice UK Management of Medical Gases [27-2526]

This annual audit ensures compliance with relevant legislation, including the Medicines Act (1968), Misuse of Drugs Regulations (2001), and Health Act (2006), concerning safe management of medical gases.

The audit, conducted jointly by the Nursing and Estates teams, assessed eight key areas and reported an overall compliance score of 96%:

- Standard Operating Procedures
- Personnel
- Ordering and Receipt
- Storage
- Oxygen Concentrators
- Prescribing
- Administration

Decontamination and Discharge

Key actions included:

- Updating the Medical Gases Policy and Procedure
- Ensuring the Helpdesk captures all necessary information for gas cylinder ordering and receipt

A re-audit is scheduled for next year.

Admission Avoidance Audit [22-2526]

With increasing pressure across the healthcare system, all providers have a responsibility to prevent inappropriate admissions to acute hospitals. St Helena is uniquely placed to support patients to remain in their preferred place of care. The multidisciplinary team works collaboratively to prevent unnecessary hospital admissions wherever possible.

Admission avoidance can be difficult to define, as it is inherently subjective. It could be argued that a significant proportion of work undertaken by the Hospice in the Home multidisciplinary team contributes to preventing inappropriate hospital admissions, as without this intervention many patients would likely be admitted to an acute hospital.

For the purposes of this audit, admission avoidance was defined as preventing admission to an acute hospital and enabling a patient to be supported and, where applicable, die in their preferred place of care. The intervention must prevent admission for a minimum of seventy-two hours.

Actions taken to prevent admission included carrying out urgent assessment and timely symptom management; assessing and implementing domiciliary care packages via St Helena Homeward or continuing healthcare assessment; arranging care in settings other than an acute hospital, including the hospice Inpatient Unit, nursing homes, or community hospitals; providing urgent equipment to enable care to be delivered in the community; and facilitating advance care planning discussions when patients were rapidly deteriorating, enabling informed choice at the end of life.

The previous admission avoidance audit was completed in October 2024. This re-audit allowed direct comparison to identify any recurring themes in how the Hospice in the Home team contributes to preventing

acute hospital admissions. This was the fourth re-audit.

The audit took place over a two-week period from 5 January 2026 to 18 January 2026 and, for the second time, included data from both day and night shifts following the integration of community nurses' night visits into the service in April 2024. When clinicians felt that their intervention had prevented an admission, they informed the auditor. The auditor then reviewed each patient record to confirm that the patient had not been admitted to hospital within seventy-two hours of the intervention.

This year's audit also included data for patients cared for within the hospice Inpatient Unit and on the hospice specialist palliative care virtual ward. These patients often require intensive specialist support and may be in crisis.

Over the two-week period, hospice teams prevented a total of two hundred and eighteen patients from being admitted to an acute hospital. This represented an 85% increase compared to the previous audit. Following intervention, all patients remained in their preferred place of care, and at the time of writing ninety-two patients (42%) had died in their preferred place of care.

A re-audit is planned for January 2027.

Discharge Data Audit [56-2526]

St Helena clinicians identified an increase in discharges from East Suffolk and North Essex NHS Foundation Trust (ESNEFT) that resulted in crisis calls and urgent intervention by SinglePoint. Safe, timely, and well-coordinated discharge planning is essential to ensure continuity of care from acute hospitals into the community. When done effectively, this enables patients to be discharged to their preferred place of care in a seamless way, promoting choice and dignified end-of-life care. Failures in this process can place patients and families at risk of avoidable distress, increase pressure on community services, and lead to unnecessary readmission.

An increase in calls to SinglePoint from patients, families, and community nurses highlighted concerns following hospital discharge. Many of these patients were not actively managed by St Helena, which limited the information available and created additional challenges for clinical staff.



To explore this further, the auditor developed a spreadsheet to identify common themes. Data collected included NHS number, date and location of discharge, and contextual comments.

Thirty-one cases were identified between 10 September 2025 and 29 November 2025. Common themes included patients discharged with no or limited medication supply; missing authorisation forms for syringe drivers and PRN anticipatory medications; lack of referral to community nursing for ongoing syringe driver care; inaccurate information on discharge summaries; and ReSPECT forms

completed but not sent home with patients.

During the data collection period, ESNEFT was transitioning to its new electronic patient record system, EPIC.

The findings reinforced the importance of robust discharge planning, accurate documentation, and effective communication with community services to ensure safe, compassionate, and patient-centred end-of-life care.

Recommendations included ensuring a minimum of seven days' supply of medications on discharge, particularly for patients using syringe pumps; completing accurate authorisation forms and sending copies directly to community nursing teams; sending referrals to community nurses for patients requiring daily syringe pump recharging; and ensuring accurate documentation on electronic discharge summaries, with completed advance care planning documents sent home with patients.

Following completion of the audit, the auditor presented the findings to ESNEFT and worked with the ESNEFT pharmacy lead to address medication supply, identified as the most significant issue. As a result, arrangements have been strengthened to ensure patients are discharged with seven days' worth of medication.

A re-audit is planned for summer 2026.

Hospice UK Controlled Drugs Accountable Officer Self-Assessment [39-2526]

This annual Hospice UK audit ensures that the appointment of the Controlled Drugs Accountable Officer (CDAO) and the discharge of their responsibilities meet the requirements of the Misuse of Drugs Regulations 2001 (as amended in 2007), the Health Act 2006, and the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

The audit covered four areas: appointment of the CDAO; role and responsibilities of the CDAO; annual review by the CDAO; and continuous quality monitoring.

The audit achieved an overall score of 96%. Re-audit will take place in one year.

Hospice UK Management of Controlled Drugs [41-2526]

This annual Hospice UK audit assesses whether the management of controlled drugs (CDs)meets the requirements of the Misuse of Drugs Regulations 2001 (as amended in 2007), the Health Act 2006, and the Controlled Drugs (Supervision of Management and Use) Regulations 2006.

The audit reviewed seven areas: adequacy of premises and security; procurement; examination of stock held; controlled drugs registers, records, and audit; prescribing of CDs; administration of CDs; and destruction of CDs.

The audit achieved an overall score of 100%. Re-audit will take place in one year.



2.6 Participation in Research

Following participation as a study site in the CHELsea II study, St Helena Hospice is keen to continue and build on this work. The team has contributed to workshops aimed at shaping future research into Virtual Wards for palliative and end of life care.

St Helena Hospice is a member of local, regional and national research groups, supporting early identification of future research opportunities. The hospice has also supported a National Institute for Health and Care Research (NIHR) grant application to enable a clinician from a neighbouring hospice to work across hospice settings to deliver research projects and support wider research collaboration between sites. This application was successful, and collaborative work will begin in the coming year.

2.6.1 Use of the CQUIN Payment Framework

St Helena's income for 2025–26 was not linked to quality improvement or innovation targets under the Commissioning for Quality and Innovation (CQUIN) framework, as we are not party to any NHS National Standard Contracts.

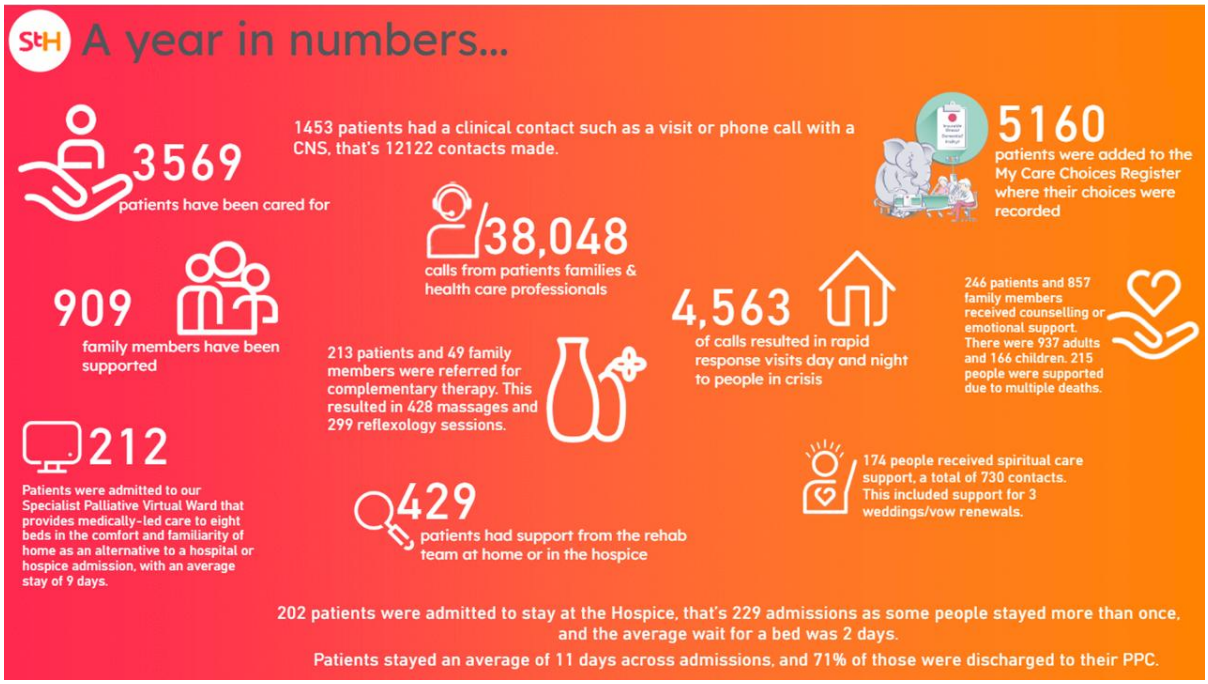
Every time I'm in contact with the hospice I am treated with respect, care and I feel important.... Nothing has been too much bother for anyone I've been in contact with and you make me feel my life is worth living.

This whole experience nearly broke me – the support & guidance just wasn't out there in one place, until St Helena got involved. Our society needs more places like St Helena

...Thank you so much for looking after my husband ... For two weeks while I have been recovering from surgery. He has thoroughly enjoyed his time with you, your kind care and attention and have a menu to choose from each day. A real treat for him. He speaks very highly of you all. For myself, it has meant that I could rest at home following my operation and get back to normal before I had to consider the needs of someone else...

... staff ... were entirely faultless from the moment we arrived at the hospice to the moment we left. They not only cared for my husband but for myself, my three children and their partners.


St Helena
hello my name is...
Paula



3 Review of Quality Performance

3.1 The Hospice

The Hospice multidisciplinary team (MDT) includes registered nurses (RNs), healthcare assistants (HCAs), physiotherapists and occupational therapists based on our inpatient unit (IPU). They work alongside the medical team, counselling and emotional support service, spiritual care team and complementary therapy service, which is shared with the Hospice in the Home MDT.



The IPU is a short-stay unit with 18 beds, of which eight were in use during 2025-26. It provides specialist palliative care for people facing incurable illness, delivered by the full MDT.

Activity, achievements and contribution to quality

During 2025-26, the IPU recorded 229 admissions. Staff maintained a high standard of care, and the average wait for admission was two days.

Average bed occupancy by quarter was:

- Q1: 90%
- Q2: 87%
- Q3: 85%
- Q4: 91%

The annual average was 88%, exceeding our target of 85%.

In April 2025, we restarted our respite service after an agreement with East Suffolk and North Essex NHS Foundation Trust (ESNEFT) came to an end. This agreement had provided additional beds for patients from Colchester General Hospital during the

winter months, helping to ease pressure on hospital services.

We had a successful year delivering respite care, generating income above our planned budget. From April 2026, respite has stopped to allow us to focus on refurbishment work on the inpatient unit.

From Q3, we began working with staff to gather their ideas and feedback on the IPU refurbishment, and this work is ongoing.

Staffing

In Q2, we were able to lift the recruitment pause on the senior sister role and appointed to this post on a part-time basis from within our team.

In Q3, a senior co-ordinating nurse joined the IPU, supporting complex discharges and managing the senior healthcare assistant team.

By the end of Q4, our healthcare assistant workforce was fully established, and we were recruiting for one registered nurse.

During the year, we began working with two nursing agencies to strengthen staffing resilience. We have also increased our bank staff for both RNs and HCAs.

We continue to support three apprentices in their nurse training, one of whom qualified as a registered nurse associate at the end of March 2026.

Challenges and problems

As with all clinical services, the IPU went through a staff consultation process and entered Q2 with a reduced staffing model. We have continued to monitor our services closely to make sure this has not affected patients and their families.

The Hospice matron and clinical quality lead started a review of patient need and acuity in January 2026, and this work is ongoing.

Following the consultation, we introduced regular informal staff meetings to support wellbeing and provide a safe space to raise concerns. During a period of particularly high patient need, we were also able to slightly increase staffing levels so staff could take time away from the ward when needed.

Plans for 2026-27

IPU building works, including refurbishment of patient bays, a new reception area, an additional nurses' station, a new drug room and new internal doors.

The IPU matron will work with the team to review our services and understand the impact of how they are delivered.



Figure 1 2025–26 Hospice activity statistics

3.2 Medical Team

The medical team provides 24/7 cover across both multidisciplinary teams, supporting patients on the inpatient unit and in outpatient settings. The team also advises healthcare professionals across the locality, attends disease-specific multidisciplinary meetings and undertakes home visits. Out of hours medical support is provided to patients at Colchester General Hospital, with several team members working across both sites, supporting teamworking and continuity of care.

The team includes palliative medicine consultants, specialty and specialist doctors, advanced clinical practitioners, a pharmacy technician and a secretary. The service also hosts placements of up to 12 months for trainee hospital doctors, general practitioners, palliative medicine trainees and medical students.



Team members hold a range of leadership roles, including medicines management, training programme director for the East of England palliative medicine training programme, lead for end of life care across East Suffolk and North Essex NHS Foundation Trust (ESNEFT), guardian of safe working for ESNEFT, and leadership in advanced clinical practice and research. The team is also active in research, teaching, audit and quality improvement.

In the first quarter, one specialty doctor undertook a four-month secondment to ESNEFT, providing an opportunity to further develop experience and strengthen joint working.

From September, a reduced staffing model within the team,

alongside wider organisational changes, required adaptation in several areas. The team has continued to work flexibly across services to ensure medical expertise is available where it is most needed. This has included taking on additional responsibilities, most notably in relation to safeguarding.

In spring, the team split into two groups to enable focused sessions exploring how recent changes to the team and wider hospice services affect senior and middle grade roles. These sessions supported engagement in shaping future roles, identifying opportunities for improvement and considering succession planning. This work has resulted in an action plan, with a number of audits and quality improvement projects now underway.

Following a reduction in inpatient beds, the team has focused on developing the specialist palliative care Virtual Ward and maximising its impact, ensuring that patients who require inpatient-level care are able to access the support they need.



The team has also focused on supporting clinical nurse specialist colleagues. A specialist trainee completed a project to identify areas for additional support, resulting in the introduction of monthly caseload supervision with a consultant, which has been well received. In addition, three nurses have been mentored to complete their non-medical prescribing qualification.

Medical student placements were provided during the year for students from the University of Cambridge, Anglia Ruskin University, and St Bartholomew's and the Royal London School of Medicine and Dentistry. These placements ranged from one-day compulsory experiences prior to starting work, to four-week modules for students with a particular interest in palliative medicine.

There has also been an increase in requests for medical work experience from prospective medical students. Where possible, two days of shadowing are offered. Feedback has been positive, and in February the team welcomed a trainee who had previously completed work experience with the service prior to a successful medical school application.

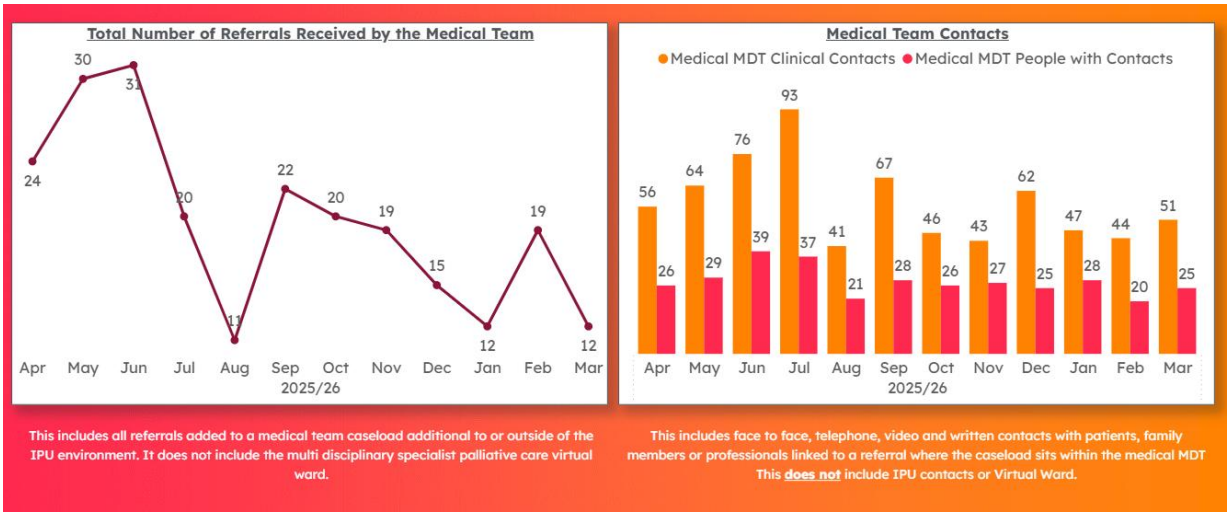


Figure 2 2025–26 Medical Team activity statistic

3.3 Hospice in the Home

Hospice in the Home focuses on patients with specialist palliative care needs. SinglePoint coordinates care for specialist patients who are registered with St Helena Hospice or listed on the My Care Choices Register with a green, amber or red status.

