Quality Account

2023 - 2024

Contents

Acknowledgements

Thank you to the following St Helena staff who contributed to this Quality Account.

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1. Statement on Quality

Figure 1 Mark Jarman-Howe, Chief Executive

1.1. CEO Statement

At St Helena, we embody our core values to be **bold**, **passionate**, and **caring**. These principles drive our commitment to providing compassionate care and support to local people and their families facing incurable illness and bereavement in north east Essex.

Our Commitment to Excellence

St Helena has earned a reputation for excellence in care delivery and our charitable services are rated 'Outstanding' by the Care Quality Commission (see page 73). We continuously innovate and adapt to meet the diverse needs of our community.

Transforming End-of-Life Care

We believe that end-of-life care should be better for everyone across North East Essex, regardless of their location, age, or diagnosis. Collaborating with partners in the North East Essex Health and Wellbeing Alliance, we have developed a population-based approach to end-of-life care. This approach focuses on the ten outcomes that matter most to individuals and their families during their last year of life. We are proud that this work has been recommended by both Sue Ryder and the King's Fund as an example of commissioning best practice.

Embracing Change, Inspiring Care

Our strategic pillars, as outlined in our ten-year strategy called 'Embracing Change, Inspiring Care', guide our actions:

1. **Grow the Outcomes-Based Population Health Model**: We are committed to expanding our outcomes-based approach to end-of-life care. By focusing on measurable results, we aim to enhance the quality of life of those we serve.
2. **Embrace Technology and Digital Transformation**: Technology is a powerful tool in improving care delivery. We actively explore digital solutions to enhance efficiency, communication, and access to our services.
3. **Be Commercially Disciplined and Enterprising**: Financial sustainability is essential for our mission. We approach our work with a business mindset, ensuring that our resources are used effectively to benefit our community.
4. **Support Our Colleagues to Grow and Thrive**: As we navigate change, we recognize the importance of nurturing our team. We provide leadership, training, and coordination to empower our colleagues to excel.

Our Service Delivery Model

St Helena's service delivery revolves around two multi-disciplinary teams:

1. **The Hospice MDT (inpatient care)**: Providing comprehensive care within our hospice facility at Myland Hall in Colchester.
2. **Hospice in the Home MDT (community and home-based care)**: Supporting patients and families in their own homes.

Our 24/7 SinglePoint palliative care coordination centre and end-of-life care hub ensures seamless coordination across local providers, including GPs, district nursing, Colchester General Hospital, out-of-hours services, and the Ambulance Service. The My Care Choices Register (see page 41) captures and shares people's wishes for their last year of life.

Compassionate Communities

In addition to core services, we offer complementary and support services, including spiritual care. Our Compassionate Communities programme fosters collaboration with local providers and community groups.

Bereavement Support

We provide comprehensive bereavement services for adults and children, regardless of the cause of their bereavement.

Our Commitment to the Future

Last year we supported over 4,200 people. Moving forward, we continue to aspire to personalise care, and address inequalities in both access and outcomes.

For more information about St Helena, please visit our website: www.sthelena.org.uk

Mark Jarman-Howe
Chief Executive

…Thank you so much for taking such care of our wonderful mum in her final weeks…

1.2. Statement from Board of Trustees

Figure 2 Nigel Pye, Chair of the 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.

We have had no changes of Chairs of our three main committees since the last report. Dr Fran Hyde continues as Vice Chair for the Board and Chair of Governance. Richard Pollom is Chair of Finance and Operations, and Ken Aldred is Chair of Patient and Family Services (PFS). Ken has been Chair of PFS for several years and we have planned for a successor, whom I will be able to report in next year's Quality Account. 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.

Last year, I reported that one of the key decisions forthcoming would be

the potential relocation of St Helena. This decision has been postponed until the economic climate improves and Trustees hope to be able to progress this project further towards the end of 2024-25.

As part of efforts to establish reliable sources of income, we have set up a wholly owned subsidiary social enterprise, St Helena Trading Limited (SHTL). SHTL has its own board made up of two trustees, two independent non-executive directors from local businesses, and three directors from St Helena. The aim of SHTL is provide a dependable and increasing income to the Charity from commercial enterprise.

Our focus on better recording and mitigating of risks continues. Much work has gone in to make our Risk Register clearer and more effective. For the first time, Trustees have conducted audits of the Risk Register and provided feedback.

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 them. As part of our continuous drive for the most effective way of supporting the Hospice, we are continuing to investigate new ways of working for the Trustees, with potential changes to the frequency of meetings and composition of the committees. I will be able to report on the conclusion of this work in next year's report.

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.

The Trustees fully endorse this Quality Account.

Nigel Pye
Chair of the Board of Trustees

1.3. Executive Summary

In 2023-24 St Helena continued to support patients and families throughout North East Essex (NEE) while streamlining and remodelling our services to face new challenges. We were also very pleased to receive another 'Outstanding' rating following our Care Quality Commission inspection in February 2024 (see page 73).

In Part One of this Quality Account, you will read about our 11 priorities for 2024-25 (see page 5). These include consolidating our new service model, developing our Specialist Palliative Care Virtual Ward model, delivering digital innovation, and creating a new carer strategy. On page 6, 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 14) 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 (pages 20-26).

In Part Three, we provide individual updates from our services. Our Hospice Matron reports on developments on our Inpatient Unit, including the creation of our new Operational Hub and managing staffing challenges (page 27). Our Hospice in the Home Matron discusses our community services and the results of our Paramedic pilot (page 30), and there's an update on our Compassionate Communities activity,

including work to achieve Compassionate City status for Colchester (page 33). We update you on our new Counselling and Emotional Support Team (CEST) on page 34) and our new, 'Oasis,' multifaith space on page 35. On page 43, we report on the first full year of our joint venture with St Elizabeth Hospice, 'Hospice Education' and plans to link up with St Nicholas Hospice in Bury St Edmunds.

Elsewhere, we discuss our work on infection prevention and control (page 56), volunteering (page 48), and medicines management (page 55). Towards the end of this report, we summarise the complaints we have received and how we've dealt with them (page 69).

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

To face death is unbelievable. My family and I are so grateful for your support and help in this the most challenging time in our lives.

2. Priorities for Improvement in 2024-25

…The weeks our sister was in your care was wonderful she had great confidence in you all and she was much more contented with you than at home, are for that we were and are very grateful, you also made us very welcome and we were with her every day and we never felt that we were in the way, also you let us stay overnight for her last three days…

During 2023-24 we significantly remodelled our clinical operations to address the budget deficit while maintaining a quality service for our community. Our priorities for 2024-25 reflect this situation.

1. We will consolidate the new service model, addressing any associated risks and delivering within budget. This includes embedding the St Helena population model, enabling service information to be shared with people in the last phase of life who consent to receive it.
2. We will work with other organisations and citizens within Colchester to achieve Compassionate City Charter status.
3. We will grow and develop the Specialist Palliative Care Virtual Ward model and create a cost-effective, high-quality model of care for people who wish to remain at home but require specialist palliative care input to do so.
4. We will collaborate with other Hospices to create an equitable and sustainable bereavement service model for people in our system.
5. We will continue to develop our workforce, implementing the proposed career pathway for nursing and allied health professionals, supporting the 'grow your own' approach, including developing a robust model for implementing the Advanced Nursing Practice Framework.
6. We will work with our commissioners to secure a five to seven-year commissioning agreement to offer stability and security to our clinical service.
7. We will deliver digital innovation to improve efficiency and improve the day to day working experience of our teams.
8. We will reinvigorate the My Care Choices Register (see page 41), widening access, improving staff confidence, and information quality for the benefit of people in the last phase of life in our community.
9. We will embed the new patient and family feedback system, aligned to the priority outcomes, to enable us to continue to improve outcomes and address inequalities.
10. We will create a St Helena carer strategy, and we hope to secure new income streams to enable innovation to support local carers.
11. We will expand the Safe Harbour programme, addressing inequalities for traditionally under served communities, seeking funding to secure its future.

2.1. Priorities for Improvement from 2023-24

2.1.1. 23-24 Priority One

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

What we wanted to achieve

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 Operational 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.*

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

6. *To treat people at end of life as individuals, with dignity, compassion, and empathy.*
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.*

What we have achieved

We have simplified our Model of Care, allowing us to improve the ways St Helena and other local health and social care providers can support patients and families to help achieve the Ten Outcomes That Matter. This simplified Model is tailored for growth, which will help us to achieve our strategic aim of doubling our reach within ten years. It will also enable us to measure our outcomes, aligning feedback with the Ten Outcomes, allowing us to gather evidence to demonstrate the effectiveness of our services, and thereby supporting our efforts to secure more funding from commissioners.

Underpinning all this is improved communication with people facing end-of-life care and bereavement, ensuring they have access to the information and support they need to live and die well with dignity and choice. We are working to engage with patients and families to discover what's important to them and help them achieve it. We're also evaluating the level of contact we have with them, and how we elicit their communications preferences.

Our new model identifies three main categories of people:

- Those we would traditionally describe as a St Helena patient – hospice led care.
- Those people who don't require direct clinical input, but who are still part of the St Helena community - community led care. These people have, in the past, lacked communication from us, so initiating regular contact with them will ensure they have access to the information and support they need to live and die well with dignity and choice.
- Those within compassionate communities. These people may be in the last phase of life or grieving a bereavement, or supporting someone who is. This group is growing, but it will be harder to measure their outcomes, as they don't have direct contact with St Helena.

We have mobilised the new Operational Hub, bringing together the functions of the Referrals Team and the IPU Care Co-ordinators to ensure efficient processes for referrals and co-ordination of care. We have now launched our night sitting and visiting

service through Radfield Colchester alongside our new "Home Ward" service following the transition from the St Helena Virtual Ward. This has coincided with the launch of our new 'Specialist Palliative Care Virtual Ward' (SPCVW).

The SPCVW aims to provide excellent, medically led care to patients whose needs cannot be met in the community without additional support and who would otherwise require admission to Hospital or our Inpatient unit. It mirrors the NHS virtual ward model and allows patients the choice to remain at home for treatment, thus reducing the number of admissions and allowing treatment to be initiated, reducing the length of any subsequent admission.

You are the most wonderful and caring people… there is nowhere else that gives such excellent nursing care and makes the patients comfortable and safe. We are so grateful for everything you did.

The Bereavement Service has expanded to become the Counselling and Emotional Support Service (CEST, see page 34), amalgamating counsellors and family support workers from the Hospice and Hospice in the Home MDTs. We continue with our transformation plans to provide a new service offer and reduce waiting times.

The unplanned community night nursing service successfully transitioned to St Helena on April 1st, 2024, and has already led to a more coordinated and responsive service for patients in the community at night.

We have commenced work on ensuring we can evidence our services' contribution to the outcome priorities for end-of-life care. This should be aided by our decision to move to a new system for collecting patient feedback, which will enable us to create questionnaires for patients and their families specifically evidencing these outcomes. This is due for launch over the summer of 2024.

The remodel of the Integrated Care Board's (ICB) *To Live with Dying* website is now live. Our Marketing teams are working on promoting this across the locality. In addition, the NEE Bereavement Service Network continues to work collaboratively on how we direct referrals to the most appropriate provider. We hope to see a reduction in referrals for whom responsibility sits with St Helena. We have also gone live with the Forget-Me-Not paid for bereavement service.

The secondment of St Helena's senior nurse to Colchester hospital has come to an end; however, they have now been appointed to the hub at Colchester General Hospital and this has enabled them to continue to influence appropriate discharges at the end-of-life within their new role.

2.1.2. 2023-24 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.

What we wanted to achieve

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.

What we have achieved

The Paramedic pilot (see page 15) was successful and demonstrated excellent outcomes for patients and was well received by staff in both organisations. The pilot is now complete, and we are working for this to be recurrently commissioned. We have also successfully recruited Paramedics to the SinglePoint, which has strengthened the skill mix within the team.

We are further developing the way we listen to the experience of our service users and carers so we can 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 are refreshing the points in patient pathways at which we collect feedback. We hope that this new approach will be finalised early summer 2024.

Thank you so much for looking [after] my uncle. I visited him recently in the hospice. You care[d] for his sister about 8 years ago. I loved them both. I will continue supporting the hospice for as long as possible.

As part of our night integration project, we reviewed the skills mix within SinglePoint and introduced a band 5 role into the service. We have also recruited an existing Primary Care Network (PCN) Clinical Nurse Specialist (CNS) into the Operational Hub to focus on early triage, in line with our new Model of Care. The aim of this is to reduce the number of patients needing to progress onto Clinical Nurse Specialist caseloads. Early data suggests this is having a positive impact on the caseloads of our PCN CNSs.

The Carers' Working Group continues to make progress with our strategy for carers and how we deliver against the principles within the North East Essex Alliance Commitment to Carer's pledge. A questionnaire is being designed to obtain feedback from existing carers about how St Helena can further support them. The Group

has had advice from the NHS England Carers' Lead, and now includes some carer representation to further support the development of our strategy.

We have several staff on apprenticeship pathways to ensure they have the skills required for our workforce in the future. Another unregistered nurse commenced an apprenticeship pathway to registration in January, joining the two people we already have on this pathway.

We are continuing to work on identifying where digital developments can help us release precious clinical time and support efficiencies within our services.

The joint frailty project with the Frailty team at Colchester General Hospital has continued, with two more CNSs having rotated through the project and worked to ensure patients have the opportunity for advance care planning. There have been some challenges with getting this approach embedded into the wider frailty offer, and the project is now due to come to an end. A member of our advanced clinical practice Nursing team and Chief Clinical Officer are working with the wider system to take this forward.

2.1.3. 22-23 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.

What we wanted to achieve

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.*

What we have achieved

St Helena's Equality, Diversity, and Inclusion (EDI) Group continues to meet monthly and has had input from representatives from a variety of organisations sharing their knowledge and experience to help us shape our services. In recognition of the EDI agenda's impact on all areas of the organisation, the Group now reports directly to our Senior Leadership Team (SLT).

The Safe Harbour (see page 38) project lead continues to build links with Black, Asian and Minority Ethnic (BAME) communities and, together with the Spirituality Lead, ran a 'Hospice for All' open morning for faith leaders, which was attended by representatives from the local Buddhist centre, Orthodox church, Chinese Church, Jewish synagogue, Anglican church, and the Meditation Centre. Work has also been taking place in the deprived communities of Jaywick and Greenstead, including building new partnerships with community representatives. Awareness raising about the availability of Hospice services has been included in this work. We have made two successful applications for funding to further the Safe Harbour work. Following from last year, the Group is continuing to develop ethnicity recording.

You were all so patient and understanding with [him], giving him the very best of care and even when he couldn't respond you all still spoke to him as if he was present. All of you made a really difficult time more bearable for us.

The previously discrete Breathlessness Service has been successfully embedded across our wider Hospice in the Home MDT. This work will ensure sustainability and aims to improve end-of-life outcomes for this patient group.

We continue to progress our Compassionate Communities work (see page 33) for the population, as outlined in our revised Model of Care. We have delivered 'Compassionate Conversations' and 'Care for Friends and Family' awareness training sessions with local communities. We have also hosted three 'Demystifying End-of-life Care' workshops themed around Advance Care Planning & Legal

Considerations, Celebrating Someone's Life & Funeral Planning, and 'A Hospice For All.' This latter workshop focused on the care that St Helena provides at the hospice and in the community. These events are helping break down barriers that prevent people from planning for end-of-life and support our Compassionate Community ambition to improve end-of-life care for everybody in North East Essex.

We have led the development of a co-produced Compassionate Charter of actions and Compassionate City self-assessment, in collaboration with strategic partners and community assets representing Colchester. If approved in May 2024 this will be the first such accolade for anywhere in the East of England. This work was acknowledged in the Suffolk & North East Essex Integrated Care Board's (SNEE ICB's) newsletter, *NHS Suffolk, and North East Essex - Stakeholder briefing.*

We have launched weekly 'Meet & Greet' events at St Helena to help raise awareness of end-of-life care options and to build trusted relationships with partners, funders, and supporters across sectors. These sessions include a guided tour of the hospice and informal question and answer sessions with our Nursing and Community teams. Our visitors so far have included Essex Child and Family Wellbeing Service, Healthwatch Essex, the North East Essex Alliance Neighbourhood Team, Age Well East, Greenstead Community Centre, Colchester Borough Homes, Tendring Primary Care Network (PCN), and Birkett Long Solicitors.

