Quality Account

2022 - 2023

Contents

Acknowledgements

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1. Statement on Quality

1.1. CEO Statement

St Helena helps local people facing incurable illness and bereavement in North East Essex.

Safety and quality are at the heart of the care and support we provide, and we welcome the opportunity to share our progress and priorities in this report.

Our organisation has a reputation for excellence in the care it provides and has an 'Outstanding' Care Quality Commission rating for its charitable services. It has developed innovative approaches across an increasingly diverse range of services.

At St Helena, we want end of life care to be better for everyone across North East Essex, regardless of where they live, how old they are or their diagnosis. We have worked with partners in the North East Essex Health and Wellbeing Alliance to develop a population approach to end of life care focused on the 10 outcomes that matter most to people in the last year of life and their families.

We continue to explore new ways to provide our care and support to more local people. This includes increasing the scope and reach of our care, developing new services and programmes, working with community groups and voluntary organisations, and making sure our facilities are sustainable and future proofed.

At St Helena we recognise that others have an essential role to play in good palliative and end of life care, so we embrace partnership working; and, to get the most from this, we provide leadership and coordination on behalf of our population. This includes a local leadership role regarding the provision of education and training in palliative and end of life care. We jointly deliver the Hospice Education offer with our colleagues at St Elizabeth Hospice.

Our service delivery is organised around two multi-disciplinary teams – The Hospice MDT (inpatient care) and the Hospice in the Home MDT (community and home based care). We offer support to patients, family members, and professionals through our 24/7 SinglePoint palliative care coordination centre and end of life care hub. SinglePoint coordinates end of life care services across local providers including GPs, district nursing, the acute hospital, out of hours services, and the ambulance service. It also coordinates the My Care Choices Register, a means of capturing and sharing the wishes of people in the last year of life.

In addition, we provide a range of complementary and support services, including spiritual care, through our own teams and in partnership with community groups and other local providers as part of our Compassionate Communities programme.

We provide a comprehensive Bereavement Service for all adults and have recently been commissioned to extend this support to children, regardless of the cause of their bereavement.

Last year was our busiest year ever, and we supported over 4,300 people in one year for the first time. We want to do more and are seeking to further strengthen our work to personalise care, widen access, and tackle inequalities in both access and outcomes.

Mark Jarman-Howe
Chief Executive

1.2. Statement from Board of Trustees

The Board of Trustees is accountable to all stakeholders for the quality of care given by St Helena. This accountability is a central focus of the Board's activity.

Following the lifting of many of the COVID-19 restrictions, the Board is once again meeting face to face whenever possible. Although we believe we were very effective meeting virtually, there is no doubt that the discussion is richer when all Trustees are in the same room.

Since the last report we have a new Vice Chair in Dr Fran Hyde, who also chairs the Corporate Governance and Risk Committee. We have a new Treasurer in Richard Pollom who also chairs the Finance and Operations Committee. We continue to achieve a sound turnover of Trustees, giving us an effective balance of maintaining corporate knowledge and developing fresh ideas. We also continue to maintain a balance between clinical skills and business acumen among Trustees.

One of the key decisions forthcomings for the Board is the potential relocation of St Helena. There is no doubt that that Myland Hall has served us well, but within a few years it will no longer be fit for purpose. Trustees have taken very close interest in and examined the work done to assess the feasibility of the various options open to us, and once a decision has been taken on the best way to proceed additional corporate structures and governance arrangements will be put in place to oversee the running of the project.

To provide better clarity of risk across the organisation, we have more closely integrated our Board Assurance Framework and our operational risk registers. This ensures that while each risk is managed at the appropriate level, senior managers can monitor them.

The Governance and Risk Committee continues to check annually that all committees consider their terms of reference relevant and workable and seeks assurance that each committee is fulfilling those terms of reference.

The Board is ever mindful that the only way we can help the people of North East Essex face life limiting disease, multiple co-morbidities, and frailty is through our exceptional team of people at St Helena. The Board acknowledges and thanks all staff and volunteers for all they do on behalf of the people of North East Essex.

We fully endorse this Quality Account.

Nigel Pye
Chair of the Board of Trustees

1.3. Executive Summary

In 2022-23, St Helena operations emerged further from under the shadow of the Pandemic and, by end of year, life was largely back to the 'new normal', although we continued to admit patients with the virus.

In Part One of this Quality Account, you will read about our priorities for the coming year. These are:

- Focusing on the sustainability of our services to ensure they contribute to meeting the outcomes that matter (see page 4).
- Increasing our reach by exploring where St Helena can make a positive difference and ensuring our

workforce is equipped with the skills to be able to meet the challenge (page 5).
- Continuing to ensure every community is prepared to help, and all St Helena employees contribute to both our compassionate community approach and addressing inequality (page 5).

We also provide an update on our progress with our priorities from the previous financial year.

In Part Two, we present the results of a selection of our clinical audits during the year (page 13) and provide a breakdown of the services we provide and how they are funded (page 13). We also reproduce the posters our staff presented at the most recent Hospice UK conference (page 19).

In Part Three, we provide individual updates from our services. Our Hospice Matron reports on developments on our Inpatient Unit, including decorative work and new flooring and increased bed occupancy. We also report further relaxation of PPE and visiting rules following the Pandemic (page 26). Our Hospice in the Home Matron discusses our community services and our new Paramedic pilot (page 30), and there's an update on our Compassionate Communities work promoting better death literacy in the community, including local business (page 31).

On page 33, the Bereavement Services Manager discusses the introduction of our new service for counselling bereaved children, and our new Spirituality Lead provides an update on page 34. On page 40, we tell you about our new joint venture with St Elizabeth Hospice, 'Hospice Education.'

Elsewhere, we discuss our work on Infection Prevention and Control (page 49), volunteering (page 44), and Safeguarding (page 39). On page 58, we discuss the work we do to protect patients' confidential data and report on our expanded information governance walkthroughs. Towards the end of this report, we summarise the complaints we have received and how we've dealt with them (page 63).

Note: Throughout this report we share some of the valued feedback we have received from our patients and their families, like this:

You gave [the patient] back her confidence, when she needed it most, and the bond that you made with her, the camaraderie, was something to behold. The laughter that she shared was like seeing sunshine on a bleak rainy day.

2. Priorities for Improvement in 2023-24

2.1. Priority One

Focus on the sustainability of our services and ensure they contribute to meeting the outcomes that matter.

We want to ensure we prioritise our services in areas where they have the most impact on outcomes for patients and families. The North East Essex Health and Wellbeing Alliance has identified outcome priorities for end of life care, and we want to be able to demonstrate how receiving hospice care influences the achievement of these outcome priorities. To do this, we will collect data for each of our services that will evidence the part they play in helping to achieve these outcomes. We will ensure colleagues have access to this information and use it to further develop their services. We will also clarify, as part of our work to articulate our model of care, how we will use the Outcome Assessment and Complexity Collaborative (OACC) suite of outcome measures.

As well as demonstrating the impact of our services, we also want to deliver them as efficiently as we can, to make the most of our resources. We will continue to look for opportunities to integrate our services for the benefit of patient care. We have secured funding for a night sitting[1] pilot and will use the lessons from this to enhance the care we provide.

We will create a St Helena operations hub to act as a single point of access to our services, ensuring that we get patients on the right pathway of care as quickly as possible. We plan to embed one of our senior nurses at the local acute hospital (Colchester General) to advise about end of life pathways and provide support and education to their staff.

Our Bereavement Service has seen an increase in the number and complexity of clients referred to the service and, as a result, waiting times are too long. We will reform the service, bringing all counselling support into one team, to reduce waiting times and ensure we have a sustainable model of care for the future.

The Ten Outcomes that Matter are:

1. To identify and recognise people in the last 12 months of life.
2. To inform people thought to be within the last 12 months of life and their families.
3. To elicit and record people's preferences for care during the last 12 months of life.
4. To respect people's preferences for care during the last 12 months of life.
5. To ensure people's preferences for care are accessible to all parts of the health and social care system/end-of-life-care system.
6. To treat people at end of life as individuals, with dignity, compassion and empathy.

[1] A night sitting service allows trained carers to keep patients and families company, so their regular care provider can take a break.

7. To control pain and manage symptoms for people during the last 12 months of life.
8. To minimise inappropriate, unnecessary and futile medical intervention during the last 12 months of people's life.
9. To ensure that people at end of life have equitable access to flexible 24/7 end-of-life-care services irrespective of the place of care or the organisation/s providing care.
10. To provide support to the families and other carers during and after their loved one's end of life.

2.2. Priority Two

Increase our reach by exploring where St Helena can make a positive difference and ensuring our workforce is equipped with the skills to be able to meet the challenge.

St Helena has an ambition to increase the reach of its services. We will begin to test initiatives within areas such as frailty and dementia. We will participate in a project with the local frailty service to ensure that advance care planning is embedded in their care and share our knowledge of palliative and end of life care with them. In addition, this will upskill our clinical team in how to care for frail people.

We are keen to listen to the experience of our service users and carers and use this information to help us co-produce services that improve lives. To do this we want to make it easier for users to provide feedback in real time, so we will refresh the points in patient pathways at which we collect feedback.

We will also focus on strengthening support for carers. We have established a working group focusing on our offer for carers and will act on its recommendations to ensure the support we provide is clear and consistent.

To achieve our ambitions, we will need to ensure our workforce has the knowledge and skills to provide care for the population we serve now and in the future. We will continue to promote development opportunities to enable staff to progress their careers at St Helena. We will test innovative roles such as that of the Paramedic within our SinglePoint service. The current Paramedic pilot will conclude within the year, after which we will evaluate it and make plans to sustain it.

As new roles emerge, we will review the skills mix within each of our clinical teams to ensure we are able to deliver care as effectively as possible. We will also explore where digital innovation can help us do this, working to develop the digital skills of our clinical workforce.

On behalf of my father ... our family wishes to acknowledge the fantastic care and support he (and we) received from all the SinglePoint carer's in his final weeks. I wish I could remember all the names to personally thank them… Many thanks for the fantastic work you do.

2.3. Priority Three

Continue to ensure every community is prepared to help, and all St Helena employees contribute to both our compassionate community approach and addressing inequality.

St Helena's Equality, Diversity, and Inclusion (EDI) Group has the following objectives:

- To widen access and improve the experiences of individuals, and their families, in accessing care with an end of life diagnosis,
- To understand, evidence, and articulate gaps in healthcare provision.
- To build cases to address gaps in service, including, where appropriate, accessing funding to support delivery.
- To record priorities and outcomes identified in the NHS Equality & Diversity Framework (EQIA) Impact Assessment Policy.

Our Safe Harbour project will continue to increase links with, and volunteers from, marginalised communities. We will repeat our Hospice for All events through the year. The project will continue to build on the success of our work last year in developing links with marginalised groups and ensuring we create a long term, sustainable and trusted link with these communities. We will look to start a similar, focussed piece of work to engage and build relationships with people in known areas of deprivation.

We know that patients with respiratory disease have poorer end of life outcomes than other groups and will work to understand how to transform our established Breathlessness Service so it can contribute to addressing this inequality.

St Helena has made significant progress with our compassionate community approach over recent years. This year, we will focus on embedding this approach across all our services so that all play an active role in developing and using locally based assets to ensure every community is prepared to help.

St Helena will also collaborate with community stakeholders to further the recommendations outlined in the North East Essex End of Life Community Assets Mapping report to:

- Improve communication and language around end of life;
- Provide accessible education and support to help build knowledge, skills, and confidence gaps;
- Involve and integrate carer support services within the planning and delivery of wraparound, holistic end of life care;
- Build a social model of care which complements the medical model and supports individuals and families more holistically through end of life;
- and explore how the health care system can be supported to increase the number of My Care Choices Records completed.

Dear all the staff at St Helena Hospice. Just wanted to thank you all for looking after my husband so well for his last few days. You all do a wonderful job. With best wishes and love.

2.4. Priorities for Improvement from 2022-23

2.4.1. 22-23 Priority One

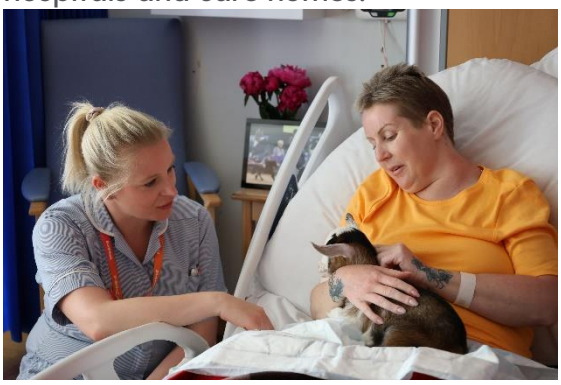
We will progress our work to address inequalities to ensure all groups are able to access our services and achieve improved outcomes. This requires us to engage with the population we serve to co-produce services with them and address the issues they experience in accessing services.

What we wanted to achieve

We will work to use our Inpatient Unit (IPU) capacity to its fullest and serve as many patients and families as we can. We have already increased our Virtual Ward capacity through joint working with Bluebird Care, and plan, in the early part of 2022-23, to pilot adding another four beds to those we provide directly. This will enable us to see how well this additional capacity can support not only admission avoidance and early discharge for patients of Colchester General Hospital (ESNEFT)[2] who are eligible for fast track funding, but also improved flow from our IPU by flexing the criteria for this service. Once this pilot is complete, we will update our referral criteria and share these with system partners via an updated Access to Services Policy (904).

To understand where and why people have unequal access to our care, we need reliable data. We will continue to improve the data collection and processing we use to inform service planning. Our Equality Working Group will further refine its action plan to address areas identified for improvement. These will include expanding our Safe Harbour project to collaborate with ESNEFT to explore barriers in end of life pathways. Where needed, we will develop outreach groups and services.

Recognising that we need to take our services to our local community, we will work to increase the number of visits our SinglePoint service carries out and collaborate with our community nursing service partners to explore opportunities for increased integrated working. We will also explore how we can more effectively provide support to patients within local community hospitals and care homes.



To support people after their loved ones' end of life, we will try to reduce waiting times for our Adult Bereavement Service. We will also be launching a Children and Young People's Bereavement Service in Summer 2022 to fill a known gap in service provision.

All our clinical services will work to define the difference they make to service users and the outcomes they help them achieve. We begin to co-produce services with our local population to better understand the barriers they experience in accessing our services.

What we have achieved

Despite challenges with various Estates & Facilities projects, which have reduced our available bed days on the IPU, we increased occupancy during

[2] East Suffolk and North Essex Foundation Trust.

the year. The average wait for inpatient care remains three days, and we have focused our efforts on supporting referrals from Colchester General Hospital. We have also relaxed our referral criteria in response to local bed pressures.

To all the staff. Thank you so much for giving my mum a comfortable and dignified stay at the hospice. Thank you

Through the year, we increased our capacity within the Virtual Ward, with Bluebird Care providing up to four teams supporting patients in their final 12 weeks of life. This returned to two teams at the end of the year, but we have been able to increase our directly delivered Virtual Ward beds from eight to 12.

We completed a pilot of revised referral criteria and, as a result, provided care to patients thought to be in their final 12 weeks of life instead of six. We have updated our standard operating procedure and referral form accordingly. The Clinical Nurse Manager for the Virtual Ward has formed good working relationships and promoted efficient communication with local organisations, including the transfer of care hub at Colchester General. This helps ensure as many patients as possible are discharged home for the final weeks of their life if that is their wish. An admission avoidance audit conducted during the year demonstrated that an admission to acute care was avoided for 80% of patients referred to the Virtual Ward. In addition, some patients benefited from the service while they waited for us to admit them to our IPU.

To support our work in addressing inequalities, we have reviewed how we collect ethnicity data and aligned our reporting with the most recent categories used in the national census. We've also developed a tool to support our staff in collecting this data.

We have adjusted the structure of our EDI Group and updated our policy statement. The Group has outlined its objectives and is working towards these by developing Hospice policies and practices, providing suitable training for staff and volunteers, focusing our community services on targeted

groups, involving marginalized communities in the co-production of services, and collaborating with partners.

Our Safe Harbour Project Lead continues to work with local communities to understand and address barriers to accessing end of life care and co-produce services. We held a Hospice for All event, which invited members of local communities to visit our Myland Hall site to increase their understanding of hospice care and explore some of the issues they experience in accessing it. We have created new partnerships with marginalised communities to help us understand, co produce, and provide better end of life support for all. The EDI Group has invited speakers to share their knowledge and experience to help us improve our services. These speakers have come from the Alzheimer's Society, the Colchester Dementia Friendly community, the Essex Partnership University Trust (EPUT) Dementia Intensive Support team, the Islamic community, the Nepalese community, and St Elizabeth Hospice.

We have also helped our staff support patients and carers facing the

'Cost of Living Crisis' by creating a directory of resources able to offer support.

I want to thank you and all the nurses for the way you cared for my husband whilst he was in your care at the end of December. It was an extremely stressful time for me, but this was alleviated by your excellent services and I am truly grateful.

Throughout the year, we have increased the number of visits undertaken by our SinglePoint service to patients and families experiencing crisis and needing support. We have also partnered with SignVideo, so deaf people can video call us via a British Sign Language (BSL) interpreter. In addition, we have introduced on demand video remote interpreting, which means staff will be able to communicate with deaf patients and visitors on the spot, as and when needed.

The Medical Team is supporting our local community hospitals with a session per week, and SinglePoint continues to support patients and staff in care homes.

Unfortunately waiting times for our Adult Bereavement Service have not improved, despite increasing the number of hours of counselling we provide. This is because of the increased prevalence of complex grief requiring an enhanced level of support. The Children's Bereavement Service launched in the summer and is taking referrals.

We have relaunched the Outcome Assessment and Complexity Collaborative (OACC) suite of measures over the year to help us demonstrate the impact of our services.

Finally during the year, we carried out a consultation with local stakeholders about our Chaplaincy Service. As a result, we redesigned the Lead Chaplain role and have now recruited to it under the title of Spirituality Lead.

The care and support that a friend of … received recently from SinglePoint was amazing.

While addressing inequality is not a standalone priority for 2023-24, it is an integral part of Priority Three: Continuing to ensure every community is prepared to help (page 5) and remains an implicit goal for all our clinical services.

2.4.2. 2022-23 Priority Two

Develop our workforce to be able to meet the current and future needs of the population we serve.

What we wanted to achieve

To meet the current and future needs of our population we need a workforce with the requisite skills. We will develop a workforce plan to help us understand the profile of our current workforce, what our patients and families will need from us in the future, and how we can innovate to ensure we have the skills and capacity to deliver the right care.

We want to develop our staff so they can work flexibly across different settings and ensure that we have a robust succession plan for key roles, such as Non-Medical Prescribing Clinical Nurse Specialists and Counsellors. We want to maximise opportunities, from apprenticeship pathways through to registered roles, to help us to better retain our staff. We also plan to pilot some initiatives such

as a Paramedic role within the SinglePoint service and a Registered Nurse rotation with ESNEFT.

Promoting the health and wellbeing of our clinical workforce will remain a priority and we will invest in clinical leadership and developing clinical supervision to ensure staff are well supported in caring for their patients.

With St Elizabeth Hospice, we have launched Hospice Education, which offers a programme of study and training supporting end of life and palliative care. The next step will be completing a training needs analysis to inform the development of a prospectus for North East Essex partners. We will continue to offer student placements and participate in relevant research projects.

What we have achieved

During the year, we completed work on a clinical workforce strategy, which includes development and career pathways for both registered and unregistered roles. We secured some funding for backfill roles and, as a result, two unregistered nurses have commenced their apprenticeship pathway through to registration. In addition, a Therapy Assistant has also started her apprenticeship pathway to Allied Health Professional registration.

We are continuing to work on ensuring we have robust succession plans for key roles and have made progress further developing our non medical prescribers.

Working with the East of England Ambulance Trust (EEAST), we set up a pilot for a Paramedic role within our SinglePoint service. This pilot involves four Paramedics, who divide their time between SinglePoint and their usual Paramedic role. The potential benefits of this initiative are to bring Paramedic skills to SinglePoint and to increase knowledge of palliative care and end of life care among staff at EEAST. Together we have agreed the terms under which we will evaluate the project's success.

Unfortunately, we have not been able to progress the Registered Nurse rotation with Colchester General Hospital.

The family of … wanted me to pass on their thanks to everyone who provided support to them recently. … was visiting her daughter locally where her condition deteriorated quickly, following rapid response visit and implementation of ACP, prescribing and ongoing support from the Virtual Ward ... was able to die peacefully with her family around her. They were impressed by the responsiveness of our services and will be making a donation over the coming weeks.

We conducted a review of staff benefits to support health and wellbeing, and, as a result, all staff now benefit from an additional 'health and wellbeing' day of leave. We continue to monitor access to clinical supervision for eligible staff and a member of staff completed their Professional Nurse Advocate training to enhance this offer.

Hospice Education completed a training needs analysis with partners across North East Essex and an associated programme of education has been developed to address the issues it raised. Our Practice Educators have moved to become fully embedded within Hospice Education and are working on delivering projects to support end of life care education across North East Essex.

The CHELsea II research study launched in early April. Those with specific roles in it have undertaken the requisite training, and other staff given information about the study.

During the year, we have hosted several student placements, including a Nursing Associate student.

2.4.3. 22-23 Priority Three

Further develop our compassionate community programme to enable increased resilience within the local community – every community is prepared to help.

What we wanted to achieve

Building on our population health approach and desire to utilise existing community assets, St Helena plans to act as a catalyst to grow community networks that will promote more and better community-based care. We will maximise the use of volunteers within our community where we can, to help these networks become self-sustaining, and actively seek new opportunities for making connections.

The Compassionate Communities programme will give us unique insights into the difficulties our communities face and help us to work with them to build services that will meet their needs. We will do this by understanding their lived experiences, using this knowledge to inform how we deliver care. We will develop our spirituality offer based on the findings of our recent survey of service users and partners.

Following the pilot of our Compassionate Workplace programme, we will roll this out to local businesses.

While wanting to share best practice about our approach, we are also keen to work jointly to produce an academic evaluation of it. We are already exploring connections with local higher education institutions, which also supports our workforce development work in Priority Two.

What we have achieved

We have increased awareness and support for a public health approach to end of life care by developing key partnerships and involving local communities.

This has included delivering shared education through 'Demystifying EoL Care' workshops run with the Compassionate Tendring network. These workshops have been themed around 'Caring for Family and Friends', 'Caring for Mental Health,' and 'Caring in the Workplace'.

During the year, North East Essex Compassionate Communities Steering Group agreed a future governance structure and vision to become a world-class compassionate community. It aims to improve 'death literacy', remove the social stigma and taboos around death, to upskill local communities, and promote and deliver social value.

We have also contributed to the strategic development of a Compassionate Communities approach at Integrated Care System (ICS)[3] level with a collective agreement to support Compassionate Community Charter accreditation by the North East Essex, Ipswich & East Suffolk, and West Suffolk Health and Wellbeing Alliances. This will further embed the concept of a public health approach to end of life care across the ICS and strengthen Alliance collaboration in support of end of life care. We did have plans to arrange an academic evaluation of our work, but we have not been able to

[3] Integrated care systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services in local areas.

progress these so far, so we are focussing instead on accreditation.