Challenges and problems

In the first quarter, a staff consultation was launched to support the development of a new model of care designed to operate within a constrained financial envelope. The consultation concluded in July and informed the final model.

The consultation process had an impact on staff morale and caused some disquiet. The Hospice in the Home management team has responded by providing one to one support, holding team meetings to listen to feedback, and introducing morning huddles to discuss concerns and plan daily work.

...His peaceful death, and the fact that I could be there with him, right to his last breath, is an enormous comfort to me...



3.3.1 PCN CNSs

The primary care network (PCN) clinical nurse specialist (CNS) team proactively supports people with level three and level four specialist palliative care needs. This includes pain and symptom management and advance care planning. The team works within defined geographical areas, supporting allocated GP practices.

The team received a total of 1,101 referrals during the year.

Two CNSs provide support to the Tendring and Ranworth GP projects. One works 30 hours per week and the other works 15 hours. This proactive, integrated model links PCNs with St Helena Hospice and supports increased advance care planning and ReSPECT conversations for people living with frailty and multiple

comorbidities. The work has increased the number of people recorded on the My Care Choices Register and helped reduce avoidable hospital admissions. Collaboration with Ranworth Surgery in Clacton has resulted in a significant increase in patients with a completed ReSPECT form, currently at 90 percent.

The family administration of medication (FAM) policy has been improved, with St Nicholas Hospice Care and St Elizabeth Hospice agreeing to use St Helena Hospice's version as a standalone policy. Although changes have been made, this has not prevented FAM being used where clinically appropriate.

CNS outpatient clinics have been introduced over the last year. There have been challenges securing suitable clinic space, and appointment numbers remain small. There are plans to increase clinic capacity over the coming year.

Challenges and problems

The team experienced periods of both long-term and short-term sickness absence during the year, including among referral CNSs. This resulted in the team supporting some patients who were not case managed by them. To mitigate this, some registered nurses within SinglePoint have been trained to support referral triage.

Embedding the new model of care following consultation has also presented challenges, particularly in managing the expectations of external services. This led to a productive collaborative meeting with the community nursing service, where shared pressures were acknowledged and joint working improved.

The CNS team received positive feedback from healthcare professionals, patients and family members, including:

'I have just taken a call from the wife of a patient who went into a care home on Friday where he is comfortable and feels safe. She would like to thank everyone but particularly SinglePoint NMP, CNS and all the call handlers who answered her many calls.'

Plans for 2026-27

- We will align the CNS team more closely with neighbourhood teams.
- We will increase the number of patients and families supported to use family administration of medication.
- We will increase the number of outpatient clinic appointments.
- We will reduce the time spent on documentation, with support from the IT team.



3.3.2 SinglePoint

SinglePoint responds to telephone calls from patients with complex palliative care needs, including people at end of life and those recorded on the My Care Choices Register (MCCR). Where required, non-medical prescribers attend rapid response visits. The team includes call handlers, senior nurses, paramedics and non-medical prescribers.

SinglePoint also provides the community nursing night service to patients in their own homes between

8pm and 8am. This service plays an important role in supporting admission avoidance from acute care and enabling people at end of life to remain at home.

Night service visits include:

- Palliative support, including setting up new syringe drivers and providing symptom control.
- Catheter support for blocked or bypassing catheters.
- Bowel management, where medication intervention may be required.



Activity, achievements and contribution to quality

During 2024–25, SinglePoint managed a total of 38,048 calls and supported 3,152 individuals. The team completed 4,563 rapid response visits, with 79.7 percent of patients seen within two hours, exceeding the key performance indicator target of 70 percent.

Compared with the previous year, home visits increased from 4,334 to 4,563, while overall call volume reduced from 44,371 to 38,048, which was expected following the consultation.

SinglePoint received a significant volume of positive feedback from families and healthcare partners, including:

'A granddaughter of a patient, called to commend a SinglePoint Non-Medical prescriber (NMP), they found them to be the nicest, kindest person, so incredibly helpful and have made everything so much easier, no-one has helped as much through this entire process & the granddaughter was extremely grateful for the home visit.'

'I have just spoke to a patient's son, he was immensely grateful for all the support he received from both our team at St Helena and the community UCRS team as his mum had deteriorated very quickly. He says he doesn't feel he could have done it without this support and she really wanted to remain at home which she did.'



A senior sister within SinglePoint has been awarded the Queen's Nurse title. Queen's Nurses are community nurses in the UK who have demonstrated a high level of commitment to patient care and professional practice. The title is awarded by the Queen's Nursing Institute, a charitable organisation that supports community nursing. Hospice in the Home now has a total of four Queen's Nurses.



Two clinical nurse specialists have completed their non-medical prescribing qualification.

Challenges and problems

Throughout the year, the service experienced periods of both long-term and short-term sickness absence. Following the staff consultation and implementation of the new model of care, some registered nurses made the decision to leave the service. To strengthen resilience, a more robust staff bank has been established, and two nursing agencies now support registered nurse shift cover. Agency nurses have completed a structured induction, including medication competency assessments, to ensure safe and consistent practice. By the end of 2025–26, SinglePoint had returned to established staffing levels.

Following the consultation, the new model of care was shared with external partners, including community nursing team leads and GP practice managers. To support improved collaboration, the integrated care board facilitated a multi-agency meeting. A key outcome was a team-

building day to develop a shared understanding of roles and service delivery. This has resulted in improved clarity and collaboration between community nursing and Hospice in the Home teams.

3.3.3 Night Integration

During the year, 2,038 patients were supported through the night service and 2,821 patients received a rapid response visit. 83.5 percent of patients were seen within two hours, exceeding the key performance indicator target of 70 percent.

Challenges and problems

- The introduction of multi-factor authentication (MFA) has resulted in delays when accessing patient records overnight.
- There were issues with phone voicemails not being received because of poor phone signal. A new process has now been implemented to retrieve messages, and this is being actively monitored.

Plans for 2026-27

- We will increase the number of non-medical prescribers.
- We will continue to work collaboratively with the community nursing service.
- We will maintain the target of 70 percent of patients being seen within two hours.

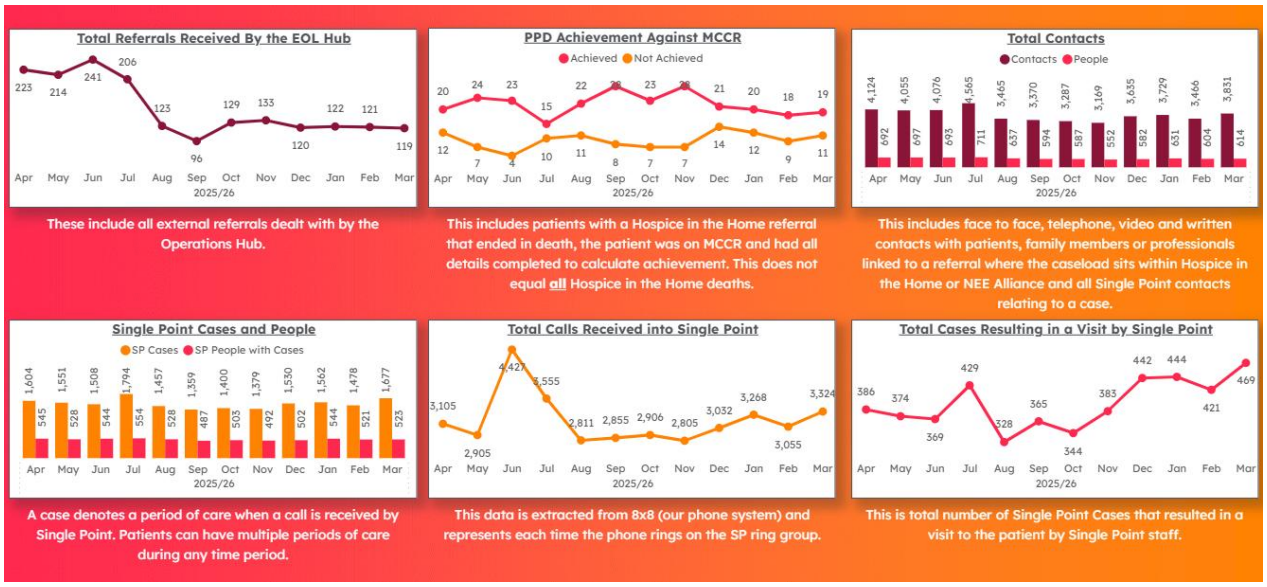
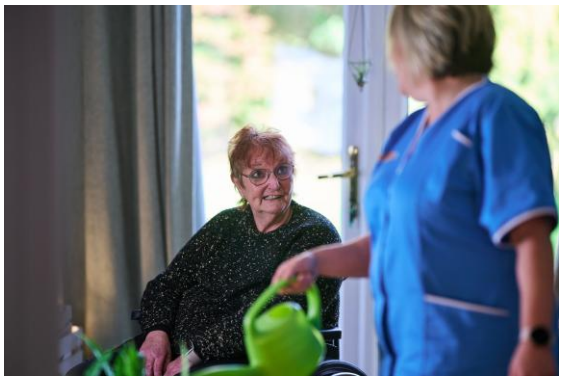


Figure 3 2024–25 Hospice in the Home activity statistics

3.4 Home Ward (St Helena Care and Support)



St Helena Hospice's Home Ward provides personal care and support to people in the last weeks of life. The team supports patients with all aspects of personal care, including washing, mouth care and the administration of medication. They also provide support to families, helping people to remain in the comfort of their own homes.

The aim of the Home Ward is to support patients to stay at home if this is their preferred place of care, and to prevent unwanted or unnecessary admission to hospital. The team can also support patients to be discharged from hospital when home is their preferred place of care at the end of life.

Care is delivered by the care and support team, who are trained in end of life care. This is overseen by the management team, with additional support from nurses across St Helena Hospice. Care is tailored to each person's individual needs.

Recent activity, achievements and contributions to quality

During the year, the team provided 10,086 hours of care and support to 271 people who wished to be cared for at home. Improvements to the operating model enabled the team to deliver an additional 886 hours of care to 39 more people compared to 2024-25.

The care and support team achieved the end of life and palliative care accreditation awarded by the hospice education team. They are the first home care service in north east Essex to receive this accreditation. This provides reassurance to families and commissioners, while strengthening the confidence and expertise of the team.

The team received training from the Essex County Council CareTec team to build their knowledge of technology-enabled care solutions that support independence and recovery. Senior care and support assistants are now trusted assessors and are able to assess and arrange equipment for people using all St Helena Hospice services.

In addition to the Home Ward pathway, the team provides a hospital discharge service for patients who have a plaster of Paris or a body brace in place. The team works in partnership with East Suffolk and North Essex NHS Foundation Trust (ESNEFT) community teams to deliver the urgent community response service, providing up to 48 hours of support in people's homes to avoid hospital admission.

St Helena Hospice is part of the Essex County Council 'Live at Home' framework, which means the team can provide care for people funded by adult social care. The service is also available to those who choose to pay privately for their care.

Staffing

The team includes 52 care and support assistants and eight senior care and

support assistants, providing care between 7am and 10pm.

A team of six referral co-ordinators manages referrals and provides remote support to staff between 7am and 10pm.

The service is currently fully staffed.

Plans for 2026-27

The team plans to expand its role to support the development and delivery of a day service. This will help create a community where people facing dying, death and bereavement can receive compassionate, personalised support and share their experiences with others, enabling them to live with dignity.

The service will offer structured support sessions led by the care and support team, working in partnership with clinical teams to meet a range of community needs.

There are also plans to launch 'Friday Friends', a day respite group for people living with frailty, dementia or an incurable illness. This will provide social support for patients and planned respite for carers.

...She reported that the care on IPU was amazing, and that it was a lovely and calm atmosphere. Her mum was peaceful when she died and she was present with her. She described her death as 'just perfect' and 'couldn't have asked for anymore'...

3.5 Rehabilitation Team

The rehabilitation team provides specialist support to patients under the care of St Helena Hospice, both on the inpatient unit (IPU) and through Hospice in the Home. They support patients with complex needs (levels three and four), as well as their families.

The team currently includes four members of staff, equating to 1.4 whole time equivalent (WTE) physiotherapists and 1.0 WTE occupational therapist.

Working closely with the multidisciplinary team (MDT), the rehabilitation team carries out person-centred, holistic assessments. Their aim is to help patients maintain independence, comfort, dignity and quality of life. This includes assessing mobility, daily activities, and risk of falls, as well as offering non-drug approaches to help manage symptoms such as pain, fatigue and breathlessness alongside medical treatment.

Within Hospice in the Home, the team provides home visits across north east Essex for patients registered with primary care networks (PCNs). They work closely with St Helena Hospice care and support assistants and the senior co-ordinating nurse to support timely discharge from the inpatient unit.

The team also advises the wider MDT on equipment needs and supports learning through student placements, work experience and induction for new staff.

'We want to thank you for all of the kindness, help, care and support you showed us on your visits and follow-

up phone calls. During this difficult time, your support and compassion brought us comfort, knowing he was so well cared for.'

Recent activity, achievements and contributions to quality

During 2025-26, the team received a total of 731 referrals across both services, with 486 in Hospice in the Home and 245 in the inpatient unit.

Following service changes and required financial savings in the previous year, the team adapted to a reduced staffing model. Despite this, they have worked proactively to prioritise their workload and manage waiting lists to provide the best possible care.



A key strength of working across both the inpatient unit and Hospice in the Home is the continuity of care this provides for patients and families.

Additional achievements include:

- Two team members took part in the St Helena Hospice Thankathon.
- Three team members supported St Helena Hospice 'Taster Day' sessions led by the education team, promoting rehabilitation roles and career opportunities. This included interviews with local media to raise awareness of rehabilitation in hospice care.
- As part of the falls lead role, a physiotherapist spent time with the East Suffolk and North Essex NHS Foundation Trust (ESNEFT) falls lead to share learning and explore ways to improve falls assessment and management.
- The team contributed to plans for the redesign of the inpatient unit and external building works, ensuring rehabilitation needs are considered in the environment.
- The team hosted a university student for a four-week placement, as well as offering shadowing opportunities for sixth form students and supporting new starters.
- One team member reviewed and updated the inpatient unit bed rails policy.
- The team supported the purchase of new equipment for the inpatient unit, including a floor bed, specialist cushions for riser recliner chairs and a Sara Plus stand assist device.
- One team member continued to contribute to the mortality review group.
- The team maintained strong links with North East and Mid Essex Equipment Loans (NAMEEL), continuing to support staff in Hospice in the Home with equipment advice.

Staffing

This has been a particularly challenging year for the rehabilitation team.

At the start of the financial year, the team included:

- 2.0 WTE occupational therapists
- 2.0 WTE physiotherapists
- WTE associate practitioner

This equated to seven staff members.

Following organisational changes because of financial pressures, the team now includes:

- 1.0 WTE occupational therapist.
- 1.4 WTE physiotherapists.

This equates to four staff members.

This reduction has significantly affected team resilience and the ability to cover absence. The team continues to manage this by carefully coordinating annual leave to reduce overlap.

Challenges and problems

Adjusting to the reduced staffing model has been challenging, although the team continues to adapt with support from their manager.

High demand and increasing patient acuity (meaning how unwell patients are and how complex their care needs are), combined with reduced staffing, make it increasingly difficult to complete follow-up visits as quickly as the team would like.

The large geographical area covered also limits the number of home visits that can be carried out each day. This can increase waiting times and may contribute to delays in discharge from the inpatient unit.

The loss of the associate practitioner role has reduced the team's capacity to carry out timely assessments and follow-up visits, which were previously supported by this role.

Delays in receiving rehabilitation support can lead to a decline in patients' condition, which may affect their quality of life.

High clinical demand has also reduced the time available for non-clinical work such as audits, service development, falls investigations and mandatory training.

The team continues to work closely with their manager, supported through regular one-to-one meetings to help manage workload pressures and identify solutions.

Plans for 2026-27

The team will complete an audit comparing referrals from 2025 and 2026 to understand the impact of the new model of care.

They will review and update key assessments, including falls risk, bed rails risk and moving and handling risk, as well as improvements to falls reporting.

The team will continue to be actively involved in discussions about the inpatient unit redesign to ensure rehabilitation needs are fully considered.

They will also continue to provide education and training to staff and students.



3.6 Compassionate Communities

St Helena supports the development of a Compassionate Community approach to end of life care in North East Essex, with the aim of improving care and support for everyone in the community.

St Helena has been an anchor partner in developing the Compassionate Communities approach, working with hospice colleagues, community assets, partners, the local authority, and ICBs. We believe that strong community networks and natural support improve people's wellbeing and resilience. This approach builds on a co-produced public health model of palliative and end of life care that supports the following outcomes.