We have also obtained project income of £61,000 from the end-of-life (EoL) Working Group for St Helena's role in 'Combating Inequalities – Early EoL Assessment in Tendring.' This project will be delivered with Tendring PCN and aims to improve end-of-life care outcomes for our patient population and address socioeconomic and cultural inequalities in Tendring (identified by the Office for National Statistics as one of the most deprived areas in the UK). We will reach those in the last phase of life through early identification of end-of-life patients, provision of timely holistic reviews, recording of advance care planning preferences, providing peer and carer support, and signposting to appropriate community assets and services. We will increase awareness of the services and support available for both patients and carers with a targeted campaign and activity programme that will develop relationships and improve communication with local community assets. We will work with the Compassionate Community network in Tendring to do this.

We also obtained project income of £16,000 from the EoL Working Group for St Helena's role in delivering 'EoL Campaign Stage 2 – Your Voice'. This project will deliver key 'campaign' activities that support year one of a three-year EoL Communication and Engagement Strategy, co-produced with Compassionate Community partners and community assets. It aims to establish a sustainable 'Talk Radio' programme of activities, an incentive scheme to recognise and celebrate compassionate people, places, and projects, and to train Compassionate Community Connectors.

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

2.2.1. Review of Services

During 23-24, 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 Therapies service for both inpatients and community patients, as well as the Spiritual Care Lead and 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 comprises the Nursing Team, a Specialist Physiotherapist, Specialist an Occupational Therapist, a Therapy Assistant, Specialist Social Worker support, a Counsellor, and a Family Support Worker.
- The Medical Team, supporting both MDTs.
- The Counselling and Emotional Support Team (CEST) provides psychological support for anyone over the age of five who is affected by life limiting illness or bereavement. We support clients, patients, families, and friends and work across both of St Helena's MDTs. The Bereavement Service is open to referrals for adults and children, regardless of the cause of death.
- The Compassionate Communities Programme, encompassing our Safe Harbour project and Compassionate Workplaces programme.
- Hospice Education in collaboration with St Elizabeth Hospice in Ipswich.

2.2.2. 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 25% of our total income, meaning that for every £1 of NHS money that was invested in our services, we were able to deliver £2.16[2] of value of care to our patients and their loved ones. Our

[2] Note that we reported the figure for last year as £3.70 when it should have been £2.10.

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.

2.2.3. Clinical Audit

National Audits

We did not participate in any national audits this year.

Local Audits

The clinical annual audit programme for the year began in April 2023, designed by our Clinical Compliance Officer together with service leads. The programme ended in March 2024. Table 1, below, summarises the outcome of the 2023-24 programme.

Audit Status	Total
Completed	48
Not completed	12
No Longer Required	4
Total	64

Table 1 2023-24 clinical audit summary

12 of the 64 audits were not completed and have been added to the 2024-25 programme. These were not completed either because of lack of resource (e.g. the audit lead is no longer employed here) or because they were care plan audits, postponed because of changes made to care plans in November 2023, which could not be completed in time.

Note. The numbers in Table 1 relate to each overarching audit and do not include each cycle.[3] The number of total audits completed will therefore be much higher. Audit frequencies range from as often as weekly, to annual.

Our Clinical Quality Group (formerly the Quality Assurance and Audit Group) meets monthly to monitor our annual audit programme, quality reporting, and patient experience. Our Clinical Compliance Officer manages the clinical audit programme on a dedicated module of our governance system, Sentinel, to allow for reporting of completion rates, monitoring of actions, and so forth. The planned programme is supplemented each year by ad hoc audits. All staff completing audits are supported by our Clinical Compliance Officer.

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

Graded Pressure Ulcer Documentation [28-2223-2]

The purpose of this audit was to monitor how well the graded pressure ulcer care plans used on the Inpatient Unit (IPU) were being completed. The previous audit was completed in April 2022.

10 patient records were audited in April 2023 against a set of pre-agreed questions regarding the correct use of the care plan. The results were excellent, evidencing that the care plan was being used correctly with a high level of good quality supporting free text.

Re-audit will be in April 2024.

Side Rails Assessments [37-2324]

Side rails can be fitted to beds to help keep patients safe. This audit examined how well the side rails assessment was being used on the IPU. A weekly care plan was introduced during September 2020, requiring an assessment to be competed on admission and a re-assessment weekly.

[3] Repetitions of the same audit within the year; e.g. weekly hygiene audits.

This was the third re-audit. The IPU Senior Sister audited the records of the 12 current patients on 30th August 2023. All 12 patients had an admission assessment completed and all 10 who had been inpatients for longer than one week had had weekly re-assessment.

There were no concerns identified during this audit and, as a result, re-audit is not required.

Oral Hygiene Documentation [35-2324]

This audit examined how well the oral hygiene care plan was being used on the IPU. This daily care plan contains an oral hygiene assessment tool and both plan and tool were audited, along with the quality of any free text documentation. This was the sixth re-audit.

…she called the virtual ward staff "their angels in blue"… they washed her so professionally and sang to her and then she died just as they left the house.

All admissions from June 2023 where length of stay was more than one day (34 patients) were audited to examine whether both the assessment and care plan were being completed daily.

Results were much improved from the previous audit in December 2022, with 82% compliance for completing the daily oral hygiene assessment compared with 64% in December. Compliance with daily care plan review and recording of consent continued to be excellent (99%).

The audit findings suggested that the care plan instructions could be altered to ensure staff are all documenting care needs consistently. At the time, all mandatory care plans were being reviewed and recommendations from this audit informed this review.

A re-audit was proposed for after the care plan review project was complete.

To Do Lists Six Month Report [23-2324-1]

This is a monthly audit that examples compliance with mandatory care plans by auditing the 'to do list' feature in our patient administration system, SystmOne. Dependency colours for each inpatient are also audited to check that they match the patient's individual dependency assessment.

This summary covers monthly audit between April 2023 and September 2023, completed by an IPU Deputy Sister.

Average mandatory care plan compliance and average correct dependency colour compliance were both above 90%. This was an increase for correct dependency colour compliance.

On 1st November 2023, a revised set of mandatory care plans went live on the IPU. There was a period of transition where both old and new care plans were being used. As a result, there was a pause in this audit between October 2023 and January 2024, following the transition.

Paramedic Rotational Model Review [24-2324-1]

This audit examined the effectiveness of the role of the Paramedic within the SinglePoint team. This summary is for the first re-audit, which covered activity during Q1 (23-24).

The aims of the project continued to be met. There were 678 contacts during Q1 for 269 patients, which was an increase on the previous quarter.

Inappropriate admissions had been avoided; of the 40 patients records reviewed during this audit, only two had been admitted to secondary

care (appropriately) with a reversible cause. 95% of the patients who had an intervention from the Paramedic remained at home for 72 hours post intervention, and 75% had no admissions in the last 90 days of their lives/or until death. 82% remained in their preferred place of are (PPC).

The 100% positive feedback from the MDT in questionnaires given to staff suggests that the palliative MDT continued to benefit from the addition of the rotational Paramedic role, improving collaborative working, utilising the Paramedics' enhanced clinical assessment skills, and sharing expertise. Other themes were broadly like the previous audit in terms of general support to SinglePoint and the access to East of England Ambulance Trust (EEAST) systems that the Paramedic role provides, emphasizing the continued benefit of the role to the wider hospice team.

The next audit was planned for January 2024 but was not reported soon enough to be included in this Quality Account.

Admission Avoidance [40-2324]

With the increased strain on healthcare nationally, all healthcare providers have a duty to prevent inappropriate admissions to an acute hospital. St Helena is in a unique position to support patients to remain in their preferred place of care (PPC) and the multi-disciplinary team works to prevent inappropriate admissions.

The most recent admission avoidance audit had been completed in June 2022 and this re-audit allowed direct comparison of the results to see if there were common themes in how the Hospice and the Hospice in the Home teams were involved in preventing acute hospital admissions. This was the second re-audit.

The audit took place over a two-week period (25/09/23 to 08/10/23). Following any given clinical intervention, if the clinician felt this had prevented an admission, they informed the auditor. 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 28 patients were prevented from being admitted to an acute hospital following the intervention by the Hospice in the Home team. After the intervention, all patients were able to remain in their PPC and, at the time of the audit report, eight patients had died within their PPC.

The data also highlighted the new SinglePoint Paramedic role, which was helping prevent hospital admissions. The auditor assessed that out of the interventions provided by the SinglePoint Paramedics, over the two-week periods six 999 ambulance calls had been prevented.

Re-audit will be in one year.

Role of the Referrals CNS [39-2324]

A new role was created in September 2022 within the Referrals Team for a band 7 CNS to undertake one-off CNS assessments identified at the point of triage.

To understand how the role was functioning, an audit was recommended to look at statistics on the key components of the role.

The Referrals Assessment CNS works 30 hours per week. They undertook 125 assessment visits during the period of September 2022 and April 2023, averaging 15 per month. The CNS also supported with telephone triages of new hospice patients and conducted all due work within the four pillars of advanced practice.

A proposed benefit of the role would be that the patients seen by the CNS would be more likely to contact SinglePoint than patients who had not had a face-to-face assessment. We saw an average of five calls per patient seen by the CNS.

The audit also showed that the interventions by the Referrals CNS had influenced assigning patients to Level 3/4 caseloads (see Table 2 on page 30), as the role had progressed and follow-up calls had been introduced. This had often saved the need to assign to a CNS for ongoing input.

The audit showed the value of the Referrals Assessment CNS role in ensuring patients receive the appropriate level of ongoing input, and awareness of the role of SinglePoint.

neither of us realised how very ill he was… From the moment we arrived it was clear that the level of care and kindness was everything we had hoped for and it was a huge relief to know that every effort was being made to … keep him peaceful and pain free during his last days of life. The level of professionalism, kindness and genuine caring from every single member of staff and volunteer was outstanding and has made the heartbreak... more bearable

Community Monitoring of FP10s [38-2324]

St Helena monitors the use of community FP10 prescriptions to ensure that standards for ordering, receipt, storage, and use are met. In July 2023, a new Sentinel module was implemented for prescribers to record their issued prescriptions and the first audit of this new system took place in September 2023. The system was designed to make both recording and monitoring more efficient than the previous system (an Excel spreadsheet).

The first audit in September 2023 found that documentation was generally very good. Using Sentinel eliminates the risk of clerical errors such as missing digits on NHS numbers or prescription serial numbers. There were some gaps showing in some prescription pad records and prescribers were asked to confirm the use of these prescriptions and document them. Mostly these were gaps from the switch from one system to another.

The audit found that some full prescription pads were stored in the safe but had no corresponding Sentinel record. These were added post audit. The audit also found that the standard operating procedure for monitoring of FP10s had not been updated for the new Sentinel module. This was reviewed post audit.

A re-audit took place in in November 2023 and showed that all open prescription pads were up to date and correctly documented, apart from one prescriber who had advised after the original audit that they had not yet had the training to use the Sentinel module and so were still recording prescription use on the spreadsheet. The Compliance Officer arranged training with this member of staff.

Both audits also included a review of the security of the safe and there were no concerns identified on either audit.

The next audit was planned for the end of January 2024 with a decision on regular re-audit frequency to be made at that time.

Admission Documentation Audit [43-2324]

In November 2023 after several months of work to review mandatory care planning on SystmOne, several amended care plans were introduced on the IPU along with a new admission assessment process. This ad hoc audited was completed to review how

well the new processes had been implemented.

A Deputy Sister from the IPU manually examined the records of all current inpatients on the date of the audit to ensure that the admission documentation had been used correctly and was complete, and to review how well the new Rounding care plan and the Patient Story care plan were being completed following any changes made.

The audit found that documentation in some areas was excellent but in other areas was minimal. The audit also identified some technical problems with the set up on SystmOne, which have since been rectified.

The Deputy Sister worked with the Nursing team on improving the quality of documentation to ensure care planning is personalised and complete, with a view to re-auditing in February 2024.

Note: The February 2024 audit did not report in time for inclusion in this Quality Account but showed excellent results.

Patient Lockers Audit [27-2324]

This observational audit examines patients' own medication lockers on IPU to ensure that they were clean, tidy, and contained the correct medication for the correct patient. This audit is completed quarterly. This report covers the audits completed in July 2023 and November 2023 (an October audit was postponed to November).

The results showed improved, or consistently good, compliance with the standards expected.

During 2023 the Operational Medicines Management Lead had been accompanying nurses on drug rounds on an ad hoc basis to improve compliance. Nurses had also been self-auditing their lockers on shift informally to ensure compliance. This is no longer needed, and formal auditing of lockers will continue quarterly.

A re-audit scheduled for February 2024 was delayed until April because of short staffing.

Hospice UK Self-assessment Audit for the Controlled Drugs Accountable Officer (CDAO) [42-2324]

This is an annual audit carried out using a Hospice UK audit tool to ensure that the appointment of the CDAO and the discharge of their responsibilities in the management of controlled drugs (CDs) meets the requirements of the Misuse of Drugs Regulations (2001) (as amended 2007), The Health Act (2006), and the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

The audit had four sub-topics: Appointment of the CDAO, Role and Responsibilities of the CDAO, Annual Review by the CDAO, and Continuous Quality Monitoring.

The audit scored 93% overall and re-audit will be in one year.

Hospice UK Management of Controlled Drugs [43-2324]

This is an annual audit using a Hospice UK tool carried out to ensure that the management of controlled drugs meets the requirements of the Misuse of Drugs Regulations (2001) (as amended 2007), The Health Act (2006) and the Controlled Drugs (Supervision of Management and Use) Regulations 2006.

The audit had seven sub-topics: Adequacy of Premises/Security, Procurement, Examination of Stock Held, CD Register, Records and Audit; Prescribing of CDs, Administration of CDs, and Destruction of CDs.

The audit scored 94% overall and re-audit will be in one year.

2.3. Participation in Research

We are a site for the ChelSea II study, which looks at artificial hydration at the end-of-life.[4] With the support of research nurses from the National Institute for Health and Care Research (NIHR) we have successfully recruited 17 patients. This project has provided a range of staff members with experience being involved in various stages of the research process.

We also presented several posters at the Hospice UK (HUK) conference in Liverpool in November 2023:

- How compassionate is your workplace? Supporting local businesses to be compassionate workplaces (page 20).
- Mortality Review: Learning from deaths in palliative care settings (page 21).
- What are the barriers affecting the full utilisation of paramedics within hospice care? Is a rotational model the answer? (page 22).
- A 10 year retrospective of SinglePoint access (page 23).
- Rotational specialist palliative care paramedics (page 24)
- Gathering Population Feedback at the End-of-life (page 25).
- Admission Avoidance: Preventing unnecessary hospital admissions in the last phase of life (page 26).

2.3.1. Use of the CQUIN Payment Framework

St Helena income in 2023-24 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.

[4] https://www.surrey.ac.uk/chelsea-ii-trial

How compassionate is your workplace?

Supporting local businesses to be compassionate workplaces

Background

The impact of the Covid-19 pandemic highlighted that many organisations needed to review their practices to support their workforce facing loss, grief and bereavement. The Chartered Institute of Personal Development (CIPD) states: "A compassionate approach is vital to remain connected, mentally healthy, and productive while we battle through the challenges we face at work and beyond".[1]

Research highlights the importance of compassion in the workplace following a bereavement to ensure retention of staff and healthy mental wellbeing.[2,3] It was recognised that developing training would be beneficial for organisations to support compassion in their workplace.