We aimed to build four communities of practice during the year and have been successful in developing these in various ways. They include the North East Essex Compassionate Communities Steering Group and the Compassionate Tendring network.

Eight co-production workshops have been held in the Tendring area, providing a platform for local people and organisations to share their experience, knowledge, and ideas. These events will continue to help build a local network and deliver benefits for the local community. During the year, we also conducted an exercise to gather the views of local stakeholders to overhaul the spiritual care we provide.

The family of [the patient] are very thankful for all the care and support they received from the Hospice and that this allowed [the patient] to die at home as he wished even though at times it was very difficult. They said they could not have done this without us particularly as everything changed so quickly. They were very appreciative of the support from… SinglePoint, Rehab and the Virtual Ward.

Our Compassionate Workplaces programme is established internally, with all line managers expected to attend a session, and we have now begun to roll it out to other organisations. We also delivered the Compassionate Conversations programme jointly delivered with St Elizabeth Hospice.

During the past 12 months, we have been able to connect with and support over bereaved 50 people by welcoming them to our monthly Compassionate Walks, which begin from our Myland Hall site. We've also arranged a quarterly 'Walk for Wellness' in partnership with Community360. One of our volunteers has attended a 'Walk Motivator' training session, so that they can help set up public walks elsewhere.

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

2.5.1. Review of Services

During 22-23, St Helena provided the following services:

- Inpatient services – 18 inpatient beds with support from the Hospice MDT, which includes the Nursing Team, Care Co-ordinators, a Specialist Physiotherapist, a Specialist Occupational Therapist, Counsellors, and Family Support Workers. This MDT also hosts the Complementary Therapy service for both inpatients and community patients, as well as the Spirituality Lead and team of volunteers. A Specialist Social Worker supports both inpatients and community patients.
- Community services – acting as the End of Life Hub for North East Essex, co-ordinating all out of hospital care. It comprises the SinglePoint Service (24/7 advice, support, and information), Virtual Ward in collaboration with Bluebird care, and the Community Clinical Nurse Specialist (CNS) Team. The Hospice in the Home MDT consists of the Nursing Team, a Specialist Physiotherapist, Specialist an

Occupational Therapist, a Therapy Assistant, Specialist Social Worker support, a Counsellor, and a Family Support Worker. Our Breathlessness service also sits alongside the Hospice in the Home MDT.

- The Medical Team, supporting both MDTs.
- Bereavement Service open to all adults and children in North East Essex.
- The Compassionate Communities Programme, encompassing our Safe Harbour project and Compassionate Workplaces programme.
- Hospice Education in collaboration with St Elizabeth Hospice.

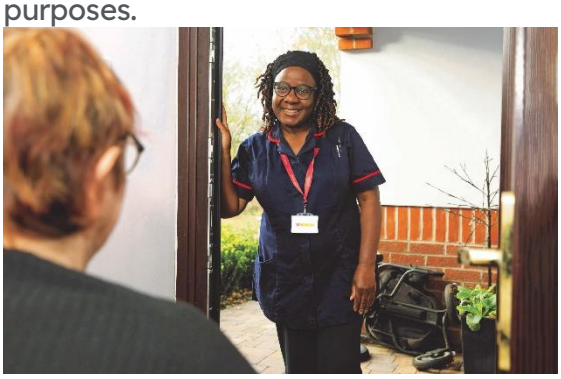
2.5.2. Funding of Services

St Helena is an independent charity using a differentiated commercial model to fund delivery of care in line with our charitable objectives. In 2022-23 our NHS grant funding represented 27% of our total income, meaning that for every £1 of NHS money that was invested in our services, we were able to deliver £3.70 of value of care to our patients and their loved ones. Our diverse range of income streams include commercial ventures, lottery services (through which we also support a range of other charities), High St. and online shops, and the valuable help we receive from our supporters via corporate events, donations, gifts in wills, and other fundraising activity.

I just wanted to say thank you for all the wonderful care that you all gave my darling husband while he was at home. He wasn't able to communicate very well but I knew he appreciated everything you did… thank you for always being there for me too at that difficult time.

2.5.3. Clinical Audit

During 2022-23, St Helena participated for the first time in the National FAMCARE Service Evaluation of Bereaved Relatives' Satisfaction with End-of-Life Care, run by the Association for Palliative Medicine. Results are expected in April 2023 and will include St Helena's own data and comparable anonymous data from other participating services for benchmarking purposes.



Local Audits

The clinical annual audit programme for the year began in April 2022, and was designed by our Clinical Compliance Officer together with service leads. The programme is managed using a dedicated module of our Sentinel system, which facilitates compliance reporting for audits and any resulting actions.

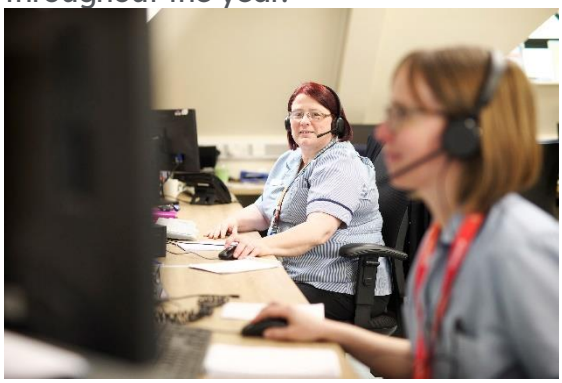
The Clinical Compliance Officer provides frontline support for all staff conducting clinical audits, including help with data collection, analysis, and preparing reports.

The programme ended in March 2023 with 63 out of 65 audits completed, the frequency of audits ranging from weekly to annual. Two were not completed because of insufficient staff time, but these are added to the new programme for 2023-24. The annual programme is supplemented each year by *ad hoc* audits where needed.

Our Quality Assurance and Audit Group (QAAG) meets monthly to monitor our annual audit programme, quality reporting, and patient

experience data. It approves the programme and individual reports and mandates and monitors any resulting actions.

Below, we present summaries of a selection of clinical audits conducted throughout the year.



Non-urgent call bell activity on the IPU [34-2223]

Our Inpatient Unit (IPU) has a wireless nurse call system. It became apparent that the system requires a software upgrade to allow easy retrieval and reporting of all call point service activity. This is being followed up and the purchase and installation is imminent.

Following a concern brought to our attention, while waiting for the upgrade, we decided to audit non urgent call bell response times. An original audit was completed in March 2022 and an SOP for the management and monitoring of the call bell system was written. This first re-audit was completed in June 2022.

The average mean response time was 2.76 minutes. To note, there were some outliers but due to the complexity of patient dependency and staff capacity at those times it was not possible to ascertain the reason for the slower responses.

MND care during the COVID-19 Pandemic [30-2223]

This audit was carried out to determine whether patients with motor neurone disease (MND) were negatively affected by pandemic restrictions in accessing St Helena services and/or face to face support.

A report was provided by the SystmOne Manager of all referrals to St Helena between 1st September 2019 and 31st December 2021 for patients diagnosed with MND. A second report contained all activity data for this list of patients. The Clinical Compliance Officer then provided a Clinical Nurse Specialist (CNS) (and MND link nurse) with a referral overview of each patient, including time from diagnosis to referral, number of St Helena services accessed, and how much input the patient had. The CNS then selected four patient records to review thoroughly to examine whether COVID-19 impacted the care provided.

…You allowed him to pass with dignity and grace. Thank you so very much.

The results showed some evidence that care was affected, in that face to face support was reduced, but telephone support was increased. There was no evidence to suggest that hospital admissions increased, and no evidence to suggest that admission to IPU was affected.

Review of the patient records showed that there was not always consistent support in line with NICE guidance for MND patients, which states that on diagnosis MND patients should be given a single point of contact coordinator.

The recommendation following this audit is that every MND patient sits on a routine caseload with monthly support if thought to be stable, so that deterioration can be captured and so they have a coordinator contact, as per the guidance.

Re-audit is planned for May 2023.

OOH Unit Case Audit [33-2223-1]

This audit was carried out to determine how well patient contact is documented

on our SystmOne out of hours (OOH) unit.

Previous audits, carried out by the SystmOne Manager in January and June 2022, assessed the improvement in record keeping following the changes made to the working processes in 2021. The results showed improved documentation in all areas. The report recommended re-audit for September 2022.

This cycle of the audit showed that improvement in the use of the OOH unit continues.

Admission Avoidance – Hospice in the Home [40-2223]

With the increased strain on healthcare nationally, all healthcare providers have a duty to prevent inappropriate admissions to acute hospitals. St Helena is in a unique position to support patients to remain in their preferred place of care (PPC), and our multi-disciplinary teams (MDT) work together in preventing inappropriate admissions.

An original admission avoidance audit was completed in September 2021, and this re-audit allowed direct comparison of the results to see if there are common themes to how our Hospice in the Home (HitH) Team is involved in preventing acute hospital admissions.

The audit took place over a two-week period in June 2022. Clinicians were asked to inform the auditor following any intervention they felt had prevented an admission. The data was then collated, and each patient's record was reviewed to confirm the patient had not been admitted to hospital within 72 hours of the intervention.

Overall, over the two-week period, all 19 patients were spared an admission to an acute hospital following the intervention of the HitH team. After the intervention, all patients were able to remain in their PPC and, at the time of the audit, five patients had died.

The husband of [the patient] is so incredibly grateful for all the support that he and [the patient] received both within the community and in the hospice and he asked me to pass this thanks on.

Patient Story Documentation [42-2223]

This re-audit was carried out in July 2022 to measure the effectiveness of the Patient Story care plan on the IPU, which is used to evidence that patients' psychosocial needs are being met. This care plan should be completed daily.

An IPU RN audited 25 patient records against the prompts given on the Patient Story care plan. The results showed that the Patient Story care plan was completed with a compliance rate of 94%, and that patients were named in care plan entries 91% of the time.

The audit also showed that the data entered into the care plan was thorough and of a good quality. It was noted that sometimes details entered into the Patient Story care plan might have been better suited to other care plans, or the details were duplicated in other care plans. The care plan instructions have been amended following this cycle of the audit to decrease duplication and ensure that this care plan is used to capture psychosocial needs rather than, on occasion, general needs.

Re-audit will be in July 2023.

Side Rails Assessments [39-2223]
The side rails assessment is used to determine whether a patient needs sides rails on their bed for safety. This audit examined how well the side rails assessment was being used on the IPU. A weekly care plan was introduced during September 2020, with an assessment completed on admission and re-assessment carried out weekly. This was the second re-audit.

The Hospice Senior Sister audited 14 admissions from June 2022 where length of stay was longer than one week and found that all 14 patients had the side rails care plan in place from assessment on admission. That said, only 12 patients had the weekly assessment (questionnaire) completed as part of the care plan update.

A reminder was sent to all staff to ensure the questionnaire is completed once a week alongside the care plan update. Re-audit will be in August 2023.

We are so grateful that [the patient] managed to get one of your priceless beds. You looked after [the patient] so beautifully.

My Care Choices Register Awareness Audit [54-2223]
The My Care Choices Register (MCCR) is a database on which people can record their priorities for their future care. The record is created usually in Primary Care, but can also be created by St Helena, district nurses, or hospital teams.

The recruiter for this survey reported that some of the people contacted were not aware that they had preferences recorded on the MCCR, which raised concern about the quality of the consent process. This audit was designed to investigate this concern and improve the quality of advance care planning and its recording on the Register.

11 people over a three month period reported to the survey recruiter that

they had not heard of the MCCR. Clinical teams (not necessarily at St Helena) were informed and asked to check their records to confirm that, for each respondent, there was a documented discussion about the MCCR and consent to share. Of the nine who responded, all confirmed clear evidence of a discussion had been recorded.

Re-audit will be in October 2023.

I would just like to say a huge thank you to you all for all the support, care and kindness you showed [the patient] and I during his last days with me. You all truly do an amazing job and I cannot praise you enough, you are a very committed, compassionate and empathic team of lovely ladies. Kindest regards x

Moving & Handling and Falls Audit [44-2223]
St Helena Hospice has robust processes in place for the prevention and management of inpatient falls. These are expected to be implemented to support a person's care while an inpatient on the IPU. The two local policies that underpin our practice are the Moving & Handling of Patients Policy and Procedure [089] and the Inpatient Unit Prevention and Management of Falls Policy and Procedure [055].

Following a complaint, it was decided to audit our practice against these policies; in particular, whether falls assessments are conducted on

admission, reviewed daily, and updated whenever a patient falls.

The audit also looked at whether there is any correlation between a patient's Australian Karnofsky Performance Status (AKPS) and likelihood of falling.

The audit found that most falls occurred when a patient's AKPS was 40%, (in bed more than 50% of the time). Therefore, a patient is most likely to fall with an AKPS of 40%.

Data collection to determine if a Moving & Handling Questionnaire and Falls risk assessment had been undertaken within 24 hours of a person falling was not robust. Two methods were used, which highlighted an inconsistency with the documentation on SystmOne, and data collected was contradictory.

A new and improved reaudit was planned for April 2023.

Community DNACPR Audit [41-2223]

This audit examined how the community Clinical Nurse Specialist (CNS) team is evidencing that they are completing DNACPR forms on SystmOne. This is to ensure that there is a uniform approach to the language used, both on the forms and in SystmOne documentation. The DNACPR forms that were completed and the content that was documented on SystmOne and Valida were audited.

This was the first reaudit following initial audit in November 2021. The results were similar to the previous, in that they showed a mostly consistent approach to how the forms are being completed and the subsequent documentation.

Re-audit was recommended for November 2023, with a view to decreasing the frequency of the audit if results remain consistent.

Dear SinglePoint team, Thank you SO much for all your care of [the patient] and for all the support you have to our son and to me. I haven't the words to express how grateful we are but please know we feel it very, very deeply. Thank you.

Patient Comfort (Rounding) Documentation [47-2223]

This fourth re-audit examined how well a care plan for documenting patient rounding was being completed on the IPU. The previous audit was completed in June 2021.

An IPU Deputy Sister audited the records of all patients admitted in October 2022. Daily rounding (four times a day) was completed 100% of the time. Free text documentation within the care plan was noted to be of a good quality, and most of the time entries were backdated to the time the review was carried out.

Re-audit will be in December 2023 to ensure that compliance remains high.

Visual Skin Assessments [49-2223]

This re-audit was carried out to ensure that visual skin assessments are carried out within six hours of admission to the IPU or, if not, that a reason and handover is documented. This was the fifth re-audit.

All current inpatients (17) on 17th February 2023 were audited, looking at when a visual skin assessment was documented during admission and at the quality of related documentation. The Tissue Viability (TV) Lead found that most of the time a visual skin assessment was documented on admission, but that documentation during admission could be clearer when a patient declined assessment. The audit also found that, on occasion, the Post Admission Skin Integrity Check care plan was used incorrectly.

The TV Lead communicated to staff the purpose of the Post Admission Skin Integrity Check care plan with when to launch it and what to document and requested that documentation is

clearer when a patient declines a visual assessment.

Re-audit was scheduled for three months later, with a view to increasing to six monthly if no concerns are identified at that time.

Admission Avoidance – Virtual Ward [51-2223]

The SinglePoint Virtual Ward (VW) is a nurse-led community model that supports patients with intense multiple needs at a time of crisis at end of life being cared for in their own homes. The aim of this increased support is to maintain the patient in their usual place of residence by offering personal care visits to prevent inappropriate admission to hospital and facilitate discharge form hospital where home is the preferred place of care.

This original audit was carried out to examine how well the VW service was preventing inappropriate hospital admissions. A working group reviewed all patient records for referrals received during January 2023 (62) against a pre-agreed set of questions to determine whether admission avoidance was achieved.

The review confirmed the VW service supports admission avoidance by providing timely care and allowing people to remain at home if this is their wish.

To the amazing carers at SinglePoint/Virtual Ward. A massive thank you to you all for making dad's last few weeks a little more bearable. He always looked forward to your visits, you made a huge difference to our lives. You were so kind and gentle to him… We will be forever grateful for the support you gave us.

Hospice UK – Management of Controlled Drugs [32-2223-1]

This annual audit using a Hospice UK audit tool examines whether the management of controlled drugs (CDs) meets the requirements of the Misuse of Drugs Regulations (2001, amended 2007), The Health Act (2006), and the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

The audit comprises seven sections: Premises and Security, Procurement, Stock Held, CD Register and Records and Audit, Prescribing of CDs, Administration of CDs, and Destruction of CDS. Overall compliance for all seven sections was 95%. Any non-compliance related to CD corrections in the Register.

Re-audit will be in March 2024.

2.6. Participation in Research

During the year, we were successfully accepted as a site for the CHELsea II study. This is a cluster randomized trial to assess the role of assisted hydration at the end of life. A lot of work has gone into ensuring everything is in place and that those staff involved have had adequate training and support, building up to officially launching in April 2023. It has also been an opportunity to form links with NiHR[4] and colleagues locally also undertaking the study.

The implementation phase of the research project into Needs Rounds concluded at the end of June and we await the analysis and conclusions, which are due out in the first half of 2023.

You made a very difficult time a little bit easier.

[4] The National Institute for Health and Care Research.

2.6.1. Use of the CQUIN Payment Framework

St Helena income in 2022-23 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because we are not party to any NHS National Standard Contracts.

2.6.2. Hospice UK posters

In November, various staff were accepted to present posters at the HUK conference in Glasgow. Overleaf, we reproduce these posters.

We were so relieved to get mum home to die peacefully in her home she had lived in for 50+ years with her family at her bedside. This would have been impossible without you all. Your support however was so much greater than this. It takes a tremendous amount of skill, courage and expertise to step into a family's life when they are at their most vulnerable, to take charge, make a difference and for it not to feel like an intrusion. Thank you all so much for making mum comfortable, for treating her with dignity, for listening to us and for making us feel that nothing was too much for my mum emotionally. Please appreciate the work you do makes a HUGE difference and my family will always be exceptionally grateful to you all, from the ladies who answered the phone to the nurses who attended mum at home…

Guideline for Venous Thromboembolism (VTE) Prophylaxis

for patients admitted to the hospice

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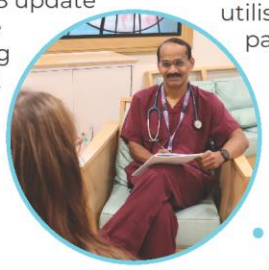
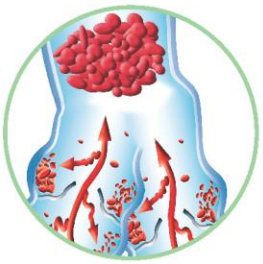
Venous thrombosis most commonly occurs in the "deep veins" in the legs, thighs, or pelvis. This is known as a deep vein thrombosis (DVT). If the clot lodges in the lung a very serious condition, pulmonary embolism (PE), arises. DVT and PE are known as venous thromboembolism (VTE)[1]. The 2018 update of NICE VTE prophylaxis guidance[2] for Palliative care patients suggests to consider VTE prophylaxis taking into account temporary increases in thrombotic risk factors, risk of bleeding, likely life expectancy, and patient preference. VTE prophylaxis should not be offered in the last days of life.



There is little evidence to support or refute routine use of VTE prophylaxis in palliative care patients. This uncertainty hinges on the following issues:

- Unlike hospitals, an admission to hospice may not be associated with acute change in medical condition or mobility.
- In general, focus of care is placed on quality of life rather than life extension. It is unclear whether VTE prophylaxis reduces symptoms if a clot does develop.

We developed a guideline for VTE prophylaxis based on NICE guidance and we embedded the Phase of illness as the starting point.



St. Helena guideline:

- All patients admitted to hospice should receive a 'risk assessment'[3] and the 'decision making tool' should be utilised to guide patient selection. Phase of illness[4] for a patient can be stable, unstable, deteriorating or dying.
- VTE prophylaxis should not be given to people in dying phase, stable phase with no change in their mobility status and deteriorating phase of illness with prognosis of weeks.
- For people with unstable phase, with deteriorating phase with months prognosis and with stable phase with reduced mobility, VTE prophylaxis should be considered by taking into account thrombosis risks, bleeding risks and patient preference.
- Patients are not for VTE prophylaxis if there is a bleeding risk.

We developed a decision-making tool as described above with a flow chart and embedded in SystmOne.

VTE Prophylaxis Flow Chart

Patients with:-
1 Pancreatic cancer on chemo
2 Any cancer or disease modifying treatment and additional thrombosis risk factor
3 Myeloma – receiving steroids and thalidomide, pomalidomide or lenalidomide

Consider VTE prophylaxis – regardless of mobility

Assess the Phase of illness (POI)

i) **DYING** ii) **STABLE** with no change in mobility iii) **DETERIORATING** (with weeks prognosis)	i) **STABLE** ii) **DETERIORATING** (with months prognosis) iii) **UNSTABLE**
NOT for VTE prophylaxis	**Complete Modified DoH risk assessment for VTE**

Step 1 – Loss of mobility/reduced mobility
Step 2 – Thrombosis risk(ref. Modified DoH VTE risk assessment tool)
Step 3 – Bleeding risk(ref. Modified DoH VTE risk assessment tool)

Bleeding is generally high in palliative care patients

All patients admitted to hospice may have at least one thrombosis risk

(a) If bleeding risk is present → then not for VTE prophylaxis

(b) If no bleeding risks, then consider VTE prophylaxis
- Discuss with patient/LPA if lacks mental capacity and discuss with senior physicians if doubtful
- ENOXAPARIN – Dose as per renal function (eGFR) in the guideline
- Monitor and review as per the guideline

Modified DH (Department of Health) Risk Assessment for Venous Thromboembolism

Thrombosis Risk
Patient related:
Active Cancer or Cancer treatment
Age > 60
Dehydration
Known Thrombophilias
Obesity(BMI > 30 kg/m2
One or more significant medical comorbidities (eg.heart disease; metabolic, endocrine or respiratory pathology; acute infectious diseases; inflammatory conditions)
Personal history or first-degree relative with a history of VTE
Use of Hormone replacement therapy
Use of oestrogen-containing contraceptive therapy
Varicose veins with phlebitis
Admission related:
Significantly reduced mobility for 3 days or more
Hip or Knee replacement (recent)
Hip fracture (recent)

Bleeding Risk
Patient related:
Active bleeding
Acquired bleeding disorders (such as acute liver failure)
Concurrent use of anticoagulants
Acute stroke
Thrombocytopenia (platelet < 75x109/l)
Uncontrolled systolic hypertension (230/120mmHg or higher)
Untreated inherited bleeding disorders (such as haemophilia and von Willebrand's disease)
Admission related:
Neurosurgery, spinal surgery or eye surgery(recent)

Phase of illness definitions, Palliative Care Outcome Collaboration

STABLE
Patient's problems and symptoms are adequately controlled by established plan of care
Family/ carer situation is relatively stable and no new issues are apparent
UNSTABLE
Patient experiences a new problem that was not anticipated in the existing plan of care
Patient experiences a rapid increase in the severity of a current problem
Family/ carers circumstances change suddenly impacting on patient care
DETERIORATING
Patient's overall functional status is declining
Patient experiences a new, but anticipated, problem
Family/carer experience gradual worsening distress that impacts on the patient care
DYING
Dying: death is likely within days.