- Increasing death literacy and access to information.
- Encouraging people to undertake advance care planning.
- Reducing health inequalities and isolation.
- Strengthening communities and building natural support.
- Reducing hospital admissions towards the end of life.

Recent activity, achievements, and contributions to quality

Compassionate community meet ups have continued on a bimonthly basis, engaging local organisations and community assets to build a culture of collaboration and compassion.

In December 2025, 24 people attended, including one new attendee. The session was hosted by Africa UK and included contributions from African Families in the UK (AFiUK), Refugee, Asylum seeker & Migrant Action (RAMA), The Art Harbour, and St Helena Hospice Care and Support.

In March 2026, 19 people attended, including two new attendees. The session was hosted by Kind and Co, with contributions from Kind and Co and speakers including builders and archaeologists.

In May 2026, 19 people attended, including three new attendees. The session was hosted by Lexden Golf Club, with contributions from Lexden Golf Club, the Centre for Action on Rape and Abuse (CARA), Rafiki, and Be More Dandelion.

We have begun discussions with other Compassionate Communities, including St Elizabeth Hospice, Farleigh Hospice, and Compassionate Communities UK, to explore how we can strengthen our outreach and better align our offer with the original objectives of the programme.

The Ageing Well project at Beth Chatto, funded by the End of Life Board, supported people living in residential care to access the community while creating a positive space for meaningful conversations about end of life care. This project and its funding concluded in Quarter 4.

Winter Wellbeing Workshops, funded by the End of Life Board, provided seasonal support in Tendring for people living with respiratory conditions. This project and its funding also concluded in Quarter 4.

Compassionate Community Connectors funding was secured during the year for an 18 month programme in North East Essex to enhance end of life care. Connectors will be based in local hubs such as cafés, libraries, shops, and community

venues. They will initiate conversations about care provision, signpost to community support, promote the Frontline App, and encourage social connectedness, helping to address gaps in support related to loss, grief, and end of life care.

Staffing

During the year, Compassionate Communities services moved into the Directorate of Community Development and Care Services, aligning St Helena's approach to community support with integrated community care. The team includes a Senior Care and Community Development Coordinator and a Community Projects Coordinator, ensuring that this work continues while strengthening the Care and Support offer and supporting collaboration with external partners.

Plans for 2026-27

We will focus on delivering the outcomes of the Community Connectors project while seeking further funding to sustain and expand the initiative.

We will continue to work with key community partners and explore opportunities to collaborate with hospices across Essex to develop a broader and more equitable Compassionate Community approach.

3.7 Counselling and Emotional Support

The Counselling and Emotional Support Team (CEST) provides psychological support to anyone over the age of five affected by incurable illness or bereavement. The team supports patients, clients, families and friends, working across both of St Helena Hospice's multidisciplinary teams.



At the end of 2025-26, the service comprised two service coordinators, three support workers, five counsellors, two volunteer counsellors, ten support volunteers, three student counsellors on placement, and one sessional counsellor. The team is led by two lead counsellors who report to the director of care.

All counsellors are registered with the British Association for Counselling and Psychotherapy (BACP), the UK Council for Psychotherapy (UKCP), or the National Counselling and Psychotherapy Society (NCPS). All staff and volunteers complete regular mandatory training alongside ongoing professional development.

The external children's bereavement service, relaunched in July 2022, continues to grow. Our counsellors and family support worker advise parents, carers, healthcare professionals and educational settings on how to support bereaved children. Where more specialist support is needed, individual one to one counselling is offered.

The team follows the four-tier model for psychological support, as recommended by the National Institute for Health and Care Excellence (NICE), to guide triage and staff allocation.

During 2025-26, CEST focused on improving access to bereavement

support while adapting to workforce changes and increasing demand.

Staffing changes enabled the introduction of lead counsellor roles, strengthening clinical oversight and improving caseload management. However, this transition temporarily reduced counselling capacity, which contributed to continued pressure on waiting times. Recruitment of student counsellors, volunteers and sessional staff helped to stabilise the service and increase capacity over time.

Reducing waiting times remained a key priority. Referral rates stayed high throughout the year, averaging more than three referrals each day. In response, early intervention was strengthened through the introduction of one-off information and support sessions for newly referred individuals. These sessions aimed to provide immediate guidance and coping strategies, ensuring earlier access to support while individuals awaited further care. However, feedback from clients indicated that this approach was not effective, and it was discontinued after a four-month trial.

Referral criteria for the external adult bereavement service were revised to accept referrals from 12 weeks after a death, supporting more timely and appropriate intervention. Alongside this, the triage process was reviewed and redesigned to be more personalised, with implementation planned for early April 2026.

A significant development during the year was the introduction of community bereavement cafés as part of the early intervention model. Funding was secured, staff and volunteers were trained, and the first café was successfully delivered with positive feedback. This initiative has increased access to community-based support and will continue to expand.

Volunteer recruitment and training were strengthened, with new bereavement visitors and a volunteer counsellor joining the service. Student counsellors also played an important role, contributing to service delivery and supporting future workforce sustainability.

Across the year, the service supported approximately 1,235 people across pre- and post-bereavement services. Despite ongoing challenges, including staffing changes and increased referrals, waiting times improved from more than 100 days earlier in the year to 61 days by year end, alongside an increase in the number of people supported.

A focus on early intervention has meant that development of the Forget Me Not service has been paused to ensure safe and ethical delivery of care.

Overall, 2025-26 has been a year of development and adaptation, with clear progress in improving access, strengthening early support, and building a more sustainable model of bereavement care.



3.8 Spiritual Care

During the year, the spiritual care service supported 198 patients and their families, delivering 1,070 recorded contacts. Around a quarter of patients (56 people) requested religious support, while most sought non-religious pastoral and emotional support.

The introduction of two honorary chaplains, one Buddhist and one Christian, increased the team's capacity to provide faith-specific care and supported completion of spiritual care assessments.

The service also continued to be supported by five volunteer visitors, along with a gardening volunteer who helps run the bereavement gardening group launched last year.

'My husband had been the gardener and I now need to learn in order to look after the garden. The club is a safe place where I feel able to express my grief and deep down feelings, and being with others in the same situation really helps. I feel warmth, kindness, comforted and cared for.'

– Feedback from Gardening Group participant

The spiritual care team conducted seven funerals during the year, raising £2,050 for St Helena Hospice. The team also supported two wedding blessings on the inpatient unit and one renewal of vows in the community.

'One of my friends said she felt the service was a near to Heaven as you can get! Need I say more on how it felt. Thank you so much.'

– Feedback received at a patient's funeral.

The service provided at least 83 staff support contacts over the year. This included one to one pastoral conversations, reflective practice sessions and structured debriefs.

A staff wellbeing initiative, 'Rest, Reset, Restore', was introduced in quarter two and has developed into a regular weekly meditation group and yoga sessions for staff.

'Debriefs have been very helpful and found them beneficial to continue in job role. More small group chats/ debriefs would be helpful.'

– Feedback following an IPU debrief

A structured spiritual care training programme for hospice staff has been developed in partnership with the hospice education team and is due to launch next year.

External training delivered to care homes and domiciliary care providers generated £4,000 in income for St Helena Hospice.

'It was very helpful, informative, helpful for myself and my work. He explained it all.'

– Feedback from care home training session.

Seasonal services included Light up a Life, with around 300 attendees across two services, an act of remembrance on Remembrance Day, and Christmas carols on the inpatient unit.

The service remained actively involved in regional and national networks, including the College of

Healthcare Chaplains, the UK Board of Healthcare Chaplains, the National Chaplaincy Forum, and the Essex and East London Lead Chaplains Group.

A full review of the spiritual care service began in quarter four. This has included benchmarking visits to three hospices, a staff survey, and a review of activity, referral pathways and group provision. Work has also progressed on updating the spiritual care policy to reflect national guidance and professional standards.

The review is expected to provide a clearer understanding of demand, referral pathways and how best to use volunteer and honorary chaplain roles. Findings, alongside staff feedback and benchmarking, will inform future priorities such as education, volunteer involvement and the sustainability of group support.

3.9 Complementary Therapies



The complementary therapies and wellbeing (CTW) service works alongside clinical care to relieve stress and anxiety, manage pain, and promote overall wellbeing and quality of life. A qualified complementary therapy practitioner leads the service, and a dedicated group of volunteers supports delivery, including qualified complementary therapists, social wellbeing volunteers, and therapy dog volunteers.

The service supports patients and families on the Inpatient Unit (IPU) and provides one-to-one treatments for community patients, families, and counselling and emotional support team (CEST) clients at the Joan Tomkins Centre. In addition, CTW contributes to wider wellbeing support for St Helena Hospice staff, recognising the importance of compassionate support for those delivering care. Treatments include aromatherapy massage and inhalers, massage therapies such as the 'M' Technique, holistic massage, holistic facial massage, and Indian head massage, as well as reflexology, holistic facial therapy, the HEARTS (Hands-on, Empathy, Aromas, Relaxation, Textures and Sound) process, and Reiki.

...Mum had never in her 81 years had a massage until her ones with you, and she absolutely loved them... even as she became more unwell, she was till focussed on how she was going to be able to have her leg massage!

The service also delivers social wellbeing support on the Inpatient Unit, where trained team members provide meaningful interactions and relaxation treatments for patients and

their families. When capacity allows, the team extends this support to staff wellbeing, recognising the importance of sustaining the health and resilience of those delivering compassionate care.

Recent activity, achievements, and contributions to quality

During the 2025–2026 period, the service delivered 1,186 treatments from 287 referrals. Therapies provided included:

- 272 Reflexology treatments
- 100 Reiki sessions
- 146 Holistic Massage treatments, which includes Aromatherapy, facials, body massage, and Indian Head Massage
- 310 contacts by the social wellbeing volunteers on the IPU provided meaningful social and emotional support, including 291 'M' Technique hand and foot massages, and HEARTS relaxation and therapy dog visits
- Look Good Feel Better (LGFB) skin care and makeup sessions for people diagnosed with cancer.
- 47 Aromatherapy inhalers were distributed to help manage stress, anxiety, sleep disturbances, and nausea.

Where capacity allowed, the team prioritised staff wellbeing and delivered 30 complementary therapy treatments during the year. Feedback consistently demonstrated the value of this support, alongside donations that help sustain ongoing service delivery.

Referrals and IPU activity decreased during the year, reflecting service changes introduced to support the sustainability of hospice care provision. Despite this, the service maintained strong impact, with continued focus on development, strengthening support, and growing the volunteer offer.



Measuring impact: MYCaW® evaluation

We use MYCaW® (Measure Yourself Concerns and Wellbeing), a licensed patient-centred outcomes tool designed to evaluate personalised, holistic support. The tool integrates easily into consultations and helps individuals identify and prioritise their concerns and wellbeing.

Service users most frequently identified stress and worry, anxiety, nausea, pain, scans and treatment, life changes, and loss and grief as their main concerns. Over the past year, service users reported an average improvement of 73 per cent in wellbeing and concern scores, while 21 per cent reported no change and 6 per cent reported deterioration. These results show that most patients, carers, and clients experienced a positive impact, with measurable improvements in both concerns and wellbeing.

Training, events, and income generation

The team continued to strengthen service quality and extend its reach through training and external delivery

with Essex County Council (ECC) Adult Social Care. This work supported capability development among staff and care home workers while contributing to income generation. The CTW Lead delivered eight commissioned training workshops through the Quality Innovation Team at Essex County Council. These included three Namaste Care courses focused on an evidence-based approach for people living with advanced dementia, three HEARTS workshops adapted for the care home sector, and two wellbeing sessions designed to support both residents and care workers.

Participants provided overwhelmingly positive feedback. The team also delivered a two-day HEARTS process course for new CTW volunteers and an Inpatient Unit nurse. Participation in the annual St Helena Hospice Family Fun Day raised the profile of the service and generated income through aromatherapy products, mini treatments, and relaxation sessions, showcasing the therapeutic support available to patients and families.

Staffing

The team welcomed a new administrator in September and recruited new volunteers to replace those who had left their roles. By year end, the team included 19 volunteers, including therapy dog volunteers, social wellbeing supporters, and a qualified complementary therapist. The team continues to work closely with the Volunteer Services Team to maintain recruitment and support future service development.

Challenges and problems

Recruiting suitably qualified complementary therapists who wish to volunteer remains a challenge. The team continues to focus on recruitment to support future growth and ensure continued delivery of this valuable care service.

Plans from last year

The team successfully delivered three Look Good Feel Better workshops, recruited three therapy dog volunteers to the IPU, and provided HEARTS process training to staff and volunteers. Staff wellbeing support continued, with regular opportunities offered throughout the year.

Cancer is a dark and cruel disease, often shrouded in fear...having you meant that while we couldn't take away the uncertainty, we always had someone to ask and to talk to/cry with when we were ready...

Plans for 2026-27

Over the coming year, the team will strengthen outcome measurement through a review of MYCaW processes and update clinical documentation templates within SystmOne. The team will deliver further volunteer training through the HEARTS process programme and schedule additional workshops with the Quality Innovation Team at Essex County Council. Recruitment of volunteers will continue, alongside the introduction of regular therapy meetings to support ongoing skills development and role progression.



3.10 Safe Harbour

Safe Harbour aims to improve access to high-quality end of life care for people from minority, marginalised and vulnerable communities. The service is delivered by a project manager and a community connector, who work alongside colleagues across St Helena Hospice, as well as volunteers and partner organisations in the statutory, voluntary and community sectors.

A successful National Lottery funding bid has secured the future of the service for the next three years.

Recent activity, achievements, and contributions to quality

Learning disabilities and autism
Community consultation identified communication barriers as the main challenge for people accessing care.

In partnership with the equality, diversity and inclusion (EDI) group, improvements were made within St Helena Hospice to help reduce these barriers.

The community connector strengthened engagement with learning disability communities, delivering Compassionate Conversations training for care home staff and 'No Barriers Here' workshops for residents.

Joint working with the learning disability nursing team supported four patients and enabled training for healthcare assistants to improve confidence and skills.

Traveller communities
Initial work began to build relationships with this previously unreached group.

This included learning from professionals with experience in working with Traveller communities.

A key partnership with the Essex Council Traveller Unit led to a first successful meeting with the nearest fixed Traveller site.

Socioeconomically deprived communities
A continued presence in community spaces across Tendring led to meaningful engagement with 58 residents.

A three-month project was completed in a Walton care home, delivering advance care planning conversations with all residents.

The team partnered with the SOS Bus to reach several communities, raising awareness of end of life care and St Helena Hospice services.

LGBTQ+ communities
The *Being Ready* training programme was delivered, equipping 30 professionals with the knowledge and skills to provide inclusive end of life care for transgender people.

Learning from this work has been shared across St Helena Hospice to strengthen practice.

Ethnically diverse communities
The team maintained strong relationships through Refugee Week, the Colchester Diverse Communities Network carnival and outreach with local community groups.

Work with Rafiki African Women's Group helped to explore and address barriers to accessing bereavement support.

In partnership with University of Essex language students, My Care Choices booklets were translated into five additional languages. St Helena Hospice's work was also presented at the annual translation challenge.

Patient care and care choices service

The service supported 49 patients and carers from marginalised communities to access appropriate care.

A year-long pilot of the Essex-based Care Choices Service launched in February. This offers home-based conversations about future care planning, delivered by trained volunteers.

Staffing

Two part-time community connectors left during the year, which created short-term capacity challenges. A full-time community connector was successfully appointed in February.

Challenges and problems

Reduced staffing slowed progress in engaging with learning disability communities and developing accessible communication resources. This work will continue in the next year.

The care choices service has also faced challenges due to pressure on partner organisations. This has provided valuable learning to support long-term sustainability.

...From the moment we arrived you treated us all with such kindness, compassion, and most importantly, dignity. ... was always such a bright, happy and funny lady and she loved to make people laugh. You saw all that she was and supported her in a way we all appreciated. You gave us the freedom to spend out last days together wrapped in love and peace...

3.11 Equality, Diversity & Inclusion

St Helena Hospice remains firmly committed to reducing inequalities in end of life care and ensuring that every patient, family member, volunteer and staff member feels respected, represented and supported. The equality, diversity and inclusion (EDI) group has continued to lead this work by strengthening organisational learning, improving practice and embedding inclusive approaches across services.



Recent activity, achievements, and contributions to quality

Team development and governance

The EDI group reviewed its membership during the year, bringing in colleagues from previously unrepresented teams. This has broadened representation across the organisation, strengthened the group's collective expertise and improved the reach of EDI initiatives. The group also completed a full review of its terms of

reference and agreed a strategic plan to guide priorities for the coming year.

Provision for people with learning disabilities
Safe Harbour presented findings from its consultation with the learning disabilities community. The consultation identified communication as the primary barrier to accessing services. The organisation is addressing this through the Accessible Communication Project.

[She] was very unsure about moving to the hospice, but I know it was the best decision and as a family, we feel lucky that she was able to get a bed in times of financial cut backs in this sector I have many wonderful memories...but I will always remember when we bathed [her] we had Take That blaring and we were all dancing!!