Aim

- To develop a training session that engages employers to support and guide their workforce during life's most difficult moments
- To deliver the training to external organisations and businesses
- To support a compassionate communities approach to improve end of life care and support to all

Method

Training was developed using a multi-disciplinary approach, specifically to support and guide local business workforce by:

- Providing a framework to understand loss, grief, and the impact of bereavement
- Developing empathetic conversations
- Improving management of staff and colleagues with kindness
- Promoting compassionate leadership culture
- Providing resources for policies, wellbeing, and guidance

Result

Training has been/is being delivered to a range of organisations. The responses and feedback provided after attending this have been very positive:

- 100% of participants agreed their knowledge about planning for end of life has increased
- 100% of participants agreed their understanding of a compassionate approach in the workplace has increased
- 100% of participants recommended other organisations attend this training

Conclusion

85 attendees from at least ten different workplaces have completed the training so far, with the unanimous message being that all workplaces should implement a compassionate approach to grief and bereavement. The outcome shows that hospices can effectively influence the workplace culture to become compassionate workplaces.

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Mortality Review

Learning from deaths in palliative care settings

Background

Mortality review is a means of reviewing the quality-of-care patients receive at or near the time of death[1]. This is advocated across all healthcare settings and the results can highlight deficits in service provision, knowledge, and skills[2]. This learning can then be used to inform service delivery and educational needs.

Aim

To review the deaths of patients dying within their own home, hospice, hospital, and care home setting. Highlighting exemplary or poor experiences and exploring factors which contributed towards patients dying contrary to a patient's preferred place of death (PPD).

Method

Each month a multidisciplinary team met to review patients chosen at random by a non-clinical team member. Patients records were reviewed using an audit tool devised by the team evaluating areas including recognising dying, communication, symptom control, advance care planning (ACP), and PPD.

Result

- Between April 2022 to March 2023 a total of 40 patients were reviewed.
- 90% of patients discussed had ACP discussions documented.
- 72.5% of patients had achieved their PPD.
- For the majority of patients, there was excellent documentation regarding recognising dying and communication with families.
- Timely symptom control was being achieved by collaborative working.
- Patients in residential settings often had limited input from specialist palliative care.

Conclusion

The data highlighted some excellent examples of care, and also identified some areas of improvement to action which included:

- Advocating earlier referrals into the Hospice, ACP discussions and use of the electronic palliative care register.
- Recommending ACP is reviewed and updated regularly particularly RAG status when patients are deteriorating.
- Promoting clear documentation specifically regarding communication with family members.
- Encouraging early referral to the hospital palliative care team for patients admitted to an acute hospital to enable timely assessment.
- Promoting specialist palliative care services within local residential homes with support from the hospice education team.

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What are the barriers affecting the full utilisation of paramedics within hospice care?

Is a rotational model the answer?

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Palliative Care Paramedic

Background

With increasing demand for community-based palliative and end of life care, paramedics are being recognised as a potentially valuable assets to a multidisciplinary workforce[1]. But there are barriers that prevent paramedics from being routinely found within the multidisciplinary teams in hospices. These barriers include; lack of specialised training, lack of confidence in leaving dying patients at home[2] and concerns of losing the unique acute skills gained in Paramedicine.

Aim

Can we combat the barriers hindering full utilisation of paramedics in palliative and end of life care by applying a rotational model where paramedics retain employment with the ambulance service and split their working hours between frontline ambulance shifts and integrating into a rapid response hospice team.

Method

Four paramedics commenced a rotational role with East of England Ambulance Service and St Helena hospice SinglePoint team, we undertook a comprehensive training program followed by a period of joint working with Registered Nurses (RN's) and Non-Medical Prescribers (NMP's) leading to a blend of duel and autonomous rapid response visit and telephone triage, mainly focusing on presentations suggestive of reversible causes, chest pains, neurological symptoms and traumatic injuries from falls including wound closure.

Outcomes

The application of a rotational model has allowed the paramedics to practice Paramedicine in an acute setting ensuring they maintain their acute skills.

The integrated working with the SinglePoint and training team has provided specialised training, increasing the paramedic skills and confidence in palliative care.

Conclusion

A rotational model can help overcome some of the hurdles faced when integrating paramedics into hospice care and has additional positive outcomes in staff retention for the ambulance service, increased hospital avoidance, opportunities in disseminating learning to other frontline paramedics and providing specialist learning and development pathways. However, the pilot is in its infancy and the development of the role should continue to evolve and be regularly evaluated.

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East of England
Ambulance Service
NHS Trust

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A 10 year retrospective of SinglePoint access

Background

Palliative and end of life care (PEOLC) should be coordinated[1] and include access to out of hours care[2]. It is recommended that high-quality out of hours community services need to be prioritised as deaths are predicted to increase[3].

The St Helena SinglePoint of access was launched in 2013. The SinglePoint 10-year anniversary offers an opportunity to reflect on the challenges and successes of the last decade.

Aim

To develop a telephone triage service for people in the last year of life in north east Essex, including a rapid response visiting service.

Method

Beginning as a 12-hour service, it was quickly expanded to 24/7. In 2020, due to the first wave of the Covid-19 pandemic, it expanded into a PEOLC hub, coordinating discharges from hospital, fast track continuing healthcare and taking referrals to the community nurse palliative care team, the hospice rehabilitation team and the Virtual Ward service for people in the last weeks' of life.

In 2022 the team was expanded by four rotational paramedic roles in collaboration with the local ambulance trust.

Its work is supported by a well-embedded Electronic Palliative Care Coordination System.

Results

In 2022/23 the service included 32 full time equivalent roles, including call handlers, senior nurses, non medical prescribers, night time healthcare assistants, occupational therapy, physiotherapy, and a therapy assistant, in addition to the four new rotational paramedic roles. Last year SinglePoint of access received 45,554 calls relating to 2,553 people and delivered 1,103 rapid response visits. The average wait for a visit was 91 minutes.

Service audits show high achievement of preferred place of care and patient feedback is positive.

Conclusion

Hospices can deliver integrated 24-hour PEOLC services to support care coordination for people across the community.

Last year

SinglePoint received
45,554 calls
relating to
2,553 people
and delivered
1,103
rapid response visits
91 minute
Average wait for a visit

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Rotational specialist palliative care paramedics

Background

The ambulance service was experiencing challenges retaining experienced paramedics; as was the Hospice with recruiting experienced nurses. This role offers a unique opportunity for collaborative working, while sharing skills and knowledge was identified by both organisations.[1]

Aim

- Improve recruitment and retention of experienced paramedics and nurses
- Share the skill set between the hospice and ambulance service
- Improve confidence and knowledge
- Prevent skill fade
- Increase the responsiveness of specialist palliative care in the community
- Improve individualised care
- Reduce avoidable hospital admissions[2]

Method

We recruited four paramedics working alternate weeks between the hospice community team and ambulance service.

Week one of a six-week, classroom based induction, focused on core elements of palliative care:

- Holistic assessment of patient and carers
- Symptom control
- Care in the last days of life
- Communication skills

Each paramedic was allocated a non-medical prescriber mentor and shadowed the team during induction, applying theory to practice.

The paramedics:

- Triage phone calls
- Attend crisis home visits, using their clinical assessment skills
- Support with decisions regarding potential hospital admissions
- Identify reversible causes in deteriorating patients

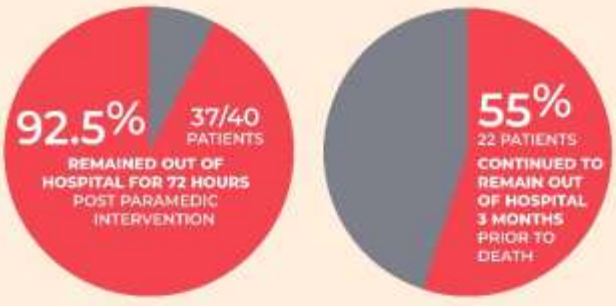
When on ambulance service shifts, the paramedics identify patients who require palliative/end of life support and cascade specialist palliative care knowledge to their colleagues.

Outcomes

In the first quarter, 82 patients were seen. A random audit of 40 cases showed 37/40 patients remained out of hospital for 72 hours post paramedic intervention and 22 continued to remain out of hospital three months prior to death. One patient had an appropriate acute admission; one patient was admitted to a community hospital; and one patient admitted to the hospice IPU. The paramedics are now fully embedded and we anticipate the data to show even greater outcomes.

Feedback received from colleagues in the hospice is 100% positive, demonstrating the MDT has benefited from the additional role, improved collaborative working and sharing of expertise.

In the first quarter, 82 patients were seen in total. During a random audit of 40 of these patients:



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Gathering Population Feedback at the End of Life

Background

Capturing feedback about the quality of End-of-Life care (EoLC) is challenging and historically dominated by bereavement studies.

Locally we have an integrated population outcome-based accountability model for EoLC designed to improve 10 priority coproduced outcomes. Only 6 of these outcomes had a relevant pre-existing data source to enable programme monitoring.

Aim

To design and implement a feedback system for patients approaching the end of life, aligned to priority outcomes, to inform the population-based EoLC programme.

Method

A working group was created including the hospice, the integrated care system business intelligence team, and a patient feedback business consortium. Appropriate information-sharing agreements were created to support data flow.

People are recruited for the survey via telephone after being identified by their registration on the Electronic Palliative Care Coordination System.

Consenting participants are sent a monthly survey by text asking them to score their experience of the sensitivity of the initial conversation about their priorities, the dignity with which they have been treated, the perception of care provision for their needs, symptom control and satisfaction with carer support. Free text comments on the best and worst of their experience are requested.

10 outcomes that matter at the end of life

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 of the likelihood of death within the next 12 months sensitively and honestly
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 their 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
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

Result

187 people have been recruited so far. Half of the respondents are patients and half are carers. Response rates vary from 12-23% each month.

Answers are pseudo-anonymised and passed to the hospice and then relinked to their diagnostic group and Primary Care Network registration. This data passed to the Data Services for Commissioners Regional Offices (DSCRO) and through to the Alliance EoLC dashboard.

Respondents report the following outcomes are achieved all or most of the time:

"The nurse from the Hospice was polite and kind, caring and gave my husband plenty of time to discuss his needs"

"Very helpful phone consultation with oncologist when I was unwell and unable to attend my outpatient appointment."

Conclusion

Population outcomes can be successfully measured using a text-based survey to inform an integrated EOLC programme

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Admission Avoidance

Preventing unnecessary hospital admissions in the last phase of life

Background

With the increased strain on healthcare nationally, all healthcare providers have a duty to prevent inappropriate admissions to an acute hospital[1]. Hospices are in a unique position to support patients to remain in their preferred place of care (PPC) by utilising the skills and knowledge of the multidisciplinary team[2].

Aim

To evaluate the role of the hospice in preventing inappropriate admissions to hospital. For the purpose of the audit, admission avoidance was defined as; preventing someone from being admitted to an acute hospital and allowing them to be supported and die within their PPC. The intervention taken place must prevent admission for at least 72 hours.

Method

The audit took place within the hospice in the home multidisciplinary team over a two-week period. Clinicians informed the auditor if their intervention prevented an admission into hospital. The data was then collated and at the end of the two-weeks each patient record was reviewed to confirm that the intervention prevented admission.

Result

19/19 patients reviewed were able to remain in their PPC and were prevented from being unnecessarily admitted to hospital. The hospice rapid response team prevented the most admissions however this was expected due to the nature of the role and 24/7 working pattern.

Common themes included:

- Rapid assessment, prescribing and symptom control
- Initiating urgent care packages via the hospice virtual ward
- Timely advance care planning allowing informed decisions about their future care
- Urgent admission into the hospice or nursing home placement
- Joint working with the ambulance service supporting patients to remain in their PPC
- Provision of urgent equipment

Conclusion

The audit has provided evidence that the hospice is actively preventing admissions into the acute hospital. The interventions taken place have supported patients to remain in their PPC by providing timely person-centred care.

19/19 patients reviewed were able to remain in their preferred place of care and were prevented from being unnecessarily admitted to hospital.

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3. Review of Quality Performance

3.1. Overall referrals to St Helena

Figure 3, below, illustrates how many referrals we received during 2022-23, where they came from, age distribution and so on.

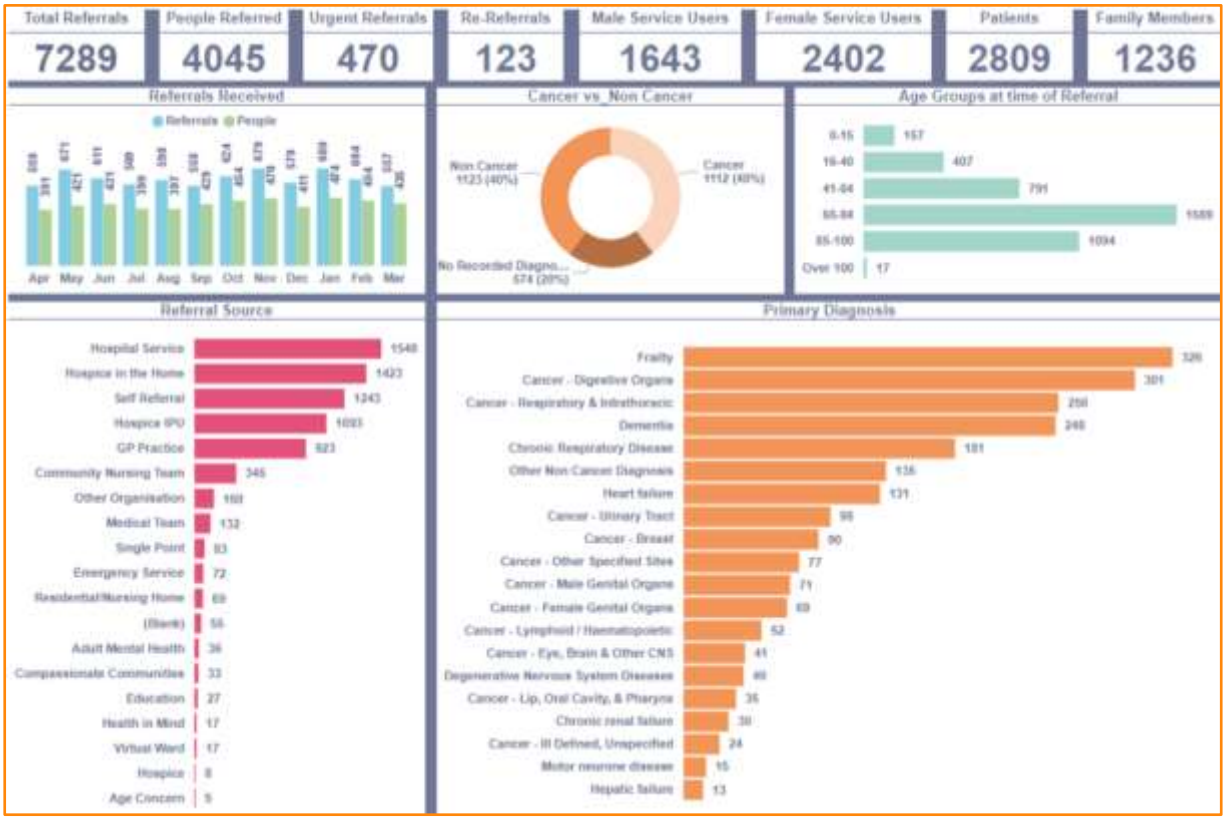

Figure 3 2023-24 referral statistics

3.2. The Hospice

The Hospice MDT comprises Registered Nurses (RNs), Clinical Support Workers (CSWs), Physiotherapists, and Occupational Therapists who are based on our Inpatient Unit (IPU), plus the Medical Team, the Counselling and Emotional Support Service, the Spiritual Care team, and Complementary Therapies whom we share with the Hospice in the Home in the Home MDT.

The IPU is a short stay unit consisting of 18 beds, providing specialist palliative care to patients with life limiting illnesses, utilising all the skills from The Hospice MDT members.

Recent activity, achievements, and contributions to quality

Over the year, there were 406 admissions to IPU. Staff have worked hard over the year to aid admissions and discharges, and, on average, we achieved admission in line with our target of three days. During the first quarter of the year, the Care Coordination team amalgamated into the Operational Hub, and, despite the transition, admissions remained high.

Average bed occupancy across the quarters fluctuated between a high of 90% in Q1 and a low of 83% in Qs 2&3 but exceeded our annual target of 85%. Admissions were reduced by room closures necessitated by repairs and tests on the water system. In addition, we had to temporarily close some beds during Qs 2&3 because of short staffing.