Authors
Dr Ramesh Thulavavenkateswaran (Specialist Grade Doctor)
Dr Emma Tempest (Medical Director & Consultant in Palliative Medicine)
Dr Katherine Oakley (Consultant in Palliative Medicine)

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Addressing inequality of access

to Hospice in the Home (HitH) care in the UK's most deprived neighbourhood by adopting a hybrid model of working

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Background

Patients living in Jaywick, Essex, live in the most deprived neighbourhood in the UK. Jaywick has a high elderly population and high rates of poverty, deprivation and low socioeconomic status (SES)[1]. It is proven that those in low SES settings are more likely to have emergency hospital admissions in last months of life and less likely to die at home[2]. The COVID-19 pandemic has strained hospice services across the country with increase in demand[3] and changes to workforce delivery to protect the most vulnerable patients[4]; the pandemic has added difficulty reaching and providing HitH care to patients in Jaywick.

Methods

We obtained statistics from our health database of HitH patients living in the CO15 2 postcode and created a table of the number of patients accessing HitH support and the number of clinical contacts those patients received and categorised these per annum over a period of three years.

Results

Each year over the last three years, we supported ten more patients in the CO15 2 postcode each year, and there were 100 more clinical contacts with each year. The clinical contacts included face to face, telephone and virtual assessments made by the HitH team.

Aim(s)

St Helena Hospice aimed to increase the number of patients living in Jaywick to access HitH specialist palliative care support and to also increase the amount of clinical contacts with each patient by introducing a hybrid model of working, which would include telephone and virtual assessments and reducing the number of face to face home visits.

Conclusions

The study shows the value of hybrid working as a means for hospice clinicians to reach to wider populations, included those living in deprivation. The results also demonstrated that hybrid working is not just a model used during the COVID-19 pandemic but can be adopted into hospice policy across the nation[5].

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We've made your bed, but Would you lie on it?

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Improvement measures in the inspection and decontamination of dynamic mattresses between patient use

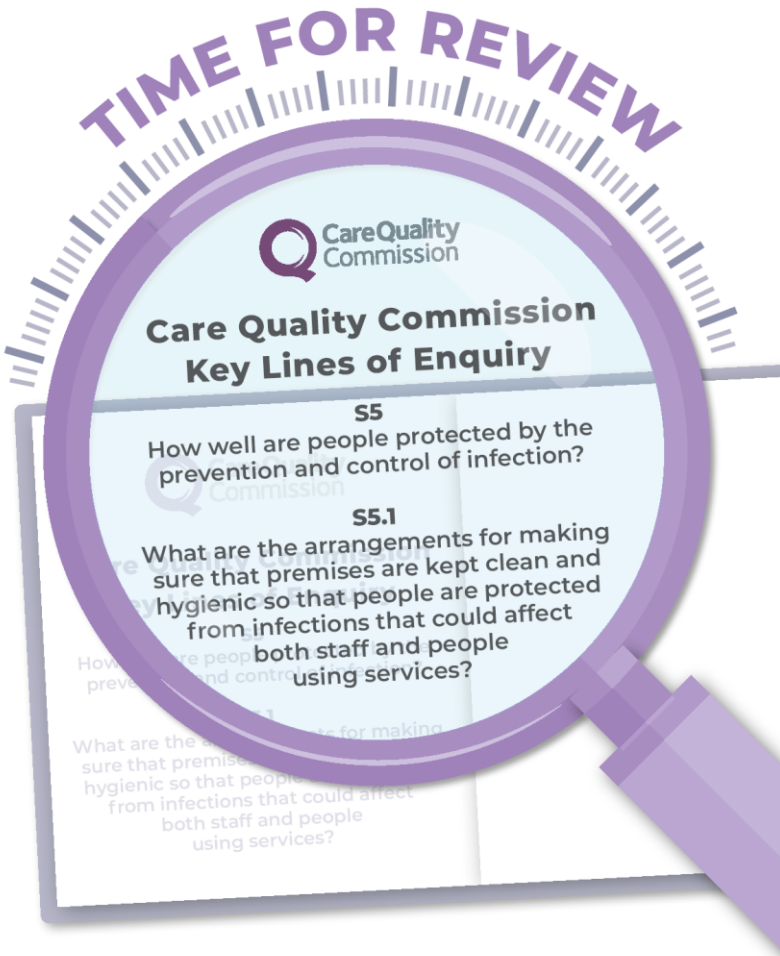
Aim

Following the Care Quality Commission reclassification of Hospices as acute providers[1], St Helena commenced an Infection Prevention and Control review of care activities and the hospice environment. The processing of mattresses was quickly identified as a possible risk to clinically vulnerable patients. Historically, dynamic mattresses were surface cleaned by the domestic team. Due to a lack of space to open up and thoroughly inspect and disinfect the dynamic mattresses, a review was instigated.

Change Journey

The review of the mattress cleaning process involved the following:

- Examining current procedures and identifying areas for improvement
- A visit to a mattress manufacturer that has dedicated professional mattress cleaning facilities
- Introducing a colour coded segregation process where red bags are deployed for used mattresses and ensuring decontaminated mattresses returned in clear bags
- Completion of a Business Case which was approved by Senior management team for additional expenditure to outsource the service



Results and Conclusion

The review of infection prevention and control standards has helped improve patient safety. The process changes have also freed up nursing resource. It has also meant that assurance is now in place for mattress decontamination since all mattresses are processed through a dedicated automated process.

Support from an Infection Prevention and Control expert to review hospice care and the hospice environment helped maximise protection of clinically vulnerable patients. Improvements in infection control standards were introduced, and assurance that mattresses are appropriately de-contaminated, in accordance with the National Infection Prevention and Control Manual for England[2].

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How safe is your Hospice laundry?

My Beautiful Laundrette

Background

Support from a specialist Infection Prevention and Control (IPC) Consultant instigated a review of existing laundry and linen processing and identified a lack of assurance with regard to onsite laundry management. This created a potential infection control risk for clinically vulnerable hospice patients(1).

The purpose of the review of laundry management was to prevent any outbreak associated with linen management in the hospice setting, and provide assurance that the laundry process adhered to the appropriate standards(2).

Method

To improve laundry management the following activities were carried out:

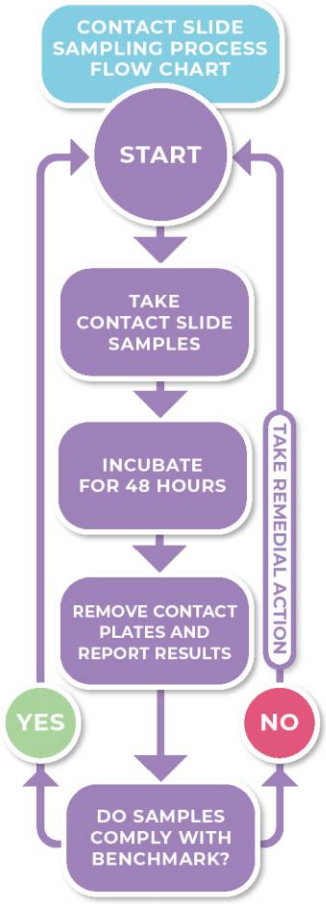
1) Outsourcing of bulk linen items (sheets, towels and pillow cases) to professional provider

2) Introduction of assurance processes for items laundered inhouse(3) (slings, slide sheets and hoists)

3) Training of domestic staff with regard to one way flow of dirty to clean and importance of environmental decontamination to reduce the risk of contaminating freshly laundered items

4) Introduction of regular contact slide testing of laundered linen and equipment to compare against benchmarks, as recommended by the Society of Hospital Linen Service and Laundry Manager.

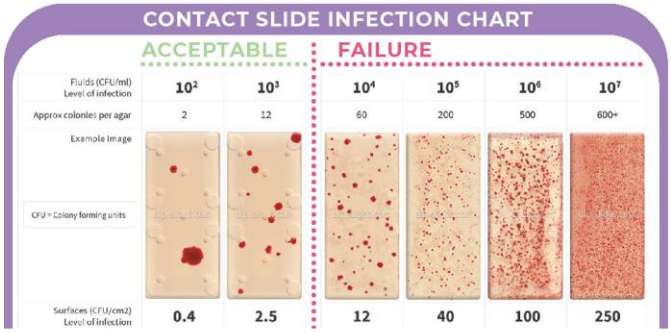
5) Reporting of results along with other IPC audits to Hospice IPC Group and Trustee Committee



Results and Conclusion

Specialist IPC knowledge brought significant value to improving the care environment. This involved a multi-disciplinary approach. This integrated method of working developed a more accountable culture, with all staff understanding the need for change in order to protect vulnerable patients.

The introduction of contact slide testing provides evidence that laundering processes are safe and effective. If audits fall below required standards, additional decontamination procedures are instigated. These improvements were achieved with minimal cost implications.



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Plan your work, then work your plan

Maintaining a safe Hospice environment

St Helena
Helping local people face incurable illness and bereavement

Background

Estates and Facilities is fundamental to the overall care a hospice provides. Maintaining a safe and clean[1] environment is paramount for all service users and workforce, alongside the CQC and the HSE. The Estates and Facilities team ensure planned maintenance checks are completed and evidenced for vital equipment[2] and systems.[3]

Aim

The Maintenance Team were struggling to maintain sufficient, accurate records, which proved an issue for accountability with missing paper records or duplicate spreadsheets. The importance of traceability has increased and completing a vast number of tasks, all with specific instructions and different frequencies, was a challenge. The Quality and Compliance Team offered to trial a bespoke electronic reporting system to remove the need for calendar reminders, wall planners, and folders of paper records.

Method

The Estates and Compliance teams selected vital checks that happen on a daily, weekly, monthly etc. basis. After creating the records, system triggers were activated to auto-create on the desired day and time to populate a team dashboard. This enabled the team to view lists of work for the day, week or month etc., effectively creating central to-do lists. This began a continuous cycle[4] of planning new records, building them in the system, trialling them, and refining where necessary.

Results

The team interact with the new system on tablets, and it is constantly evolving, such as marking non-compliant work, enabling the manager to develop a picture of team resource capability.
The module is rapidly expanding to replace paper and provide remote access to required evidence.

Conclusion

The system provides the Estates Manager clear oversight of planned work, allowing for effective time management and enabling him to report on specific factors, such as faulty equipment, pre-empting replacements[5] for budget setting and overdue tasks, aiming to justify any supplementation of resource for a business case.

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‘Have we got a policy for that?’

Monitoring of clinical policies and procedures using data management software

St Helena
Helping local people face incurable illness and bereavement

Background

An effective monitoring system for the management of clinical policies and procedures ensures that documents remain up to date with best practice, that Care Quality Commission regulations[1,2] are adhered to, and that a systematic archive is in place.

Aim

The creation of a bespoke system for robust monitoring would ensure improved oversight by both the clinical governance sub-group responsible for clinical policies and procedures, and for service leads. Prior to this there was little ownership and oversight; administrative management was led by one member of staff using a non-centralised database. The database often lacked key information, such as review dates, making effective monitoring difficult.

Method

A bespoke system was designed and created for effective monitoring and robust version control. Individual records were created for each policy/procedure, and populated with relevant information such as ownership, review dates, and previous versions, to create a full history of each document.

Reports were created to enable service leads to monitor policies/procedures for their own service, and for the Clinical Policies and Procedures Review Group to maintain oversight at monthly meetings.

Results

Using the new system has resulted in improved governance in this area, with managers having clear oversight of any reviews due or overdue. The Clinical Policies and Procedures Review Group are able to monitor and chase overdue reviews, which did not happen before.

Using the system to create an archive of previous versions of documents ensures a high standard of record keeping and records management[3] is maintained.

Conclusion

An improved policy management system has meant that leaders and trustees can be assured of effective governance processes and that the organisation remains up to date with best practice guidance[4].

Using a bespoke system means that every aspect of policy and procedure management can be captured under one roof, providing assurance that governance processes are in place, in turn assuring CQC of the same.

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3. Review of Quality Performance

The daughter's of [the patient] are so grateful for all the support they received in the last week of [the patient]'s life. They said that everyone involved was lovely and made them feel so at ease.

3.1. Overall referrals to SH

Figure 1, below, illustrates how many referrals we received during 2022-23, where they came from, age distribution and so on.

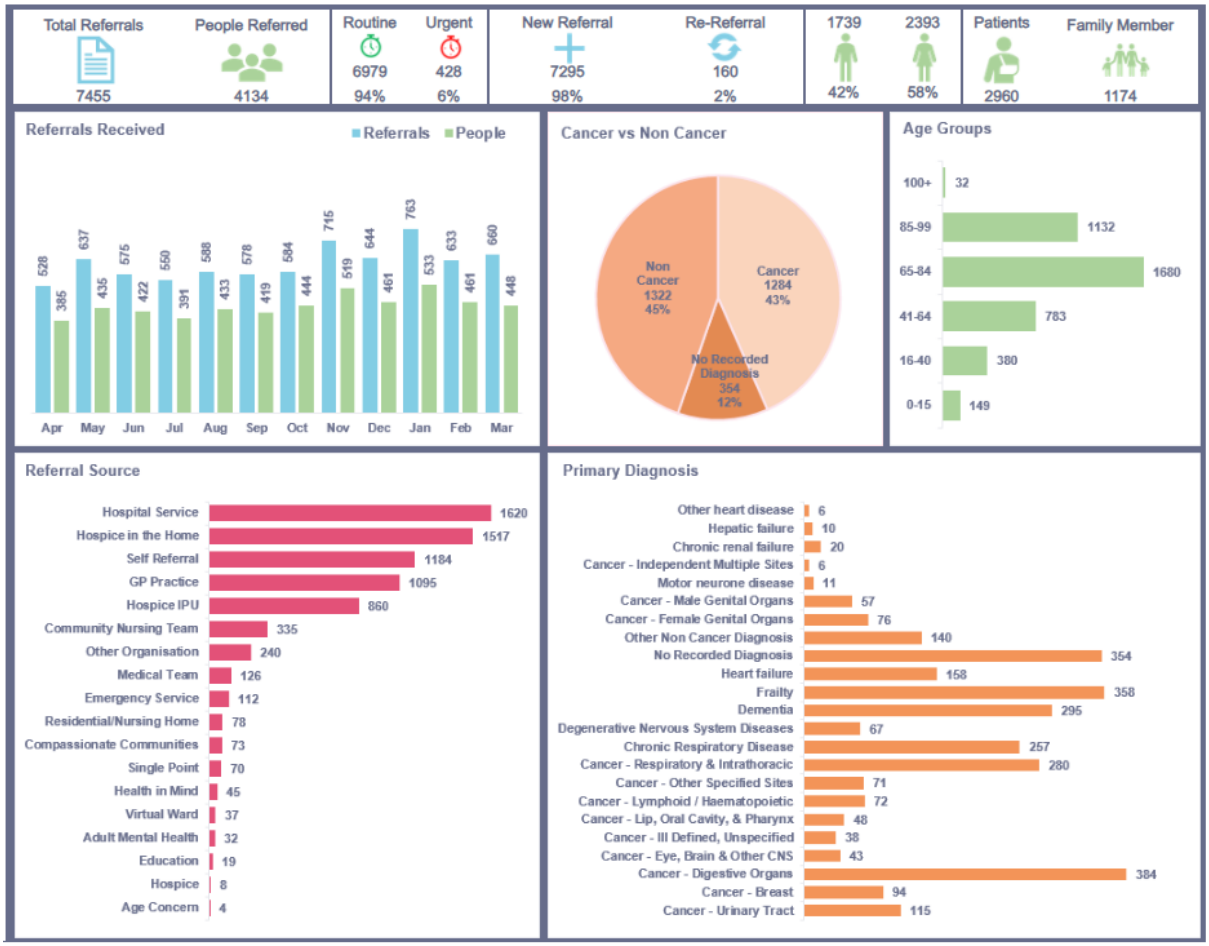


Figure 1 2022-23 referral statistics.

3.2. The Hospice

The year started with the IPU having all 18 beds available for admission, in contrast with the restrictions during the Pandemic, when we could make only 11 beds available for reasons of infection control.

This year has seen bed occupancy increase, and we have welcomed a large number of patients. The final quarter saw us meet our occupancy

KPI across the three months. This is something the whole team have worked very hard on, and it has had a great impact on the number of admissions and patients we can accommodate.

Throughout the first quarter, we made several cosmetic changes to our Myland Hall site. We received a grant from a fundraiser specifically to update the farmhouse lounge. New carpet was laid, and the room was painted, and new furniture purchased. This gave the farmhouse an updated but still homely feel. The fundraiser came to view the room when it was finished and was very pleased with the results.

At the same time, we started the flooring project on IPU, which saw new, Altro flooring laid in place of the carpet. It was jointly coordinated between the Maintenance and IPU teams and was completed in several phases throughout the year. Although disruptive at the time, this work is now complete.

The wife of … wanted to pass on her thanks for all of the support from the hospice during …'s time under our care. In particular she wanted to thank Nicky Holland, and Rachel Hill who she described as comforting when she visited yesterday.

Throughout the year there have been several functional improvements to IPU. One of these was to make water supply and pressure more robust; however, this work uncovered several new problems. We found, for instance, that we had l legionella species (not Legionella Pneumophilia) in some of the patient room showers and taps. We took immediate steps to address this, and our Maintenance Team and Infection Control Consultant have further planned preventative work to remedy the longstanding issues, which is underway.

We kept visiting to IPU under review throughout the year. We first increased visiting hours to 08:00-20:00. Later in the year, we stopped taking set bookings for visiting, allowing visitors to come in as they choose. Additionally, we stopped requesting Lateral Flow Tests (LFTs) from visitors and asked that they exercise caution and not visit if unwell. Throughout the year, we asked that visitors wear a face covering

when visiting IPU. We reviewed the rules on visiting COVID-19 positive patients and took a more pragmatic approach, instead individually risk assessing patients according to their circumstances.

This year, we ran RN study days, as well as specialised Clinical Support Worker (CSW) study days. The RN days focused on learning from complaints, updates to training, and a chance for feedback. The bespoke CSW days focused on a piece of work we had completed on drug errors and the second checking of medications by CSWs. This was a very popular day and we received excellent feedback on it. We also reintroduced team meetings and have welcomed presentations from staff throughout the organisation

(including Lotteries, Fundraising, Chaplaincy, SinglePoint, work force planning, and the Senior Leadership Team). We have also helped two CSWs to start their CSW to RN apprenticeship programme. In addition, the Matron is undertaking her master's degree in advanced clinical practice, and the Senior Sister has commenced a degree.

Throughout the year we focused on 'special moments' for patients. Helping to plan anniversary meals, delivering their favourite coffee, or ensuring that a couple can share the cuddle bed together. At times we have asked for the whole organisation to help us get a message from a patient's favourite band or find a beauty therapist to come into the hospice. Helping patients achieve items from their 'bucket lists' is one of the most rewarding and fulfilling aspects of our work.

3.3. Medical Team

Throughout 2022-23, the Team have continued to provide Medical support across both MDTs. The increased activity and occupancy on the IPU have required more input from us. Despite this (and staffing challenges) we have worked hard to maintain the number of patients we have cared for in the community. That said, as we have improved the accuracy of our reporting, it is difficult to meaningfully compare our activity, year-on-year.

After one of our Specialty doctors was promoted to a Specialist role, we were able to return to a 1 in 5 senior on call rota, allowing us to provide more resilient and sustainable consultant level cover, 24 hours a day, 365 days a year, across all services in North East Essex.

The family praised the hospice for the seamless approach to care and support that their father had.

For several years now, we have hosted a Foundation trainee and GP trainee on our IPU. They spend four months with us, building their skills and knowledge in palliative and end of life care that they can then apply during their future careers. In August 2021, we began hosting GP trainees in our community services on a six month placement where, following induction and training, they spend two days a week with us and two in primary care. This is now established and well evaluated and has helped us increase the number of community visits we can make.

We also host a specialist trainee on a one year placement. Changes to the Palliative Medicine curriculum have meant that they now spend three months of this at our local acute trust. This allows them to use their palliative care knowledge in the hospital while bringing the latest thinking on acute management back to St Helena. This placement also has the potential to help us build a close relationship between the services. It does unfortunately reduce the Team's capacity between February and May (including on call), so we rely on the Team's flexibility, and our bank staff, to fill the gaps. This included working together in March to limit the impact of the Junior Doctors' industrial action.

We continued to encourage student placements. We hosted final year medical students from the University of Cambridge, helping prepare them for their transition to junior doctors in August.

To all my little angels. Thank you for looking after me so well. Miss you all very much.

Also in June, Dr Kath Oakley and Deborah Smart, our Medicines Management leads, attended the palliative and end of life care (PeoLC) Sharing Good Practice Spring Conference. They led a workshop on the role of pharmacy support for our IPU, and the improvements in quality, safety, and patient experience this has brought. The workshop was well received, and participants were particularly interested in our experience of e-prescribing, which many are now considering or starting to implement.

During 2022-23, we continued to operate as a pilot site for the Medical Examiner system. This now well established system allows Medical Examiners at ESNEFT to virtually review the circumstances of deaths and the accuracy of death certificates. We have shown this to be well received by bereaved families and it has not delayed registration of deaths. Working together with the Medical Examiner team has also increased understanding of the Hospice's work and raised the profile of St Helena at ESNEFT. The original aim was for the system to be rolled out to all community deaths during April 2023; however, this has now been postponed nationally.

In August, we began regular Consultant led in-reach sessions at both Clacton and Harwich community hospitals. The purpose of these is to increase their staff's knowledge of palliative and end of life care and to allow better identification of those patients who would benefit from Hospice input. These staff report that they have found this work to be very valuable and we are currently working with ESNEFT to formalize the arrangement.

In September, we held a team day, which we used as an opportunity to take a step back from daily pressures

and think about how we would like to see our services develop in the future.

In November, two members of the team attended the annual Hospice UK conference, where we presented a poster on our guidelines for venous thromboembolism prophylaxis (see page 19). Other team members have attended a variety of training and shared their learning with the medical and wider teams.

Across our ICS the new Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms began rolling out from March 2023. The ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices. We're pleased to say that we implemented this new initiative across all our services from the very first day of the roll out.

A huge thank you to all the doctors, nurses, canteen staff, cleaning team, and volunteers for being such a wonderful, caring, empathetic team to [the patient]. He had been very anxious regarding an "assessment admission" but has really enjoyed his stay, and I know he has made quite an impression with his sense of humour, cheekiness and stories of his life.

3.4. Hospice in the Home

Hospice in the Home (HitH) is the end-of-life hub for North East Essex. The HitH team comprises Primary Care Network Clinical Nurse Specialists (PCN CNSs), SinglePoint, the Psychosocial Team, Rehab Team, and our Referrals Team. During the year, we handled 4842 referrals, 2876 of which went to our own teams and the remainder to partner providers.

3.4.1.1. PCN CNSs

At the beginning of the year, we had several vacancies that were a challenge to fill, but the team is now fully staffed. We have nine PCN CNSs and two developmental PCN CNSs who are completing the competencies necessary to become a PCN CNS. PCN CNSs manage level 3 or 4 patients (see Table 1, below). We created a new post for an RN to work in the team and they support and cover for the PCN CNSs, who have particularly demanding caseloads. The team received 2103 referrals during last year.