Accessible Communication Project
The group reviewed the findings of the Accessible Communication Report, developed by a dedicated task and finish group. Following detailed discussion, it agreed a set of recommendations and submitted them to the clinical senior leadership team for approval. In line with the Accessible Information Standard (AIS), the organisation has developed an Accessible Communication Policy and activated the NHS Digital flag on SystmOne. Work continues to strengthen delivery of the AIS's five principles — ask, record, flag, share and act — to ensure consistent, person centred communication across all services.

Transgender inclusion
The group reviewed St Helena Hospice's provision for the growing population of older gender diverse people. In response, it delivered a full day transgender inclusion training session focusing on the needs of transgender individuals at the end of life. Several EDI group members attended and shared their learning more widely. A condensed, clinically focused version of the training has since been rolled out to clinical teams to support inclusive and affirming care. The organisation has also established a focus group with local LGBTQ+ organisation The Outhouse to help guide implementation.

My Name Is campaign
In March, the group launched the My Name Is campaign in partnership with Race Equality Matters. This month long initiative raised awareness of the impact of name mispronunciation and encouraged staff to include phonetic spellings in their email signatures. While a formal audit is ongoing, early feedback from colleagues with frequently mispronounced names suggests the campaign has opened constructive conversations, increased confidence in correcting mispronunciations and been experienced as validating and supportive. Many staff have already adopted phonetic spellings in their signatures.

Deaf awareness
The group facilitated a deaf awareness training session for all staff and began planning for Deaf Awareness Week to further build knowledge and confidence.

EDI learning programme
To strengthen organisational knowledge and support informed decision making, the group invited several guest speakers with lived experience to share insights on key areas of inequality.

Challenges and problems

Staff turnover and availability have delayed completion of both the Accessible Communication Project and the transgender inclusion workstream. The organisation will now finalise these projects in the coming year.

Plans for 2026-27

- We will review and enhance support for neurodiverse staff.
- We will complete the Accessible Communication Project by publishing the Accessible Communication Policy, auditing the use of reasonable adjustment recording tools, developing an accessible website and creating a dedicated resources hub.
- We will celebrate Pride Month with a campaign encouraging staff to wear pronoun badges.
- We will introduce EDI champion roles across St Helena Hospice to share specialist knowledge.
- We will create a digital passport to support inclusive care.
- We will develop our understanding of the traveller community to inform a strategic approach to engagement and support.
- We will deliver a Deaf Awareness Week campaign, including the launch of a sign language course.

3.12 The My Care Choices Register

The My Care Choices Register (MCCR) is a digital platform for storing advance care plans and priorities for future care for people in north east Essex who are living with incurable illness, dementia or frailty. St Helena Hospice has hosted the system since its inception in 2013. This year, the register has also been launched in Suffolk, with plans for use in Norfolk.

There have been over 6,500 users of the register over the last year, with more than 4,000 people with dementia or frailty having a record.

The likelihood of an unplanned hospital admission in the last 90 days of life, and of dying in hospital, is much reduced for those who have an advance care plan on the My Care Choices Register.

3.13 Safeguarding

Safeguarding means protecting a person's health, wellbeing and human rights, and making sure they are free from harm, abuse and neglect. It is a key part of providing high-quality care.

At St Helena Hospice, safeguarding is led by the safeguarding lead, supported by 11 safeguarding deputies who provide guidance and support for staff. This approach reinforces that safeguarding is everyone's responsibility.

Recent activity, achievements and contributions to quality

St Helena Hospice works closely with partner agencies to ensure a joined-up and effective approach to protecting people at risk. In 2025-26, St Helena Hospice made 14 adult safeguarding referrals and no child safeguarding referrals. All referrals were reported to the Care Quality Commission (CQC) in line with requirements. They were reviewed by the safeguarding group, chaired by the safeguarding lead, and then by the risk and incident group, chaired by the Medical Director.

Staff and volunteers complete safeguarding training in line with the Intercollegiate Framework 2025. All new clinical staff and trustees are introduced to St Helena Hospice's safeguarding structure and policies during their induction, alongside those of the local authority.

New safeguarding awareness posters are now displayed across all areas of the hospice. These support consistent practice and act as a reminder of key safeguarding principles and how to raise concerns.

The Adult Safeguarding Policy and Procedure [008] was reviewed during the year to ensure it remains up to date.

In March, the safeguarding lead and the director of care delivered level one safeguarding training to the board of trustees.

Staffing

- This year, St Helena Hospice welcomed a new member of the administration team to support safeguarding work.
- Jo Tonkin, a respected former Director of Care at St Helena, has been appointed as trustee safeguarding lead.

Plans for 2026-27

Training for the safeguarding lead and deputies has been arranged and will be delivered in May 2026.

3.14 Hospice Education



Hospice Education is a joint partnership between St Helena Hospice (Colchester, Essex), St Elizabeth Hospice (Ipswich, Suffolk) and St Nicholas Hospice Care (Bury St Edmunds, Suffolk). It is a shared education department that supports the internal needs of all three organisations and provides a range of external education opportunities. The service comprises a head of department, a team leader, two practice educators, two clinical trainers, two administrators and two volunteers.

Recent activity, achievements and contributions to quality

A new virtual learning environment, Synergy, has been developed and launched. Synergy provides a shared platform for clinical education across the partner hospices, supporting induction, ongoing learning and knowledge sharing. The programme includes peer learning, registered nurse (RN) and healthcare assistant (HCA) study days, the advanced clinical practitioner framework and coaching development. It also includes a range of learning formats such as podcasts, masterclasses and opportunities to ask subject experts.

Funding from the Suffolk and North East Essex Integrated Care System (SNEE ICS) workforce development programme has

supported delivery of taster days focused on roles within palliative and end of life care. Hospice Education has also worked with further and higher education providers to deliver teaching on palliative care, including advance care planning and dignity and respect.



Workshops and webinars have supported workforce development across competencies, best practice, coaching and new ways of working. During the year, two frailty conferences and one advanced clinical practitioner conference were delivered.

Hospice Education achieved continuing professional development (CPD) accreditation for Optimising Comfort – Pain Assessment and non-pharmacological interventions in palliative care. This is the first of ten courses planned for accreditation in 2026.

Care home accreditation has progressed, with five care homes fully accredited and five having completed the programme and awaiting Care Quality Commission (CQC) inspection. Four further care homes are currently in progress.

Work has continued with the St Helena Hospice care and support team to complete care agency accreditation, with a target date of April 2026.

Feedback from training

The following feedback was received from training sessions on sensitive conversations:

‘Spikes model and how to start difficult conversations.’

‘I have a better understanding of how to approach difficult situations and how to handle them’

‘The discussions so we were able to talk about what we have all encountered in our roles.’

Feedback from two frailty conferences held across Suffolk and north east Essex included:

‘The speakers in each field were very informative & have inspired me to sought more related training.’

‘An excellent comprehensive account on how to understand frailty.’

‘Thought provoking, dispelled myths. This should be a mandatory training day for all health and social care professionals.’

‘Took a lot from today and gained a lot of knowledge.’

Mandatory training compliance at year end was 92 percent. A significant factor in the 2025–26 position has been the requirement to source and book staff onto the Oliver McGowan lived experience sessions.

Study days for clinical staff are planned for 2026, with a three-day programme for registered nurses and clinical support workers/healthcare assistants. Topics include skin integrity and pressure ulcers, blood transfusion, duty of candour and Caldicott Guardian responsibilities, de-escalation techniques, resilience and pain assessment.

Apprenticeships

Work continues to maximise use of the apprenticeship levy. There are currently nine active apprenticeships.

Staffing

Administrative support across the Hospice Education partnership is currently under review to develop a more streamlined team structure.

Budgets

Income for the year was £29,538 against a budget of £34,910, resulting in a deficit of £5,372.

Challenges and problems

- St Nicholas Hospice Care withdrew from the partnership in March 2026.
- Securing places and funding for the Oliver McGowan lived experience sessions has been challenging.
- Coordinating IT systems and marketing access across multiple organisations continues to present practical difficulties.
- There has been a reduction in externally commissioned training across the NHS and wider health and social care sector because of financial pressures. This may impact the ability to achieve income targets in 2026.

Other activity this year

Digital learning through Synergy has been launched across the partner hospices (March 2026 at St Helena Hospice and April 2026 at St Elizabeth Hospice).



Work has begun to review and implement end of life care learning pathways, aligned to career pathways, core capabilities in practice and the education framework. Initial partnership discussions have taken place and collaboration is being explored.

Governance arrangements are being reviewed, including renewal of the Hospice Education memorandum of understanding and transition to service level agreements between St Helena Hospice and St Elizabeth Hospice.

Partnership development work has taken place across Essex, with engagement meetings held with Farleigh Hospice (Chelmsford), St Luke's Hospice (Basildon), St Clare Hospice (Harlow) and Havens Hospices (south Essex).

Plans for 2026-27

- We will continue the rollout of Synergy across both hospices, with launch at St Elizabeth Hospice planned for June 2026.
- We will complete phase one of the Oliver McGowan programme action plan.
- We will expand the partnership to include Farleigh Hospice, with onboarding planned for July 2026.

- We will establish service level agreements with Havens Hospices and St Clare Hospice.
- We will strengthen workforce capacity by securing additional roles, including education administration support and an operations lead.
- We will support a multi-hospice working group to progress clinical pathways in palliative and end of life care, with a report due in June 2026.
- We will further develop and embed the eight-day palliative care programme for new clinical staff.
- We will develop four new education sessions across the Hospice Education partnership.
- We will introduce a two-day education update course to support staff to meet the requirements of the education framework.
- We will launch a new IPU accreditation scheme based on the Kirkpatrick model, to support the application of learning in practice.
- We will identify key roles within Hospice Education and develop a clear succession plan.

We are and will forever be grateful that... Mum had a comfortable and dignified death, and most importantly for her, one where she felt safe, loved and held.

3.15 Internal Support Groups

St Helena Hospice continues to demonstrate its commitment to staff wellbeing through a range of internal initiatives and support networks. These include mental health first aiders (MHFA), freedom to speak up guardians (FTSUG), and women's and men's health champions. Staff and volunteers can access a dedicated SharePoint site providing information, signposting and wellbeing resources, alongside a shared Teams folder for reporting contacts and accessing support.

With level three recognition from Essex Working Well, St Helena Hospice continues to position itself as a compassionate and supportive workplace. These initiatives help foster an open, inclusive and supportive organisational culture.

Further support is available through:

- SHIFT (Stories of Hearts to Inspire for Transformation), an internally developed reflective space.
- An employee assistance programme available to all staff.
- Pastoral support provided by the spiritual lead and team.
- Complementary therapies available to staff and volunteers.

3.15.1 Freedom to Speak Up

Freedom to speak up supports a positive culture where individuals feel safe and confident to raise concerns or share ideas, knowing they will be

listened to and treated with respect. Conversations can take place in confidence, with appropriate action taken where required.

The guardian role is currently held by two staff members and one trustee, following the recent appointment of a new trustee after the departure of the previous postholder.

During the year, one formal contact was recorded, arising during the staff consultation process and reaching a successful outcome. Team feedback indicates that several informal conversations also took place. These did not require further action at the time; however, guardians continue to offer opportunities for concerns to be raised formally where appropriate, supporting psychological safety, transparency, accountability and effective issue resolution.

'The daughter of a patient called to say thank you to the Singlepoint Team, she felt very supported & couldn't have coped without the support.'



3.15.2 Mental Health First Aiders

A mental health first aider is a trained individual who can recognise signs of mental ill health and provide initial support. MHFAs offer short-term assistance, share information, signpost to appropriate services and encourage individuals to seek professional help where needed.

There are currently ten trained and accredited mental health first aiders, comprising nine staff members and one volunteer.



Activity summary during the year

- A total of 63 initial contacts were made.
- Twenty-seven contacts related to work-related stress and ongoing workplace challenges. Support focused on workload pressures and the impact of internal team changes. Individuals were encouraged to speak with their line manager or the people and culture team, and to consider a freedom to speak up conversation where appropriate.
- Ten contacts related to a combination of workplace stress and personal pressures, most commonly balancing family responsibilities alongside work demands.
- Twenty-six contacts related solely to personal challenges, with individuals seeking advice or a supportive conversation.

- Fifty-five contacts included follow-up support and ongoing check-ins.
- A range of internal resources continues to be available, including support materials, information links and workshops, such as those offered through Essex Working Well.
- Three mental health first aiders completed their three-year refresher training during the year.

3.15.3 Women's Health Champions

Women's health in the workplace includes both physical and psychological wellbeing and plays an important role in creating a healthy and inclusive working environment. The women's health support group includes two menopause champions and one women's health champion.

Support is provided to colleagues seeking advice about perimenopause, menopause and the impact these can have on working and personal lives. International Women's Day was marked as an opportunity to raise awareness of key women's health issues. Dedicated drop-in sessions were held at different times to improve accessibility and encourage open conversation.

Line manager guidance was developed and shared, including menopause guidance with action-planning support and newly introduced menstruation guidance. During the year, six individuals accessed direct menopause-related or women's health support.

3.15.4 Men's Health Champions

Men's health champions provide approachable, informal peer support and encourage open conversations about health and wellbeing. They act as a bridge between colleagues and more formal health and wellbeing services, helping to reduce isolation and raise awareness.

Three contacts were recorded during the year. Information and resources continued to be shared, including signposting to online support groups and awareness materials relating to men's health and cancer awareness.

3.15.5 Other activity

Plans from 2025–26

- The health and wellbeing policy was updated and published.
- Level three Essex Working Well re-accreditation continued.
- Regular wellbeing and awareness sessions were delivered.
- The workplace health committee was fully established and active.

Plans for 2026-27

- We will maintain and strengthen the organisational focus on wellbeing and positivity, aligned with St Helena Hospice's refreshed strategy.
- We will develop a staff wellbeing and culture committee to strengthen staff voice, build trust and support a thriving workforce.
- We will continue to deliver regular SHIFT sessions and

review opportunities to recruit and train additional facilitators.

- We will develop line manager guidance relating to men's health and recruit two new men's health champions.
- We will encourage greater staff engagement with the Ele wellbeing platform by promoting sign-up across teams.
- We will work with the people and culture team to prepare for the introduction of mandatory menopause action plans under the UK Employment Rights Act 2025, building on existing guidance and support.
- We will develop neurodiversity awareness and support guidance across teams and services.

She was so relaxed whilst in your care. Loved her spa baths, foot and hand massages, hair washes etc. The hospice is a beautiful and calm place with wonderful carers, I'm so grateful she was able to spend her last few days there.

3.16 Quality of the Environment

Recent activity, achievements, and contributions to quality

The condition of Myland Hall's car park deteriorated significantly during the year, presenting an increasing health and safety risk. Funding from Hospice UK enabled resurfacing works, which began in Q3. Improvements include additional parking bays, installation of an accessible pathway from the IPU terrace to the pond, and screening fencing for patient rooms.



Plans for the IPU redesign are progressing, focusing on ward priorities and drawing on staff and service user engagement.

The listed main reception doors at Myland Hall were identified as a risk because of their ageing structure and failing mechanisms, creating a potential security issue. Replacement has been included within the IPU redesign and is scheduled for Q1 2026–27.

A new ceiling hoist was installed in the IPU main bathroom, replacing ageing equipment and improving patient handling.

The pond area had become overgrown. Following engagement with a local contractor, who volunteered labour and waste removal, the area has been restored and a more sustainable maintenance approach established.

As part of regulatory compliance, the Energy Savings Opportunity Scheme (ESOS) submission was reviewed, updated and submitted via the government portal.

In Q4, the business intelligence team supported estates in developing enhanced utilities reporting, improving visibility of consumption data and helping to identify future cost saving opportunities.

Solar panel bird-proofing has been installed to prevent ongoing debris accumulation on the IPU terrace.

The estates team supported the installation of a replacement CCTV system across the site.

- Plans are underway to close the Phoenix Square Unit 6 offices and relocate teams to Myland Hall and Westside.
- The estates team supported a range of procurement and installation projects funded through Hospice UK. These included:
- New furniture including beds, reclining chairs, visitor chairs, and equipment for the IPU and the Joan Tomkins Centre counselling spaces.
- Two hybrid cars for the community teams.
- EV chargers.
- A new nurse call system.
- A biometric key cabinet to enhance security in the IPU.
- Drugs cabinets for the new drugs room.
- Syringe drivers.
- Creation of additional office space in the learning and development centre.
- New flooring across a large proportion of the Myland site.
- New air conditioning units in office spaces across Myland Hall.
- Plumbing works to improve supply and pressure across Myland Hall.
- Replacement appliances and equipment for the catering service.
- Upgrades to the learning and development centre, including roof repairs, air conditioning replacement, roof guard rail installation, redecoration, new flooring, lighting and emergency lighting, and septic tank improvements.
- Replacement flooring in the IPU kitchen and dining area.
- A farmhouse roof survey, which returned positive results.

Health and safety

In September, Essex Fire and Rescue Service completed its three yearly audit of Myland Hall, resulting in a satisfactory outcome with no formal actions. This reflects the strong fire safety management and documentation maintained by the maintenance team.

The community nursing team received an upgrade to their lone working devices, including a timed activity function that triggers an alert after a set period. Training was delivered and recorded to ensure access for all staff.



A tree risk assessment carried out by an Arboricultural consultant informed a programme of works for the mature trees across Myland Hall.