Words never seem enough, but we are all so very grateful for your compassion, professionalism and gentleness in your care you showed her in the last days of her life. Your support for our family was also extremely appreicated, nothing was too much trouble - and you all made us feel so welcome and your words of love a comfort at such a difficult time were deeply appreciated too.

Staffing

We raised a risk over shorting staffing to better manage the problem but closed it once we had recruited new RNs. We have continued to look at workforce planning throughout the year, as well supporting three Clinical Support Workers (CSWs) in their apprenticeships to become RNs. Despite these shortages, we have not used any external agency staff and have grown our regular bank staff to help keep costs low.

Challenges and problems

As discussed, staffing was a challenge for the first six months of the year. Patient dependency has been high, and we have had several patients remain on the IPU for extended periods, affecting how many new patients we could admit. Our ongoing financial deficit has had an impact on staff morale.

Plans for next year

- Work on utilising different funding agreements for IPU beds.
- Focus on helping staff achieve the goals that were identified during appraisal.
- Continue to build on the respite beds.

3.3. Medical Team

Our Medical Team has continued to provide 24/7 cover to both the Hospice and the Hospice in the Home MDTs. As well as conducting daily reviews of patients admitted to IPU, we offer advice to any healthcare professional across the Hospice catchment area, outpatient appointments, disease specific multidisciplinary meetings, and

home visits. Out of hours, this includes advice regarding inpatients in Colchester General Hospital. Some Team members work across both the Hospice and the Hospital, providing important continuity for patients and enhancing teamwork across settings.

We have continued to take lead roles in medicines management, providing the Training Programme Director for the East of England Palliative Medicine Training Programme, the Lead for End-of-life Care across ESNEFT,[5] the Guardian of Safe Working for ESNEFT, and Research and Frailty work.

At the beginning of the year, we concluded some work on historic caseloads, which means our dashboard data accurately reflects the activity of the Team outside of work on IPU, on call time, and advice given to other professionals.

Although we started the year with an Advanced Nurse Practitioner (ANP) vacancy we successfully recruited to this and have continued to develop the role to include providing on call cover to IPU. This significantly improves the resilience of our rota albeit we are still relying on bank staff to cover some shifts because of the vacant Specialist Trainee post. Recruitment of Palliative Care Trainees has been a challenge nationally (56% fill rate) and the Eastern Deanery was allocated no trainees despite having 11 vacancies. As a result, our Specialist Trainee post has remained unfilled since September 2023. This reduces the staff available to cover IPU but also impairs our skills mix. We have adjusted our senior supervision, and the Team is working flexibly on IPU and in the community to compensate.

Strikes throughout the year affected the Team, both directly and indirectly, because of the added pressure on the system. Despite this, the Team was able to offer a safe and responsive service throughout.

Having successfully piloted senior Specialist Palliative Medical input to our community hospitals, we secured agreement from our local Trust to fund one session per week in the two community hospitals in Tendring. Not only does this offer specialist input directly to patients, but it also supports the Nursing staff there and builds good relationships between the two services.

Dr Thulavavenkateswaran presented a session at GeriPalCon 2024 in January. This was a hybrid conference in India titled 'Challenges in Geriatric and Palliative Care.'

In addition to continuing to support the existing services, we launched the Specialist Palliative Care Virtual Ward on 18th March 2024. This

[5] East Suffolk and North Essex NHS Foundation Trust.

service aims to provide excellent Medical led care to patients whose needs cannot be met in the community without additional support and who would otherwise require admission to Hospital or our IPU. As well as allowing these patients the choice to remain at home for treatment, the project aims to reduce the number of admissions and allow treatment to be initiated at home, reducing the length of any subsequent admission. It operates alongside our existing Palliative and End-of-life care services and is based on the model of virtual wards being established in the NHS.

We have continued to welcome medical students supporting the Hospice. These have included apprentices from Cambridge University Medical School, and students from St Bartholomew's Medical School, Hull York Medical Schools, and Anglia Ruskin University.

We have worked with volunteer services to develop a process for Sixth Form students wishing to apply for Medical School. We have supported three students this past year and received positive feedback.

We want to thank you and express our love and respect for everything you do for patients and families. … was just as blown away and amazed by the care that you give to all and the incredible safe space you have created.

3.4. Hospice in the Home

The Hospice in the Home MDT is the end-of-life hub, acting as a co-ordinator for all out of hospital end-of-life care. The MDT consists of the Operational Hub, SinglePoint, the Primary Care Network Clinical Nurse Specialists (PCN CNSs), Rehab,[6] and the Home Ward. The Operational Hub team manages and triages all new community referrals into St Helena, signposting them either internally or externally, to ensure patients receive appropriate and timely support. This includes managing the referrals for Home Ward. The Operational Hub also leads on IPU admissions and discharges.

3.4.1.1. PCN CNSs

The PCN CNS team proactively supports Level 3 and 4 patients who have specialist, complex palliative care needs. This includes pain and symptom management and advance care planning. They work in a geographical area supporting allocated GP surgeries.

Level	Description
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 2 CNS levels of management

[6] Rehabilitation.

Activity, achievements, and contribution to quality

During the last year, a CNS team member has been working on a frailty project alongside ESNEFT, sharing their skills in difficult conversations and advance care planning and engaging with patients earlier.

A CNS transferred to the Operational Hub to complete a three-month pilot. They visit patients who may only require a single assessment, thereby helping to lessen the new referrals routed to the CNS team.

Challenges

Throughout the year, staffing levels have fluctuated because of sickness, the need to cover for the CNS working on the frailty project, and because of the transition to the Operational Hub. We have also had to induct several new team members, either as CNSs or in a developmental role.

Plans for next year

The CNS will continue to support any further projects that may arise.

As financial pressures have meant we have needed to reduce our provision of services to Mid-Essex ICB patients, we are no longer able to offer them access to SinglePoint; however, they will still be supported by the CNS allocated to this area.

3.4.1.2. SinglePoint

SinglePoint takes calls for all end-of-life patients and provides rapid response visits when required. The team consists of call handlers, senior nurses, and non-medical prescribers.

Activity, achievements, and contribution to quality

SinglePoint received 41,924 calls during the year, supported 2540 people and attended 2,359 rapid response visits. The average wait for a visit was 69 minutes.

The Paramedic pilot, which consisted of four Paramedics working jointly with the East of England Ambulance Trust (EEAST) and SinglePoint, demonstrated the value of the Paramedics in helping prevent admissions to hospital and St Helena upskilling paramedics in end-of-life care. The pilot received 100% positive feedback via an MDT questionnaire, demonstrating that staff benefited from collaboration and sharing expertise (see page 15 for more details of our evaluation of the project).

I would like to extend my thanks to your organisation for the support and care that you have given to my mum in her last hours before she died. You only received our referral yesterday morning and care was provided that evening. The two carers were outstanding, kind warm and understanding of the family and my mum, they treated us with such care and support, they spoke so kindly to my mum and treated her with dignity and kindness, after they had gone mum looked beautiful, clean and so comfortable and cosy. Unfortunately my mum died early this morning, however I just wanted to say thank you for the care she received in her final hours. Thank you.

Challenges

- We had to stop the Paramedic pilot when the funding ran out.

- Short staffing due to long term sickness and maternity leave reduced the number of rapid response visits we could make.
- We have been supporting the team through a period of change and uncertainty caused by the pending introduction of a night integration service where SinglePoint will manage all out of hours community calls.

Plan for next year

We will begin the night integration service and SinglePoint will receive all out of hours community calls, which was work previously shared with the community service. This will include patients who do not have a life limiting illness.

Unfortunately, the SinglePoint service has not been recommissioned within Mid Essex, so patients will be directed to primary care.

thank all at SinglePoint for your care support and understanding in the care you gave to my husband … and the support you gave to me so together we were able to allow … his wish to die at home. [His] end… was quiet and peaceful and I lay with him as he took his last breath. Thank you.

3.4.1.3. Operational Hub and Virtual Ward

The Operational Hub was formed in June 2023 by amalgamating the Referrals team, Virtual Ward, and the Care Coordinators. The team comprises a Team Leader (1.0 WTE[7]), a Referral Assessment CNS (0.8 WTE) and an Admin Support (0.8 WTE).

The Hub triages all external referrals for patients unknown to St Helena for community hospice service and all referrals for requests for care from patients in the last 12 weeks of life.

[7] Whole time equivalent.

It also manages admissions and discharges within the IPU.

The Virtual Ward provided personal care for patients in the last four weeks of life, twice a day.

Activity, achievements, and contribution to quality

At the start of the year, the Virtual Ward continued to support patients and receive referrals. Towards the end of 2023, we gradually reduced the number of beds we as the service was taken over by our subsidiary, Radfield Homecare, and became the Home Ward.

We secured funding from the End-of-Life Board for three months for a further 1.0 WTE Referral Assessment CNS, and successfully recruited to the role.

Your support enabled mum to die peacefully at home surrounded by family as she wanted.

Challenges

- Accessing care because of the reduction in Virtual Ward beds.
- Getting all the Operational Hub staff trained up in all elements of the new role.
- Short staffing because of long term sickness.
- Triaging referrals in a timely manner while the Operational Hub was being created.

Plans for the year

- To continue with the assessment CNS role and audit its impact on the CNS team in terms of reducing referrals.
- Introducing a Clinical Support Worker (CSW) role to support with admissions and discharges on IPU and fast track and

Continuing Healthcare (CHC) referrals.

- Changing the Hub's structure by replacing the Team Leader role with extra hours of an RN. It is hoped this will reduce the waiting time for triaging referrals. The Hub will also be managed jointly by the Hospice and Hospice in the Home Matrons.

3.5. Compassionate Communities

St Helena plays a key role as a leader and enabler of a Compassionate Community approach in North East Essex. This initiative aims to improve end-of-life (EoL) care and bereavement support for all, following the ethos of a Public Health Approach to Palliative and End of Life Care. Key goals include increasing advance care planning registrations on the My Care Choices Register (see page 41), increasing discharges to preferred places of care, and reducing emergency hospital admissions at the end of life.

Activities and Achievements during the year

Workshops and Training

- *Demystifying End of Life (EoL) Care Workshops:* Held in partnership with Compassionate Tendring network, focusing on dementia (May), cancer (June), and other themes throughout the year.
- *Compassionate Conversations and Care for Friends and Family Training*: We conducted multiple sessions across the year in Colchester and online, enhancing community awareness and skills.
- *Compassionate Workplaces Awareness Training:* delivered for Compassionate Tendring Network and Colchester City Council.

Community Engagement and Support

- *Public Engagement Events:* Organized in Colchester to inform the development of an EoL Public Communications & Engagement Strategy.
- *Weekly Meet & Greet Events:* Launched at St Helena to raise awareness of end-of-life care options and build relationships with partners and supporters.

Compassionate City Initiative

- *Compassionate City Status for Colchester:* Sourced funding and collaborated with local councils and community groups to pursue this accolade, the first in the East region.
- *Compassionate Charter Development:* Led the creation of a charter of actions and a self-assessment process for Compassionate City status.

Public Awareness Campaign

- *Stage 1: Learning and Discovery:* Focused on promoting public discussion through 'Talkaoke' sessions, addressing social stigma, improving death literacy, and identifying support gaps.
- *Stage 2: Your Voice:* Part of a three-year EoL Communication and Engagement strategy, establishing a sustainable 'Talk Radio' programme, an incentive scheme for compassionate efforts, and engaging community connectors.

Collaborative Efforts and Strategic Partnerships

- **Equality, Diversity & Inclusion Services**: Worked with Essex

County Council's Equalities & Partnerships team, Alzheimer's Society, and Hospice UK to shape services and develop hospice LGBTQ+ policies.

- **Community of Practice Workshops**: Hosted themed workshops on community assets, equality, diversity, inclusion, frailty, and faith.

Funding and Projects

- **Early EoL Assessment in Tendring**: Secured funding for a project aimed at improving EoL outcomes in Tendring, one of the UK's most deprived areas. This includes early identification of EoL patients, holistic reviews, and increased awareness of available services.
- **Compassionate Community Connectors**: Engaged and trained community members to support EoL patients and their families.

During the year, St Helena's Compassionate Communities initiative has made significant strides in improving end-of-life care through workshops, community engagement, strategic partnerships, and targeted projects. These efforts contribute to a supportive network that helps individuals and families navigate the challenges of life limiting illnesses, caregiving, bereavement, and loss. The pursuit of Compassionate City status for Colchester and the ongoing public awareness campaigns, reflect the commitment to building a compassionate community in North East Essex.

3.6. Counselling & Emotional Support Team

The Counselling and Emotional Support Team (CEST) provides psychological support for anyone over the age of five who is affected by life limiting illness or bereavement. We support clients, patients, families, and friends and work across both of St Helena's MDTs.

During the year, we have focussed on merging our Bereavement and Family Support teams to form the new Counselling and Emotional Support Team. At the end of 2023-24, our team comprises two service coordinators, three support workers, 10 counsellors, six support volunteers, three student counsellors on placement, and one qualified volunteer counsellor. The team is directly managed by the Deputy Director of Care after the service manager left the organisation, and our recent focus has been on rebuilding the team and improving processes and ways of working.

All our Counsellors are registered with governing bodies for counsellors and psychotherapists, namely the

British Association for Counselling and Psychotherapy (BACP), the United Kingdom Council for Psychotherapy (UKCP), and the National Counselling Society (NCS). All staff and volunteers complete regular mandatory training and continued professional development.

The Children's Bereavement Service, which launched in July 2022, has continued to grow. Our counsellors give advice to parents, carers, healthcare professionals, and people working in education on how they can support bereaved children. Where the needs of the child are more extensive, we will offer 1:1 counselling.

The service employs 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.

We have been working with partner organisations to design a collaborative model that reflects the offer across the Integrated Care System (ICS). This has resulted in significant updates to the *To Live With Dying* website www.tolivewithdying.co.uk and we are now looking at ways to embed use of this as a signposting tool across the system.

Our adult waiting list remains a challenge. We have continued to offer support groups to try to reduce the numbers waiting, and we have reviewed our session model. We will continue working to signpost referrals to other providers where possible.

To further support the sustainability of the charitable bereavement service, we have developed a fee paying Counselling service.

I am so grateful to have had you to talk to especially about … without worrying that the other person feels uncomfortable. You are amazing at your job and made me feel relaxed and safe to talk to you however I was feeling. I will miss you but there are a lot of people out there I know you will be such a help to.

3.7. Spiritual Care Team

The Spiritual Care team works across both MDTs to care for the pastoral, spiritual, and religious needs of patients, carers, staff, and volunteers. The team comprises a Spirituality Lead supported by a group of volunteers.

We recognise that spirituality means different things to different people, so we are focused on supporting people as they want to be supported: working with diverse faith groups as well as offering non-religious care. The team offers a listening ear and prioritises asking questions over giving answers.

During the year, the team supported 195 referrals for patients and their families, making over 700 contacts, both on the IPU and in the community. This is up from 110 referrals and 284 contacts the year before. These contacts have given patients and their loved ones a safe space to talk through and explore life's big questions, as well as supporting with practical arrangements for funerals, weddings, and other milestones. The team has also worked to support hospice staff and volunteers, delivering one-to-one support sessions, group debriefs, offering training around spiritual care,

and running a regular weekly staff meditation group.

The spiritual care team is so understanding and supportive, they make me feel at ease and I often seek them out. They helped my partner to find peace. I can't thank them enough for this.

Supporting our Spirituality Lead, we have six regular volunteers. Four of them visit the IPU weekly and one supports the Lead with community visits. The sixth volunteer runs the meditation group for staff. To meet the needs of the local population, our volunteers come from a variety of spiritual backgrounds and belief systems, both theistic and non-theistic. We also have a list of interfaith honorary chaplains, to help the hospice in meeting specific religious needs when they present themselves.

In August 2023, the NHS released their new chaplaincy guidelines, and the team has been working to ensure we are compliant with them, including by re-writing our Spiritual Care Policy, our volunteer job descriptions, and by appointing a chaplaincy champion on the Board of Trustees. We have also been looking at how we collect patient feedback.