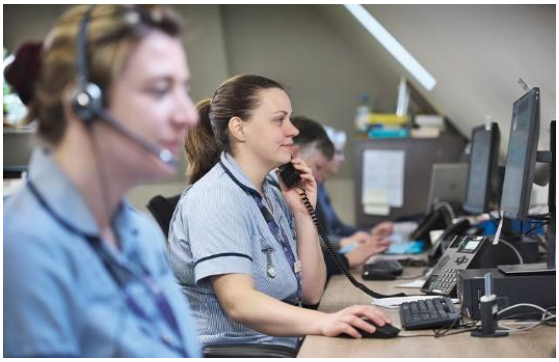
Level	Explanation
1	GP case manages these patients.
2	The DN's case manage these patients.
3	Non intense CNS caseload (generally requiring only telephone calls).
4	Intense CNS caseload (requiring regular visits from the CNS).

Table 1 CNS levels of management.

3.4.1.2. SinglePoint

SinglePoint is the central hub for all out of hospital end of life care in North East Essex, providing a single point of contact for all aspects of end-of-life care in the community.

During the year, SinglePoint received 45,554 calls and supported 2464



people. The team made 2,188 home visits, with the average wait for a home visit 91 minutes. We have increased the number of home visits over the past year, despite Pandemic and staff sickness in the HitH service.

During the year, we commenced a paramedic pilot in collaboration with the East of England ambulance Trust (EEAST). The aim of this pilot is to increase the skills, knowledge, and confidence within both EEAST and SinglePoint, learning the other's skills and role. Four paramedics were recruited to work on a weekly rotation between EEAST and SinglePoint. Each completed an induction including formal training (e.g. Syringe drivers, drug competencies etc.). They also shadowed our non-medical prescribers (NMPs) and RNs. They are now working autonomously and have established their role within the SinglePoint team. An audit is currently taking place, and the provisional feedback on the role has been very positive.

3.4.1.3. Psychosocial and Rehab

The HitH Physiotherapist, Occupational Therapist, and Therapy Assistant work closely with the PCN CNSs and SinglePoint. They also work with the Community Rehab Team and attend regular meetings to discuss complex patients. The Therapy Assistant is currently on an Allied Health Professional (AHP) apprenticeship. During the year, the team received 646 referrals, supporting 423 people.

The HitH multidisciplinary team (MDT) has two counsellors who job share, providing psychological support to patients and their families (including children) and carers. Most of their referrals are received from the PCN CNSs. During the year, they received 333 referrals, supporting 307 people.

The wife of [the patient] will forever be grateful to the staff at SinglePoint who were always there for her at the end of the phone, she can't thank us enough.

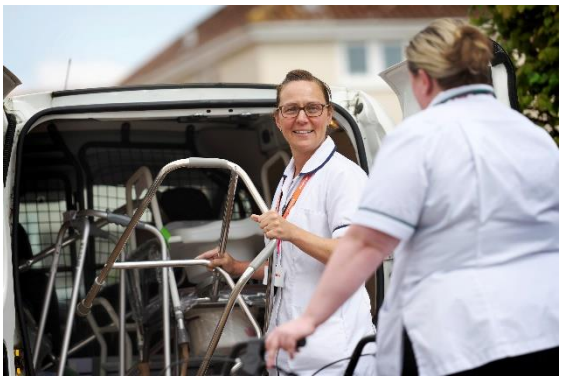
3.4.1.4. Virtual Ward

The Virtual Ward (VW) comprises a Clinical Nurse manager, senior Staff Nurse, an RN on secondment for six months, an administrator, and fifteen health care assistants (HCAs). It receives referrals from GPs, District Nurses, Colchester General Hospital (ESNEFT), and elsewhere within St Helena.

The service provides twice a day personal care to patients in the home who are within the last four weeks of life. The VW also has a rapid response team provided by the Bluebird care agency, which provides care up to four times a day for patients in the last twelve weeks of life. This has enabled VW to support more patients in the community to remain at home with their loved ones in their preferred place of care. The team not only cares for the patients but offers valuable support to the families. The service the VW provides receives a great deal of positive feedback from relatives.

3.4.1.5. Referrals Team

The Referrals Team has had some personnel changes over the year, but is now fully staffed, including a new CNS role. This CNS visits patients who have been referred to the End-of-Life hub and who may require perhaps a single visit to establish their needs. The role has not been formally audited yet, but it is anticipated that it will reduce the number of patients referred to the PCN CNS team for single visits, while making the patient and family aware of



SinglePoint and the support available in the community.

3.5. Compassionate Communities

St Helena is a key leader in developing the Compassionate Communities approach in North East Essex. This approach aims to improve end of life care and bereavement support for all by ensuring that every community is prepared to help. At its heart is the belief that collaborative social networks

can better identify and bridge gaps in care provision, building on the ethos of a Public Health Approach to Palliative and End of Life Care. The outcomes we hope to achieve include:

- Increasing the number on the My Care Choices Register with advance care planning in place.
- Increasing discharges to preferred place of care by building community capacity and capabilities.
- Reducing emergency admissions to hospital near people's end of life.

Working through the Pandemic had been a challenge, but we secured additional funding to extend the role of our Personalised Care Project Coordinator by six months. This project focused on enabling conversations with people in care homes thought to be in the last year of life, targeting areas of lower levels of access to the My Care Choices register and deprivation. The original target was to facilitate adding another 100 care home residents to the Register, but this but was easily exceeded. We also used these conversations to gain feedback to inform care planning.

We also led two 'co-production' workshops in Tendring, which provided a platform for local people and organisations to share their experience and knowledge. We delivered Compassionate Workplaces training for line managers at St Helena and made this training available to local businesses. We also piloted 'Compassionate Conversation' training, partnering with our colleagues in Tendring and St Elizabeth Hospice. These sessions help people develop the knowledge and confidence to help others experiencing death, dying and loss.

Compassionate Communities also supports Social Prescribing at end of life, with the aim to provide non-clinical support to people with life limiting illnesses and their families/carers to access the support and services they need. We also delivered two 'Demystifying End of Life Care' community events, which helped address the social stigma around talking about end of life, improve death literacy, and bridge gaps in support.

We've also been advocating for a 'Compassionate Charter' across our Integrated Care Board and presented an option paper in January. This resulted in a collective agreement to support Compassionate Community Charter accreditation by NEE, Ipswich & East Suffolk, and West Suffolk H&W Alliances. This will further embed the concept of a public health approach to EOL care across the ICS and strengthen Alliance collaboration in support of EOL care. Meanwhile, the NEE Compassionate Communities Steering Group has agreed a future Governance Structure and vision - to become a world-class compassionate community with the aim of improving death literacy, breaking social stigma and taboo, upskilling our communities, and to promote and deliver social value.

Finally, our monthly 'Compassionate Walks' from St Helena, and a quarterly 'Walk for Wellness' in partnership with Community 360, have enabled St Helena to connect and support over local 50 people, while one of our volunteers has attended a Walk Motivator training session that will help establish further public walks supporting people who are bereaved.

Dear all, thank you so much for the kindness, compassion & professionalism that you showed to my family during the end of life care you gave to my late mother. We will be eternally grateful to you. I have nothing but praise for all.

3.6. Bereavement Service

The Bereavement Service counsels and supports bereaved adults across North East and Mid Essex, irrespective of the cause of death, and has also recently introduced a Children's Bereavement Service.

At the end of 2022-23, the Service comprised a manager, two administrative coordinators, ten counsellors, two support workers, ten volunteers, and two students on placement. The service manager has recruited two trainee counsellors and has start dates for a further four. An advertisement for qualified volunteer counsellors is live, and one qualified volunteer counsellor is due to start her role with the service in June.

All our Counsellors are registered with governing bodies for counsellors and psychotherapists, namely BACP, UKCP And the NCS and the service manager is also a member of The Association of Bereavement Coordinators (ABSCO). All staff and volunteers complete regular mandatory training and continued professional development.

During the year, we have organised a placement pathway for master's students from the University of Essex psychoanalytic studies course. Students who have completed the first year of their master's and are deemed competent to undertake practical support will care for bereaved clients. This is a mutually beneficial relationship and will add to the current list of training providers with who the service has a relationship. These students begin their placements in October.

To all the staff at St Helena Hospice. A huge thank you for your care of [the patient] while he had a short stay with you. We really appreciate what you did for [the patient] and the level of care was amazing. I cannot think of anywhere better for a terminally ill person to spend their final days than at your fantastic facility. Many thanks to a very professional team, not forgetting the voluntary staff for providing sustenance on demand.

The Children's Bereavement service launched at the beginning of July and the service has received 104 referrals, so far. Our counsellors give advice to educational settings on how they can support children who experience typical bereavements. The service offers a therapeutic group that can be attended by children and their care givers. The group uses creative mediums, similar to the STAR's programme, to provide therapy. A second children's counsellor started with us in September; however, the hours of this role are now shared by three counsellors.

The service adopts the four tier model for psychological support specified by the National Institute for Health and Clinical Excellence (NICE), and we use this for triaging and allocation to staff. As a result of the pandemic, we moved from face to face work to telephone or video counselling sessions and have more recently re-integrated our face to face counselling support.

During the year, we had the challenge of two members of the team being on long term sick leave, but they have now returned to work. Our adult waiting list remains a challenge as well,

as does finding suitable premises for providing counselling in Tendring.

To ensure long term sustainability of the Adult Bereavement Service, we are working with partner organisations to design a collaborative model that reflects the offer across the Integrated Care System. This has resulted in us having to review our current team structure and bring together all counsellors and support workers from across the organisation into a new Counselling and Emotional Wellbeing Service. We anticipate that this process will be complete by the end of Q1 2023-24.

The brother of [the patient] expressed his sincere thanks to the whole Virtual Ward team who he felt very supported by in the last few days. He said everyone was very helpful and he felt so supported. He couldn't have done it without them.

3.7. Spiritual Care Team

The Spiritual Care Team works across the organisation to meet the pastoral, spiritual and religious needs of patients, families, and staff, while also raising awareness of them among staff and volunteers.

During the year, the team supported 300 referrals for patients and their families, making over a thousand contacts. These contacts (both on the IPU and in the community) included being a listening ear for patients who wanted some company, delivering or facilitating religious rituals, organising weddings (three in the past six months), and arranging funerals.

We recruited a new Spiritual Care lead in December 2022, and they are now working on recruiting and training a team of volunteers to support spiritual care on the IPU. There is an ambition to make the team more religiously diverse and, in the past six months, we have recruited volunteer chaplains from the Buddhist, Jewish, Muslim, and Sikh communities.

The team has also worked with the Compassionate Communities project to deliver training around end-of-life conversations in the community and run in-house training for RNs about spiritual care. There is now a staff wellbeing and mindfulness group, which runs in the multi-faith chapel, led by the Spiritual Care Team in partnership with the Colchester Buddhist Centre.

The Spiritual Care Team recently organised a ‘Hospice for All’ open day, partnering with the Safe Harbour project. This was attended by religious leaders from the Anglican, Orthodox Christian, Jewish, Buddhist, and Brahma Kumaris communities. Participants were keen to be involved in St Helena’s work, and interest was expressed in developing an ongoing regular meeting for interfaith leaders.

Priorities for 2023-24 include:

Securing funding to make the multi-faith chapel more inclusive and accessible to people of diverse faith backgrounds.

Recruiting more volunteers to support the IPU.

Delivering training for hospice staff and volunteers on spiritual care.

Exploring and developing our communication around spiritual care; e.g. promotional materials, what we call the chapel, etc.

3.8. Complementary Therapies

The Complementary Therapy (CT) service provides therapeutic treatments, given alongside medical care, which help manage wellbeing and health. They focus primarily on the individual and their emotional, mental, spiritual, and physical health, and may be helpful in treating symptoms like pain and muscular tension, stress, hormone imbalances, depression, poor sleep patterns, lack of focus, lifestyle problems, and anxiety. By so doing, complementary therapies can improve quality of life and, when necessary, quality of death.

We offer services to inpatients, their families, community patients, and Bereavement Service clients; either at bedside, on home visits by the CT lead, or at our Joan Tomkins Centre. All our treatments are provided by qualified and regulated therapists.

Treatments include aromatherapy massage and inhalers, massage therapy (including the 'M' technique and Indian Head Massage), reflexology, Holistic Facial Therapy, and Reiki. We also have Lottie and Flora, our two Pets as Therapy (PAT) dogs who visit our IPU.

Our team comprises 12 volunteers and our full-time Team Lead. We regularly liaise with our Volunteer Services team to recruit new therapists and have a steady stream of new applicants. We employ stringent checks to ensure all our therapists are qualified and reputable.

Most of our referrals come from the CNS team in Hospice in the Home, and our IPU clients often refer themselves to us.

Can I just say a massive heartfelt thanks to all the staff at the hospice. Mum was an inpatient for the last 5 weeks of her life. Not once were we made to feel we were in the way, the care they gave to mum was outstanding. Although this sounds odd mum's death couldn't of been nicer and more peaceful, we were all able to stay with mum till the end.

In 2022-2023 we gave 1082 treatments to 303 people with Reflexology treatments being the most popular. We now offer holistic facial treatments to enhance our therapeutic treatments, providing a peaceful space to relax as well as improve one's skin health. We gave out 96 personalised aromatherapy inhalers to our service users (often sending them by post) during the year. These can help people who may be struggling with anxiety, stress, breathlessness, and nausea. We have found these to be a very effective treatment. We measure the effectiveness of our care using a licensed outcome measurement tool called Measure Yourself Concerns and Wellbeing (MYCAW).

We also provide treatments to St Helena staff, as part of general wellbeing support. For example, for a donation, we provide aromatherapy inhalers to help with work related stress and sleep problems. In addition, we provide wellbeing and mental health information, and support and guidance for staff and volunteers, including Shwartz Rounds.

During the year, we have been developing our links with St Helena's Compassionate Communities work, including facilitating a public awareness project comprising

Compassionate Workplace sessions and an associated 'toolkit'. These have the aim of improving capacity in the community to deal with death and dying, in particularly by increasing the understanding of local business, so they can better support their employees. The sessions address workplace culture and show small businesses and medium-sized business how they can improve policies and practices.

The husband of [the patient] wanted to pass on his extreme gratitude for all that everyone is doing for [the patient] and the family. Throughout [the patient] 's journey he has really struggled emotionally as he did not want her to die, he is now able to understand that she will die. This doesn't upset him any less but he has come to terms with it. Thank you so much to the team for all of the hard work you do and for the support you provide patients and families.

We held our first Compassionate Workplace session in Harwich and have others planned, including ate least one for Colchester City Council.

In the year, we were approached by Essex County Council to provide training for care home managers and workers on 'Namaste Care'. This is a person-centred, multi-sensory approach to helping people who live with advanced dementia. The sessions, which we provided with our Learning & Development team, proved very popular and three were given. To date, we have worked with 49 care homes and been featured in the March 2023 edition of the SNEE End of Life Care Newsletter. We have more sessions planned for the remainder of 2023.

3.9. Breathlessness Service

The Breathlessness Team provides support and advice for those suffering from breathlessness, including advice for the fatigue and anxiety that often accompany this symptom in palliative patients. The Team advises on breathing techniques and provides a rationale, so patients and carers understand why they are recommended.

The Team also advises on possible lifestyle changes, adaptations, and different ways of functioning so that quality of life can be maintained as far as possible. They do this via one to one clinic, (face to face or virtually), groups, or home visits for the housebound and / or hard of hearing if required.

During the year, we ran two six-week FAB Breath Happy Groups from our JT Centre, both of which were well received. In the Autumn, we were also pleased to run a group at Imperial House in Clacton. This is a great move forward in providing support for patients in this area and dates for the coming year have already been secured.

3.10. Safe Harbour

The Safe Harbour Project was established to make good end of life care more accessible to minority, vulnerable and hard to reach groups. This includes members of the BAME community and those with drug addiction, mental illness, and learning disabilities. It is aligned with the Compassionate Communities approach and, latterly, supports our CNS team to help patients with complex needs. Recently, our newly recruited Project Manager had ben focused on increasing cooperation with partners including Colchester's homeless charity, Beacon House, and Refugee Action. They are also looking to tackle the high level of preventable deaths among patients with learning disabilities.

The project has also been building relationships with local Hong Kong, Thai, Pilipino, Indian, Bangladeshi, Muslim, Nepalese, African, and Chinese communities to learn more about the barriers their communities experience.

This work included a 'Hospice for all' open afternoons offering a tour of our services, followed by a session to hear about their needs and concerns. The event was well received, and attendees fed back that it changed their perception of hospice care and gave them the confidence and information they needed to encourage members of their community to receive care from St Helena when needed.

New relationships have also been established with refugee groups including Essex County Councils refugee project and RAMA and the LGBTQ+ organisation, Outhouse. Through conversations with these groups, we have been able to identify several practical barriers to accessing care. We have also established community partnerships in local deprived areas, such as Greenstead in Colchester and Jaywick in Tendring.

To all the amazing staff at St Helena. Thank you so much for taking such excellent care of my dad. It was such a relief to hand the responsibility of caring for him over to a team who we trusted implicitly, to allow us to go back to being his family. Your kindness, patience and compassion to both him and us were outstanding and it is a great comfort to know he felt safe and was where he wanted to die.

3.11. Equality, Diversity & Inclusion

St Helena is committed to addressing inequalities in the provision of care at End of Life for patients and their families in North East Essex (NEE). We recognise the five-year UK wide hospice sector strategy to 'Open Up' hospice care, and in particular its first pillar to 'tackle inequality and widen access to hospice care', and have established an Equality, Diversity and Inclusion Working group to oversee progress. Its objectives include:

- Widening access and improving the experience in accessing care for individuals and families dealing with an end of life diagnosis.
- Understanding, evidencing, and articulating gaps in healthcare provision.

- Building cases to address gaps in service, including accessing funding to support delivery where appropriate.
- Recording priorities and outcomes identified by the NHS Equality & Diversity Framework (EQIA) Impact Assessment Policy

During the year, we recruited to a new Spirituality Lead role, which will help us develop relationships and better support the emotional, physical, and psychological needs of diverse communities. We also backed an Alliance wide 'Cost of Living Crisis' support and communications dissemination programme, to inform staff and volunteers about the help available to our patients and their carers.

We recently invited speakers to share their knowledge and experience to help us improve our services, from the Alzheimer's Society, Colchester Dementia Friendly Community, EPUT Dementia Intensive Support team, Islamic Community, the Nepalese Community and St Elizabeth hospice.

3.12. The My Care Choices Register

The My Care Choices Register (MCCR) is for those people in North Essex who are living with incurable illness, dementia, or frailty and who wish to record their priorities for future care. St Helena has hosted the system for several years.

The Register continues to be well used, holding the continually updated end of life care preferences for 3779 people, including 1425 care homes residents.

Over recent years, we have worked to widen access to the Register for people with conditions other than cancer, and there are now 910 people on it with a primary diagnosis of frailty.

Thank you for looking after my grandpa

This year, there have been two significant developments. Firstly, people who are new to the Register and are clinically stable but at risk of being in the last year of life are now asked to participate in a monthly satisfaction survey. This enables us to see whether people are being treated with dignity, benefitting from sensitive conversations with professionals, having their symptoms properly controlled, receiving the right care, and that their carers are properly supported. Results suggest that 98% of respondents consider that they have been treated with dignity and respect all or most of the time and 87% believe that their symptoms have been controlled all or most of the time.

We will continue to build this survey over the next year to enable us to identify and address areas of inequality.

The kindness, dedication and professionalism you all show is both inspiring and humbling. As I have said to many people the service you offer is the gold standard that we should all strive for as Healthcare Professionals, and I am proud to have had a chance to see it in action.

The second development has been updating the MCCR to allow recording of whether a patient has a ReSPECT form. This form is a replacement for the 'Do not attempt cardiopulmonary

resuscitation (DNACPR)' form and records a treatment escalation plan for clinical care that includes, but is not restricted to, a recommendation about CPR. For more information on ReSPECT, see page 29.

3.13. Safeguarding

To improve patient safety and ensure resilience across St Helena, during 2022-23, we implemented a new safeguard structure of 'Go-To' people. This includes a Safeguard and Prevent Lead, three Safeguard Deputies (one for each clinical area), and seven safeguard champions who work in areas such as the Medical and Domestic teams. The new structure has helped to embed the concept of safeguarding being 'everyone's business' and, as a result, staff, volunteers, and service users can access advice and support more readily.

During the year, we made a substantial change to our model of safeguard training and adopted the Intercollegiate Framework, which identifies the competencies required for all healthcare staff as well as specific detail for chief executives, chairs, board members, and lay members.

This training has increased staff knowledge and confidence in recognising and dealing with potential concerns. From now on, we will offer a blended approach to safeguard learning, with development opportunities to support all learning styles, including face to face, eLearning, multi-disciplinary discussion, self-learning, and links to safeguard partners such as Essex and Thurrock Domestic Abuse Board (SETDAB). This will provide staff with the additional hours required and assures on-going competence.

To fully embed mental capacity skills across the hospice we delivered one of several tailored training packages on Safeguarding, risk assessment, mental capacity assessment and Best Interest decisions. Feedback has been positive, with delegates incorporating the learning into their day-to-day practice. Our Safeguard Lead also provides an induction for all new staff, covering our safeguard structure, policies, documentation, and the local statutory referral pathways and procedures.

Throughout 2022-23, the Safeguard Working Group met quarterly and increased its membership, with staff from across all clinical teams. This is helping to develop a strong safeguard culture. The Group oversaw the changes to the safeguard structure and training model and reviews safeguard incidents. Where we identify themes and lessons learnt we document the actions we take in response. One example of this was how to accurately record safeguard concerns on our electronic patient record, SystmOne. This led to increased support and guidance for staff and resulted in an increase in the number of concerns being reported and an improvement in our response time.

We continued to work effectively alongside other safeguard partners, such as adult and children's social care, the Police and its MOVOSO unit, and health, education, and mental health services. Our Safeguard Lead has been involved with the Liberty Protection Safeguards joint workstream, which has members from ESNEFT, Essex County Council (ECC), Provide, and other local

hospices. This has facilitated excellent networking and sharing of ideas and resources, such as a six question Mental Capacity Act (MCA) audit, which we have added to our annual programme.

We regularly post Safeguard information on the Hospice Workplace forum, including learning from serious case reviews. These posts increase staff awareness of current 'hot topics' and so make our service users safer.

To all the staff at St Helena Hospice, Thank you for your dedicated care and compassion towards [the patient] I will remember your lovely gardens and beautiful house.

3.14. Hospice Education

This year, St Helena joined with St Elizabeth Hospice in Ipswich to establish Hospice Education, a jointly branded education department providing internal and external training services for both organisations. Our team comprises the following staff:

- Department Head
- Three Practice Educators (two at St Helena and one at St Elizabeth).
- One Clinical Educator (based at St Elizabeth).
- Two Administrators who support both sites.

The team offers training and support to local health and social care professionals involved in the care of individuals facing incurable illness and bereavement.

We provide a range of courses, from introductory sessions to palliative care masterclasses and full study days. Sessions are offered both online and in person and cover an extensive array of topics for healthcare professionals working in end of life care and bereavement support.