In Q4, the health and safety team worked with the compliance team to develop a new Personal Emergency Evacuation Plan (PEEP) risk assessment form to support consistent documentation of individual evacuation needs.

Average compliance with lone working device activation remained above the 65 percent industry benchmark, with quarterly levels of 80 percent in Q1, 83 percent in Q2, 74 percent in Q3 and 76 percent in Q4. Use of these devices continues to be encouraged.

Water hygiene

The estates and project manager completed Water Responsible Person training for healthcare premises in Q1.

Routine monitoring identified one low level pseudomonas aeruginosa result in March 2025 from 20 samples, which resolved following retesting in line with HTM 04-01 guidance. All samples in September 2025 were satisfactory.

Legionella testing identified one unsatisfactory result in June 2025, resolved through increased flushing and a clear retest. In December 2025, three unsatisfactory results were identified; two resolved following resampling, while one high reading in an IPU shower required remedial works. As the outlet did not fully clear and was within a planned refurbishment area, the room was removed from use.

Staffing

The maintenance team experienced a challenging year because of retirement and significant sickness absence, alongside increased workload. A business case for a fixed-term maintenance technician was approved, and the post has been filled.

A catering team restructure, completed alongside clinical remodelling, has at times placed pressure on team capacity and resilience.

Plans for 2026-27

- We will continue to respond to changing service demands. While the organisation has adjusted to a reduced estate, the IPU redesign will support future flexibility, including any increase in bed capacity.
- We will produce a carbon reduction plan in line with ESOS requirements.
- We will continue to promote engagement with health and safety across staff and volunteers, building on learning from the external audit and new role developments.
- We will complete the Phoenix Square closure, including dilapidations and team relocation, in Q1.
- We will review health and safety priorities and agree a refreshed action plan.
- We will complete redecoration of the IPU kitchen and dining area.
- We will recruit bank cooks and porters to strengthen resilience in the catering team, while continuing to review the new service model.
- We will plan for additional security systems across the Myland Hall site.
- We will embed new waste regulation requirements across all sites to ensure compliance is achieved in the most cost effective way.

- We will commission a grounds utilities survey to better understand and manage this aspect of the estate infrastructure.



3.17 Volunteering at St Helena

Volunteers play a vital role in the delivery of high-quality, compassionate care at St Helena Hospice. They add significant value to the organisation by complementing the work of paid staff, increasing capacity, extending service reach and strengthening connections within the local community. Through their time, skills, knowledge and experience, volunteers enable services to remain responsive, innovative and sustainable.

The contribution of volunteers supports the organisation to:

- Increase service capacity and flexibility without significant additional cost.
- Enhance the experience of patients, families, customers and service users.
- Strengthen engagement and connections within the local community.
- Bring diverse skills, perspectives and experience.
- Support innovation and responsiveness to changing needs.



The volunteer services team sits within the wider People & Culture (P&C) team and is responsible for the strategic and operational management of volunteering across the organisation. This includes overseeing recruitment, onboarding, training, retention, compliance and ongoing support for both volunteers and line managers. The team plays a key role in embedding the volunteer strategy and ensuring a consistent, high-quality volunteering experience.

Volunteer numbers have continued to grow, with steady increases year on year. Retail volunteering has seen particularly strong development and represents a core area of organisational activity and impact. The estimated annual contribution of volunteers is valued at approximately £2.1 million, with around 210,000 hours given. This demonstrates the significant scale and importance of volunteering to St Helena.

... you have walked alongside us ... being whatever has been needed, whether that be sharing in humour, listening to fears/concerns, giving a hug, having honest conversations, or fighting battles.



This year, growth has stabilised, reflecting a more targeted and strategic approach to recruitment aligned with service needs. Retail volunteering remains a priority area, while other services are supported through more responsive, service-led recruitment approaches. This shift reflects a move from growth to sustainability, quality and the effective deployment of volunteers.

The volunteer services team continues to collaborate across departments to ensure appropriate volunteer support is in place. This includes working closely with the fundraising team to provide volunteers for events so they can take place safely and successfully and partnering with commercial teams to support the expansion of retail services through effective recruitment planning for new shop openings.



St Helena is proud to engage volunteers from a wide range of backgrounds and offers many different roles across hospice services, the community and commercial operations. Regardless of their role, volunteers make a meaningful contribution to the care and support provided to patients, families and the wider community. Each volunteer brings unique skills, perspectives and experiences, creating a positive and lasting impact.

The work experience programme continues to expand, with increasing numbers of students completing Duke of Edinburgh placements, alongside strengthened partnerships with local education providers. These opportunities offer valuable hands-on experience, help build confidence, improve employability and may inspire future careers.

Corporate volunteering has also grown, with more local businesses supporting St Helena as part of their corporate social responsibility commitments. These partnerships enable the delivery of impactful and mutually beneficial opportunities, while also creating further engagement over time.

The dedication, compassion and generosity demonstrated by volunteers is exceptional, whether they are regular volunteers, work experience participants, part of a corporate placement or trustees. Their continued commitment reflects the positive experience of volunteering at St Helena and is essential to delivering high-quality care and support. Volunteering remains a mutually beneficial partnership, enriching both the organisation and those who give their time so generously.

Volunteer data for the past financial year:

- Number of volunteers at year end: 911
- Number of new starters: 316

- Number of volunteers who left: 288
- Number of retail volunteers at year end: 706
- Work experience placements: 56
- Corporate volunteer organisations: 44
- Hours of regular volunteering given: approximately 210,000
- Estimated value of volunteer hours: approximately £2.1 million



3.18 Quality Markers

3.18.1 Infection Prevention & Control

The IPC specialist nurse provides detailed reports to the Clinical Quality Group each quarter. St Helena Hospice also displays key IPC audit results at the entrance to the inpatient unit. The results of some of our audits are shown in 3.18.1.1, below. This provides reassurance to patients, visitors and staff about the high standards of IPC maintained across the hospice.

During the year, the inpatient unit did not need to care for any patients identified with Covid-19. This is a reduction from four patients in 2024–25 and reflects lower levels of circulating virus in the community, alongside the impact of vaccination.

St Helena Hospice has continued to follow national guidance for Covid-19 case management and precautions and has at times introduced additional measures to protect vulnerable patients. The hospice also aligns its approach with local acute hospital trusts.

Staff can continue to wear facial protection if they choose and will do so if a patient requests it. Visitors to the inpatient unit are no longer routinely asked to wear masks. Staff use personal protective equipment (PPE) based on risk assessment, in line with standard IPC precautions, including when there is potential contact with blood or body fluids, or when caring for patients with confirmed or suspected Covid-19 or flu-like symptoms.



The Hospice reviews and updates its Covid-19 policy whenever new national guidance is published.

During the reporting period, the inpatient unit cared for three patients with Clostridioides difficile (previously Clostridium difficile), compared with six in 2024–25. One patient was toxin negative (indicating carriage rather than disease) and this was known at admission. One patient initially tested toxin negative but later tested positive, and a third tested toxin positive following a delay in sampling due to intermittent symptoms. Staff cared for all three patients in single rooms. Both toxin positive cases were

identified more than 48 hours after admission, with internal reviews completed and learning shared with care teams.

Throughout the year, staff also cared for patients with other infections, or who were contacts of known infections. These were identified at admission and managed appropriately in single rooms.

The hospice has continued to manage intermittent findings of Pseudomonas aeruginosa in water outlets within the inpatient unit. This issue, first identified in autumn 2022, remains under review. Pseudomonas aeruginosa is commonly found in soil and groundwater and rarely affects healthy people, but it can cause infection in those with weakened immune systems.

The IPC nurse specialist has advised risk assessment for all patients in affected areas and avoidance of placing patients with open wounds or invasive devices in those areas. Where this is not possible, the outlet is taken out of use. The hospice continues to monitor water quality, with results reported to the patient safety and water safety groups. Planned refurbishment of the inpatient unit in summer 2026 will remove one problematic bathroom and address part of this risk.

The hospice continues to monitor the quality of its external laundry service. Routine contact plate testing has previously identified issues, and results are reported to the patient safety group and kept under review.

The IPC nurse specialist remains the main source of advice and support on IPC. She continues to support staff across St Helena Hospice through site visits, remote working, virtual meetings and telephone advice. In April 2025, she attended a two-day national IPC conference, and in August 2025 she renewed her nurse registration to continue supporting the hospice.

3.18.1.1 Infection Control Audits

We carry out a number of Infection Prevention and Control (IPC) audits of varying frequency. These are reported to and scrutinised monthly at the Patient Safety Group, chaired by the Director of Care. Any concerns are addressed at the time of the audit. Lower compliance is discussed at the Patient Safety Group and actions taken are documented in the minutes. Audit results are also included in our quarterly quality reports. The results for the year are shown in the charts below.

Note. Numbers in brackets in tables and charts represent the number (e.g. of patients or staff) audited.

Every time I'm in contact with the hospice I am treated with respect, care and I feel important.... Nothing has been too much bother for anyone I've been in contact with and you make me feel my life is worth living.

You looked after my wife well before she died, trying everything possible to make her as comfortable as she could be. You also went to great lengths to support my daughters who visited most often, making sure they could be with her 24/7 over her last few days. The holistic approach to care was exemplary.

Hand Inspection, Hand Washing, PPE, Commode Hygiene

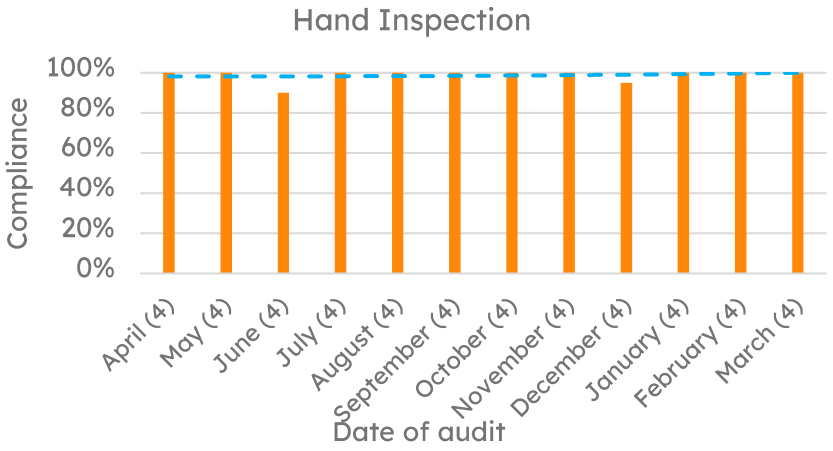


Figure 5 2025-26 Hand inspection audits.

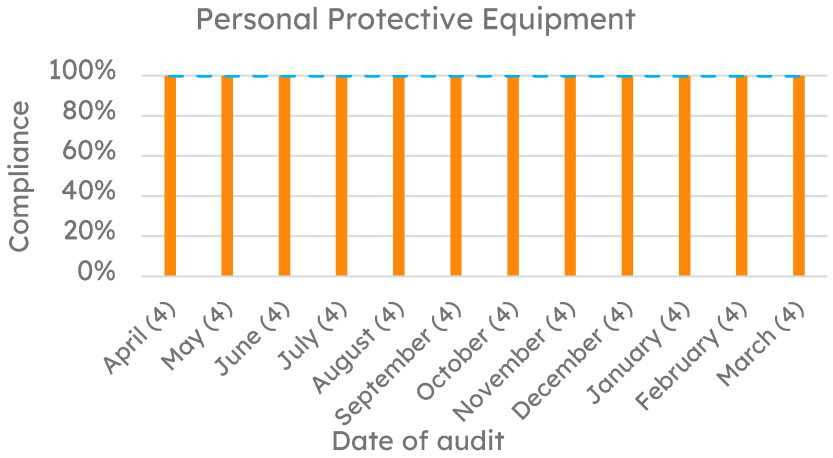


Figure 6 2025-26 PPE compliance audits.

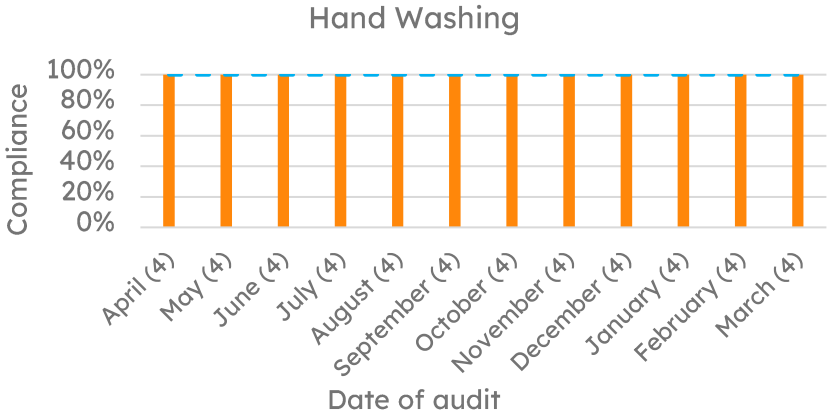


Figure 4 2025-26 Hand washing audits

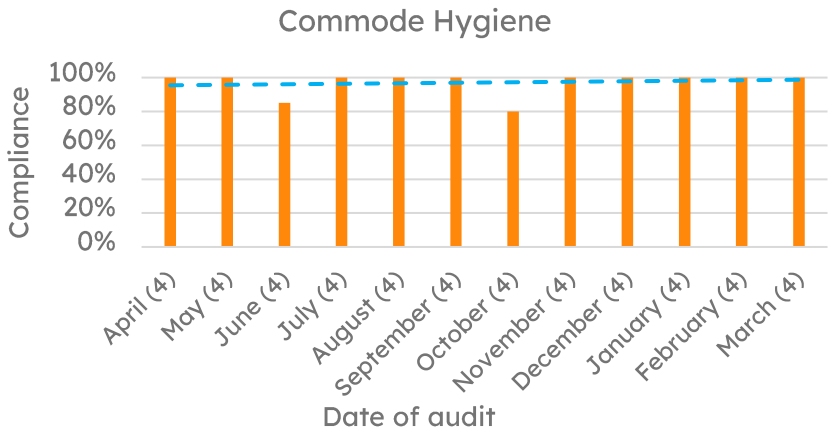


Figure 7 2025-26 Commode hygiene audits.

High Impact Interventions

High Impact Interventions are a set of national audit tools used to assess the effectiveness of clinical processes and identify areas for improvement. These tools designed to reduce the risk and spread of healthcare-associated infections by focusing on key risk factors, such as hand hygiene and the use of intravenous lines.

High Impact Interventions - Catheter Insertion and Ongoing Care

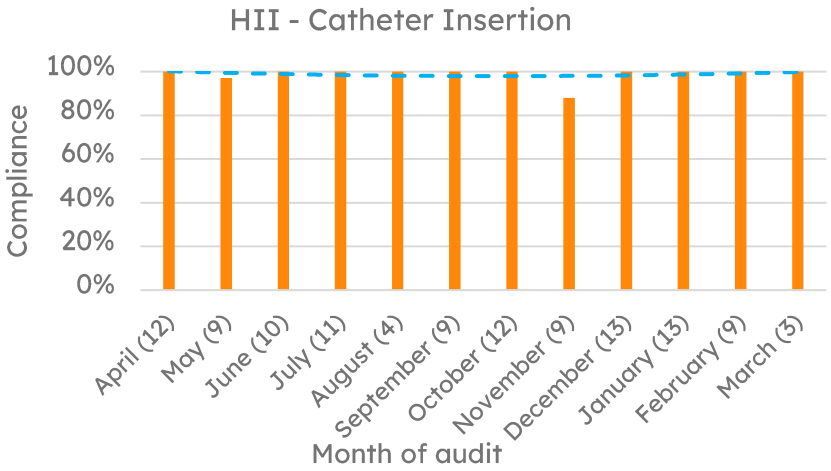


Figure 8 2025-26 Catheter insertion audits.

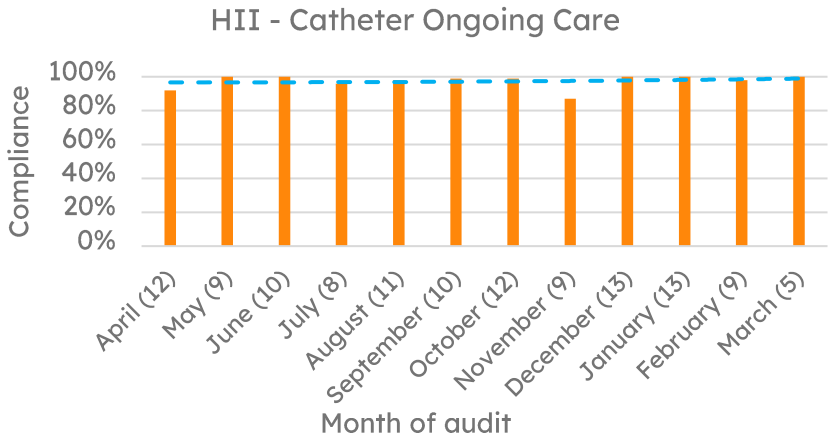


Figure 9 2025-26 Catheter care audits.