One of the key changes we've made has been to what we used to call the multi-faith chapel. The NHS guidelines recommend that spiritual care spaces are presented in a way as to make it clear that they are not exclusively religious spaces. As such, in consultation with hospice staff, we have renamed the space 'The Oasis.' With the support of the Fundraising Team, we obtained a grant to develop The Oasis and we've used that to buy new furniture and resources to make it clear that the space is for people of all faiths and worldviews.

The spiritual care team listen really well. They will often refer to previous meetings in our conversations. They are compassionate human beings.

During the past year, we've also connected with several external groups and initiatives. St Helena is now a signatory of the Essex Faith Covenant, which promotes and encourages collaborative working between faith groups and the public sector. St Helena is also represented at the Essex & East London Healthcare Chaplaincy Steering Group, the Association for Hospice and Palliative Care Chaplains, and the College of Healthcare Chaplains. We've also supported Farleigh Hospice and Essex Mind & Spirit with some of their teaching and training events.

Internally, as well as offering training and CPD,[8] the Spiritual Care team has given teaching sessions for hospice staff with guest speakers and time for reflection. We've also supported with fundraising events (for instance the Daisy event and Light up a Life), Compassionate Communities events (Compassionate Conversations and 'Talkaoke'), Safe Harbour 'Hospice for All' open days, and attended Colchester's Rice and Spice festival.

[8] Continuing professional development.

3.8. Complementary Therapies

The Complementary Therapies (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, lifestyle challenges, and anxiety.

Treatments include aromatherapy massage and inhalers, massage therapy (including the 'M' technique and Indian Head Massage), reflexology, Holistic Facial Therapy, the HEARTS process, and Reiki.

Recent activity, achievements, and contributions to quality.

During 2023-2024, the service provided 1429 treatments and accepted 454 referrals, including 412 reflexology sessions, 261 reiki sessions, 184 holistic massages (including aromatherapy massage, body massage and Indian head massage), and 112 'M' technique hand/foot massages. We gave out 64 aromatherapy inhalers for managing stress, anxiety, sleep related issues, and nausea. We made 385 social wellbeing contacts, comprising 'Pets As Therapy' (PAT) dog visits, the HEARTS[9] process, and coffee morning support for carers and family members. We also provided wellbeing support to 14 IPU staff members for work related pressure. In addition, we provide wellbeing and mental health information, and support and guidance for staff and volunteers, including Schwartz Rounds.

We continue to use the MYCAW10 outcomes measurement tool. The principal areas of concern that people record are stress, anxiety, and symptoms such as nausea and pain. During 2023-24, on average, service users reported a 60% improvement in their concerns and wellbeing score, although 30% of respondents reported their concerns remaining at the same score. This information provides evidence of meeting two thirds of patient/carer/client needs within the service.

Staffing

The service has 16 volunteers, including 10 highly qualified and experienced volunteer complementary therapists, who work closely with the CT Team Lead. Other roles include four Social Wellbeing volunteers who support with wellbeing advice, such as the HEARTS process, and cake and coffee mornings for families and carers with loved ones on IPU. Other support includes our regular PAT dog visits to IPU.

[9] Hands-on, Empathy, Aromas, Relaxation, Textures and Sound. This helps with sleep support, breathing exercises, and relaxation techniques.

[10] Measure Yourself Concerns and Wellbeing.

Challenges and problems

To ensure we continue to meet demand the Team Lead works closely with the Volunteer Services team to promote the volunteer roles to recruit highly qualified therapists.

Plans for next year

The Social Wellbeing role is very successful, and the plans are to recruit more volunteers to this.

We will continue to deliver a Namaste Care workshop through Provide and Essex County Council, training care and nursing home staff to deliver the programme to their residents with advanced dementia. We have three sessions planned for 2024. Feedback continues to be excellent, with all commenting on the validity of delivering the person-centred multi-sensory care, and all care workers introducing hand and foot massages when providing personal care. Discussions have been had about delivering elements of the HEARTS workshops for carers and Provide has indicated it would be interested in this.

Thank you all so much for the wonderful care given to our dear brother … You all made his final days the nicest they could be for him, and for us.

We will also continue working with our People & Culture team to become a compassionate employer. There are several sessions planned with Colchester City Council, ESNEFT, and other workplaces. A new online session has been developed to roll out to the community who cannot attend face to face sessions, which aims to accredit local workplaces with a recognised compassionate workplace accreditation, as we support the City Council develop a Compassionate Colchester charter.

There are some negotiations taking place with the Look Good Feel Better (LGFB) charity to consider providing this workshop again.

3.9. Safe Harbour

The Safe Harbour Project was established to make good end of life care more accessible to minority, marginalised, and vulnerable groups. The service is delivered by a part-time Safe Harbour Project Manager working with St Helena colleagues and volunteers, and strategic partners across the public, private, and voluntary sectors, as well as local community assets.

Recent Activity, Achievements, and Contributions to Quality

Volunteer and Community Engagement

- Two volunteers completed training and began supporting the Safe Harbour project, offering one-to-one support for patients, and assisting with community engagement.
- Continued positive relationships with Black and Minority Ethnic (BAME) communities, including participation in an Eid Mubarak celebration and running a ‘Talkaoke’ discussion at Colchester’s Rice and Spice festival.
- New partnership formed with the Caribbean community, planning

an event to celebrate 75 years since the Windrush.

- Consultation with Refugee Asylum Seeker and Migrant Action (RAMA) led to changes in the referral system to make services more accessible to refugees.
- Joint open morning with the Spiritual Care team for faith leaders, attended by representatives from various faith communities. Attendees felt more informed about services and confident to recommend St Helena to their communities.
- Engagement with Jaywick residents to understand community barriers to end-of-life care, establishing partnerships for future collaboration.
- Work in Greenstead involved participating in a library event and establishing partnerships with local Police Community Support Officers and churches.
- Positive meeting with the head of ESNEFT's LGBTQ+ network, resulting in shared training opportunities and ideas to develop a similar network at St Helena.

Cultural Awareness and Inclusion

- Successful Black History Month events raised cultural awareness among staff, including a 'lunch and learn' session with University of Essex speakers and a cultural awareness event with local ethnic groups.
- Partnership with ESNEFT to address inequalities highlighted in the end-of-life dashboard.
- Continued networking with local groups to represent St Helena at cultural gatherings.

Community Research and Networking

- Referrals to Safe Harbour service tripled after promoting the service internally and having a presence at MDT meetings. Thirteen patients and families from marginalized groups received equitable care.
- Community research events organized to understand barriers faced by deprived communities, with findings shaping future strategic approaches.
- Relationships with Greenstead and Jaywick communities continued, expanding to the wider Tendring area. Collaboration with primary care staff to improve hospice service access.
- Safe Harbour completed a research project on socio-economically deprived communities, identifying awareness and access issues to St Helena's services.

Support and Awareness Initiatives

- Safe Harbour started working with local libraries, community centres, charities, and healthcare professionals to raise awareness of hospice services.
- Collaborated with Compassionate Communities to run three hospice open days for stakeholders.
- Addressed barriers in accessing primary care through conversations with primary care professionals.
- Continued support for other Safe Harbour communities, including attending 'Being Ready' training

for transgender patient support, engaging with the Bangladeshi community on end-of-life care for Muslims, and building connections with the homeless community.

- Expanded the base of professional contacts to support Safe Harbour patients and educated service providers about the needs of end-of-life patients.

Support for Patients

- Safe Harbour supported eight hospice patients and connected two residents from a deprived community to hospice services.

Staffing

- The Safe Harbour Project Manager now reports to the Deputy Director of Care instead of the Head of Partnerships.
- Recruitment of three Safe Harbour volunteers to support community engagement and collaboration.
- Funding applied for to expand work with Safe Harbour groups, with plans to recruit a part-time staff member to develop support for patients and carers and train volunteers for the 'No Barriers Here' advance care planning program.
- Successful funding obtained for two fixed-term posts: a full-time role to develop work with deprived communities and a part-time role to support unpaid carers.

Challenges and Problems

- In the early part of the year, we had challenges included meeting the needs of a growing patient caseload through a volunteer team, but we were able to resolve this with recruitment.

Plans for next year

- Recruit more Safe Harbour volunteers.
- Deliver a 'Hospice for All' event for the Bangladeshi Women's Association.
- Implement the 'No Barriers Here' advance care planning programme in collaboration with local artists.

3.10. Equality, Diversity & Inclusion

…she felt safe at the Hospice, and this brought us tremendous comfort.

St Helena is committed to addressing inequalities in the provision of care at end-of-life for patients and their families. During 2023-24, we embedded our Equality, Diversity & Inclusion (EDI) position statement, which commits us to:

- Abide by the Equality Act 2010 and all other equality, diversity, and inclusion legislation.
- Deliver equitable access to clinical services and care for all patients in our catchment who meet the criteria for hospice and related services.

- Encourage and actively support equality, diversity, and inclusion in the workplace, so that we represent our population appropriately and as far as is practicable.
- Actively challenge behaviour and practice that does not achieve our policy objectives.
- We will monitor the recorded characteristics of the workforce and of the patient population we serve, including those characteristics protected by Law.

Our EDI Group noted the following achievements in 2023-24:

- Publication of an ethnicity monitoring dashboard, which helps us to assess how representative our workforce (including volunteers) is in comparison to our local population
- Closer links between our EDI Group's strategic aims and the operational delivery of our Safe Harbour work, including the diversity requirements for things like our CQC inspections.
- Advanced training in specific diversity matters being rolled out to teams
- Refreshing our internal communications plan for EDI. All material is now available to all staff with access to our SharePoint, and there is a physical board in our main meeting area for those who cannot. For Race Equality Week in February 2024, we also experimented with using our internal Workplace forum to engage in discussion outside the usual EDI Group
- Resolving issues raised to the Group. For example, our Income Generation team engaged in conversation with a supporter who mentioned that they had no opportunity to use a gender neutral title in our website forms and our Group recommended amending our entire online platform to offer such terminology.
- Growing our Spirituality Team, which will help us develop relationships and better support the emotional, physical, and psychological needs of diverse communities.

3.11. The My Care Choices Register

The My Care Choices Register (MCCR) is a digital platform for storing the advance care plans and priorities for future care people in North Essex who are living with incurable illness, dementia, or frailty. St Helena has hosted the system since its inception in 2013.

The Register is well embedded in the local community, with almost half of eligible local people (48%, 4,534) recording their preferences on it before they die. It is increasingly used by people who are living with frailty, with 1066 people with this condition having recorded their preferences. There are now 1653 local care home residents who have recorded their preferences.

Most people who die in North Essex and have an MCCR entry are cared for in their preferred place of care (PPC) at the end of their life (85%).

People registering are invited to take part in a monthly survey about their experience of care. This year, 100% of respondents reported that conversations about their care were had in a sensitive way all or most of the time. 100% reported that they received the right care for their needs all or most of the time and 95% reported that they were treated with dignity and respect all or most of the time.

3.12. Safeguarding

Over the past couple of years we have worked towards creating a robust and resilient safeguarding structure at St Helena. We now have a Safeguard and Prevent Lead and 10 Safeguarding Deputies who work across all clinical areas and provide direct support to people and advice and guidance to staff about any safeguarding concerns.

Although we only spent a short time at the hospice my family were so overwhelmed with the kindness shown to us all during my auntie's final days. The doctor who dealt with everything answered all out questions and really helped us through such a hard time. The lovely man who came in to see what food my auntie would like and made her a special vanilla complan milkshake with icecream which became her favourite thing!

We have continued to work closely with partner agencies, ensuring a robust, joined up approach to protecting people at risk of abuse, harm, and neglect. Across the teams we have had to raise several adult and child safeguarding referrals concerning organisational neglect, financial abuse, medication theft, psychological abuse, and lack of care provision putting people at risk.

Clinical staff regularly attend adult safeguarding strategy meetings as part of Section 42 adult safeguarding enquiries and any learning from these meeting is cascaded to staff.

Following certain incidents, we have made the following changes to our processes:

- Staff are now required to present any safety concern relating to a patient at the daily Hospice MDT meeting for discussion and action.
- We have made changes to the SystmOne safeguarding template to help staff with documentation and referrals.
- We have updated the Children's Safeguarding Policy & Procedure (including Prevent), which now covers female genital mutilation, Prevent, child exploitation, and children in care.

Our staff and volunteers are trained in line with the Intercollegiate training framework and our Safeguard Lead continues to induct all new clinical staff and trustees on legislation and processes. This year, we ran five bespoke Safeguarding and Mental Capacity training sessions for the MDTs, which enabled staff to relate theory to practice and increased their confidence.

We regularly post safeguarding themes, information, and training opportunities on Workplace; for example, 'Think Family', the new Essex adult safeguarding referral portal, Clare's Law, exploitation, online abuse, and hoarding.

Priorities for 2024-25 include:

- Beginning monthly safeguarding and mental capacity audits.
- Developing face to face training based on audit findings.

- Reviewing and updating the Safeguarding Adults Policy & Procedure (including Prevent).

3.13. Hospice Education

Hospice Education is a jointly branded venture between St Helena and the St Elizabeth Hospice in Ipswich. It is a shared education department serving the internal needs of both organisations and providing a range of education opportunities externally. The service comprises a Head of Department, a Team Leader, two Practice Educators, a Clinical Educator, two Clinical Trainers, two Administrators, and two volunteers.

During the year, we completed the rollout of ReSPECT[11] across Suffolk and North East Essex (SNEE). We continue to offer paid ReSPECT and Advance Care planning for staff to maintain a working knowledge in the field.

We have successfully recruited our target of ten care homes as part of the Care Home Accreditation (CHACC) and we continue to work with the first cohort to achieve the accreditation. We are looking to recruit the next 10 care homes by the end of 2024.

We have arranged for the Radfield Care Agency to be the first agency to start the new Care Agency Accreditation in NEE.

We have completed the first phase of migration from My Learning Cloud (MLC) to Bluestream to record training education for all staff at St Helena's.

He was treated with such love, dignity & respect and we will forever be in your debt. As his family you were kind, caring and honest with us. You are all the very best of people to do what you do.

Hospice Education has been working with colleagues to record up-to-date information on clinical competencies for staff to confirm we are compliant and meeting timescales identified for new staff.

We have dramatically exceeded our budgeted income for the year by securing £94,009 grant funding for projects from the End of Life Board, as well as the commissioning of the ReSPECT education across SNEE.

We have agreed that St Nicholas Hospice in Bury St Edmunds will join the Hospice Education brand as a third member in September 2024, bringing two new staff to the team.

…like to thank everybody that we had the privilege to meet at St Helena, for not only giving our mum the professional care she needed, but also going way beyond all our expectations. It is so good to know that there's still such kindess, care and humanity at harrowing times such as this.

Apprenticeships

As part of the continual professional develop of staff, we currently have one person completing their PhD, supporting research into our services and best practice.

Eleven staff are completing apprenticeships to support our workforce development plans. We have four staff completing the Advanced Clinical Practitioner's Master's Qualification, which includes non-medical prescribing modules. Three staff are completing the Healthcare Assistant Practitioner level 5

[11] Recommended Summary Plan for Emergency Care and Treatment. The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices.

qualification, and four have completed Data Analyst qualifications.

Staff

During the year, a new Team Leader has settled in and is working successfully across both sites, supporting the Care Home Accreditation as well as the new Care Agency Accreditation.

We continue to offer education and training on a range of subjects as well as developing more opportunities to support our local higher education providers, local community, and allied health professionals.

Challenges

We have faced the following challenges during the year:

- IT problems hampering coordination between the two hospice teams.
- Extra mandatory training required for Oliver McGowan tiers 1 and 2.
- Developing a clear, constructive pathway to communication issues, questions, and options for developing our use of Bluestream.

Plans for next year

- Integrating St Nicholas Hospice into the team and sharing best practice to enable a smooth transition.
- Introducing a range of new internal education sessions for clinical and non-clinical staff to support continual professional practice, as well as enabling staff progression from band 2 to band 7.
- Coordinating meetings with management team members to plan for development linked to annual performance reviews for all staff.

3.14. Internal Support Groups

St Helena offers support to its staff using Mental Health First Aiders (MHFA), Freedom to Speak Up Guardians (FSUG), Menopause Champions, and Men's Health Champions. Each group now reports its contacts and activities centrally.