During the year, we achieved the following:

- Team working for Suffolk New College and Colchester Institute with compassionate citizenship.
- Rolling out the ReSPECT launch across Suffolk and North East Essex (SNEE).
- Care Home Accreditation. We have successfully recruited three homes.
- Healthcare Assistant and Clinical Support Worker Academy. We have funded the recruitment of a project manager and lead preceptor.
- Provided external training to hundreds of delegates, including at Colchester Institute, Colchester Football Club, and University of Suffolk.
- Provided internal education at 13 sessions for 127 members of staff (MDT training; Basic Life Support, and Schwartz Round)

All three of our Healthcare Assistants have started on apprenticeship routes, two working towards becoming Nurse Associates and one towards a Healthcare Assistant Practitioner. In addition to these pathways, we have three members of the Nursing Team starting on the advance-nursing pathway, working towards the Level 7 Advanced Clinical Practitioners apprenticeship. We also have two non-clinical staff starting Level 4 data analyst apprenticeships.

We have faced the following challenges during the year:

- Slow recovery of sector after the pandemic.
- Limited marketing in early stage of partnership.
- Developing a working knowledge of budgets for education for both internal staff development and external income.

As we move into 2023-24, our plans include:

- Continuing to support the rollout to ReSPECT across SNEE.
- Expanding internal delivery with new courses to support the development of the entire clinical team. This will include professional practice two-hour sessions in collaboration with People and Culture.
- We will have talks with St Nicholas Hospice Care to explore partnership working and them joining Hospice Education.
- Sharing best practice on the Paramedic pilot at the Hospice UK Conference in October.
- Organising a spring conference with the Mountbatten Hospice.
- Developing a care/ domiciliary care agency accreditation.

3.15. Freedom to Speak Up Guardian

Freedom to Speak Up Guardians (FSUG) are a product of Sir Robert Francis' 'Freedom to Speak Up Review' following the Mid-Staffordshire NHS scandal. Freedom to Speak Up is about encouraging a positive culture where people feel they can speak up and their voices will be heard, concerns raised in confidence, and their suggestions acted upon. During the year, there have been three to four guardians available for staff to contact, should they wish to speak about a concern in confidence. All our guardians have recently completed training (or refreshers) with the National Guardian's Office.

During the year, we logged no FSUG requests affecting Patient & Family Services.

I should also like to express my thanks for the care you provided for him in the last few days of his life to enable him to spend them at home with me and his beloved labrador. All he wanted was to get home and you and the lovely carers enabled that to happen.

3.16. Quality of the Environment

The COVID-19 Pandemic

During the year, St Helena's Infection Prevention and Control Group monitored all COVID-19 measures against national guidance. It gradually authorised removing the requirement for face masks in areas such as our IPU Kitchen, the Farmhouse, office areas within IPU, and our Joan Tomkins Centre. Although no longer mandatory, we still make masks available.

Throughout the year, our use of Personal Protective Equipment has reduced, reflecting the gradual relaxation of national guidance in the aftermath of the Pandemic. In the last quarter of the financial year, the NHS

PPE Supply Chain began to restrict quantities provided and begin charging for certain items, although we do not anticipate this will negatively affect us. In the meantime, we continue to carry out Face Fit Tester training.

Tendring Centre

In May 2022, we completed the sale of our Tendring Centre in Clacton with incident and updated the Land Registry. In the run up to the sale, the Estates & Facilities team facilitated the winding up of the Integrated Care Board (ICB)'s Vaccination Centre, which had been based there during the Pandemic.

Staffing

During the year, we appointed a new Domestic Supervisor and Estates Administrator and the Senior Leadership Team also agreed to create a new role of Facilities and Health & Safety Manager, to free up the Head of Estates & Facilities to work on more strategic projects. We also promoted the Maintenance Manager to Estates Manager and our Estates Administrator to Health & Safety Officer.

In the final quarter of the year, a wider reorganisation of St Helena saw Estates & Facilities move out of the Patient and Family Services Directorate and into Income Generation. As part of this move, the Head of Estates is now more involved in identifying new income opportunities for St Helena, while still maintaining an overview of the service.

PLACE

PLACE is the NHS Patient-Led Audit of the Care Environment. The assessments usually involve local people (known as patient assessors) going into clinical care providers as part of teams to assess how the environment supports the provision of clinical care, assessing such things as privacy and dignity, food, cleanliness, and general building maintenance and, more recently, the extent to which the environment can support the care of those with dementia or with a disability.

St Helena has carried out PLACE assessments for several years. In July 2022, we carried out the condensed 'PLACE lite' assessment, which covered our IPU and terrace. Following this, we created an action plan to address the learning points.

We conducted our latest full PLACE assessment in October 2022 with three independent assessors, as well as representatives from the Estates team from St Elizabeth Hospice. This was a learning experience for them as assessors and an opportunity for to be 'critical friends' of our PLACE process. Our results included:

- Cleanliness score was 2.9% off 100%, placing us 15th out of 222.
- Food scores were in the top 20%.
- Dementia scores were lower this year, due to the removal of some signs during the IPU flooring project, but these have now been reinstated.

We created a 55-point action plan, which is currently 67% complete.

Our next PLACE lite assessment is due in June 2023.

Water Hygiene

In November 2022 several water outlets tested positive for legionella species (not Legionella Pneumophilia), so we took immediate action to isolate the affected water outlets and, within 48hrs, carry out a full disinfection of the water system.

We then engaged a special contractor to carry out regular water inspections, which identified various maintenance problems affecting hot water provision. Following more positive tests in our IPU, we introduced portable handwash basins and risk assessed all patients. We also began use of specialised disinfection products and an overnight disinfection by an external company and installed a chemical dosing unit.

During the period, we obtained advice from our ICB, ESNEFT, and other consultants and have now established a programme of remedial works to remedy the problem.

Projects

Some of the key projects the Estates team have worked on to improve the physical environment in the last year include:

- Repairs and decorating of our Farmhouse offices.
- Replacement of the carpet in our IPU and Farmhouse with new flooring, which makes pushing beds easier, has a dementia-friendly pattern, and meets modern infection prevention and control standards.
- Water supply improvements, including a new booster tank and removal of redundant pipework.
- Dementia friendly improvements, including new signage, red and blue cutlery, and crockery, and the first work on pictorial food menus.
- Consultation with the ESNEFT clinical Dietician, who gave nutrition advice and praised our catering.
- Our fire safety arrangements were inspected by the Fire Brigade. We subsequently received a letter of compliance with just one action point, which we completed the following month.
- We created a heat health awareness video using material from the UK Health Security Agency. We also made our Farmhouse lounge a ‘cool room’ to help people manage with the extreme temperatures seen in August 2022.
- We enclosed the Myland Hall pond with a fence, in anticipation of the commencement of our new Children’s Bereavement Service.
- We made various improvements to our Mortuary, including:
    - New power sockets
    - Replacement sink and worktop unit in viewing area
    - New, dimmable lighting.
    - New blinds
    - New furniture

- We refurbished the IPU staff welfare room with new sink, worktops, an integrated fridge, and redecoration.

Figure 2 IPU staff welfare room

Hospice UK Conference 2022

The Health and Safety Team worked with the Infection Prevention and Control Group to present two posters at the HUK Conference in Glasgow last November. The first discusses the decontamination of dynamic mattresses, while the second details the compliance and assurance measures introduced in the on site laundry. To see our posters, turn to page 19.

3.17. Volunteering at St Helena

St Helena could not do what it does without the passion, dedication, and individual experience of the volunteers we attract from all backgrounds and walks of life. No matter their role, our volunteers make a huge difference to the lives of our patients and their families and the general running of the organisation.

Inevitably, the Pandemic reduced both the number of people who could volunteer and the number of opportunities we could offer. many volunteers and their roles; however, we have been recruiting rapidly to fill these gaps.

In February 2023, we ran a very successful recruitment campaign called 'Do Good to Feel Good' which focussed on encouraging findings from our most recent staff and volunteer engagement survey. This found that 80% of respondents reported that volunteering was beneficial to their physical and mental health and wellbeing. The campaign included new promotional material about volunteering, featuring a video of current volunteers telling their stories. We also had video messages from staff who had begun their journeys with St Helena as volunteers. The campaign was very successful, yielding 75 new volunteers, of whom more than 50 have joined our Retail team.

We now have over 800, nearly 600 of whom work in our shops and donation centre across Colchester, Tendring, and surrounding areas. We have begun to receive requests from managers for volunteers to visit patients in their own homes, so we are putting proper safeguards and training in place for that. We're also looking to recruit more volunteers to assist in our Inpatient Unit, as well as in Finance, Fundraising, Marketing, and general administration.

One of the biggest challenges we face is that 70% of our volunteers are between 60 and 80 years old. To encourage younger people to volunteer we have recently lowered the minimum age for volunteering in patient-facing roles from 18 to 16 (matching Retail and Fundraising). We are also working with local schools and colleges to provide work experience and Duke of Edinburgh Award scheme placements in non-clinical areas for people over 14.

We are now more focussed on recruiting to meet specific service needs instead of simply numbers recruited. With plans afoot to open more shops, Retail will be a key area of work.

During the year, we updated our onboarding process and introduced electronic document signing to make it more convenient to apply.

Our activity for 2022-23 includes:

- Volunteers leaving: 209.

- New starters: 234
- No of volunteers at year end: 805
- No. of Retail volunteers at year end: 573
- Hours of volunteering donated:160,000 (approx.)

Having completed my shadow shifts and today my first solo shift I would like to thank you for your help with my application. It's everything and more to what I expected and I just love it. All the staff have been so welcoming and being given the chance to make the patients feel special has given me a feeling of total fulfilment that is hard to explain.

3.18. Social Value

St Helena is uniquely placed in North East Essex to offer a range of social value benefits as a funder, provider, and 'voice' of end of life care. This summary uses the model award criteria[5] to describe some specific examples of social value we offer. It is not exhaustive, and we plan to share more about our social value in future quality accounts.

Theme 1: COVID 19 recovery

We provide care directly to those patients who need support on their end of life journey, as well as their families and carers. We also offer mutual aid to our local partners. We work with a range of communities to develop and strengthen access to end of life care, and understanding of the barriers that some people face when trying to access traditionally structured services. This frees up NHS resources to focus on the challenges they face in recovering from the impact of the Pandemic.

We make capacity available in our IPU as often as we can to support our local acute hospital deal with the impact of the changes in demand they face. We have adjusted our service delivery model, meaning we would be very resilient and swift to respond in the event of further business continuity incidents.

We operate a Hospice in the Home service (page 30), including Virtual Ward (page 31), providing care in a way that enables patients to remain at home and independent, freeing up other more acute resources by avoiding often unwanted hospital admissions.

Theme 2: Tackling economic inequality.

Through 'Compassionate Communities'[6] (page 31) we engage with several stakeholders, communities, and individuals to embed a compassionate approach to end of life that extends well beyond the direct scope of St Helena. This includes a specific project called 'Safe Harbour' to tackle inequalities for those facing death, dying and bereavement. Central to the ethos of compassionate communities is the commitment to acceptance and inclusion for everyone, no matter their background, demographics, beliefs or personal choices, and actively reaching out to groups and individuals who are difficult to engage through the more traditional methods used historically and in more traditional healthcare settings.

We offer a range of opportunities across hundreds of volunteer roles (see page 44) which can support people to gain new skills and experience that enable them to demonstrate that to potential employers. We also recruit into a range of employed roles locally.

We expect all our suppliers to commit to delivering social value in a way that aligns to our key objectives, and adds value, to create a whole

[5] See Social-Value-Model-Edn-1.1-3-Dec-20.pdf (publishing.service.gov.uk) for more information.

[6] See Compassionate communities and end-of-life care - PubMed (nih.gov) for more information.

supply chain approach to delivering the benefit.

We hold a fund, on behalf of our commissioners, through which we engage with interested organisations to deliver new and innovative ways of improving end of life care for our population. This allows for a more creative way to engage with small and emerging businesses and charitable organisations in a more supportive way than the traditional commissioning structure allows.

Theme 3: Fighting climate change.
We centre our services around the patient to provide the best care for them. This reduces hospital admissions, keeping service delivery as close to the patients preferred place of care (PPC) as possible. By so doing, we reduce the carbon footprint of the often long journeys now required to take someone to hospital.

Our retail teams, through 22 shops and related services offer quality second hand items, avoiding waste going to landfill and giving an opportunity for consumers to choose a more ecologically beneficial way to shop. Our waste management includes recycling at every possible opportunity, and reductions in levels of waste produced.

Our grounds are enviable, and maintained by a team of dedicated volunteers, housing a range of habitats and green space for the benefit of patients having a restful and peaceful place to receive hospice care, but with the added benefit of housing and supporting local wildlife.

We have our own solar panels, use electric cars, and have electric vehicle charging stations and bike storage on site to encourage greener travel for staff and visitors and so reduce our emissions.

Theme 4: Equal Opportunity
We are a 'Disability Confident' employer, as part of our ongoing commitment to being an equal opportunities employer, and these practices extend to our volunteers. We have an Equality Diversity and Inclusion Policy statement, which sets out our commitment to actively challenging discrimination wherever we find it and have an internal working group that reaches out to other interested parties to tackle inequalities jointly where we can.

Theme 5: Wellbeing
The hospice approach is about not just dying well but living well at the end of life. We offer some charity-funded complementary therapies to our patients and their families through our invaluable volunteers. We also deliver 'compassionate conversations' training free to people who want to find out more about having open, honest, and sensitive conversations with people about end of life.

The support we offer to improve the wellbeing of staff and volunteers includes flexible and hybrid working, training and education, counselling support, and free parking. Some of our volunteering opportunities help tackle loneliness by forming team structures around volunteers with common interests. We also welcome volunteers with a range of skills and abilities, offering opportunities to suit everyone, from physical exertion at our 'Christmas Tree-cycle' event, to checking donated jigsaws and games are complete before we sell them.

she wanted to express how grateful the family were for the care and kindness shown to [the patient] over the last few weeks from all the team at SinglePoint. It was a service they knew nothing about until recently but will be singing our praises going forward.

3.19. Quality Markers

3.19.1.1. Tissue Viability

Pressure ulcers (also known as pressure sores) are injuries to the skin and its underlying tissue, which usually result from prolonged pressure. People confined to beds, chairs, and wheelchairs are especially prone to them. Patients who are near the end of their lives are more vulnerable to them because of their reduced mobility, lack of nutrition, and disease progression.

It is a national standard that all patients have their bodies inspected for pressure ulcers within six hours of admission. When staff discover one, they log it as in incident, irrespective of its severity (category) or whether the patient had it on admission or developed it during their stay with us.

Pressure ulcer incidents are reported to our Tissue Viability (TV) Lead, and the senior nursing team are responsible for investigating them and determining whether all appropriate safeguards were in place. If not, we would deem the ulcer 'avoidable.' We also benchmark our pressure ulcer incidents with Hospice UK.

During the first quarter of the year, we were using a lot of bank and agency staff, which led to a slight drop in the standard of our reporting and documentation; however, this had improved by the following quarter.

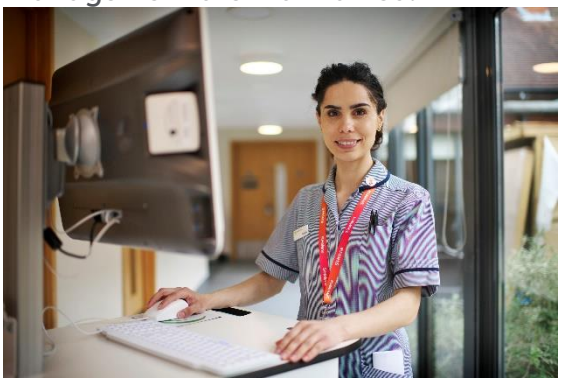
During the year, there have been multiple bed closures for maintenance works, reducing bed occupancy but this increased to maximum during the last quarter. As a result, the number of incidents increased from 66 in Q3 to 134. Fortunately, our investigation time compliance (20 working days) was not affected.

During Q4, the OSKA Academy provided the hospice with a virtual training session on pressure ulcer prevention. This was available to all nursing staff and recorded for those who could not attend.

During the year, IPU purchased a Talley air cushion for pressure area relief, and we have also acquired new recliner chairs from OSKA, which have integral pressure area relief.

Aside from the dip during Q1, documentation has continued to be of a very high quality this year, and this has been reflected in the results from all three TV documentation audits (see page 17 for an example). Two audits continue to be six monthly, and one has decreased in frequency to annual following excellent results in March 2023. The TV Lead has thanked the IPU staff for their ongoing high standard of documentation and vigilance.

For the coming year, the Tissue Viability Group will continue meeting quarterly to monitor and ensure high standards of tissue viability management are maintained.



3.19.1.2. Falls

In a setting like a hospice, it is impossible to prevent all patient falls – particularly while respecting patients' dignity and autonomy – but we strive to reduce them as much as we can. There are many things which can increase the likelihood of a patient falling, including: confusion and agitation, muscle weakness, needing to find one's way around an unfamiliar location (especially at night), being in an unfamiliar single bed, and the desire to maintain one's independence despite

physical deterioration (especially when using the toilet).

We log all falls on our incident system within 24hr of them occurring. Our Fall Leads then assess each report and determine whether all reasonable safeguards had been put in place.

These include bed sensors, bed rails and regular checks of rooms and bays (known as 'rounding'). All patients receive a falls and manual handling assessment on admission, and this is updated any time they fall.

Our Falls Group monitors the incident data and recommends actions as necessary, supported by our Risk & Incident Group, to which it reports quarterly. Following audits during the year, we decided that we needed to review our manual handling and falls assessments, and these now have an improved design with a scoring system to better alert the assessor to risk of falling. These will shortly be added to our SystmOne electronic patient record.

We recorded a similar number of falls this year (78) as last (62) and none of them rose above 'Low Harm' using the Hospice UK scale, requiring basic first aid only.

3.19.1.3. Medicines Management

Our Medicines Management Group (MMG) supervises a programme of auditing of our prescribing and administration on the IPU and investigates all medicines incidents. The Group is led by one of our palliative medicine consultants and our Senior Pharmacy Lead. Our Controlled Drugs Accountable Officer (CDAO) also reports our controlled drug errors quarterly to our Local Intelligence Network. We also benchmark our errors with Hospice UK.

An example of the Group's work this year was when we identified a cluster of errors regarding the same issue and were able to put in measures and additional staff training to reduce the risk of future incidents.

Activity by the group

- Working towards new anticipatory prescribing templates for GPs – MMG trialling the template prior to roll out to North East Essex.
- Benchmarking of opioid prescribing/errors with St Elizabeth Hospice in Ipswich, and St Nicholas Hospice Care in Bury St Edmunds.
- Therapeutics review piloted again on IPU.
- Tabards introduced for RNs on drug rounds to reduce the risk of them being interrupted.
- Both Medicines Management Leads led a workshop at a regional conference receiving good feedback (see page 28).
- Patient satisfaction post discharge from IPU – pilot introduced.
- Implementation of new SOPs - emergency supply of IPU stock to community; labelling of discharge medication; safe storage of CDs (maintenance of cupboards and locks, appropriate fittings, responsibilities).
- Updated discharge paperwork in line with national guidance to include drugs stopped on admission and doses changed during admission.
- Training on CD destruction and informal CD inspection by

a former CD liaison officer for Met Police

- Teaching: EOL/anticipatory prescribing for community pharmacists; opioid switches for all internal clinical staff.
- New drug round times and alert for 90mins window to stop night time only doses being given in the morning.
- CSW competency training days and competency assessments for all CSWs.
- New system of recording FP10 prescription pad use on Sentinel – more user friendly and easier to audit.
- Raised the issue of availability of end of life drugs in community pharmacies with our ICB.

You gave [the patient] back her confidence, when she needed it most, and the bond that you made with her, the camaraderie, was something to behold. The laughter that she shared was like seeing sunshine on a bleak rainy day.

3.19.1.4. Infection Prevention & Control

The IPC nurse specialist continues to advise and support all staff at St Helena through a combination of site visits and remote working via email, virtual meetings, and telephone.

Once again, maintaining St Helena as a COVID-19-secure site was a prime concern, even as the Pandemic abated. This year, we flexed the admission of patients directly to a single room or as the sole occupant of a four bedded bay

to facilitate admission directly to a single sex bay. We also allowed movement from a single room into a bay following two negative screens. This allowed more patients to be cared for on the IPU and provided increased support to the wider health care economy, particularly our local hospital, which is under pressure. Such admissions or moves are undertaken following individual risk assessment.

This strategy carries an inherent risk that a patient may be assessed as suitable for admission to a bay, test negative for COVID-19 on admission, but become symptomatic a few days later and this situation occurred. When it did, we reported the resulting infection cluster to our Integrated Care Board. This situation was discussed at the monthly IPC meeting, which agreed that admission to a bay following rigorous individual risk assessment should continue as the best way of optimising bed capacity.

During the year, we admitted 26 COVID positive patients. For 20, their status was either known on admission or identified from the swab taken within 48 hours. The number of infected patients we cared for reflected the prevalence of the disease within the wider community.

At the beginning of the year, we reviewed mask requirements and agreed that these no longer needed to be worn by the staff or attendees of the Learning and Development Centre. We also relaxed our visiting rules to allow open visiting for up to four people per patient between 8am and 8pm. We still generally required visitors to be symptom free and to have a negative LFD result but made some exceptions when justified. We also decided to unlock the main doors to Myland Hall when Main Reception is staff.

Following national guidance, we ceased routine COVID testing for staff in August (while still advising high

vigilance). When staff were symptomatic, we required them to remain offsite until they obtained two negative tests, two days apart.

The routine use of fluid-repellent face masks continues in the IPU and for staff visiting patients at home, as per the national guidance for healthcare settings. Full face visors, gloves and aprons are also used where risk assessed as necessary. In March 2023 we decided that masks would no longer be routinely required in our Joan Tomkins Day Centre, but staff or patients who wish one are supported to do so.

At the beginning of the year, we aligned our cleaning practices with the National Standards of Healthcare Cleanliness 2021. We finished this in the Spring, well ahead of the November target date.

During the year, we commenced a complex and disruptive project to replace the carpeting in our IPU (see page 43). IPC precautions during the period included double skinned screens to minimise dust infiltration into patient areas. The project was complete by Christmas 2022.

We completed PLACE and PLACE-lite assessments during the year, details of which can be found on page 42.

During the year, we also did a lot of work to manage a problem with legionella species, details of which can see seen on page 43.

During Quarter Three, the IPC nurse specialist worked with the Head of Estates & Facilities to create two posters for submission to the annual Hospice UK conference in November in Glasgow. Both detail improvements to patient safety. The first discusses the decontamination of dynamic mattresses, while the second details the compliance and assurance measures introduced in the on site laundry. We are pleased to report that both were accepted. To see the posters, please see page 19.

Infection Control Audits

We carry out several IPC audits, weekly and monthly. These are reported to the IPC Group, which is chaired by the Director of Care. We also include them in our Quarterly Quality Report, which we send to our commissioners and the Care Quality Commission. We present the results of these in the charts that follow.