High Impact Interventions – Cannula Insertion and Ongoing Care

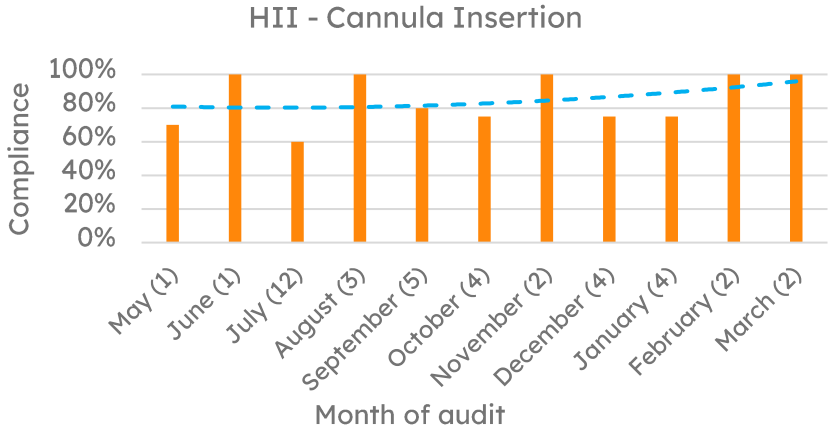


Figure 10 2025-26 Cannula insertion audits.

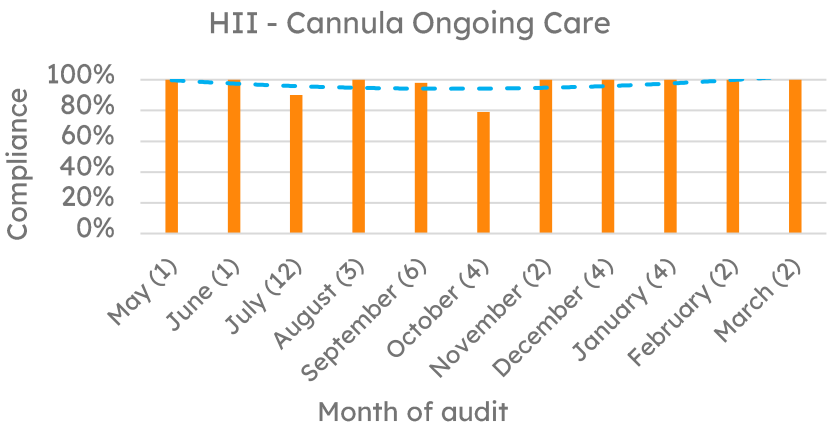


Figure 11 2025-26 Cannula care audits.

High Impact Interventions – Central Venous Access Device (CVAD) Ongoing Care

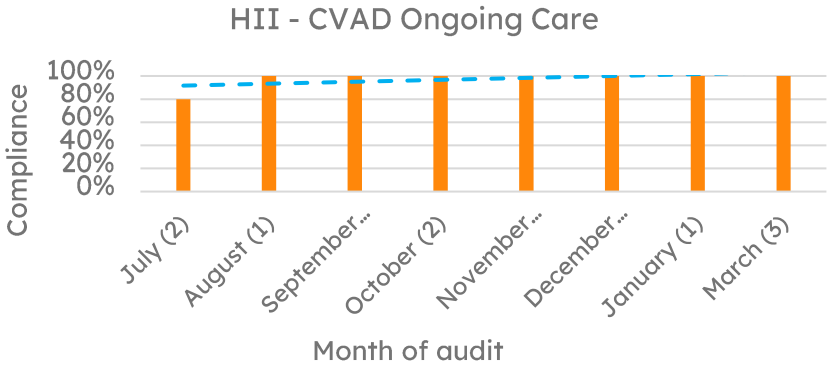


Figure 12 2025-26 CVAD care audits.

Note. There was no CVAD care to audit in April-June 2025, or February 2026.

High Impact Interventions – Antimicrobial Prescribing

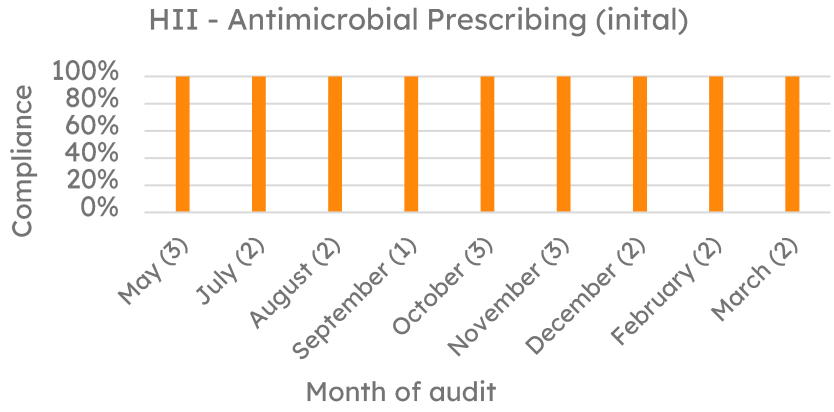


Figure 13 2025-26 Antimicrobial prescribing audits.

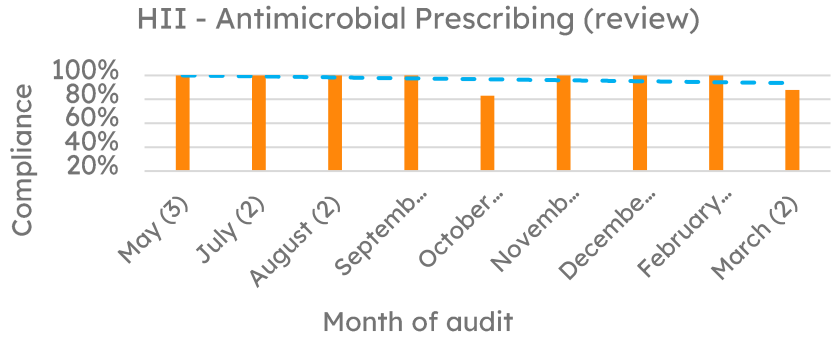


Figure 14 2025-26 Antimicrobial prescribing (review) audits.

The antimicrobial prescribing audit is carried out as a once a month snapshot so there will not always be many patients taking antibiotics on the day the audit is completed. There were no patients taking antibiotics on the day of the April-June 2025 and January 2026 audits.

The Patient Safety Group acknowledges that lower scores relate to record keeping and not to clinical practice.

Note: When small numbers of patient records are audited this has a significant impact on the results when presented as a percentage score. The Patient Safety Group acknowledges this when reviewing results.

Dress Code Audits

Compliance with the standards set in St Helena's Clinical Staff Uniform Policy [003] is audited monthly, results below.

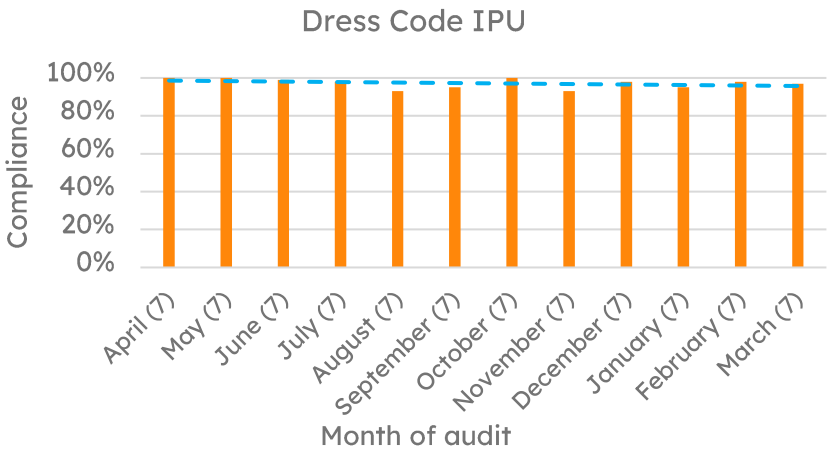


Figure 15 2025-26 Dress code audits (IPU).

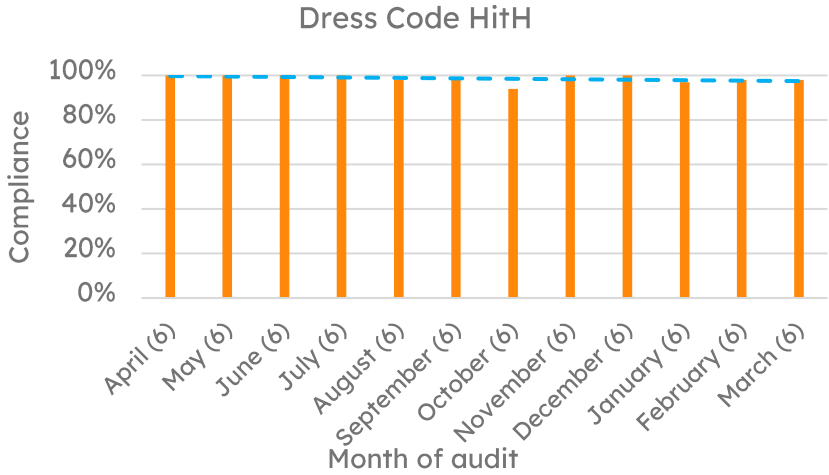


Figure 16 Dress code audits (HitH).

Weekly Kitchen Audit

The Catering Business Development Manager conducts a weekly audit of the main kitchen, focusing on cleanliness and ensuring that procedures in areas such as dry stores are being followed. The chart below presents the monthly average of these weekly audit scores.

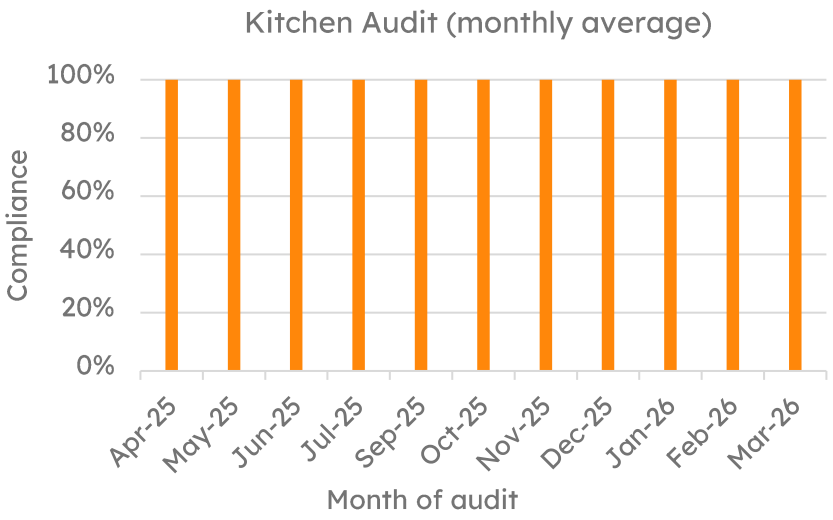


Figure 17 2025-26 Kitchen audits.

Note. There were no audits during August because of annual leave and other commitments.

Cleaning Audits

Cleaning audits are carried out in accordance with the National Standards of Healthcare Cleanliness (2021), ensuring a consistent and high-quality approach. The results are presented as a five-star rating system, which is shared openly by displaying them in patient-facing areas to provide transparency and reassurance.

FR2 – Fortnightly audit (including the Inpatient Unit)		**FR3 – Monthly audit (Ground floor of the Joan Tomkins Day Centre)**		**FR3 – Every two months (including non-IPU areas of the Myland Hall Farmhouse)**		**FR6 – Six monthly audit (Learning & Development Centre)**	
Date of audit	Star rating	Date of audit	Star rating	Date of audit	Star rating	Date of audit	Star rating
03/04/2025 - 19/03/2026	★★★★★	03/04/2025 – 05/03/2026	★★★★★	03/04/2025 - 05/02/2026	★★★★★	03/04/2025 02/10/2025	★★★★★

Table 1 2025-26 Cleaning audits.

Infection Surveillance

Infection surveillance is a key component of infection prevention. The Infection Prevention and Control (IPC) Group monitors healthcare-associated infections (catheter associated UTI; clostridium difficile (toxin positive); MRSA bacteraemia). During the year we recorded three cases of clostridium difficile, two of these were toxin positive. Further information is provided on page 51.

Laundry Dipslide Audits

We monitor infection levels in the laundry process using dipslides. Our Domestic Supervisor conducts fortnightly swab tests on a variety of items, including laundry bins, trolleys, processed linen, and mop heads. These dipslides are analysed

for colony forming units, which help indicate the presence of contamination. Any results above the established threshold trigger immediate cleaning with Actichlor.

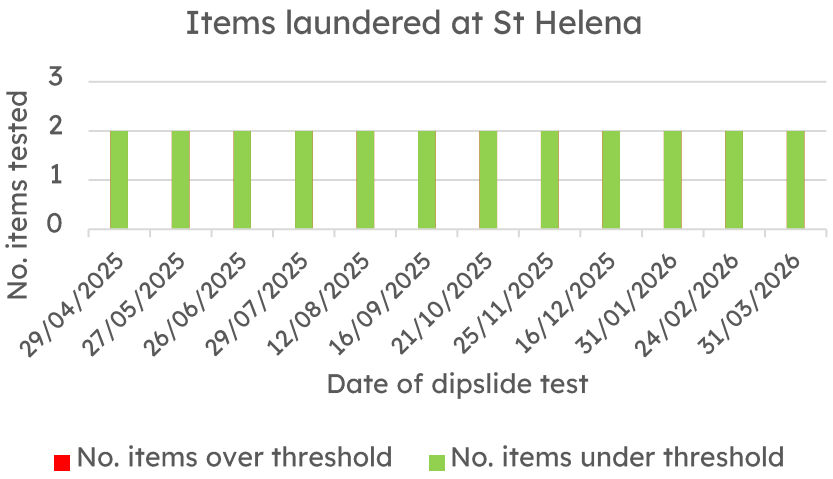


Figure 18 2025-26 Laundry (internal) dipslide tests.

The charts below display the number of items swabbed with results below the threshold for action (shown in green), and those exceeding the threshold (shown in red). The data is separated into items laundered internally and those handled by an external contractor.

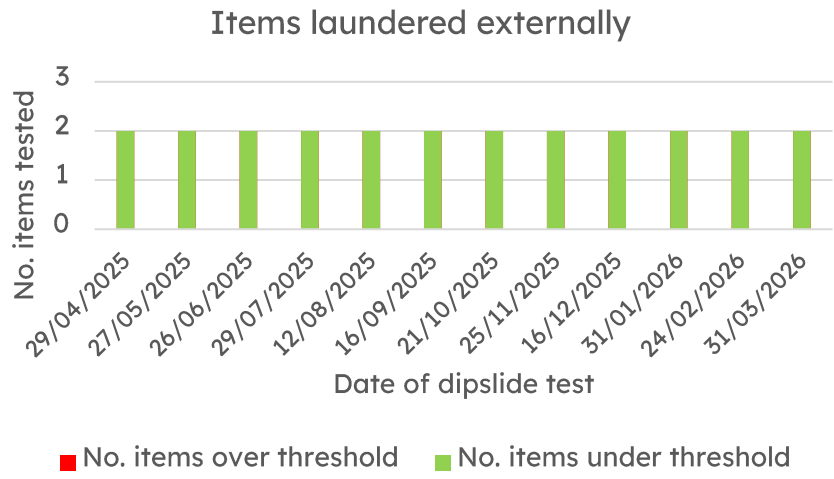


Figure 19 2025-26 Laundry (external) dipslide tests.

3.18.2 Medicines Management

The Medicines Management Group (MMG) oversees the auditing of prescribing and medicines administration on the inpatient unit (IPU) and reviews all medication-related incidents. The group is jointly led by a palliative medicine consultant and the senior pharmacy lead.

The controlled drugs accountable officer (CDAO) provides quarterly reports on controlled drug errors to the local intelligence network. St Helena Hospice also benchmarks medication incidents with Hospice UK to support shared learning and continuous improvement.

...thanks for the warmth and care you provided to all of us as we navigated one of the trickiest times of our lives. You gave mum dignity and respect, peace and reassurance.

Recent activity, achievements, and contributions to quality

- A decision was made to no longer classify drug destruction errors as medication errors. These will now be reported for information only.
- The hospice changed the brand of short-acting insulin in line with East Suffolk and North Essex NHS Foundation Trust (ESNEFT) to support cost savings.
- The group agreed to meet every two months, with the Sentinel group continuing to meet monthly. A project group was established to deliver family administered medications (FAM) training.
- The medical team completed a refresher session on electronic prescribing and medicines administration (EPMA).
- Actimorph has been added to both the hospice and hospital formularies.
- A new 'to take out' (TTO) medication form was developed and implemented.
- Work began on developing a new authorisation process for anticipatory medications.
- Drug destruction competencies are being developed to support future staff training.



3.18.3 Tissue Viability

A pressure ulcer is damage to the skin and underlying tissue. It usually develops over a bony area of the body or can be linked to a medical device. The skin may remain unbroken or develop into an open wound and can be painful. Pressure ulcers are caused by prolonged or intense pressure.

National guidance states that all patients should have a visual skin assessment within six hours of admission. If staff identify a pressure ulcer, they record it as an incident, regardless of its severity or whether it was present on admission or developed during the patient's stay.

All pressure ulcer incidents are reported to the tissue viability lead

and senior nursing team. They review each case to understand what has happened and whether all appropriate care and preventive measures were in place. If not, the ulcer may be considered 'avoidable'.