3.14.1. Freedom to Speak Up

Freedom to Speak Up is about encouraging a positive culture where people feel they can speak up and their voices will be heard, concerns can be raised in confidence, and suggestions acted upon. There are four staff members who have taken up this important role.

No contacts were reported this year.

3.14.2. Mental Health First Aiders

A Mental Health First Aider (MHFA) is a person within an organisation who can support people with how to spot the signs of mental ill health and provide help on a first aid basis. An MHFA will provide short term support at the time it is needed, until they can signpost and support the individual to professional help. We have a team of mostly staff members and one volunteer. During the year one MHFA achieved their Level 3 qualification.

There were 17 MHFA contacts reported in 2023-24, relating to personal challenges, health issues, and work-related stress.

Please accept this cake as a token of our appreciation for the amazing palliative care you gave my husband. It enabled him to have family and friends around anytime of day, or night. He wouldn't have been able to be cared for so well at his mum's home, his childhood home, without all your support.

3.14.3. Menopause Champions

Menopause champions play an active, ongoing role in ensuring menopause remains lively, relevant, and front of mind for all employees. They can act as a 'listening ear,' facilitate menopause meet ups, and offer support. Champions can also bring fresh ideas both from a personal perspective and their internal network, helping to keep menopause as a mainstream conversation, and signposting colleagues to the appropriate support and information.

One contact was reported during the year.

3.14.4. Men's Health Champions

A Men's Health Champion is someone who cares about public health and want to help improve it. This can be particularly important for overcoming potential isolation around working from home and/or being unable to attend our usual social and leisure events. Health Champions are empathetic, good listeners, willing to talk about health and other difficult issues, and to be supportive without being directive. Research suggests they can make a real difference. For men, they can be particularly useful: their more informal, 'man-to-man' approach can provide an invaluable steppingstone between the men in their community and traditional, more formal health services.

No contacts were reported this year.

3.14.5. Plans for 2024-2025

These networks are an important part of the framework supporting staff wellbeing, and we continue to promote them. Regular support posts and information are advertised on Workplace; however, after feedback a new SharePoint folder has been set up for quick and easy access to information for staff. Information for volunteers is shared by the Volunteer Services Team.

Plans are in place for peer support for people in these roles, with a view to having regular drop-in days for menopause and mental health support to provide support materials and have informal chats.

We have signed with 'Essex Working Well' and have three workplace champions who have formed a committee to keep workplace wellbeing high on the organisation's priorities. St Helena has achieved L1 accreditation for committing to workplace wellbeing support to improve the wellbeing of our workforce. The committee is working to achieve L2 and L3 during 2024-25.

I would like to say thank you to all the staff that supported … and myself at the end of his journey. The care he received was amazing and the compassion you all showed towards his family and friends meant so much.

3.15. Quality of the Environment

Recent activity, achievements, and contributions to quality

Key projects for the Estates & Facilities team this year have included:

- Applying fresh road markings at Myland Hall.

- Preparing the Joan Tomkins Centre for the launch of the Zest young adult's transition service, which saw an open day followed by monthly group sessions. The team prepared the space, with the help of a support funder. Facilities procured an accessible changing table.
- The Maintenance Manager and the Facilities and Health & Safety Manager completed the 'Water Responsible Person Training for Healthcare Premises' course and, throughout the summer, the Maintenance Team completed the 'Healthcare Technical Memorandum 04-01 Operators Training' course.
- The Domestic Supervisor has been monitoring an increased count of colony forming units on our regular dip slide tests of products received from our linen provider. As a result, we increased sampling frequency and met with the provider to investigate where issues could be arising and agreed several actions. St Helena's Infection Prevention & Control Group monitored this data closely and, when agreed actions were completed, there was a marked improvement, allowing us to reduce the frequency of testing to normal.

During the year, the Health & Safety Team:

- Began upgrading the lone working devices across all clinical teams.
- Created a conflict management information pack.
- Launched the St Helena Green Group with a focus on promoting environmental sustainability across the organisation.
- Worked with the Domestic Supervisor to create additional PPE[12] training for the Domestic team.
- Began providing training to IPU staff on the fire prevention and detection system.

After an intrusion at our Myland Hall site, we reviewed security and installed two new security gates.

The Maintenance Team have welcomed several corporate volunteering groups to Myland Hall who have helped project work. With their support, we have also redecorated the Ladies bay on the IPU.

[12] Personal Protective Equipment.

Our insurer visited Myland Hall to undertake a Risk Management inspection. Eight actions were documented and are being completed.

We have repaired the Joan Tomkins Centre decking, after it was noted some of the wood near the pond was starting to rot. We also turned the JT waiting room into an additional counselling space.

We opened 'hot desk' spaces in the Learning and Development Centre to aid agile working for all staff based at Myland Hall.

We have fitted IPC compliant blinds in all patient rooms on IPU, replacing old curtains that were highlighted as an issue during a recent PLACE[13] audit.

With support from a local councillor, we arranged for trees in the adjoining Highwoods Country Park to be cut back, thereby reducing the risk of damage to the building and leaf fall on our site.

We have fitted new signage on our rapid response vehicles at the Learning and Development Centre to discourage double parking and enable easy egress for staff.

From the very first moment mum arrived with you she was treated with respect, and you all showed true compassion and empathy. There was also a caring hand on my shoulder, a cup of tea put in my hand and a reassuring smile. At that point I knew I could once again be the daughter I so desperately wanted to be instead of being her carer… Thank you is just not enough.

[13] Patient-led Audit of the Care Environment.

Water Hygiene

Throughout the year, Estates has continued regular sampling for water bacteria and worked with our specialist contractor to respond to any unsatisfactory results. We also launched a Water Safety Group, made up of Clinical, Estates, and Compliance staff, to coordinate a more targeted approach to evidence collection and sampling, and standards and procedures.

PLACE

In November, the Estates Team carried out our annual, full NHS Patient-led Audit of the Care Environment (PLACE) assessment. The assessors comprised two members of the Estates Team, accompanied by the Chair of Trustees, the Infection Prevention and Control (IPC) Lead, and an Estates administration volunteer. An action plan was created from the assessment results, highlighting areas for improvement, and the results were submitted via the national portal for scoring.

Our category results showed that we had improved on our previous assessment in the categories of Condition, Appearance and Maintenance, Dementia provision, Disability provision, and Ward food. One category showed an 8% improvement.

The PLACE questions about food provision have been increased to include compliance with NHS and other professional practice guidelines. We will focus on these to see where we can raise our score.

We created a 67-point action plan for improvements, which is currently 87% complete.

Staffing

- The Catering Team is now managed by the Commercial Business Development Manager, with plans to innovate the service.
- We recruited a new Domestic Assistant to replace a member of the team who is now a CSW on IPU.
- Growing demands for Maintenance Team support across our clinical and non-clinical sites led us to recruit a further Maintenance Technician.
- The Domestic team recruited a new staff member, to cover hours outside the standard shift pattern, to enable offices and meeting spaces to be cleaned at the start of the day.

Plans for next year

- Working to achieve consistent engagement on health and safety matters from staff.
- Improving lone worker device testing compliance.
- Managing costs in line with budgets with ongoing high inflation increasing the costs of materials and services.
- Publishing the PLACE results and continuing to monitor the action plan.
- Launching a Hybrid Working Policy.
- Preparing to launch the staff Driver Details module on Sentinel for enhanced management in this area.

…It was never going to be easy to lose someone we loved so much but the support you gave to us all enabled us to have precious time together when we most needed it… every single person we met had something special to offer…

3.16. Volunteering at St Helena

St Helena is fortunate to have over 900 dedicated volunteers who generously contribute their time, skills, interests, and individual experience to support the care we can offer to our patients and their families.

Since before the Hospice opened its doors back in 1985, our volunteers have been an integral part of the organisation, initially helping with fundraising to build the hospice and going on to take up a variety of roles in its day to day operation.

Our staff could not achieve what they do without the incredible passion, dedication, and diverse experiences that our volunteers bring. Regardless of their role, volunteers at St Helena make a significant difference to our patients and their families and the overall functioning of the organisation. We welcome applicants from all backgrounds and cultures, valuing the diverse skills they offer, and we always strive to increase their number.

Trustees are also volunteers and, over the past year, we have worked with a Trustee to streamline their onboarding process, ensuring that effective governance and accountability measures are in place.

With nearly three volunteers for every staff member, there are few teams that do not have volunteer support. With such a high volume of volunteers, it is important to recognise that many employees will be responsible for looking after them. To support staff, we have included training sessions for Volunteer Line Managers in the Competency Framework training programme, ensuring they are fully equipped to manage and support volunteers and able confidently to address any concerns that may arise.

…You made her last few weeks as good as they could have been and supported me massively in the five days I stayed on the ward. … I could never repay you for what you've done…

Following the success of last year's marketing recruitment campaign 'Do Good, Feel Good,' we have made this an annual promotion, including volunteer stories, videos, and feedback. Once again, the campaign was a success, with 51 new volunteers joining us over a four-week period.

Volunteering at St Helena should always be in the best interests of the Hospice, but it should also benefit the volunteer in that they should have a positive experience during their time with us. The enthusiastic feedback from current volunteers about their personal experiences highlights the benefits they receive, encouraging others to get involved.

One of our biggest challenges continues to be attracting younger people to volunteer, with 70% of our volunteers being aged 60 to 80 years, particularly in our Retail team.

To encourage younger people to volunteer and gain insight into the charity and healthcare sector, in July 2023 we introduced work experience placements for school and college students and Duke of Edinburgh Award scheme participants. This initiative involved developing and implementing a short-term volunteering policy, ensuring all safeguarding processes are in place, including young person's risks assessments and providing appropriate training for line managers.

We also offer placements for sixth form students applying to medical school, allowing them to shadow the Medical Team to support their applications and provide experience in a palliative care setting. Since we started the work experience programme, 28 students have participated and feedback from both students and line managers about the work experience opportunities has been very positive.

We also offer the Skills Pathway certificate, which is evidence based training and can provide young people with proof that they have learnt specific competencies in the workplace which can be included on their CV.

Of our over 900 volunteers, more than 670 work in our Retail team. Recruitment for this area is ongoing as they require the highest number of volunteers to ensure optimum service in our shops. With plans to open more shops and cafes in the future, this area will be a key focus for our recruitment and promotional efforts. Without the support of these volunteers, our shops would not be able to generate the substantial income that they do.

For non-retail roles, especially those involving direct patient interaction, we continue to work with line managers across all the teams to recruit volunteers to target specific service needs. We are also focussing on more specialised roles such as the new volunteer Advanced Care Planner position working with our Chief Clinical Officer.

Volunteer data for 2024-25:

- No. of volunteers at year end: **908**
- New starters: **323**
- No. of Retail volunteers at year end: **673**
- Volunteers who have left: **221**
- Work experience placements: **28**
- Hours of volunteering given more than **220,000.**[14]

The commitment of our volunteers, with some completing over 40 years' service, speaks volumes about the rewarding experience of volunteering at St Helena.

Your kindness, professionalism, empathy and sheer heard work have been a model of how to approach the care of terminally ill patients AND their carers…

3.17. 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. In 2022-23, we followed the model award criteria (MAC)[15] to describe some specific examples of social value we offer. During 2023-24, we have begun to explore a broader range of social value measures alongside the MAC and will continue to develop that approach for future reporting. In 2023-24 we measured our social value as follows:

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.

It was such a comfort and relief to know that you were on the end of the phone to talk to, especially in the middle of the night when things seem so much more difficult and distressing. Everyone has been so kind, compassionate and supportive…

[14] Approximate figure, which does not include those who support ad hoc fundraising events.

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

We make capacity available in our IPU as often as we can to support Colchester General 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 disruptions.

We operate a Hospice in the Home service, including virtual beds and a 'Home Ward,' 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.

Our bereavement services and our networking with other bereavement service providers locally has enabled us to improve the waiting times for people seeking this support locally.

Theme 2: Tackling economic inequality

Through 'Compassionate Communities' 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. We also run a dedicated project called 'Safe Harbour' to tackle inequalities for those facing death, dying and bereavement (see page 38). 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 have been more difficult to engage through traditional means and healthcare settings, increasing death literacy and access to care.

Safe Harbour has completed research in 2023-24 relating to deprivation at end-of-life and the impact that poverty can have on a person's clinical and care needs at end-of-life. We will review the findings of this project through our EDI Group in 2024-25.

We offer a range of opportunities across hundreds of volunteer roles, 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 supply chain approach to delivering the benefit.

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 hospital conveyances and visiting impact.

Our Retail teams, through 27 shops and related services, offer quality second hand items, avoiding waste going to landfill and providing an opportunity for consumers to choose a more ecologically beneficial way to shop. Our waste management includes recycling at every opportunity, and reductions in levels of waste produced. Shoppers can also now find out how much environmental impact their

purchase at a shop makes with our on-line calculator and other information.

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. In 2023-24 we also established an internal 'Green Group' through which we supported staff with services such as onsite bike repair sessions to continue to encourage active travel.

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.

We always felt that he was valued and safe in your care. Nothing was too much trouble, from medical attention to dietary wishes. The chats he had with you and the comfort he felt was far reaching… It made what was a very difficult time a little less stressful.

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. Our approach to delivering end-of-life care is flexible and creative where possible, and some of our initiatives improve patient well-being in a measurable way. For example, on one occasion when goats visited the hospice and patients had an opportunity to interact with the animals during their stay, patients interacting with those animals required less pain relief medication than would otherwise have been expected, during that visit.

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. We have achieved 'Working Well Essex' level 1 accreditation in 2023-24 and we are working to achieve accreditation for levels 2 and 3 in 24-25.

…It was obviously a very emotional and difficult time for us but made a lot less traumatic with such caring and dedicated staff around us…Their personalities gelled very well and we really appreciated everything they did for Dad with a smile and cheeriness that brightened the day and for the way they supported us too. I sincerely hope that those who run SinglePoint are aware of their incredible staff and their rare qualities and are treated accordingly.

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.

We have developed our approach to creatively supporting our population using routes like our Creation Station franchise to provide funded sessions for patients and their families meeting specific criteria, to increase our impact and reach out to, for example, socially isolated groups.

3.18. Quality Markers

3.18.1.1. Tissue Viability

A pressure ulcer is localised damage to the skin and underlying soft tissue, usually over a bony prominence or related to a medical or other device. The ulcer can present as intact skin or an open ulcer and may be painful. The ulcer occurs because of intense and/or prolonged pressure.

It is a national standard that all patients are visually assessed for pressure ulcers within six hours of admission. When staff discover an ulcer, they log it as an incident, irrespective of its category or whether the patient had it on admission or developed it during their stay with us.

…He had a lovely outlook into the garden and felt safe with the care he was given. I would also like to thank all the volunteers, canteen staff and everyone who helps make St Helena run so well…

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 Q1 the Tissue Viability Group approved a new tissue viability leaflet, to be given to patients on admission. The leaflet helps to ensure that patients understand the importance of regular repositioning and skin integrity checks.

During Q2, the Risk and Incident Group agreed that Category One pressure ulcers would no longer require investigation. This was to aid with staffing pressures. These are still reported as incidents so that data is collected.

During Q3, we introduced Purpose T as the new risk assessment tool to replace the Braden scale. This was on the recommendation of Hospice UK, NHS Improvement, and in line with the National Wound Care Framework. The implementation has been positive and the tool better accounts for risk factors and vulnerable skin, as well as identifying new areas of concern.

In Q4 there was an increase in deep tissue injuries, which were either worsening existing pressure ulcers, or new pressure ulcers identified at the end-of-life. Also during Q4 a patient was admitted from home with multiple category 4 pressure ulcers. An adult safeguarding concern referral was completed and the CQC were notified.

Themes identified during the year include an increase in moisture lesions. The TV Lead found that this was because of increased understanding by staff of the difference between pressure ulcers and moistures lesions. Most of our pressure ulcers continue to be category 1 and 2. We did log some category 3 and 4 ulcers, but these were present on admission.

The TV Group has been looking at pressure ulcer relief equipment during the year and plans to purchase some during 2024-25.