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

Thank you all so very much for looking after my partner so well the last week of his life. Thank you all for everything you did for him and for treating him with such tenderness and compassion. Thank you also for looking after me and for allowing me to visit [the patient] even though I had covid, and for enabling me to stay with him the last 2 nights. The snuggle bed is a wonderful thing and our final night together was spent peacefully with me lying next to him all night. It is a memory I will treasure. Thank you for also ensuring I was eating and drinking! You're all amazing and the work you do really does make a difference. Thank you.

Hand Inspection, Hand Washing, PPE, Commode Hygiene

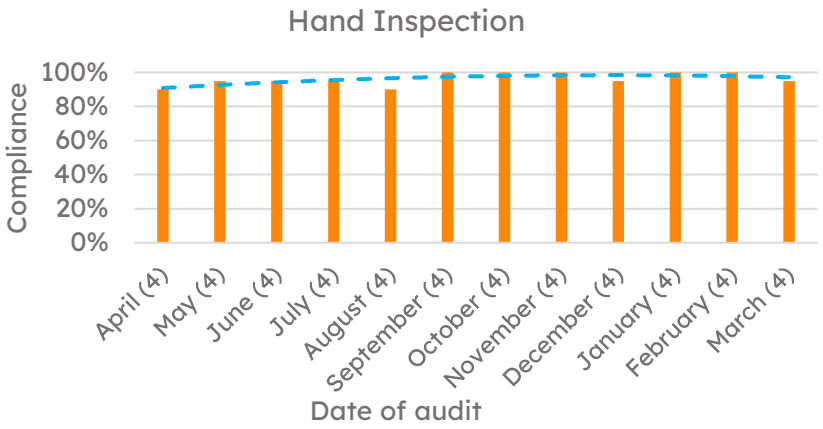


Figure 3 2022-23 hand inspection audits.

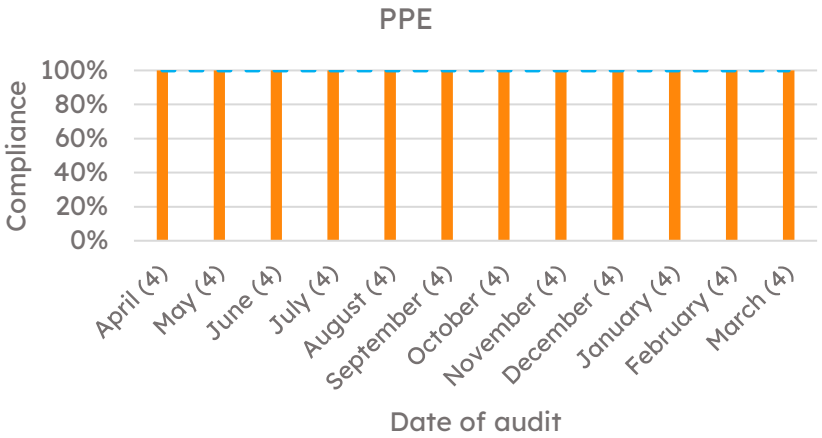


Figure 5 2022-23 PPE audits.

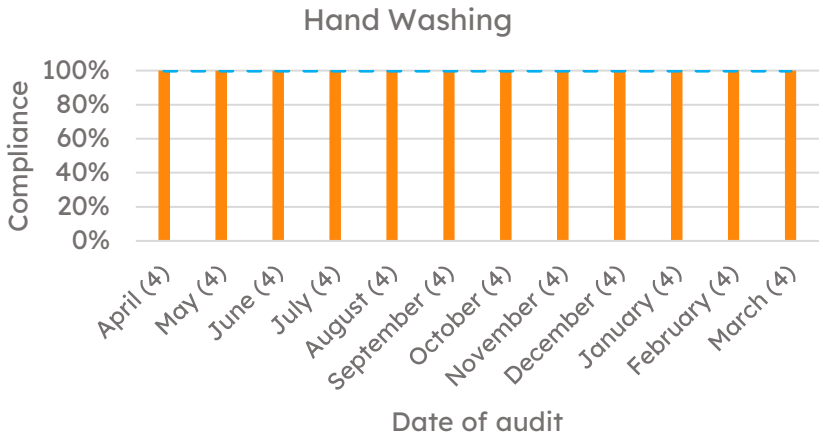


Figure 4 2022-23 hand washing audits.

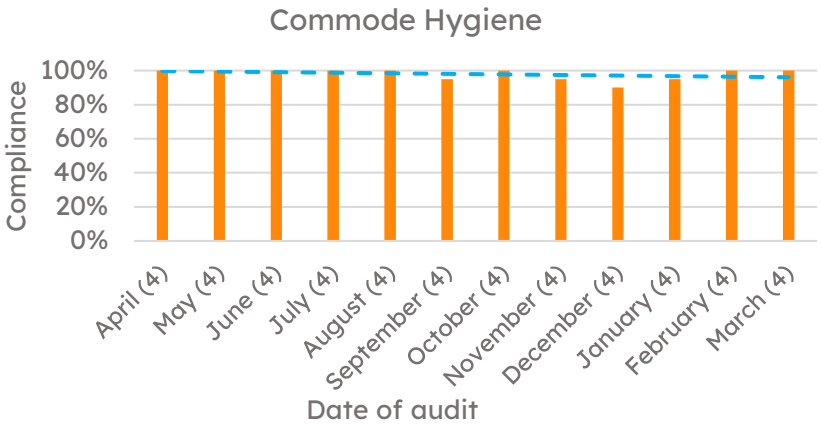


Figure 6 2022-23 commode audits.

High Impact Interventions

High Impact Interventions are a set of national audit tools for measuring how effective clinical processes are and improving them. They can help reduce the risk and spread of healthcare associated infections by focusing on the risk factors which cause them; for example, hand hygiene and the use of intravenous lines.

High Impact Interventions - Catheter Insertion and Ongoing Care

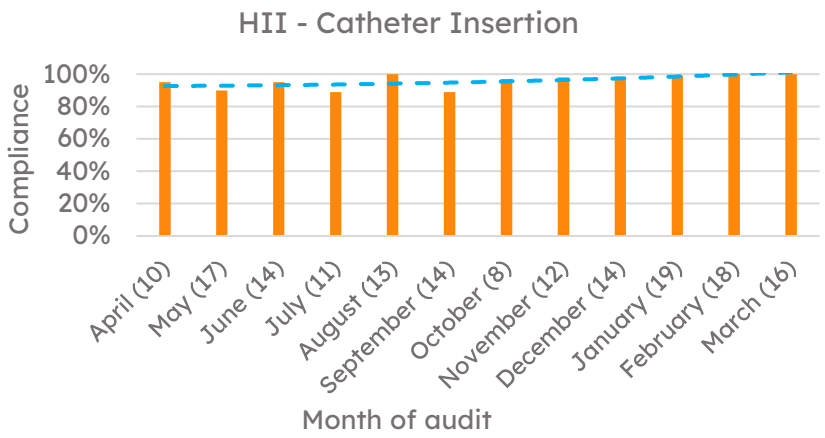


Figure 7 2022-23 catheter insertion audits.

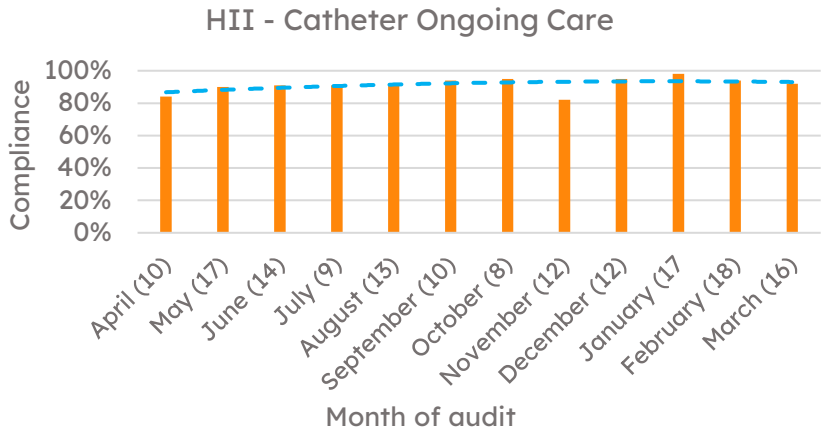


Figure 8 2022-23 catheter ongoing care audits.

High Impact Interventions – Cannula Insertion and Ongoing Care

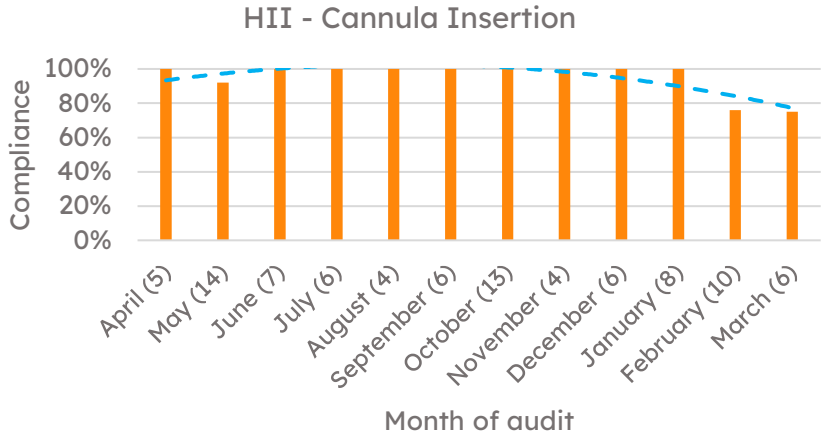


Figure 9 2022-23 cannula insertion audits.

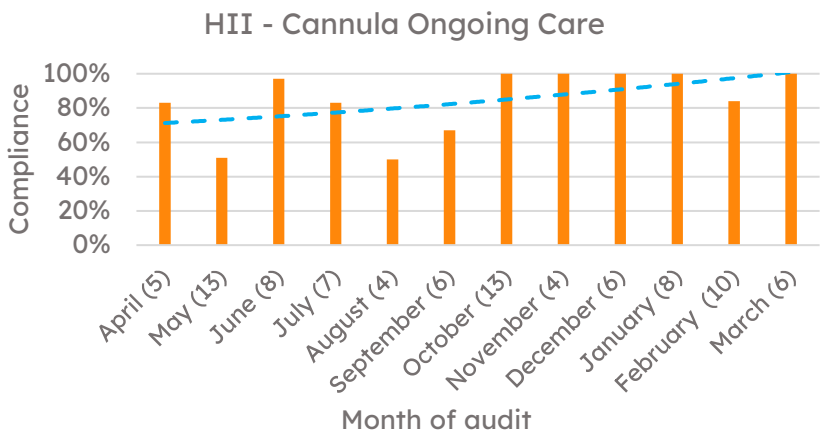


Figure 10 2022-23 cannula ongoing care audits.

Before another day passes I must say a big thank you for all the wonderful care and kindness you gave my husband … whilst with you. Sadly his body couldn't cure itself any more, but the tranquil and friendly atmosphere allowed him to die surrounded by peace and love; this meant a lot to my family and me, thank you.

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

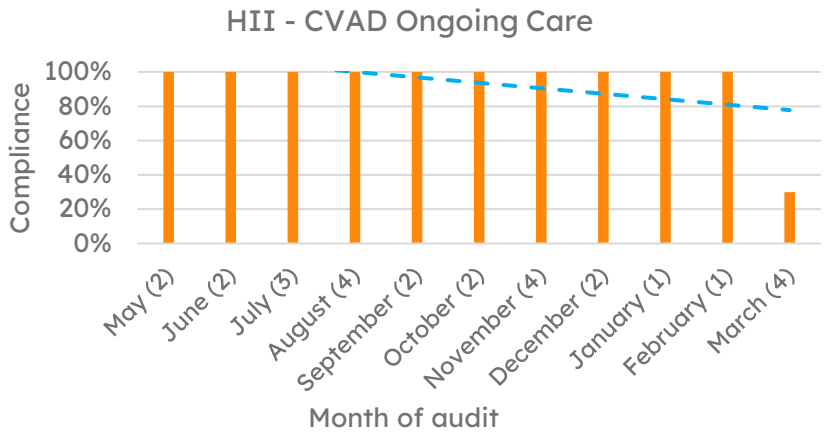


Figure 11 2022-23 CVAD ongoing care audits.

Note. There were no CVADs to audit in April 2022. An action plan is in place following the results of the March audit.

To all who helped make my birthday special a BIG THANK YOU. It was just what I wanted to spend time with my whole family and your extra little touches made it all the more enjoyable. Also thank you to the chef and kitchen staff for the food and lovely cake. You all do a difficult job but somehow manage to go that extra mile and it is really appreciated and probably not said enough. THANK YOU

High Impact Interventions – Antimicrobial Prescribing

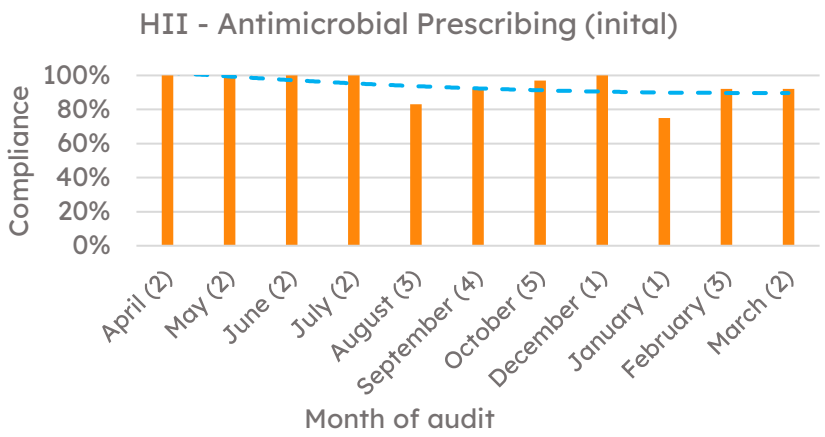


Figure 12 2022-23 antimicrobial prescribing (initial) audits.

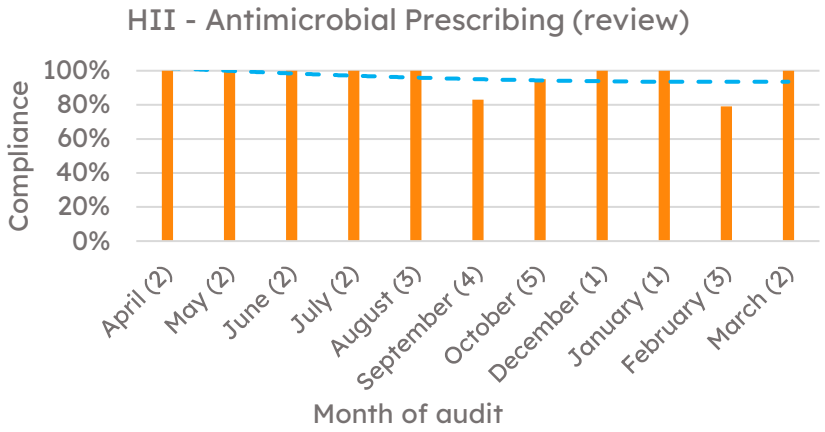


Figure 13 2022-23 antimicrobial prescribing (review) audits.

Note. 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.

IPU staff continue to work to improve documentation results and the IPC Group supervises associated action plans. The Group acknowledges that lower scores relate to record keeping and not to clinical practice, itself.

Note: When small numbers of patient records are audited this has a significant impact on percentage scores.

Dress Code Audits

Our Hospice and Hospice in the Home Matrons audit compliance with the standards set in St Helena's Dress Code Policy (601). The results are below.

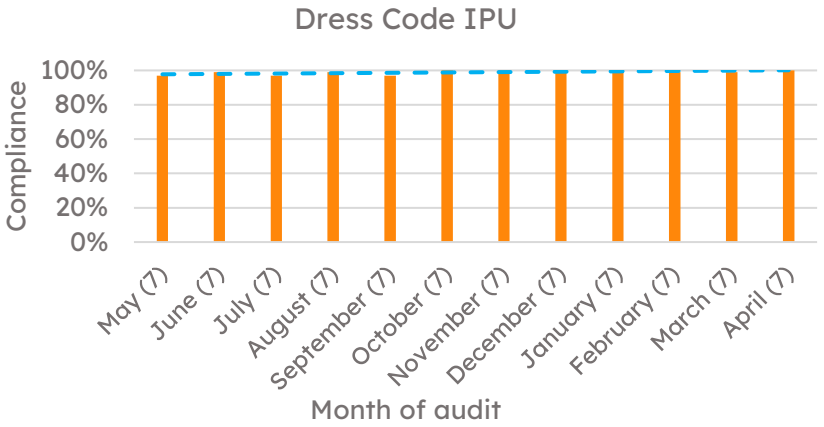


Figure 14 2022-23 dress code (IPU) audits.

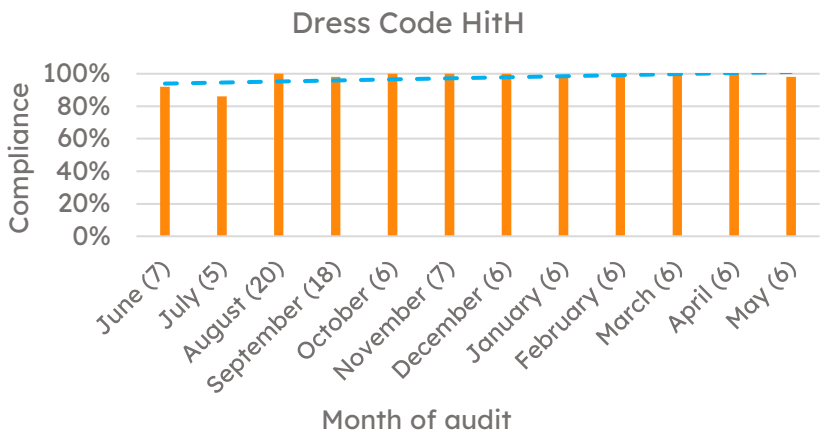


Figure 15 2022-23 dress code (HitH) audits.

Weekly Kitchen Audit

The Catering Manager completes an audit of the Main Kitchen weekly, looking at cleanliness and related topics to ensure processes in these areas are being followed correctly. Figure 16 shows the monthly average for these weekly audits.

Hospices are universally admired for the quality of care, treatment and support that they provide to those in great need and their families. The St Helena Hospice in Colchester excels in this and the kindness from nurses, doctors, all members of staff and volunteers… When asked, everyone responded with a smile and appropriate concern. There are not enough superlatives to describe our admiration for your work and results.

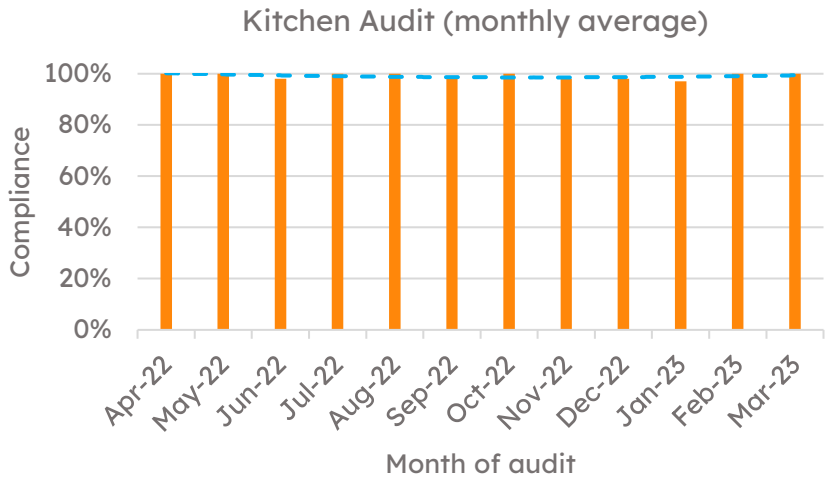


Figure 16 2022-23 Kitchen audits.

Cleaning Audits

Since April 2022, we have brought the frequency of our cleaning audits and how we report them in line with the new National Standards of Healthcare Cleanliness (2021). All NHS healthcare organisations were required to have implemented these by November 2022.

The frequency of cleaning and audit in any given area depends on the Functional Risk (FR) category assigned to that area, based on risk of infection. The assigned categories were approved by the Infection Prevention and Control Group. Audit results are now reported as a five star rating, in line with the national standards, and displayed in patient facing areas. Audit start dates were staggered so that not every area was due for audit in April.

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
07/04/2022 – 23/03/2023	★★★★★	05/05/2022 – 15/12/2022	★★★★★	02/06/2022 – 09/03	★★★★★	20/10/2022	★★★★★
		12/01/2023	★★★★★				
		09/02/2023 – 09/03/2023	★★★★★				

Figure 17 2022-23 cleaning audits.

On the date where FR3 scored a 4 star rating, this related to chair cushions needing to be cleaned, which was carried out the next day.

Infection Surveillance

Infection surveillance is a key component of infection prevention. The Infection Prevention and Control (IPC) Group monitors healthcare-associated infections (catheter associated UTIs, clostridium difficile, and MRSA bacteraemia). We were pleased to report no reported HCAIs this year.

COVID-19 Swabbing Audit

The Medical Team audits the documentation surrounding swabbing for COVOD-19. As with all IPC audits, results are scrutinised at the monthly IPC Group meetings, and actioned where necessary.

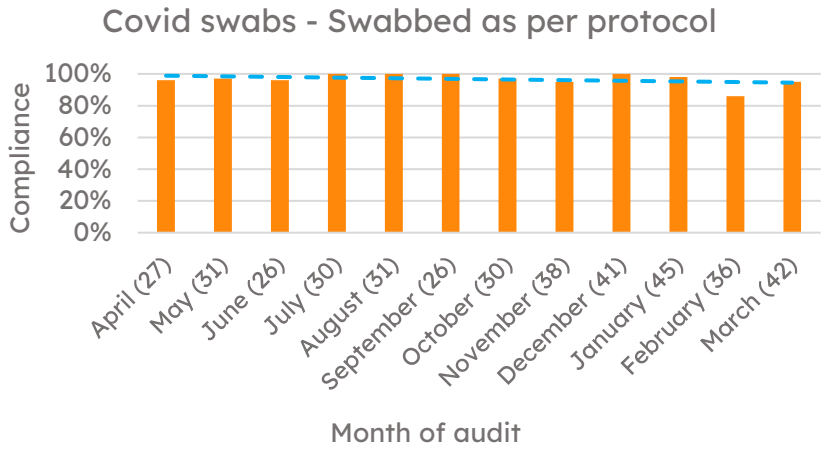


Figure 18 2022-23 COVID swabs audit.

Laundry Dipslide Audits

We monitor the level of infection in the laundry process using dipslides. Our Domestic Supervisor conducts fortnightly swab

tests on a range of items, including laundry bins, trolleys, processed linen, and mop heads. The dipslides are counted for colony forming units, the levels of which are indicative of contamination. Any items over the threshold level are cleaned with Actichlor. The chart below shows the results, green indicating the number of items below the threshold, and red indicating the number of items above the threshold (which were cleaned). No items have requiring cleaning following a dipslide audit since July 2022.