St Helena Hospice also compares its pressure ulcer data with Hospice UK and NHS Improvement to support learning and continuous improvement.

During quarter one, the tissue viability group continued using microbead pressure-relieving equipment, with positive outcomes. Plans are in place to purchase additional equipment in the next year.

In quarter two, the senior sister on the inpatient unit took on the role of tissue viability lead. Alongside the inpatient unit matron, they worked with the East Suffolk and North Essex NHS Foundation Trust (ESNEFT) tissue viability lead to ensure practice is aligned with current guidance and to support staff education.

During quarter three, changes were made to how pressure ulcers are categorised, in line with the National Wound Care Strategy Programme. Unstageable wounds and deep tissue injuries are no longer reported separately. Unstageable wounds are now recorded as category three pressure ulcers, and areas of vulnerable but unbroken skin are documented within the PURPOSE T assessment for monitoring. Reporting systems, including Sentinel and SystmOne, have been updated to reflect these changes.

The tissue viability lead also worked with the ESNEFT tissue viability lead to deliver in-house training on these updates. Changes have been shared with staff and will be included in upcoming registered nurse study days. The tissue viability policy [133] has been updated and is awaiting formal approval.

...She was so happy she was supported to keep him at home where he wanted to be. He died peacefully with them having a cuddle.

Plans for 2026-27

In the next year, the tissue viability lead will work with the digital team to develop a pressure ulcer prevention framework based on the aSSKINg approach (assessment, skin care, surface, keep moving, incontinence, nutrition and giving information).[1] This framework will support staff to deliver consistent, evidence-based care.

An audit of pressure ulcer management on the inpatient unit was completed during quarter four. Findings were positive and showed that care plans and procedures were being followed appropriately.



[1] The aSSKINg framework is an NHS-endorsed clinical care bundle used to prevent and manage pressure ulcers (bedsores). It provides a systematic checklist for caregivers and medical staff to assess risk, protect the skin, and provide targeted daily care.

3.18.4 Falls

Falls cannot be completely prevented in patients with deteriorating conditions; however, we take all practicable measures to minimise risk.

On admission to the inpatient unit (IPU), patients undergo falls and moving and handling risk assessments. These generate a score indicating whether a patient is at moderate or high risk. This score, along with a visual icon, is clearly displayed on SystmOne to support staff awareness.

Where reasonably practicable, patients are allocated to rooms that allow closer observation, and sensor mats are used where appropriate. Patients identified as being at risk of falls are placed in low-rise beds wherever possible. A floor bed has also been introduced on the IPU, reducing the height from bed to floor and therefore the impact and severity of potential injuries. This is particularly beneficial for patients who are confused or agitated.

Following changes to the staffing model, a new falls lead took on the role at the end of quarter two, requiring a period of transition. They have since worked alongside the falls lead at East Suffolk and North Essex NHS Foundation Trust (ESNEFT) to strengthen prevention practices and identify areas for improvement.

A total of 41 falls were recorded this year, compared with 108 in the previous year. This reduction reflects the decrease in inpatient capacity to eight specialist palliative care beds and one respite bed. Of these incidents, 29 resulted in no harm, 11 in low harm and one was initially recorded as moderate harm. On review, this incident involved a minor head wound with no lasting effects and would be more appropriately classified as low harm in line with NHS England guidance. We will review and update harm definitions within reporting processes to ensure alignment with current guidance.

Toileting remains a key contributing factor. Patients may not wait for assistance because of concerns about dignity and continence. For some, particularly those who are confused or agitated, toileting is an automatic action, and they may forget they require support. Regular rounding is in place but cannot eliminate all risk. Most rooms now have ensuite facilities, reducing distance to the toilet; however, limited space in some bathrooms restricts safe use of mobility aids. Commodes are used where appropriate. Planned IPU building works will include collaboration with the rehabilitation team to improve the environment and equipment, supporting both safety and independence.

Falls sensors were in use in 24 incidents. As these alert staff only once a patient has mobilised, a fall may already have occurred by the time staff respond. Reduced staffing levels associated with fewer patients, can affect response times when staff are supporting other patients.

During the year, demonstrations of alternative technologies, including laser, bed, chair and toilet sensors, were undertaken. Following changes to the IPU call bell system during refurbishment, further exploration of compatible options will continue next year, including planned trials of bed and chair sensors.

In quarter four, an increase in falls was linked to a single patient with complex needs, including cognitive impairment and a language barrier. These incidents were escalated to the Risk and Incident Group (RIG) and

reviewed in detail. Following this review, it was agreed to close the case. The IPU matron then led a wider review of ward acuity and dependency.

Two incidents were not reported within the required 24-hour timeframe because of high patient dependency at the time.

...thanks for the warmth and care you provided to all of us as we navigated one of the trickiest times of our lives. You gave mum dignity and respect, peace and reassurance.

Review of incident reports identified inconsistency in how 'bed rails in use' was recorded. IPU beds are fitted with split rails (upper and lower), and full-length use is avoided because of risks such as entrapment. In two cases, reporting did not reflect assessed practice. Terminology will be clarified across risk assessments, care plans and reporting systems over the next year.

With the appointment of a new falls lead, we will undertake a comprehensive review of falls risk assessments, moving and handling assessments, care plans and bed rail risk assessments.

We will also introduce post-fall 'swarm' huddles in line with the Patient Safety Incident Response Framework (PSIRF) to support learning and reduce recurrence. In addition, further training on falls prevention and management will be delivered across the IPU.

3.18.5 VTE

Venous thromboembolism (VTE)—the formation of blood clots in the veins, including deep vein thrombosis and pulmonary embolism — is a significant risk for patients admitted to hospice care. To mitigate this, all patients admitted to our Inpatient Unit (IPU) are risk assessed by the Medical Team for VTE. As part of this process, they are also informed about the option of receiving a daily injection to help prevent clot formation during their stay.

During 2025–26, 97% of patients admitted to the IPU had a documented VTE risk assessment recorded in their clinical notes. Compliance is reviewed quarterly by the Clinical Governance and Compliance Group, and any instances of non-compliance are investigated by a senior doctor to ensure learning and accountability.

3.19 Risks and Incidents

All incidents and risks affecting Patient & Family Services are managed by our weekly Risk & Incident Group (RIG). These are logged electronically using our online Sentinel system, which notifies the relevant staff by email. Each incident is investigated by a senior member of staff, with findings reviewed by RIG and follow-up actions assigned where necessary. Actions are embedded in the electronic record and tracked automatically to ensure completion.

Risks are scored according to their impact and likelihood of occurrence. Appropriate controls are implemented to mitigate each risk, which is then reviewed regularly according to its risk rating.



3.20 Information Governance

At St Helena, we recognise the importance and sensitivity of personal data, especially healthcare information, and we take every step to ensure it is handled with the highest level of care and security.

Our Data Protection Officer (DPO) oversees compliance with the UK General Data Protection Regulation (UK GDPR), the Data Protection Act 2018, and the Privacy and Electronic Communications Regulations 2003. This role is embedded across the organisation to ensure that all departments adhere to relevant data protection standards.

All confidentiality and data protection incidents are recorded through our incident management system. We maintain an electronic Record of Processing Activities to document how personal data is handled, and an Information Asset Register to monitor the location and flow of data. Any new initiative involving personal data is subject to a Data Protection Impact Assessment (DPIA), ensuring early identification and mitigation of potential risks.

We routinely carry out data retention audits to confirm that personal data is not held for longer than necessary. Our Information Governance Policy is publicly available on our website, alongside selected DPIAs at https://www.sthelena.org.uk/about-us/governance. Our Privacy Policy can be accessed at https://www.sthelena.org.uk/privacy-policy.

In addition to the DPO, our Medical Director serves as Caldicott Guardian, responsible for protecting the confidentiality of patient information and ensuring it is used appropriately.

The weeks leading up to my husbands death were terrible... nights where he was screaming in pain... but the moment we walked in those hospice doors we both felt a tranquillity and safe and within a few hours the relief on my husbands face showed. Everyone in the world should be given that exceptional care and it breaks my heart that so many hospices are struggling to keep going.

3.20.1 IG Incidents Closed During the Year

During 2025–26, St Helena closed 11 Information Governance (IG) incidents affecting our clinical services. This is down from 13 the previous year and two of incidents closed did not involve any errors by St Helena staff. Most were categorised as minor, involving simple clerical errors, such as misdirected emails, misfiled or mislaid documents, and minor breaches of confidentiality. In each case, remedial actions were taken and learning shared with relevant teams. One incident led to the dismissal of a volunteer for misconduct.

These incidents reinforce our commitment to maintaining the highest standards of data protection and learning from all events, however small. We also conduct quarter IG 'walkthroughs' to look for incidences of poor compliance and test staff knowledge of procedures. We're pleased to report compliance has been very high this year, rarely dropping below 80% and often near 100%.

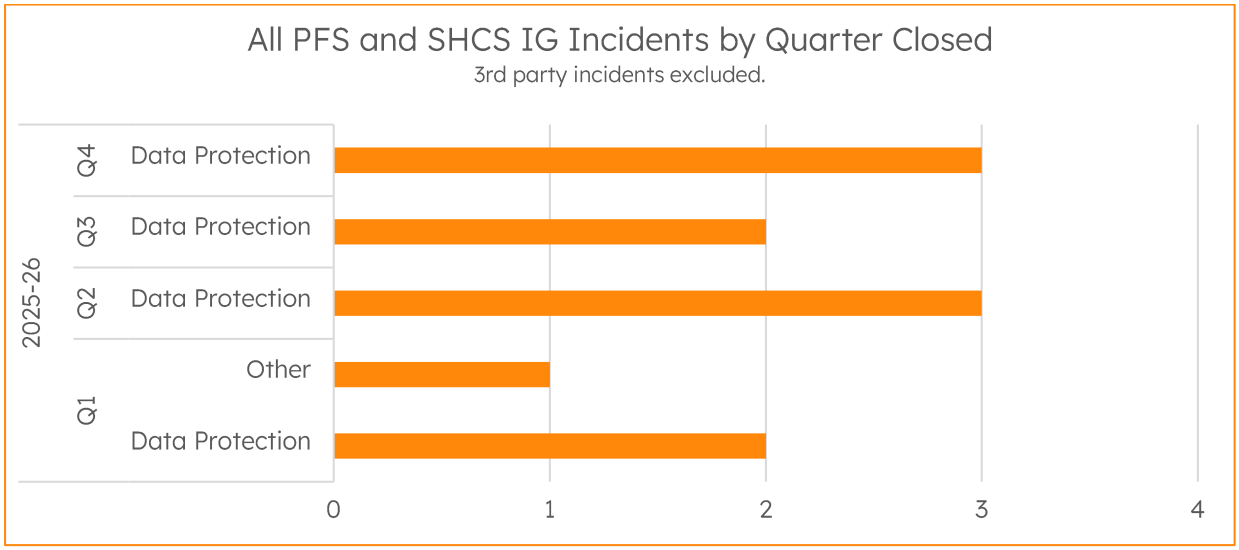


Figure 20 2025-26 IG incidents.

3.20.2 Data Security and Privacy Toolkit Self-Assessment

Each year, St Helena publishes a Data Security and Privacy Toolkit (DSPT) self-assessment, to demonstrate our high standard of information governance. All organisations that have access to NHS patient data and systems must use the DSPT to publish an assessment against the National Data Guardian's 10 data security standards. We published our DSPT for 2025–26 on 4th June 2026. Our certificate is shown in, below.



Figure 21 2025–26 DSPT certificate.

Our status can be verified by visiting https://www.dsptoolkit.nhs.uk/OrganisationSearch and using our organisation code: 8A784.

3.21 Duty of Candour

The Duty of Candour, established under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, requires providers to be open and transparent with service users. It outlines specific obligations when care or treatment results in harm, including informing the individual, offering reasonable support, providing truthful information, and issuing an apology.

Duty of Candour is embedded in our reporting processes, including as a mandatory element of our incident reporting form. Staff must record the information shared with the patient or carer, enabling effective audit and oversight. These principles are also reflected in our complaints management and incident response training.

3.22 Complaints and Compliments

3.22.1 Complaints closed during the year.

During 2025-26, St Helena Hospice closed 11 complaints. These related to a range of services including the inpatient unit, Hospice in the Home, SinglePoint and counselling services.

Themes across the year included communication, coordination with external services, access to timely support, and the clarity of processes. In several cases, outcomes were influenced by factors outside St Helena Hospice's direct control, such as GP services or commissioned providers.

Learning from complaints has been used to improve communication, strengthen processes, support staff training and reinforce partnership working. Apologies were offered where care fell below expected standards or where actions caused distress.



Complaint 564
The wife of a patient complained that SinglePoint staff had failed to attend an overnight visit for catheter care. She also reported that, when staff eventually arrived, they appeared reluctant to deliver care, and that SinglePoint had failed to respond to a voicemail.

Our investigation found no clinical need for an overnight visit, and we could not identify any evidence that care was delivered with visible reluctance. However, we did find that staff should have returned the voicemail.
We partly upheld this complaint and wrote to the complainant with the investigation findings and an apology.

Complaint 578
Hospice in the Home received a complaint from a patient regarding a delay in receiving medication. Our investigation found that, while the delay originated with the GP practice's handling of the prescription request, the issue could have been avoided had our medical team prescribed directly following the visit.
Our learning points from this complaint were as follows:
Having moved to electronic prescribing, our resident doctors are currently unable to prescribe directly through the system.

We have asked them to liaise with prescribing colleagues rather than request GP practices to action prescriptions.

We are continuing to explore options for granting direct access to the e-prescribing system.

We reminded the medical team to ensure letters are clear and concise to prevent confusion.
We upheld this complaint and wrote to the complainant with the results of our investigation and an apology.

Complaint 582
We received an anonymous complaint via the Care Quality Commission (CQC), stating that staffing had been cut.
We provided a detailed response to the CQC, explaining that, although financial pressures had necessitated service reductions and a vacancy freeze, staffing ratios had not been reduced in any service. We assured them that patient safety and care had not been compromised.
Our then associate director of clinical services, also met with clinical staff to seek their views and provide reassurance.

The CQC confirmed that no further information was required at that time.

Complaint 583
We received a complaint via our online form, but due to a technical error, the complainant's contact details were not recorded. We followed up and were able to establish contact with the family. However, no formal complaint was submitted.

Our investigation found that the patient referred to in the complaint had not been under our care.
This complaint was neither upheld nor rejected.

Complaint 585
We received a complaint about our inpatient care from the relative of a patient. There were five elements to their complaint:

1. Poor communication and understanding between St Helena and the local hospital.
2. That the patient felt unduly pressured to leave their room and the hospice and that no reassurance was given that this was not the case.
3. That we advised inappropriate exercise that caused pain and distress.
4. That a member of staff showed a poor attitude.

5. That the call buzzer did not work and was not replaced.

We could not uphold points 1, 3 or 5. We partially upheld point 2 and upheld point 4, which concerned a staff member who is no longer with St Helena. We apologised for any failings in care.

Complaint 592

An issue was raised regarding the end-of-life care provided to a patient at a nursing home, specifically around the availability and authorisation of a syringe driver following a sudden deterioration.

Our investigation found that the patient was under GP care and that anticipatory medications were available and administered. The paramedic on scene did not consider a syringe driver necessary overnight, and the GP later documented that the patient appeared comfortable. While SinglePoint provided appropriate advice and support, the investigation noted that the GP could have authorised a syringe driver during their visit, had it been deemed necessary.

We neither upheld nor rejected this complaint. We did recommend that the GP surgery review its process for completing authorisations for syringe drivers to ensure clarity and responsiveness in similar situations.



Complaint 600

We received a complaint to counselling and emotional support service about the length of their wait for a counsellor. The complainant also asked why they had not received regular updates and what processes we have in place for this, if we recognised the emotional impact of waiting for people with multiple bereavements, how we assure equity and access for people of a BAME background, what improvements we plan to make to our service, and who would be accountable for them.

We apologised for the long wait and noted that we had contacted the complainant several times with courtesy emails. We also reassured the complainant that we recognise that delays can cause distress although we had not been told about the multiple bereavements. We noted that we do record demographic information on referral but that the complainant had not provided this. We also discussed our plans for service improvement and our accountability arrangements. We partially upheld this complaint.

Complaint 601

The daughter of a SinglePoint patient complained about delays in urgent support and the verification of death, which caused significant distress to the family at the end of life. Our investigation confirmed that all urgent visits were made within the two hour target, either by community nursing teams or paramedics, although SinglePoint staff were unable to attend on one occasion due to competing urgent demands.

Verification of death was appropriately directed to NHS 111, who are commissioned to provide this service out of hours; however, there

was a delay in their attendance, which added to the family's distress.

Additional concerns raised regarding staff conduct, prescriptions, and the collection of a syringe driver were reviewed and found either to relate to services outside St Helena's responsibility or to have been managed in line with agreed processes, though an apology was given where actions caused upset. We acknowledged the emotional impact on the family, confirmed that care decisions were clinically appropriate, and highlighted learning around communication, capacity pressures, and the importance of sensitive handling at end of life.
We partially upheld this complaint.