We have completed regular audits throughout the year, with all actions completed in a timely manner. An audit of the admission process in February 2024 showed that the Purpose T risk assessments were being completed well, along with a generally high standard of documentation. The TV lead has recently commended the team for this.

I salute you for your professionalism and compassion... The job you people do is amazing...

3.18.1.2. Falls

Falls cannot be completely prevented in patients with deteriorating conditions, but we take every practicable measure to reduce the risk of them.

On admission patients are assessed and given a score for manual handling and falls, which indicates if a patient is moderate to high risk. This score and an icon are displayed clearly for staff on visual board round view on SystmOne.

When it is reasonably practicable, we admit patients to rooms where they can be closely observed.

Just knowing that I could ring you up 24 hours was a blessing for me…

Rounding checks continues throughout the day and night, and sensor mats and suitable beds and chairs placed in patient rooms. We now have 10 Oska riser recliner chairs with integral pressure relief to facilitate safer transfers. We have five low rise beds, which are essential for patients of a lower height to ease safe transfers on and off their beds.

We logged 108 falls this year (with 14 non closed falls carried over from previous year). This is an increase compared on the 78 falls last year.

69 of the falls this year caused no harm and 38 were low harm requiring minor first aid only.

We reported one serious incident in which a patient was transferred to hospital for a suspected broken hip, although on examination this was not confirmed.

All falls this year were reported by staff within 24hrs of occurrence. All but three were deemed unavoidable

The Prevention and Management of Falls Policy and Procedure has been updated this year and we will provide training on the new policy and audit compliance with it during 2024-25.

All the Rehab Team are now trained to investigate falls.

One of our challenges this year has been replacing sensor mats when they wear out because no other model is compatible with our call bell system. Also, we are no longer able to obtain spare parts for our old patient hoist, so when this breaks down, we will not be able to repair it.

We now have a new hoist on the wards that can be used on all larger patients, taking up to 200kg in weight.

… Thank you so much for the love and care you gave … from the day [he] arrived at St Helena Hospice to the day of his peaceful passing. The care [he] received made a positive difference throughout his

final weeks, so we could spend quality time with him, knowing he was not in discomfort because of the care from the nursing staff care.

Some of the toilets on IPU are too low for some patients and require a toilet seat raise. The old ones have now broken and need replacing. We plan to purchase new toilet aids to help with safe transfers for all our patients

There has been poor attendance at the Falls Prevention Group meeting because of short staffing. This has delayed an audit.

Our aims for 2024-25 are to continue to monitor falls data and carry out a small audit on the prevention and management of falls policy and procedure changes. We will also carry out a follow up audit on the documentation for repeat fallers.

We will look at purchasing more low-rise profiling beds with integral sensors as we replace our existing beds. This will hopefully cater better for patients of different heights and help them when getting on or off.

3.18.1.3. Medicines Management

Our Medicines Management Group (MMG) supervises a programme of audits 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.

By meeting frequently, we can identify problems and trends and address them promptly.

An example of MMG acting promptly this year was when the Group became aware of a run of several incidents over a few days that all concerned the use of the IPU emergency drug supply. This supply is intended for community staff to use for urgent symptom control while a patient awaits a prescription. These medicines must be prescribed in a clear and legally correct way and this activity is regularly audited. The MMG identified situations where policy had not been followed and although this was in all cases done to speed up the delivery of the drug to the patient, it demonstrated certain staff's lack of understanding about the legal requirements.

We arranged a meeting with the Director of Care, at which it was agreed to immediately stop all use of the emergency drugs and require one to one training for all staff accessing the system. The Medical Team were informed that this might lead to increased work overnight for them if a prescription was needed out of hours. The system has since been reinstated with regular monitoring to ensure compliance.

We log all medicines errors on our Sentinel incident management system, and these are report up through the organisation weekly, monthly, and quarterly. Our Controlled Drugs Accountable Officer (CDAO) reports our controlled drug errors quarterly to our Local Intelligence Network and we also benchmark our errors with Hospice UK.

Other activity by the Group this year has included:

- Updating the Medicines Management Polic and writing a new Management of Controlled Drugs Policy. Both policies include all relevant standard operating procedures.
- Updating the Carers' Administration of As Required Subcutaneous Injections in the Community Procedure.
- The Senior Pharmacy Lead has been accompanying Nurses on their drug rounds on IPU.

- We have written a new policy for handling IPU patients' drugs after death, bringing St Helena in line with ESNEFT practice
- We have demonstrated our Electronic Prescribing and Medicines Administration (EPMA) to several other hospices, sharing best practice.
- We reviewed the Alfentanil Prescribing for Community Palliative Care Patients policy.
- We implemented a new Sentinel module for recording and tracking Controlled Drug Registers.
- We invited an ex Controlled Drug Liaison Officer (CDLO) from the Metropolitan Police to provide annual sessions for all staff involved with prescribing or supply of CDs. These sessions have been very well received.
- We developed and implemented Clinical Support Worker training, targeting their roles and responsibilities regarding the administration, and checking of CDs.
- We reviewed the Drug Refrigerator Temperature Monitoring SOP and are currently amending this to improve early detection of range variances.
- We've held several EPMA review meetings to improve prescribing and drug administration on SystmOne.
- We have reviewed several patient information leaflets (*Taking Strong Opioids, Using Medicines Outside Their Licence, Medications, and Driving*) and these are awaiting re-branding.
- The quarterly Safe Storage of Medicines audit has continued.

3.18.1.4. Infection Prevention & Control

During the year, we cared for 12 patients identified with Covid 19 on the IPU. For 11 of them, their Covid status was either known at the time of admission or identified from the swab taken within 48 hours of admission. This is a significant reduction on the 26 patients admitted during 2022-23 and shows the general reduction of circulating virus in the community, which in itself is evidence of the efficacy of the vaccination programme.

The Hospice has always followed the national guidance on Covid 19 case management and precautions, sometimes implementing additional measures to protect our vulnerable patient group. At the April 2023 IPC meeting, with the better weather approaching, more windows open to facilitate air flow, and the established success of the vaccination programme, we agreed that in May we would cease the requirement for the routine wearing of fluid repellent face masks by all staff within the IPU and when visiting patients at home. We also agreed to review the decision within three months.

Staff who chose to still wear a mask could do so and if patients requested staff to wear a mask they would. Likewise, visitors to the IPU would no longer routinely be requested

to wear a face mask. Use of PPE would continue on a risk assessed basis and for any patients who tested positive. We have kept these decision under review but seen no need to reverse them. We continue to update our Covid Policy as required.

During Q3 we undertook a PLACE[16] assessment of which IPC was an important component. For more details on this see page 47.

In December 2023, members of staff from Havens Hospices visited St. Helena, primarily to look at our governance, audit and reporting systems. The IPC specialist met with them and, together with the Domestic Supervisor, conducted a tour of the IPU to share best practice ideas.

Throughout the year the IPC spent considerable time advising and supporting Facilities and IPU staff following the ongoing identification of Pseudomonas aeruginosa species from water outlets within the IPU. This issue was first identified in the autumn of 2022 and reported in last year's Quality Account.

… I will be forever in your debt for the love, support and shoulder to cry on that you gave me. I was a better daughter in those final weeks, bolstered by your kindness and never-ending cups of tea. I would not have survived the storm without you by my side…

Pseudomonas aeruginosa is a bacterium often found in soil and ground water. It is an opportunistic pathogen that rarely affects healthy individuals but can cause a wide range of infections particularly in people with a weakened immune system. Such groups include patients with cancer, new-borns and people with severe and widespread burns and cystic fibrosis. It has been responsible for outbreaks of infection in healthcare facilities.

The IPC nurse specialist's recommendations of risk assessing all patients in any affected areas and avoiding placing patients with open wounds or invasive devices in those areas (or, if that was not possible, taking water outlet out of commission) continued to be followed. Much work was undertaken throughout the year to strip back and replace pipework. This involved significant disruption for both patients and staff within the IPU. Water quality is kept under review, and the first meeting of the Water Safety Group was held in December 2023.

Early in Q3 a quality concern arose about the linen laundered by our external contractor. This was identified as part of the microbiological surveillance (dip slides which are incubated and identify colony-forming units) undertaken by the Domestic Supervisor. High readings were being obtained from various items. Meetings were held with the appropriate managers and process changes introduced. Thanks to the tenacity of the Domestic Supervisor, after several months this issue now appears resolved, but will be kept under review.

In January 2024, there was an unannounced CQC visit to St Helena (see page 73). The IPC specialist attended in a support capacity, but it became evident that IPC was not the focus of the inspection on this occasion.

In Q4 two members of nursing staff (one from IPU and the other from Single Point) completed a virtual IPC training programme offered by the Suffolk and North East Essex IPC team. This interactive programme commenced in February and ran for four weeks. It was hoped that this

[16] Patient-Led Assessment of the Care Environment.

would go some way towards succession planning for when the IPC Specialist retires in 2025. Unfortunately, feedback suggests that it proved to be less useful than had been anticipated. The IPC specialist therefore remains the focus of information and support for all IPC related subjects.

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. Throughout the year they provided seven one-hour long face to face teaching sessions with various staff groups. Such sessions supplement the mandatory e-learning and focus on 'real life' IPC situations encountered by staff on the IPU and in patients' own homes and discuss problem solving in a pragmatic way.

The IPC Lead has also supported planning for St Helena's possible move to a new site. It is important that costly mistakes are avoided by using the IPC knowledge and experience available to St Helena early in the design phase.

Infection Control Audits

We carry out several Infection Prevention and Control (IPC) audits. These are reported to and scrutinised monthly at the IPC Group, chaired by the Hospice Matron since February 2024 (previously chaired by Director of Care). Any lower compliance is discussed at the IPC Group and actions taken are documented in the minutes. Audit results are also included in our quarterly quality reports. The results for the year are shown in the charts below.

We also display the results of selected IPC audit at the entrance to the IPU, providing, we hope, reassurance to all staff, patients, and visitors about the high standards of IPC we maintain.

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

Hand Inspection, Hand Washing, PPE, Commode Hygiene

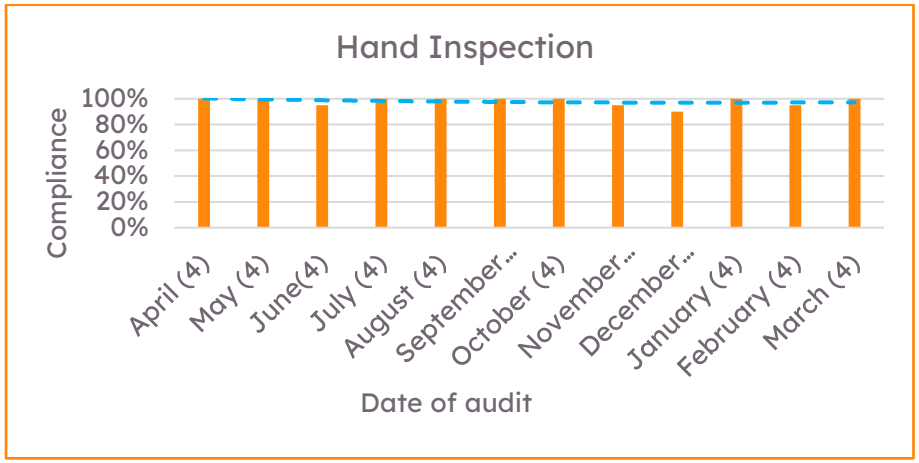

Figure 4 23-24 Hand, PPE, and commode audits

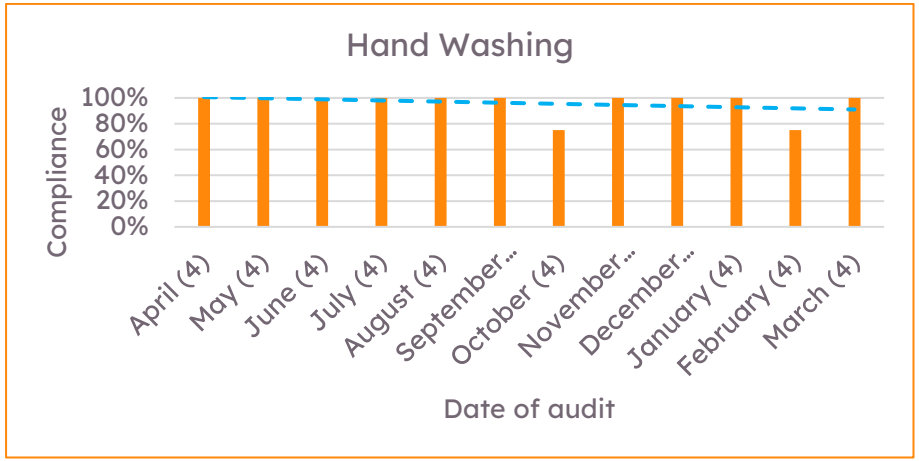

Figure 5 23-24 hand washing audits

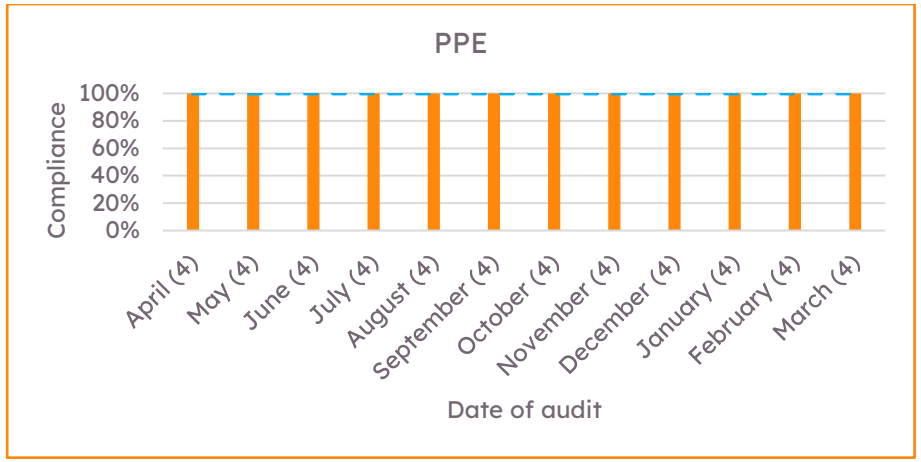

Figure 6 23-24 PPE audits

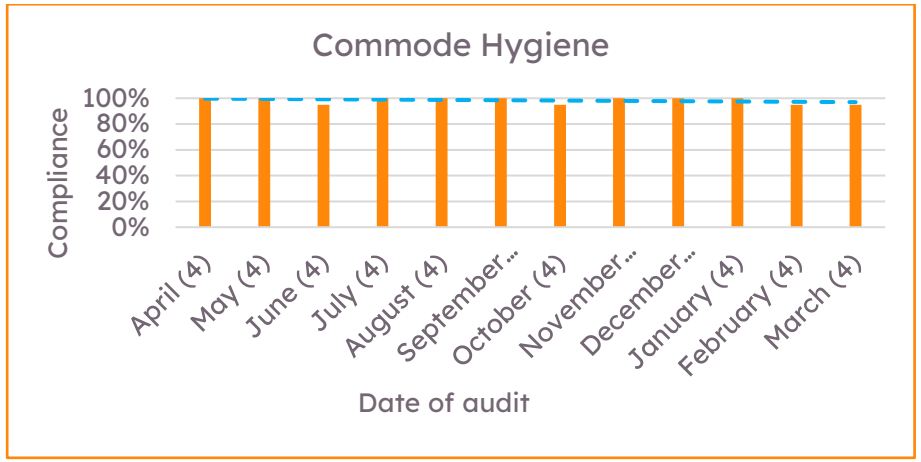

Figure 7 23-24 commode audits

High Impact Interventions

High Impact Interventions is a set of national audit tools for evaluating and improving clinical processes. Specifically, these tools are designed to reduce the risk and spread of healthcare

associated infections (HCAIs) by focusing on the risk factors that cause infections; for example, hand hygiene and the use of intravenous lines.