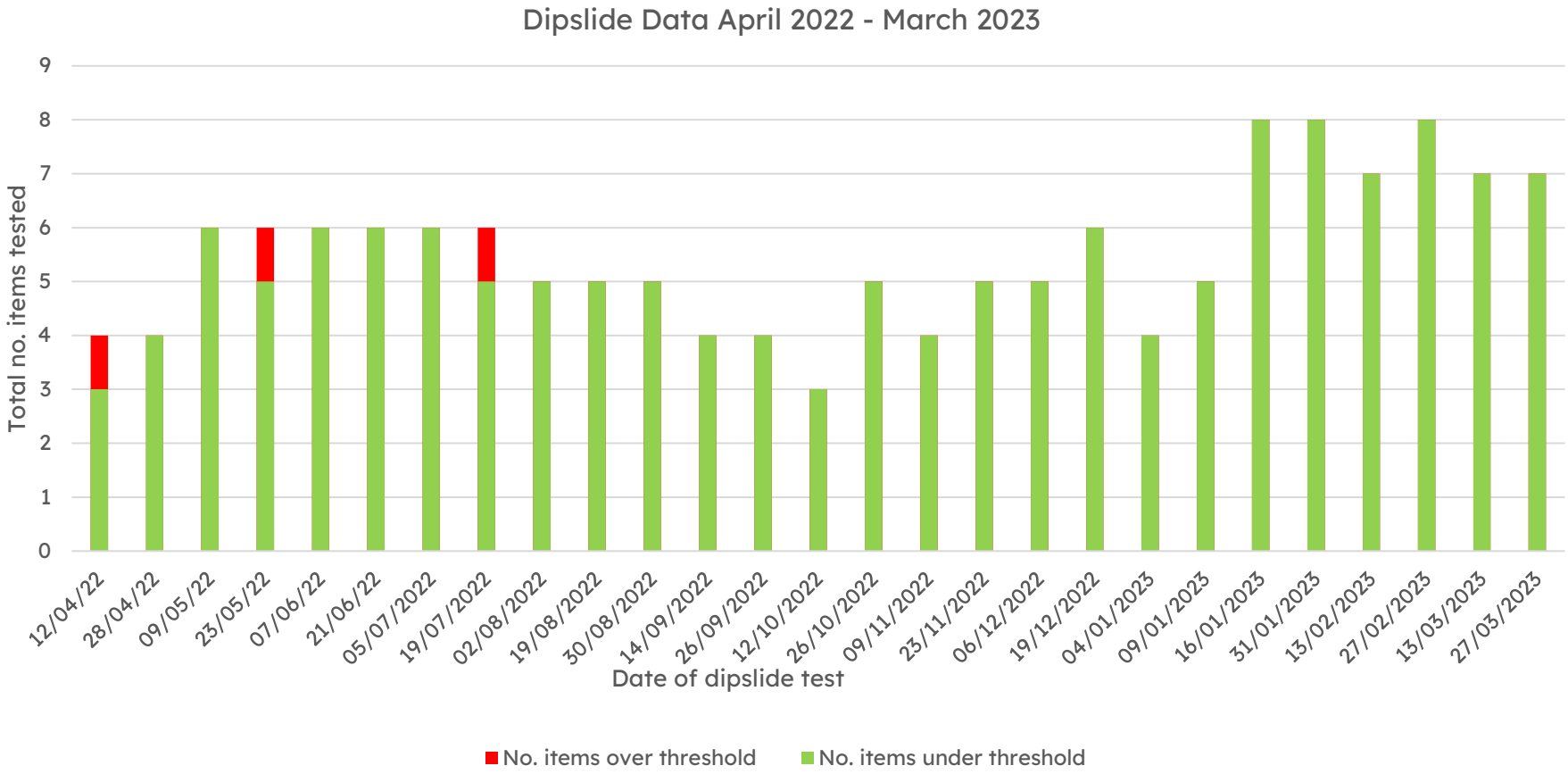


Figure 19 2022-23 dipslide data.

3.19.1.5. VTE

Venous thromboembolism is a significant risk to people admitted to hospice. We require our Medical Team to risk assess each patient we admit for thromboembolism and discuss with them whether they wish to have a daily injection to help prevent it during their admission.

92.3% of people admitted to our IPU during 2022-23 had such a risk assessment documented in their clinical record. Compliance figures are reported quarterly to our Clinical Governance and Compliance Group, and a senior doctor investigates each instance of non-compliance.

You have somehow made what was the most heartbreaking experience of our lives feel almost manageable; you have brought us comfort, compassion, laughter and such wonderful care.

3.20. Risk and Incident

All incidents and risks affecting Patient & Family Services are managed by our fortnightly Risk & Incident Group (RIG). Both are logged electronically using our online Sentinel system, which notifies the relevant staff by email. Incidents are then investigated by a senior member of staff with investigations reviewed by RIG and actions assigned where necessary. Actions are a part of the electronic record and are tracked automatically.

Risks are scored for impact and likelihood of occurrence. Controls are put in place to mitigate the risk and then risks are reviewed as frequently as needed. During 2022-23, we produced a completely new Risk Management Policy for the whole organisation and made extensive improvements to our electronic Risk Register. In Quarter Four, we began a refresh of all existing risks on our system, to improve their clarity, definition, and scoring. We also began establishing a new risk monitoring structure. This work will carry on during 2023-24.

3.21. Information Governance

At St Helena, we know that personal data, especially healthcare data, is very valuable and we do our utmost to protect it.

St Helena's Data Protection Officer (DPO) works across the organisation to ensure that we are fully compliant with the UK General Data Protection Regulation, the Data Protection Act 2018, and the Privacy and Electronic Communications Regulation 2003.

All confidentiality and data protection incidents are logged on our incident management system. We use an electronic Record of Processing Activities to manage all processes that involve processing personal data, an Information Asset Register to track the disposition of our data, and we assess all new projects involving personal data using Data Protection Impact Assessments (DPIAs).

We also carry out regular data retention audits to ensure that we do not store personal data any longer than is required.

Our Information Governance Policy is available to the public via our public website, as are selected DPIAs at https://www.sthelena.org.uk/about-us/governance

Our Privacy Policy is available at https://www.sthelena.org.uk/privacy-policy

In addition to having a DPO, our Director of Care serves as our Caldicott Guardian, tasked solely with ensuring the protection and proper handling of patient information.

3.21.1.1. Confidentiality & IG incidents

During the year, we logged 11 IG incidents concerning Patient & Family Services, all minor. All these incidents were minor and clerical in nature. They included misfiling of patient information, emailing information to the wrong member of staff, patient information left unattended in secure areas, and unintentionally using a colleague's user account.

All incidents were dealt with promptly, with appropriate reminders of good practice to the staff involved. None presented a risk to the rights and freedoms the affected data subjects or met the threshold for reporting to NHS Digital.

3.21.1.2. IG Walkthroughs

Each month, a member of our Quality and Compliance team conducts a walkthrough of clinical areas to check for IG problems. Items checked include:

- Are secure offices kept with doors closed and locked?
- Are staff wearing ID badges?
- Are all confidential conversations kept away from public areas?
- Is confidential information visible to the public or patients?
- Is there any confidential material left on printers?

At the same time, staff are also randomly selected for IG questions, such as,

- Do you know how would you report a suspected IG incident?
- Do you know how long you have to report it?
- Do you know how you would send patient confidential information to another organisation?
- Who is the Data Protection Officer?
- Who is the Caldicott Guardian?

To summarise the results for 2022-23, except for April, compliance for each location exceeded 95% for each month, with three out of twelve audits achieving 100%. Monthly compliance for the staff spot checks was sporadic and ranged between 35% and 95%; however, the trend across the year was upward, as can be seen in Figure 20.

The wife of [the patient] stated how amazing the [Virtual Ward] care team have been and how they have lifted a weight off her shoulders and allowed her to have faith in the system again. She says that [the patient] is beautifully settled in his new profile bed, although appears to be deteriorating, but she feels everything has happened in time to allow comfort at the end. She has spent so many weeks fighting to get [the patient] what he deserved in care and support, that she says it's a breath of fresh air to have the hospice involved.

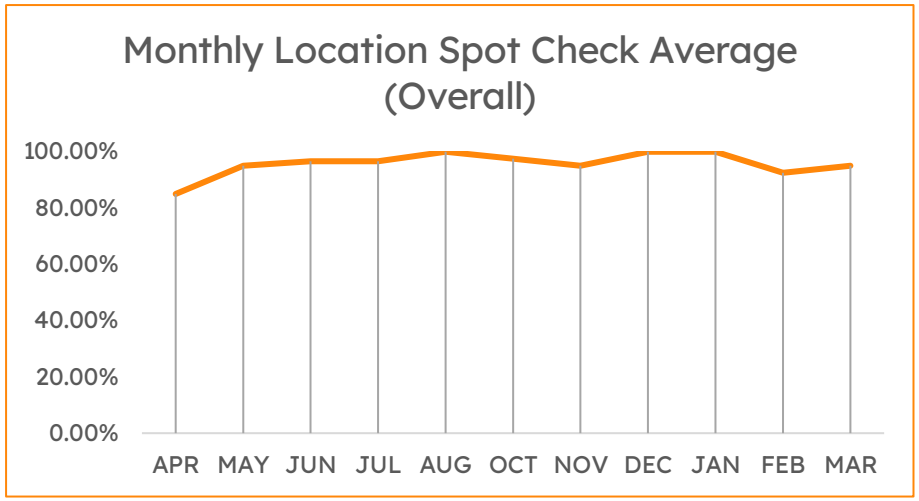


Figure 21 2022-23 IG location spot check results.

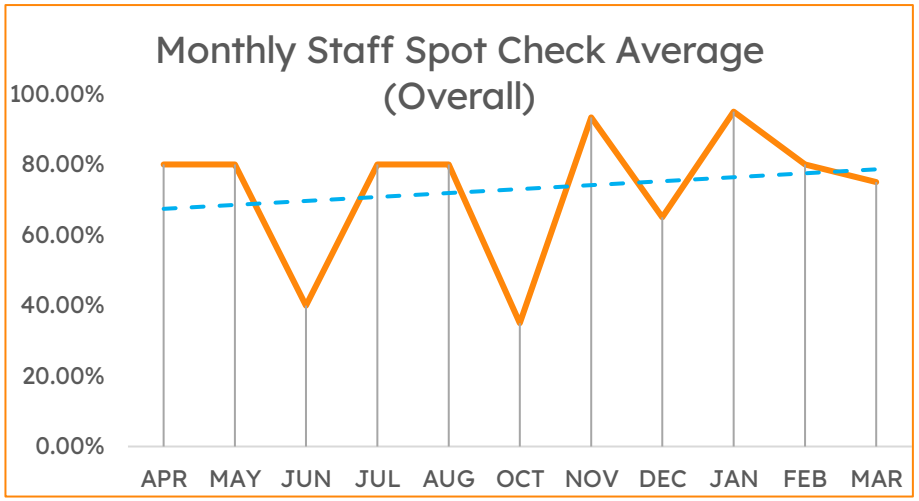


Figure 20 2022-23 staff spot check results.

3.21.1.3. Data Security & Privacy Toolkit

Each year, St Helena publishes a DSPT self-assessment, to demonstrate our high standards of information governance. All organisations that have access to NHS patient data and systems must use the Data Security and Protection Toolkit to publish an assessment against the National Data Guardian's 10 data security standards.

We published our DSPT for 2022-23 on 20th June 2023. Our certificate is shown in Figure 22, below.

The public can verify our status by visiting https://www.dsptoolkit.nhs.uk/OrganisationSearch and using our organisation code: 8A784.

In addition, we are CyberEssentials accredited.

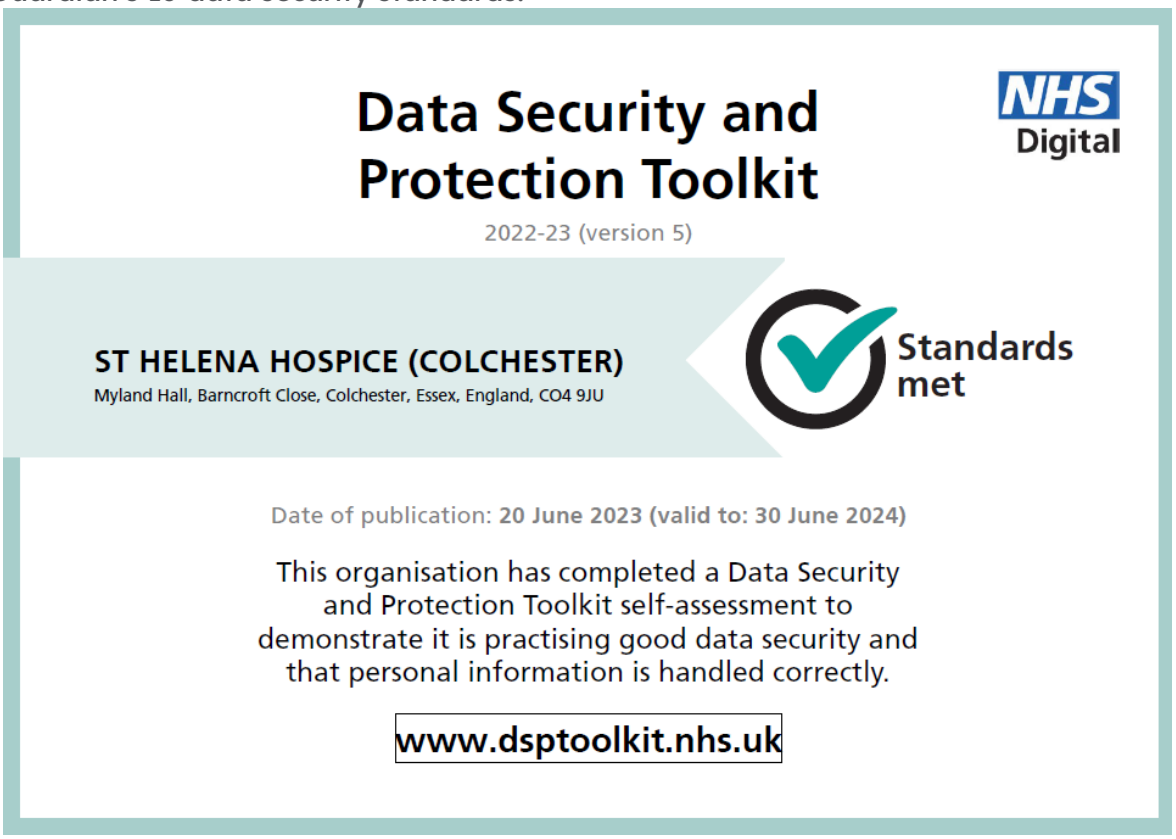


Figure 22 2022-23 DSPT certificate

3.22. Mandatory Training

St Helena requires staff to complete various modules of eLearning during induction and to refresh these at regular intervals. We manage this training using a third party, cloud-based system called My Learning Cloud, which provides reporting and automatic reminders to managers and staff when training is overdue. Non-compliance is pursued at staff supervision and, if persistent, results in disciplinary action. In the two tables that follow, we present our training compliance as it stood at the end of 2022-23, broken down by clinical and non-clinical staff.

Note. Dementia awareness compliance is currently low, as we added this course during the year.

Patient-facing

Course	Compliant	Non-compliant
COSHH	100%	0%
Cyber Security Awareness	90%	10%
Data Protection	98%	1%
Display Screen Equipment	99%	1%
Document and Record Keeping	95%	5%
Domestic Abuse	92%	8%
Dementia Awareness	79%	21%
Equality and Diversity	98%	2%
Fire Prevention and Awareness	99%	1%
Food Hygiene Awareness	100%	0%
Health and Safety Awareness	97%	3%
Infection Control	93%	7%
Lone Working and Personal Safety Awareness	99%	1%
Manual Handling	97%	3%
Mental Capacity Act	97%	3%
Safeguarding Adults	97%	3%
Safeguarding Children and Young People	99%	1%

You have somehow made what was the most heartbreaking experience of our lives feel almost manageable; you have brought us comfort, compassion, laughter and such wonderful care.

Non patient facing

Course	Compliant	Non-compliant
Cyber Security Awareness	88%	12%
Data Protection	99%	1%
Display Screen Equipment	100%	0%
Document and Record Keeping	89%	11%
Equality and Diversity	99%	1%
Fire Prevention and Awareness	99%	1%
Health and Safety Awareness	99%	1%
Lone Working and Personal Safety Awareness	100%	0%
Manual Handling	99%	1%
Safeguarding Adults	99%	1%
Safeguarding Children and Young People	99%	1%

3.23. Duty of Candour

The Duty of Candour was established under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and requires providers to be open and transparent with people who use our services. It also sets out some specific requirements we must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, truthful

information, and an apology. St Helena introduced a Duty of Candour policy during 2016-17 and this approach, along with the Being Open principles, is also incorporated into our incident and complaints policies and training. Duty of Candour is also a mandatory section of our incident reporting form, ensuring that all staff reporting an incident must address the issue and report what they have told the patient or carer. This also allows us to audit compliance, if necessary.

Thank you for turning my tsunami into more manageable waves.

3.24. Complaints and compliments

3.24.1.1. Complaints

Although St Helena is proud of the high quality care we provide, there are occasions when things go wrong, and patients and family members feel they must make a formal complaint. We take all complaints very seriously and always offer a full investigation report and face to face meeting with the complainant.

We investigate all complaints made to us unless they concern another care provider. In those cases, we refer the complaint on to the provider for investigation.

Below, we summarise the main points of every complaint we received during the year, whether we upheld them, and any actions we took as a result.

The complaints are presented in order received. Please note that Patient & Family Services uses the same complaints management system as the rest of St Helena, hence the non-sequential numbers

232

This complaint raised five issues; that IPU staff ignored or were slow to answer the call bell, that the patient had had several falls during their admission, concerns that a carer assigned by an external agency had failed to wear PPE, alleged rudeness by St Helena staff to the Complainant, and the patient returning home from IPU with a large bruise.

Our investigation found that there had been problems with the call system during that admission and that the system's function was not monitored. As a result, we have put in place a process to monitor the call bell's operation and are also investigating a software upgrade. We did not find that staff were slow to answer the bell and so we partially upheld this aspect of the complaint.

Regarding the falls, we found that some of the falls risk assessments conducted during the admission were inadequate, but we also found that the patient had also refused assistance at times. We therefore partially upheld this aspect of the complaint.

We found that the external agency carer had failed to wear PPE and we upheld this component of the complaint.

We also found that there was evidence of poor communication by two members of staff and so we partially upheld the complaint of rudeness. One staff member was asked to reflect on this, the other had left the organisation for unrelated reasons. We also reminded IPU staff of our Core Values.

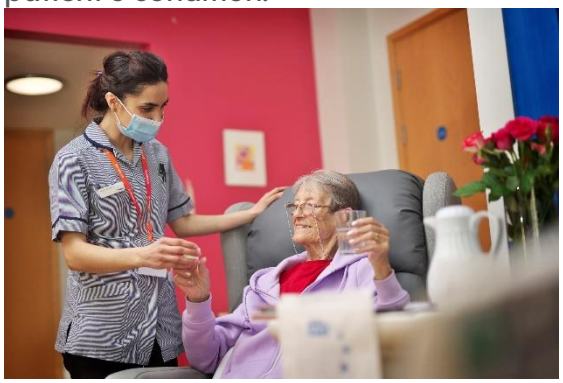
Finally, we found that our staff had not adequately documented the origin of the bruise, which was believed to have been sustained a fall. We therefore reminded our staff to document all bruises, old or new, and we upheld this aspect of the complaint.

We apologised to the Complainant and sent them a detailed report with our findings and the actions we took as a result.

We have had no reply as to whether the Complainant is satisfied with our response.

266

A family member complained that we had used sedation to control a relative during their time with us and that this had hastened death and denied them a proper opportunity to say goodbye. The Complainant also asserted that lack of food and fluid hastened the patient's death, that we did not communicate about the patient's care plan, and that there was confusion around the patient's condition.



This complaint was investigated by a Nurse Consultant, and we sent a full report to the Complainant. In our investigation, we found no evidence that medication was used to control the patient, only to relieve distress, agitation, and pain. Furthermore, we found evidence that alternative means had been attempted first. We could not uphold this aspect of the complaint.

Our investigation also could not uphold the assertion that death was hastened by a lack of food and fluid, finding that the patient, who was actively dying, and that offers of both caused distress.

We did uphold the complaint regarding communication, although not regarding the care plan. We also acknowledged the Complainant's sorrow at not having a final goodbye and conceded that we could have done more to establish a relationship of trust with the Complainant and family. We apologised for this and offered a face to face meeting.

279

The daughter of a patient complained that a member of our IPU team had been overheard via home CCTV making insensitive and inappropriate comments about her. We upheld this complaint and issued the staff member with an informal written warning.

We have had no reply as to whether the Complainant is satisfied with our response.

283

We received a complaint from a patient outlining three issues. The first was that an arranged care package following discharge was not commenced properly. The second was that topical Lidocaine caused a burning sensation but that, despite being told this, staff had carried on using it on subsequent occasions, and had restrained the patient while doing so. Thirdly, that the cap from a tube of Intrasite gel had been left in the bed and had cause an injury.

Our investigation found that the process of contacting the Continuing Health Care (CHC) team to ensure the patient's discharge was coordinated with the care agency starting did not happen, so we upheld this aspect of the complaint.

Our investigation found that the application of topical Lidocaine had caused discomfort and that one member of staff has not shown sufficient care while cleaning the patient, but that there was no evidence staff had used restraint. We therefore partially upheld this aspect of the complaint.

Finally, our investigation found that the Intrasite gel cap had not been properly removed from the bed and had caused skin redness, so we upheld this aspect of the complaint.

We apologised to the Complainant and our investigation made several

recommendations that will be monitored by our Risk & Incident Group.

We have had no reply as to whether the Complainant is satisfied with our response.

285

A family member of one of our community patients made a complaint taking issue with approximately thirty items they had noted in the patient's clinical records. We partially upheld the complaint, noting that while several of the comments were appropriate, several were either inaccurate, poorly worded, or otherwise not up to our standard.

We have had no reply as to whether the Complainant is satisfied with our response.

314

This complaint came from the family of two of our community patients. The principal points were that our staff made insufficient visits and did not provide a proper opportunity for discussions around advance care planning for one patient and, for the other, failure by the Community Nursing Team to provide a syringe driver and alleged rudeness by our staff.

For the first patient, we agreed that there were missed opportunities and that their needs had not been met. We informed the Complainant that we would feed this back to the CNS team and explained the work we have already done to reallocate CNS case load to try and improve continuity.

For the second patient, we acknowledged that there had been communication issues between SinglePoint and the Community Nursing Service and that we needed to do more to address misconceptions regarding syringe drivers and stat doses. We also accepted that one of our team has shown too little empathy.

We abided by the Complainant's request that we send no formal letter of our findings, but they were satisfied with our response.

321

We received a complaint from a nursing home that we had raised a safeguarding concern about one of their patients. Our investigation found that our communication with the home could have been better but that we had been correct to raise the concern. We therefore did not uphold the complaint.

We have had no reply as to whether the Complainant is satisfied with our response.