Complaint 614
A complaint was made about the care provided to a patient and whether a GDPR breach occurred when we shared information with a relative. The care concerns focused on communication, decision making around care provision, and whether appropriate support was offered.
Our investigation found that appropriate input from specialist palliative care services had been offered. There had been no breach of GDPR.
We could not uphold this complaint, and not further action was required.

Complaint 617
We received a complaint concerning our delayed response to a request for information about a deceased patient, which caused distress to the complainants. Our investigation found that we did miss the initial email. A second email was reviewed by the Caldicott guardian and deputy Caldicott guardian, who appropriately determined that confidential medical information could not be shared with the complainants. Unfortunately, this response was further delayed because of annual leave over Christmas. We apologised for the delay and associated distress and advised the complainants of the appropriate contact route for future information governance enquiries to ensure more timely handling.
We upheld this complaint.

Complaint 630
The wife of a patient complained about the lack of overnight support for a community patient requiring assistance with an ascitic drain. Planned support was provided earlier in the day by the community nursing team, but when further help was needed later that evening, SinglePoint advised that they were unable to provide hands on support due to training limitations and suggested contacting NHS 111, who were also unable to assist. As a result, no support was available until the following morning, leaving the patient's wife feeling unsupported and distressed. The investigation confirmed these events and highlighted challenges around training, escalation, and clarity of arrangements for community patients with drains.
An apology was given. The team is

arranging specialist training with the nurse specialist at East Suffolk and North Essex NHS Foundation Trust, who has been invited to attend both Hospital at Home and IPU team meetings to deliver the required training. Additional learning resources are being sourced from company

representatives, and the community team has provided troubleshooting advice. These actions will support improved confidence and consistency in managing patients with drains in the community.
We upheld this complaint.

3.23 Service User Survey



St Helena uses an electronic patient survey, which is called Synapta.[2] The system uses a set of web-based questionnaires that respondents are invited via SMS to complete. These SMS invitations are triggered by clinical staff at appropriate points in a patient's pathway.

We currently run four separate questionnaires, one each for the Hospice, Hospice in the Home, Complementary Therapies, and the Counselling & Emotional Support Team. The Hospice, Hospice in the Home, Complementary Therapies questionnaires are identical, but the CEST questionnaires are also sub-divided into separate question sets depending on whether the respondent is a patient or a care/family member.

With around 100 questions asked, across all four surveys, we cannot present all the results here; however,

Figure 22 (over page) shows the aggregated response, across all four questionnaires, to the question, 'Overall, how was your experience?'

[2] Supplied by Always On Mobile.

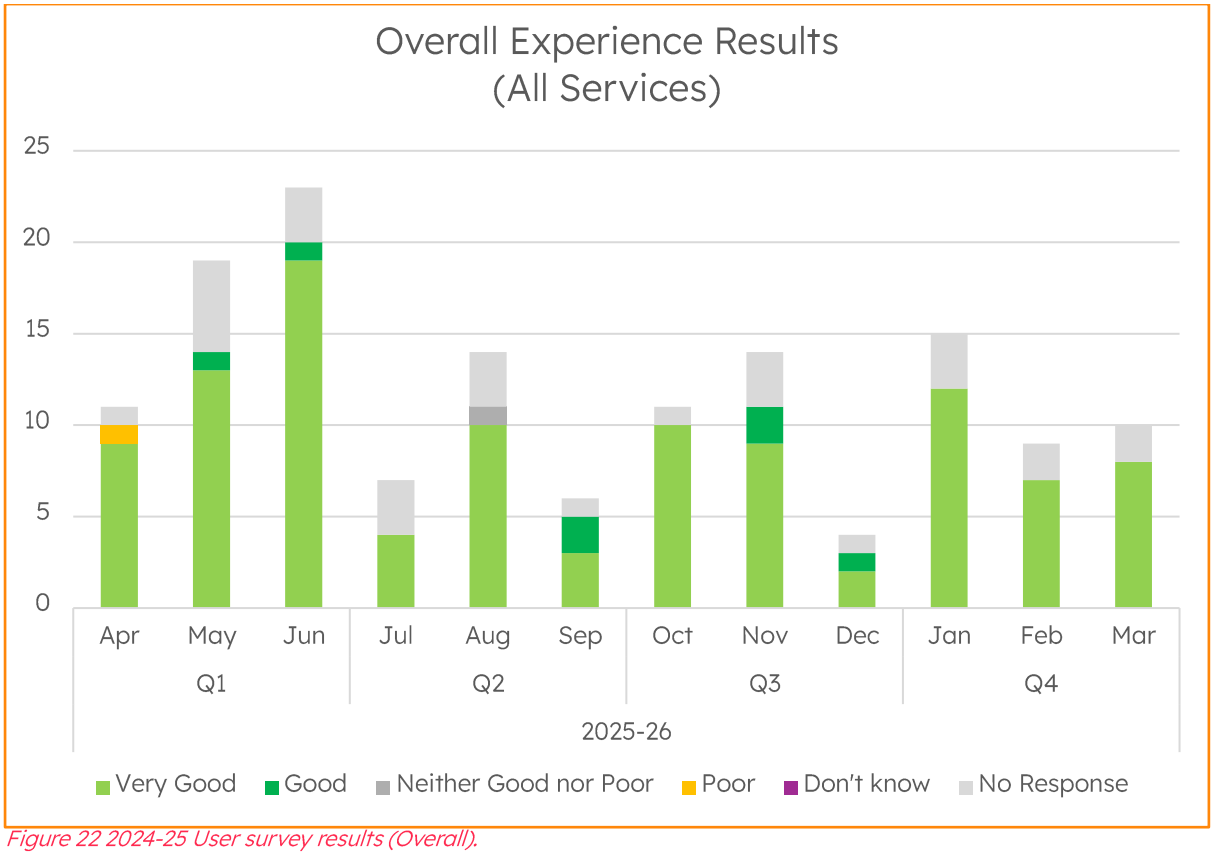


Figure 22 2024-25 User survey results (Overall).

3.24 What Others Say

3.24.1 2024 CQC Inspection Report

St Helena is registered with the Care Quality Commission (CQC) to provide treatment for disease, disorder, or injury. We are required to comply with the CQC's regulatory standards, as set out in the Health and Social Care Act 2008 and associated regulations.

Our most recent CQC inspection took place in February 2024 and involved a one-day unannounced visit. Following this inspection, we were once again rated 'Outstanding'—the highest rating awarded by the CQC. This outcome continues the rating we received following our previous inspection in 2017.

The CQC summarised their findings as follows:

'Throughout the assessment, we received positive comments and feedback from people who used the service, relatives, staff, and health professionals. All patient's felt safe, well cared for and knew who to contact should they need to. They reported they were involved in the planning of their care and were kept informed of what would happen next. Patients felt staff delivered care that enabled them to remain well and independent physically, emotionally and mentally. They were supported to live as they wished, and care was coordinated with staff working to support patient choice. Comments included, "Staff are very approachable", "Staff are phenomenal, they are people of peace", and one

patient reported his experience had "surpassed my expectations".[3]

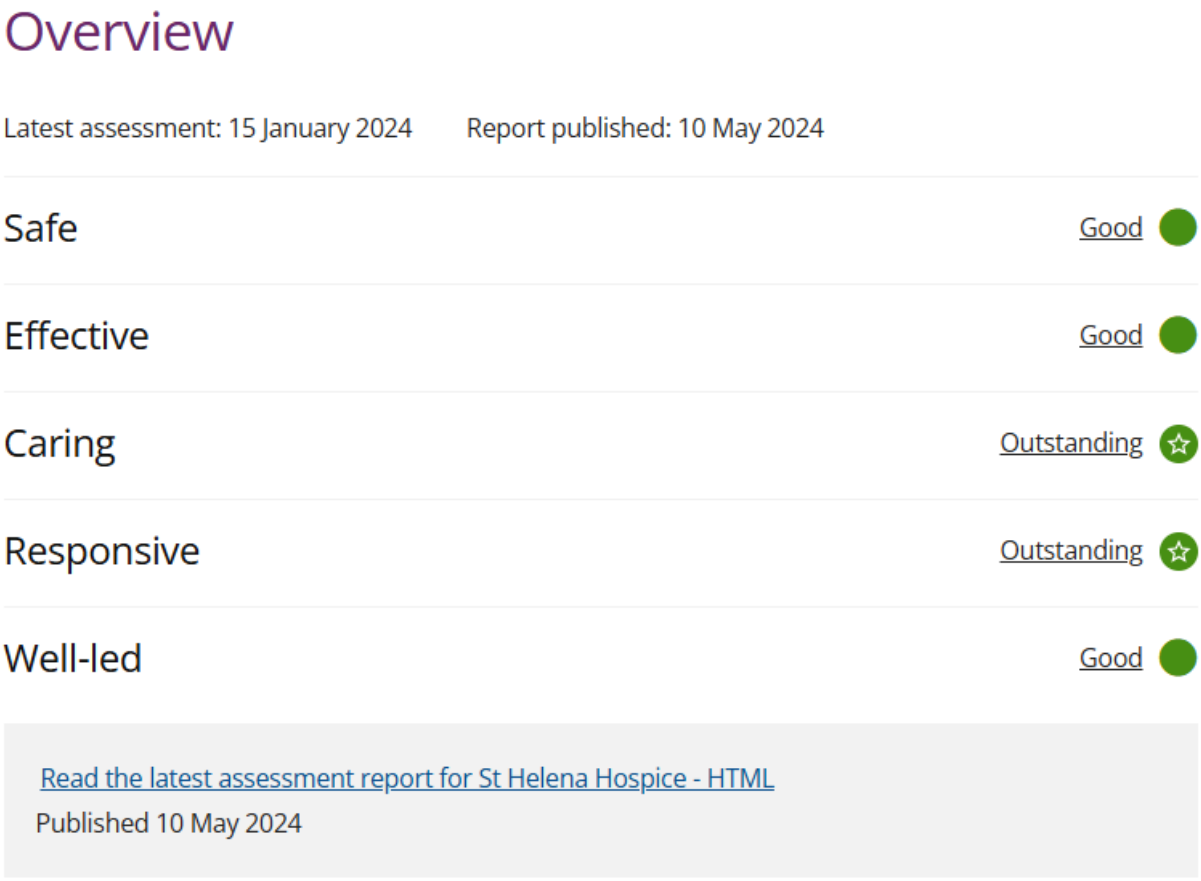


Figure 23 CQC Rating (source: https://www.cqc.org.uk/location/1-116828568)

[3] Available at https://www.cqc.org.uk/location/1-116828568/reports/AP1414/overall

3.24.2 Response from Healthwatch Essex

Healthwatch Essex is an independent organisation that works to provide a voice for the people of Essex in helping to shape and improve local health and social care. We believe that health and social care organisations should use people's lived experience to improve services. Understanding what it is like for patients, their families and their carers to access services should be at the heart of transforming the NHS and social care as it meets the challenges ahead of it.

We recognise that quality accounts are an important way for local services to report on their performance by measuring patient safety, the effectiveness of treatments that patients receive and patient experience of care. They present a useful opportunity for Healthwatch to provide a critical, but constructive, perspective on the quality of services, and we will comment where we believe we have evidence – grounded in people's voice and lived experience – that is relevant to the quality of services delivered by St Helena.

We offer the following comments on the St Helena Quality Account:

- **Funding:** Over the past year, St Helena had to takes steps to address their financial deficit by reducing services to ensure future sustainability. This is a difficult decision many organisations are dealing with and demonstrates the importance of providing sustainable funding.
- **Staffing:** As a result of the reduction in services, staffing has been affected this year. Major changes in an organisation can impact staff wellbeing and retention. Whilst this is something to monitor to ensure that it does not affect safety, St Helena are aware of this and are taking proactive steps to support staff. They have demonstrated support for staff wellbeing through one-to-one/team/huddle meetings, building up a staff bank, the 'Rest, Reset, Restore' initiative, staff access to complementary therapies, and internal support groups such as Freedom to Speak Up and Mental Health First Aiders. We are particularly pleased to see the roles of women's and men's health champions. Our work with our Fellas' Forums and Women's Forum shows a real need for these types of initiatives in the workplace to encourage open conversations and awareness raising.
- **Safe Harbour**: The Safe Harbour project continues to do vital work in reaching underserved communities. St Helena have also demonstrated some positive work around equality, diversity and inclusion this year such as their transgender inclusion training and their 'My Name is' campaign. It's important these areas of work are maintained in a time of funding and staffing challenges.
- **Care Choices Service:** Volunteers are supporting people to record their advanced care plans. The My Care Choices register has been launched in Suffolk – it is fantastic to see this system being implemented outside of north east Essex as best practice.
- **Volunteers:** Volunteers contribute a huge amount to local communities so it's great to see the recognition St Helena has on the impact of their 911 volunteers who have given

210,000 volunteer hours. This is crucial in raising capacity especially at a time of reduced funding.

- **Falls:** Reducing falls is important – their initiatives such as floor beds can make a big difference and toileting provisions such as ensuites or commodes can support dignity whilst also reducing risk.

Listening to the voice and lived experience of patients, service users, carers, and the wider community, is a vital component of providing good quality care and by working hard to evidence that lived experience we hope we can continue to support the work of St Helena.

Chloe Dench

Deputy Communications Manager, Healthwatch Essex

June 2026

The kindness and understanding from, I must say, everyone I interacted with at the hospice was incredible... sometimes it can be daunting accessing therapies and allowing yourself the time to breath and de-stress. I can't thank the charity and volunteers enough!

3.24.3 Response from Suffolk & North East Essex Integrated Care Board

NHS
Essex
Integrated Care Board

By email

Giles.thorpe@nhs.net

23rd June 2026

Subject: NHS Essex Integrated Care Board response to St Helena Quality Account 2025/26

Dear Colleagues

Essex Integrated Care Board (EICB) welcomes the opportunity to review and comment on the St Helena Quality Account for 2025/2026.

EICB is commenting on a draft version of this Quality Account; however, to the best of its knowledge, the information contained within this report is accurate and representative of the quality of services delivered. Any queries will have been fed back to St Helena prior to publication.

The Integrated Care Board recognises the valuable contribution St Helena continues to make in delivering high-quality palliative and end-of-life care services. Acknowledging the organisations continued commitment to providing compassionate and quality services, while experiencing financial, workforce, and consultation challenges.
The Quality Account demonstrates openness in reporting both achievements and areas for ongoing improvement and reflects a strong culture of quality assurance and continuous learning.

EICB particularly welcomes key areas of progress against the 2025/26 priorities:

- Remodelling clinical services in a creative way for financial sustainability
- The continued focus on person-centred care and family experience
- Investment in workforce development and staff wellbeing
- Safe Harbour - the expansion of services to enable support to a higher number of the minority, marginalised and vulnerable populations in deprived areas.
- The launch of Care Choices Services and the increase in training and access to My Care Choices Register (MCCR) across the current geographical footprint.
- Successful conferences, training, masterclasses, and The Synergy Education platform across North East Essex and Suffolk
- The formation of the Essex Hospice Collaborative

St Helena demonstrates a clear commitment to collaborative working. This is reflected throughout the document. EICB acknowledges the continued focus and improvements being made in many areas, including the ongoing review of patient needs and acuity that commenced in January 2026, renovations to the inpatient unit, resolution of staffing challenges in SinglePoint, and increasing the number of non-medical prescribers. The

NHS Essex Integrated Care Board
Seax House, Victoria Road South, Chelmsford, CM1 1QH

www.essex.icb.nhs.uk
Chair: Professor Michael Thorne CBE | CEO: Tom Abell

quality account reflects the organisational strive toward data driven, evidence-based improvements seen in St Helena's current and future audits such as the Rehabilitation Team staffing and impact audit. The principles underlying the plan to increase Home Ward to a day service reflect a compassionate and community focused agenda.
We acknowledge The St Helena future priorities; these are summarised below:

- Extend our offer in a realistic and sustainable way.
- Support carers to support those they care for
- Support and develop our expert workforce.

Sincere thanks go to St Helena's and all its staff for their hard work and dedication that has been evident over the last year. EICB would once again like to congratulate St Helena for all that it has achieved given the backdrop of increasing pressure and uncertainty which continues to impact all healthcare services.

In conclusion, EICB considers the St Helena Quality Report for 2025/26 as providing an accurate and balanced picture of the reporting period. EICB will continue to seek assurance on performance and delivery of care by regular monitoring through agreed contract processes.

Yours sincerely,



Dr Giles Thorpe RN, DProf, MSc, Bsc (Hons), MIHM

Executive Chief Nurse / Caldicott Guardian

NHS Essex Integrated Care Board
Seax House, Victoria Road South, Chelmsford, CM1 1QH

www.essex.icb.nhs.uk
Chair: Professor Michael Thorne CBE | CEO: Tom Abell

3.25 Contacting St Helena

If you wish to give feedback or comment on this Quality Account, please contact:

Dr Karen Chumbley,
Co-chief Executive Officer
St Helena Hospice
Barncroft Close
Colchester
CO4 9JU
Tel. 01206 931450
Email: kchumbley@sthelena.org.uk
www.sthelena.org.uk
Follow us:
@StHelenaHospice
https://en-gb.facebook.com/StHelenaHospice/

'...his death was just how he wanted it.'


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01206 845 566 | www.sthelena.org.uk
Registered Office: Myland Hall, Barncroft Close, Colchester, CO4 9JU

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