343

A patient of our Hospice in the Home service complained that they felt unsupported by their CNS who had not visited when arranged. The patient sought an apology and a new CNS. We apologised and arranged a new CNS. The patient died during the time the complaint was open.

352

A member of the public contacted us after noting that a member of our team had incorrectly noted a diagnosis on their shared care record, which was not only correct but had been done despite them never having been a St Helena patient. Our investigation found that this had been done in error and that the Complainant's mother had been a patient.

We upheld this complaint. We sent a report of our findings to the Complainant, corrected the record, and offered a full apology. We did not receive a response from the Complainant.

355

The daughter of a patient complained to us that we had not properly involved the patient's next of kin in decisions about their last days in life or properly noted their medical history with respect to sedation.

We partially upheld this complaint. Our investigation found no concerns about the clinical decisions made, including sedation, but did conclude that the discussion with all the family members, particularly next of kin, had been neglected, including warning them of what to expect in the final days of life.

Our investigator made several recommendations concerning refresher training for our CNS Team on communication and documentation in complex ethical situations. These recommendations were accepted as actions by our Risk & Incident Group and will be monitored.

We sent a report of our findings and planned actions to the Complainant, along with an apology. We have not received a response from the Complainant.

368

We received a complaint from a GP concerning an unprofessional communication between a staff member and a care home. Our investigation concluded that the communication had indeed been unprofessional, for which there was no excuse, and was likely to cause offence and hurt to the Complainant.

We upheld this complaint. We offered an unreserved apology and informed the Complainant of the action we would take concerning the staff member involved. The Complainant was satisfied with our response.

370

We received a complaint that our SinglePoint team had failed to offer sufficient support to the wife of a patient who had called in distress follow the patient having fallen. The Complainant was told at the time that nobody could help until after the Bank Holiday and that we could not offer respite care (although the Complainant stated their belief that the patient was in fact end of life.

We partially upheld this complaint. Our investigator concluded that even though all avenues for further support had been explored by our team, we should have offered additional support by arranging for a home visit and arranging a referral to our IPU as soon as a bed became available.

We wrote to the Complainant to share our findings and apologise for the distress we had caused. We also detailed the following actions that we propose to take:

All SinglePoint nurses to be reminded of the importance of providing a face to face visit to ensure support is provided and the patient's clinical status fully assessed with any necessary referrals made.

Individual staff member to reflect on the conversation with the Complainant and how they communicated and dealt with the call.

373

This complaint was raised by the wife of one of our inpatients. The complaint had five components. Firstly that the patient was nursed in a bay with a dying patient and a disruptive patient. Secondly that the response from the Senior Sister when discussing this had been unsatisfactory. The third part was that staff were slow to answer or ignored the call bell, there was generally poor nursing (including difficulties obtaining blood from the patient). The fourth component was perceived disdain from staff when these issues were raised, and the fifth component was concern over the noise and disruption caused by flooring renovation on our IPU.

We partially upheld the first component of the complaint, in that, while it was a regrettable necessity to accommodate the patient in a bay rather than a side room, we could not find evidence that we had given them prior notice this would be the case.

We also partially upheld the second and fourth components of the complaint on the basis that, while our staff tried to communicate sensitively, it would nonetheless have been a difficult conversation that would have caused distress to the Complainant.

We upheld the concerns about staff being slow to answer the call bell and poor nursing care, noting that call bell response times had been an ongoing problem that we were addressing.

Finally, we upheld the complaint about the renovation work. We sent a full investigation report and apology. The Complainant was happy with our response.

407

A complaint was raised to our partner agency, Bluebird Care, stating that continence care for a patient had been inadequate, resulting in their distress, and that the patient had suffered a moisture would and open sore.

Bluebird partially upheld the complaint and wrote to the Complainant with details of the staff training that had been given as a result. At time of writing, we do not know whether the Complainant is satisfied with this response.

397

A client of our Adult Bereavement Service complained about their appointment being cancelled and background noise heard during their sessions.

Our investigation found that the appointment had been cancelled because of staff illness, although as much notice as possible had been given. We also investigated the sound problem and acted with our Estates & Facilities Team to reduce the problem.

We upheld both aspects of the complaint and sent a full report and apology to the Complainant. At time of writing, we have received no response from the Complainant.

3.24.1.2. Cards and letters

St Helena receives many cards, letters, gifts, and donations each year, which is always very heartening for staff. The Clinical Compliance Officer holds a central record of unsolicited comments received via cards and letters, email, and telephone and these are presented at the monthly QAAG meeting alongside iWantGreatCare feedback. Following each meeting, the Clinical Compliance Officer posts the received feedback on St Helena's staff news-sharing website, Workplace, so that all staff can view the feedback received.

The love and support you gave us all at a very dark time was amazing and meant so much to us as a family. From the doctors to the amazing nurses, to carers, cleaners, to the canteen staff that provide the most wonderful food for everybody. Also a massive thank you to the selfless volunteers without you special people St Helena wouldn't run the way it does. I can never thank you all enough. I would also like to mention the three nurses that were with me the night mum passed, you will always be very special in my heart. To lose someone so precious to me was very scary but to have you by my side for support words can never say how much that meant to me. x x x x

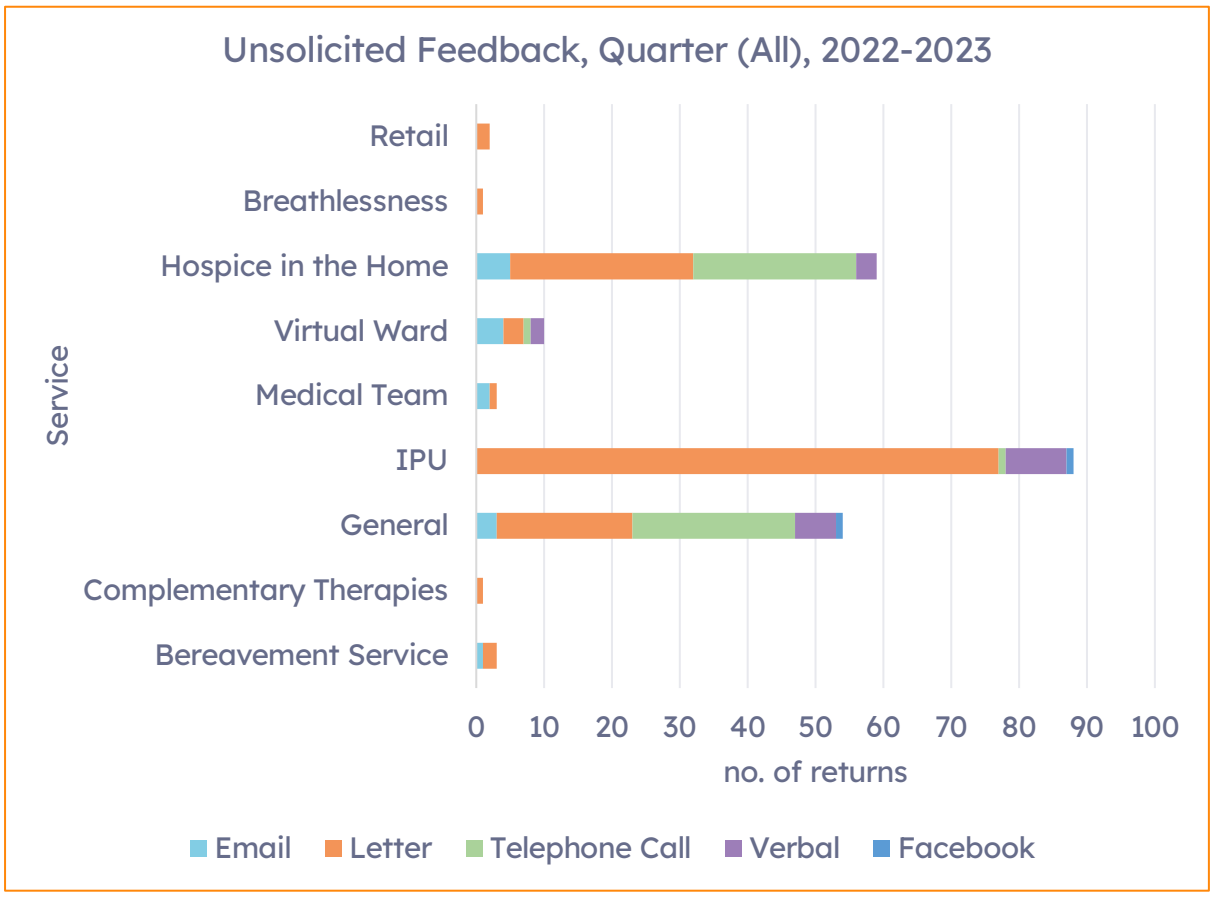


Figure 23 2022-23 unsolicited feedback.

3.24.1.3. iWantGreatCare

We have been using iWantGreatCare (iWGC) to manage user feedback since January 2016. The system is much like TripAdvisor, which is used in the hospitality sector.

Patients and families from across all our services are invited to complete paper questionnaires, which are then sent to iWGC to be scanned and collated. Alternatively, feedback can be left on the iWGC website, or via service-specific weblinks.

The feedback is aggregated, and a report of the comments received is presented each month to our Quality Assurance and Audit Group (QAAG) alongside unsolicited comments received via other avenues. QAAG looks for themes and trends and acts where possible on negative feedback. These monthly reports allow us to react more quickly to what our constituency is telling us, thereby making us a more responsive organisation. Moreover, because the website is hosted externally, we can assure transparency. While the system has safeguards in place to protect against mischievous or vexatious comments, we cannot censor or suppress genuine and legitimate criticism (although we can respond to it on the website). To view all our comments on the iWGC website, please visit https://www.iwantgreatcare.org/hospitals/st-helena-hospice-1

Generally, the number of comments received has increased throughout the year, following a period of marked decline during the Pandemic, but has not yet reached the levels seen previously.

In March, we were very pleased to be presented with a 'Certificate of Excellence' by iWantGreatCare in

recognition of our ‘consistently outstanding patient feedback’.

Figure 24 2022-23 IWGC certificate.

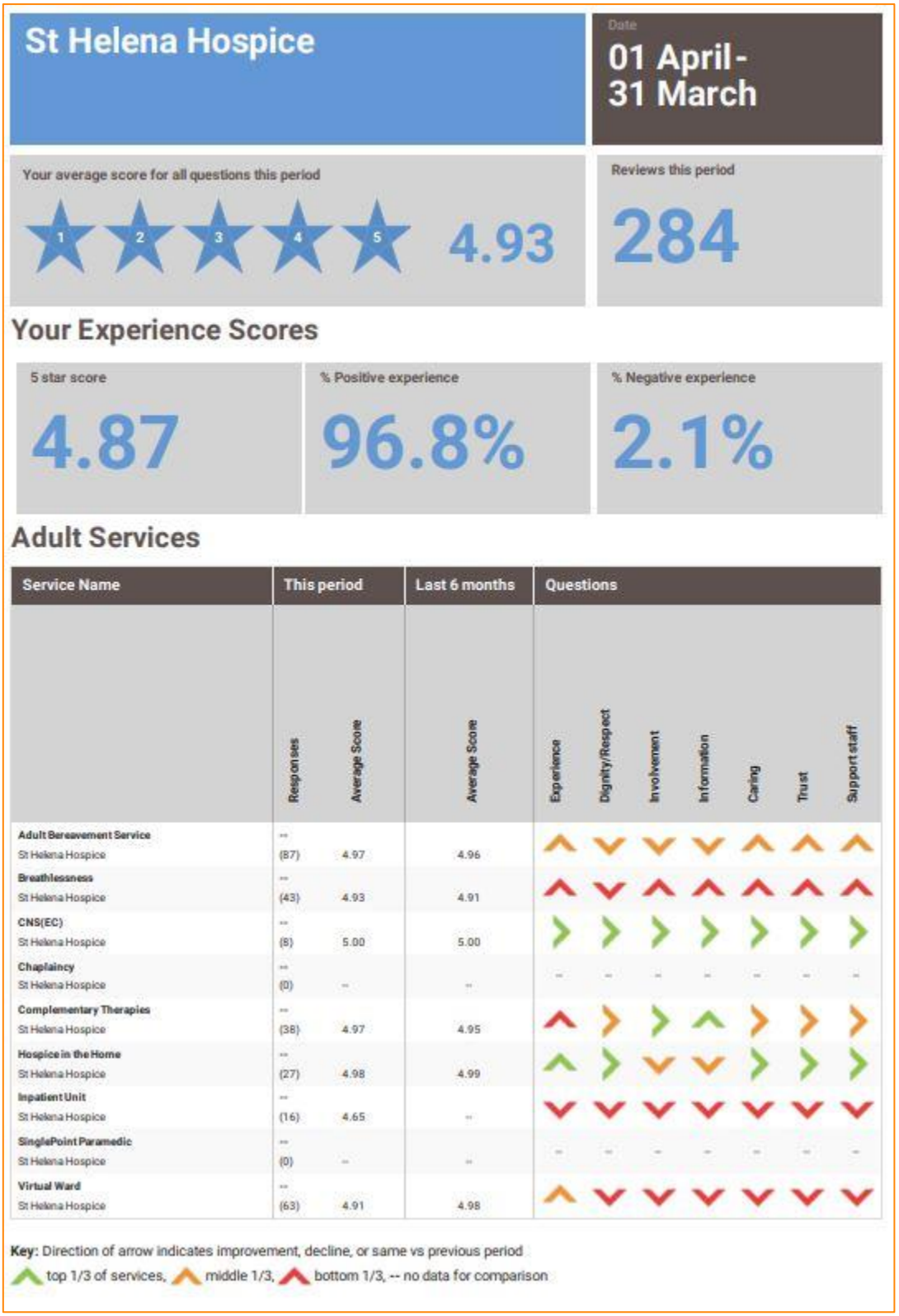
Your care and compassion meant so much to us and allowed us to stay strong even in the toughest times. Everyone who we saw or spoke to on the phone provided a sense of warmth and reassurance, and I'm not sure how we would of coped without this. Even though you were working through Christmas and missing time with your own family your work ethic and standards does not falter for a second.

The gardens were my place of solace and [the patient] loved the beauty and surroundings of them. It was lovely and fitting that he was able to feel the sun on his face and the fresh air, albeit for a very short while. To the Hospice Chaplaincy team, thank you for Blessing on our 40th Wedding Anniversary and for your support too.

Just wanted to thank you all for your help and support during mum's final days. You could not save mum's life but you certainly saved mine! Every person I spoke to was amazing so thank you! x x x

To the wonderful ladies on Reception at St Helena Hospice. Thank you for making all our lives so very easy while coming and going to see my mum this month. At what was an incredibly difficult time it meant the world to us that we were greeted each day with a smile from you all. Keep it up, you are making a big difference to a lot of fragile souls.

To the wonderful Virtual Ward team. Thank you for your endless care of … You treated him with true care and dignity. I will always remember and treasure your gentle hands, soft words, and care of myself too.



St Helena Hospice

Date
01 April - 31 March

Your average score for all questions this period

4.93

Reviews this period

284

Your Experience Scores

5 star score	% Positive experience	% Negative experience
4.87	96.8%	2.1%

Adult Services

Service Name	This period		Last 6 months	Questions						
	Responses	Average Score	Average Score	Experience	Dignity/Respect	Involvement	Information	Caring	Trust	Support staff
Adult Bereavement Service St Helena Hospice	-- (87)	4.97	4.96	▲	▼	▼	▼	▲	▲	▲
Breathlessness St Helena Hospice	-- (43)	4.93	4.91	▲	▼	▲	▲	▲	▲	▲
CNS(EC) St Helena Hospice	-- (8)	5.00	5.00	▶	▶	▶	▶	▶	▶	▶
Chaplaincy St Helena Hospice	-- (0)	--	--	--	--	--	--	--	--	--
Complementary Therapies St Helena Hospice	-- (38)	4.97	4.95	▲	▶	▶	▲	▶	▶	▶
Hospice in the Home St Helena Hospice	-- (27)	4.98	4.99	▲	▶	▼	▼	▶	▶	▶
Inpatient Unit St Helena Hospice	-- (16)	4.65	--	▼	▼	▼	▼	▼	▼	▼
SinglePoint Paramedic St Helena Hospice	-- (0)	--	--	--	--	--	--	--	--	--
Virtual Ward St Helena Hospice	-- (63)	4.91	4.98	▲	▼	▼	▼	▼	▼	▼

Key: Direction of arrow indicates improvement, decline, or same vs previous period

▲ top 1/3 of services, ▲ middle 1/3, ▲ bottom 1/3, -- no data for comparison

Figure 25 2022-23 iWGC summary.

3.25. What Others Say

3.25.1.1. 2017 CQC Inspection Report

St Helena is registered with the Care Quality Commission to provide treatment of disease, disorder, or injury.

St Helena is required to meet the Essential Standards of Quality and Safety. The Essential Standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. The CQC regulate us against these standards.

Our most recent inspection by the CQC was in November 2016, when we underwent a two-day unannounced visit. This was then followed up in February 2017 with another two days during which the CQC spoke to several people who use our services.

We were subsequently rated 'Outstanding' –the highest rating that the CQC can give. The full report is available from the CQC website using the link below. In summary, the inspectors found that 'People received excellent care based on best practice from experienced staff with the knowledge, skills, and competencies to support their complex health needs' and that our service has,

"a strong person centred approach. People's dignity was supported, and staff treated people with respect at all times. Staff were exceptional at helping people to express their views. People and their families who received care, treatment and support from St Helena could not speak highly enough about the staff who supported them. People who were challenged in coming to terms with a life limiting illness or a terminal diagnosis told us repeatedly that they were enabled to manage their condition and their emotional wellbeing because of the excellent care and support received from various departments within SHH. Staff were exceptionally kind, caring and compassionate. People we spoke with were only too pleased to share their stories of compassionate appropriate care, treatment, and support."

The CQC keep this rating under monthly review and, each quarter, we voluntarily send them our Quarterly Quality Report, which also goes to our commissioners. As of 8th June 2023, the CQC have no evidence that they need to reassess this rating

I just wanted to message to say thank you for looking after my Grandad and being an amazing Hospice Nurse. You and his carers made me want to become a care assistant and help others.

she calls [Virtual Ward] her "Angels in Blue"

Your care allowed him to be pain free and to die with dignity.

As soon as we moved my mum into the hospice you all made everything so easy and, somehow, joyous, under the most difficult circumstances. Thanks to each and every one of you for truly seeing the person inside and respecting her dignity as her body faltered. I cannot put into words how much your faultless care allowed me to feel I could stand back and just be her son again during those last 2 weeks of her life. I will treasure that time forever, thanks to you all x

From the bottom of our hearts we would like to thank you for your loving care and kindness that you showed our … Your attention to detail was always amazing! The way you treated … as a person before palliative care patient made her feel alive and that she was still living. The way you would talk about simple things like the weather, the traffic, and her cat, was appreciated with love and laughter.

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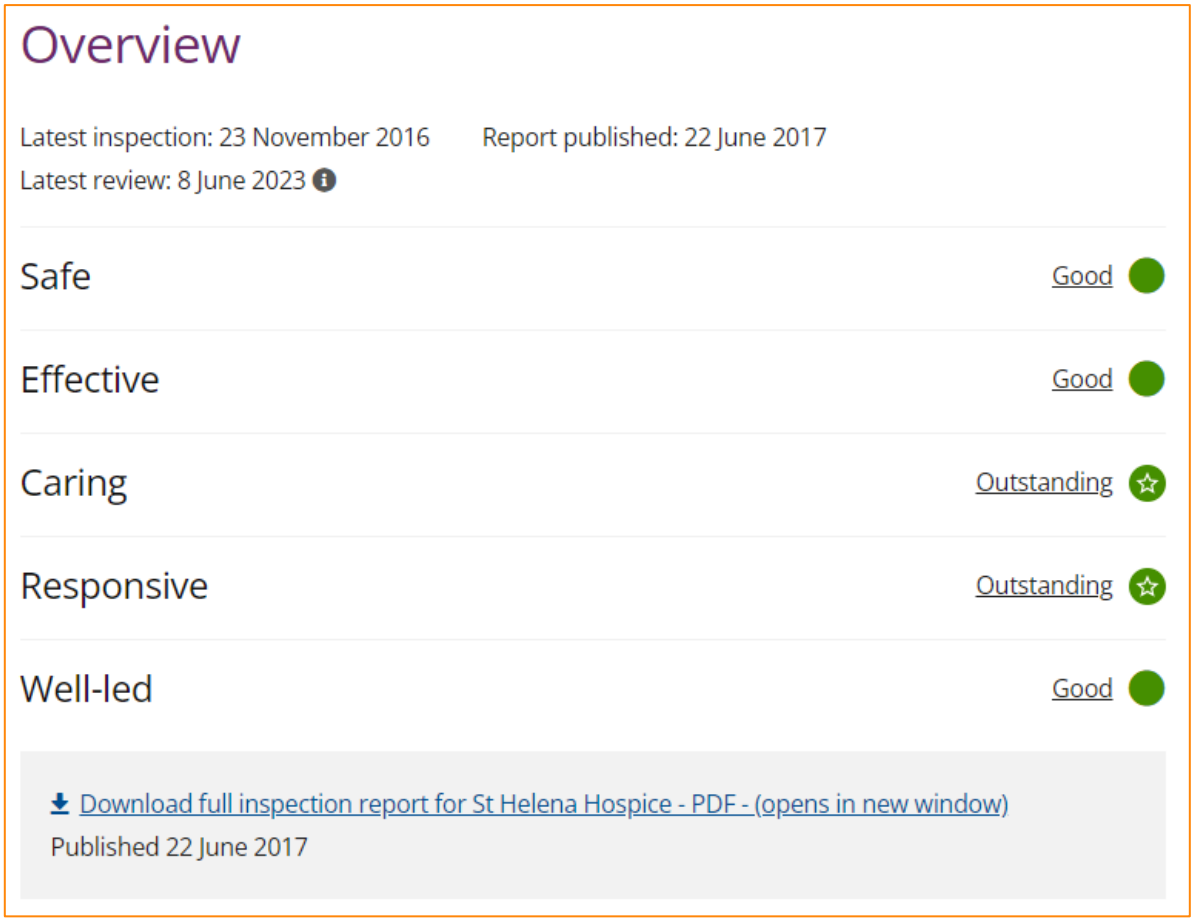

Figure 26 CQC rating details

Link: http://www.cqc.org.uk/location/1-116828568

3.25.1.2. 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 the patient, the service user and the carer 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.

This comprehensive report illustrates not only the achievements of St Helena Hospice to date, but also the commendable drive and dedication to achieving further goals throughout the coming year. The breadth of services being offered and developed is testimony to the commitment to providing the local community with a person-centred, individualistic approach to palliative care.

Getting care at the end stage of life right is of the utmost importance, and St Helena have shown transparency in detailing the complaints and feedback received by patients, their carers and loved ones. The level of attention given to each case is good practice, not only for the quality of the experience had by users of the service, but also as an invaluable source of learning for the Hospice itself.

Sharon Westfield de Cortez
Information & Signposting Manager & Safeguarding Lead, Healthwatch Essex
21st June 2023

3.26. Contacting St Helena

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

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@StHelenaHospice
https://en-gb.facebook.com/StHelenaHospice/

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