High Impact Interventions - Catheter Insertion and Ongoing Care

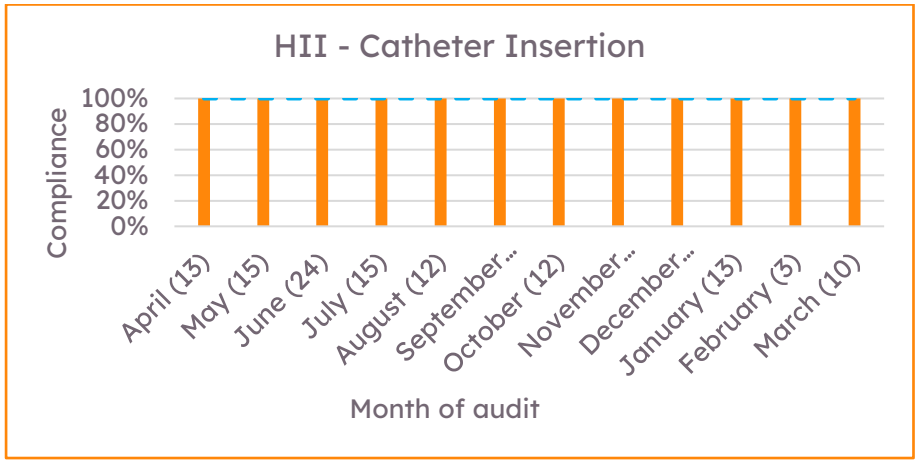

Figure 8 23-24 catheter insertion audits

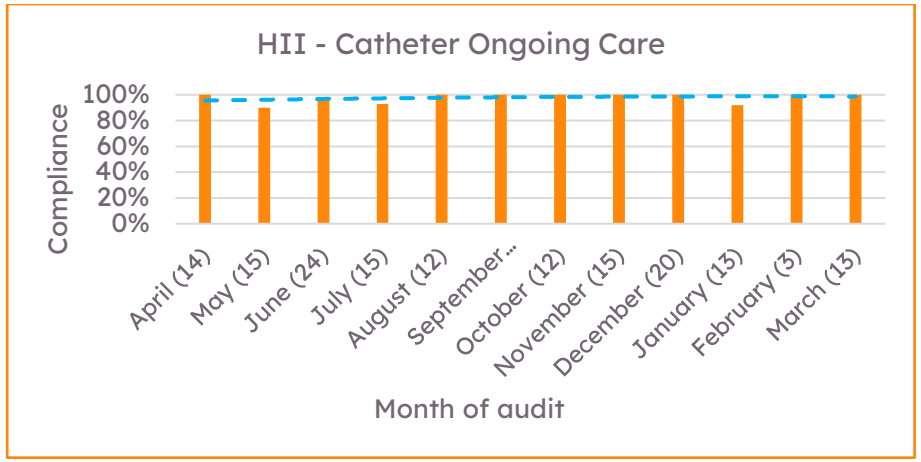

Figure 9 23-24 catheter care audits

High Impact Interventions – Cannula Insertion and Ongoing Care

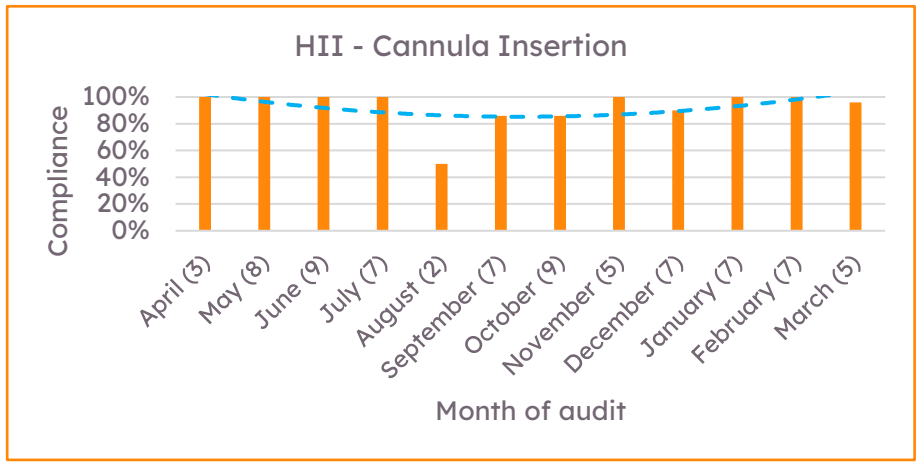

Figure 10 23-24 cannula insertion audits

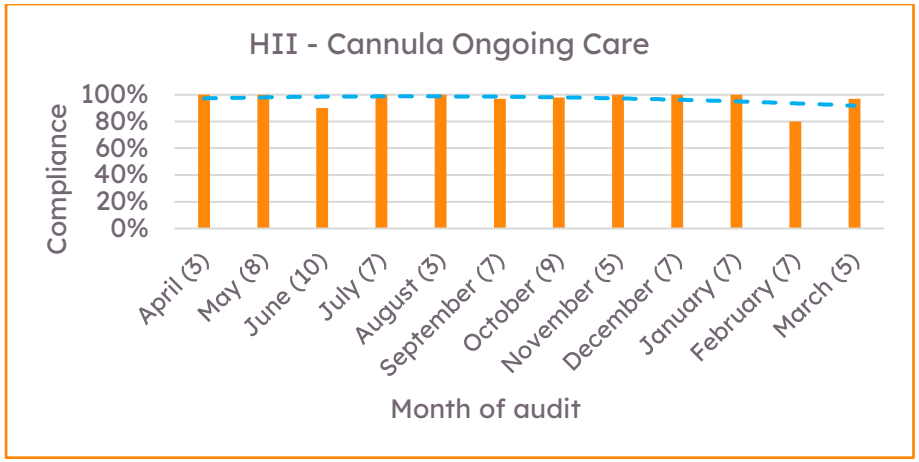

Figure 11 23-24 cannula care audits

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

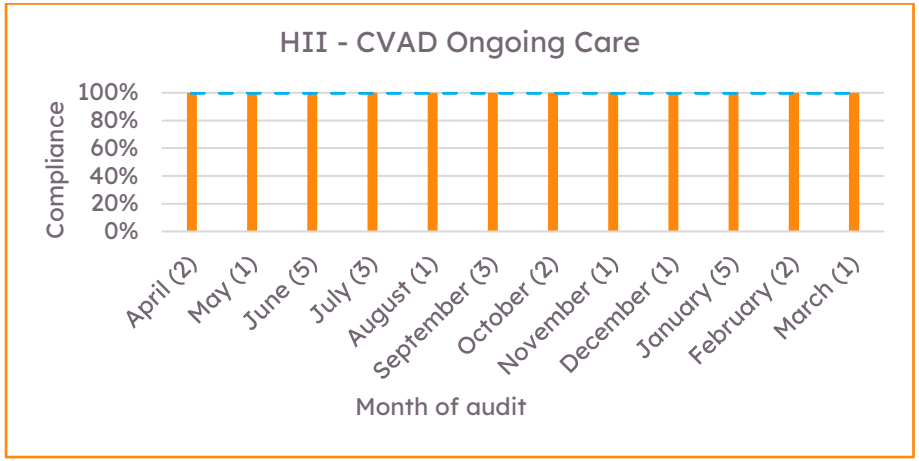

Figure 12 23-24 CVAD care audits

High Impact Interventions – Antimicrobial Prescribing

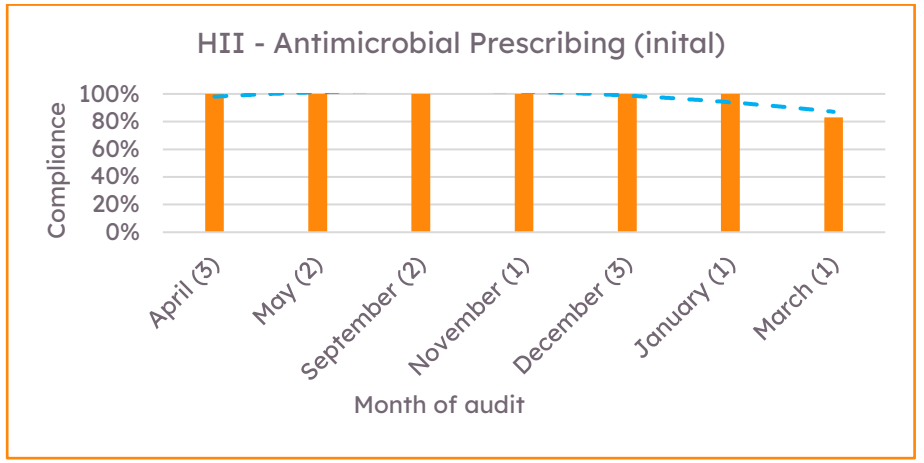

Figure 13 23-24 antimicrobial prescribing (initial) audits

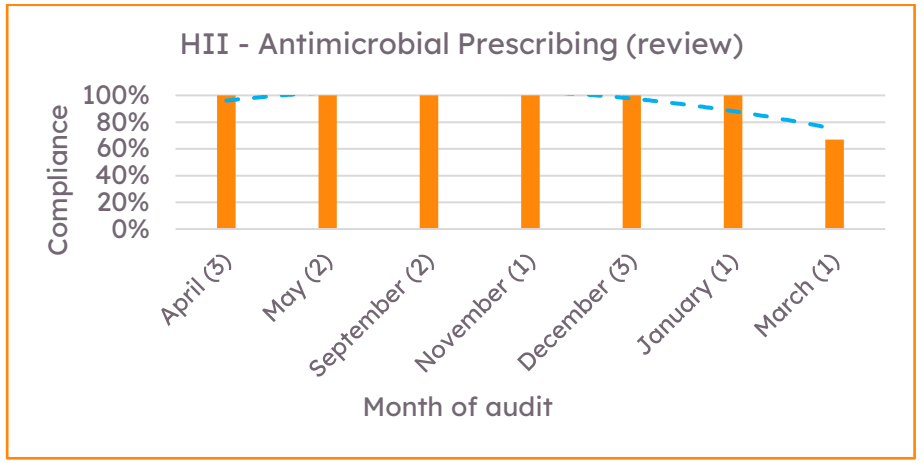

Figure 14 23-24 antimicrobial prescribing (review) audits

The antimicrobial prescribing audit is carried out as a once a month snapshot, so there will not always be many patients taking antibiotics on the day the audit is completed.

Note: The June, July, and October 2023 audits were not completed because of short staffing. There were no patients taking antibiotics on the day of the August 2023 or February 2024 audits.

Action plans for lower compliance are documented in the minutes of the IPC Group. The Group acknowledges that lower scores relate to record keeping and not to clinical practice.

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

Dress Code Audits

Our Hospice MDT Matron and our Hospice in the Home MDT Matron audit compliance with the standards set in St Helena's Clinical Staff Uniform Policy. This year's results are below.

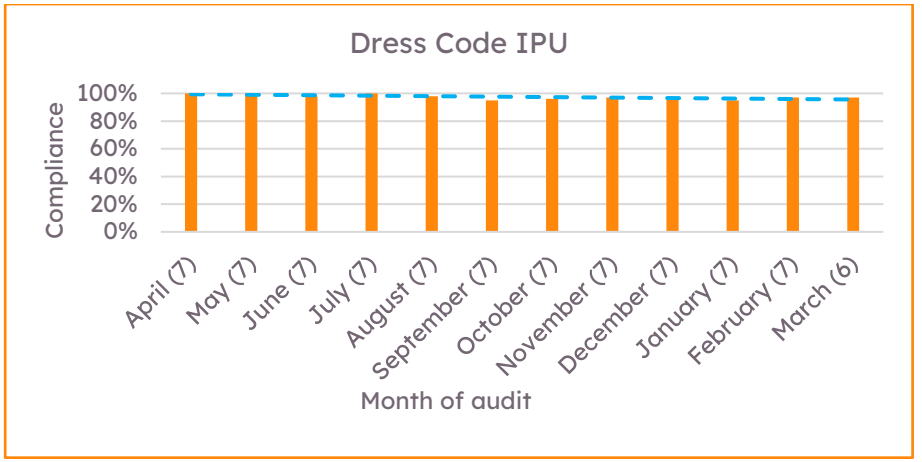

Figure 15 23-24 dress code (IPU) audits

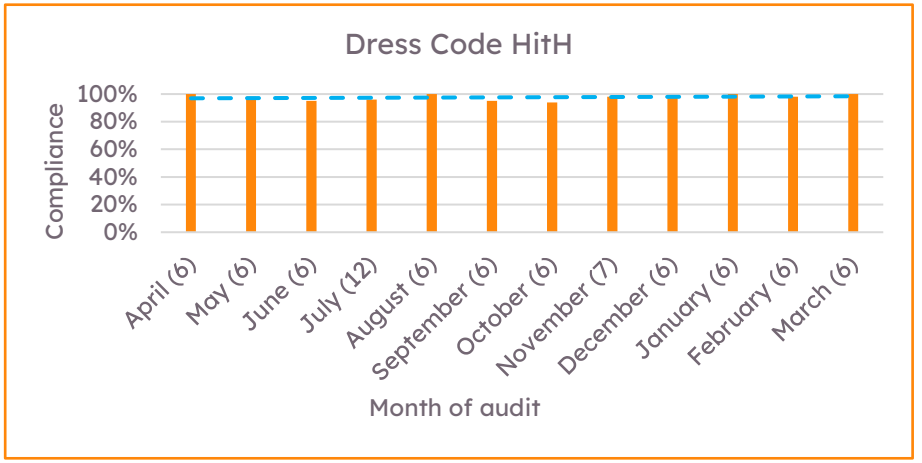

Figure 16 23-24 dress code (HitH) audits

Weekly Kitchen Audit

The Catering Manager completes an audit of the main kitchen weekly, looking at cleanliness and areas such as dry stores to ensure staff are following the proper processes. Below, is a chart showing the monthly average of the weekly audits.

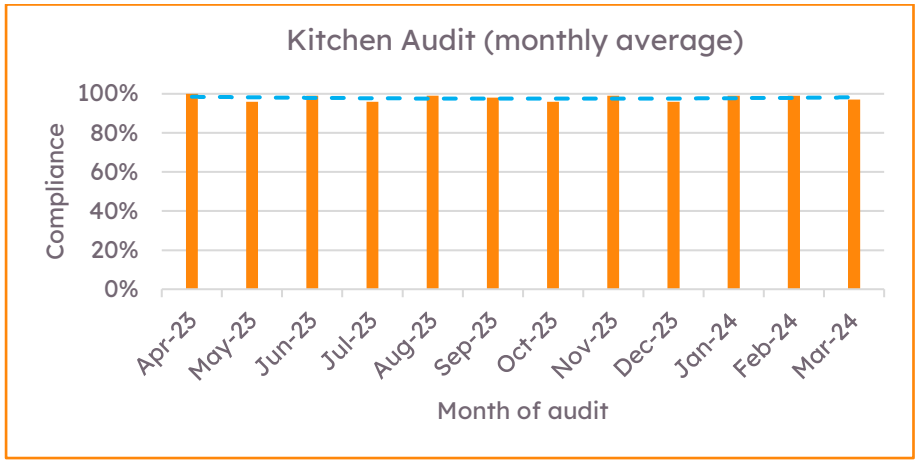

Figure 17 23-24 weekly kitchen audits

Cleaning Audits

Cleaning audit frequency and reporting is in line with the National Standards of Healthcare Cleanliness (2021). Audit results are reported as a 5 star rating and displayed in patient facing areas.

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
0/04/2023 – 28/03/2024	★★★★★	0/04/2023 – 28/03/2024	★★★★★	0/04/2023 – 28/03/2024	★★★★★	0/04/2023 – 28/03/2024	★★★★★

Table 3 23-24 cleaning audits

Infection Surveillance

Infection surveillance is a key component of infection prevention. The IPC Group monitors HCAIs (catheter associated UTI; clostridium difficile; MRSA bacteraemia). There were no reported healthcare-associated infections this year.

Covid Swabbing Audit

The Medical Team has audited the documentation surrounding swabbing for Covid-19 during the year. As of April 2024, this audit is no longer required because of changes to testing guidance.

Note: Over the summer period the audit was carried out quarterly (May, August, November) and returned to monthly audit for the winter months.

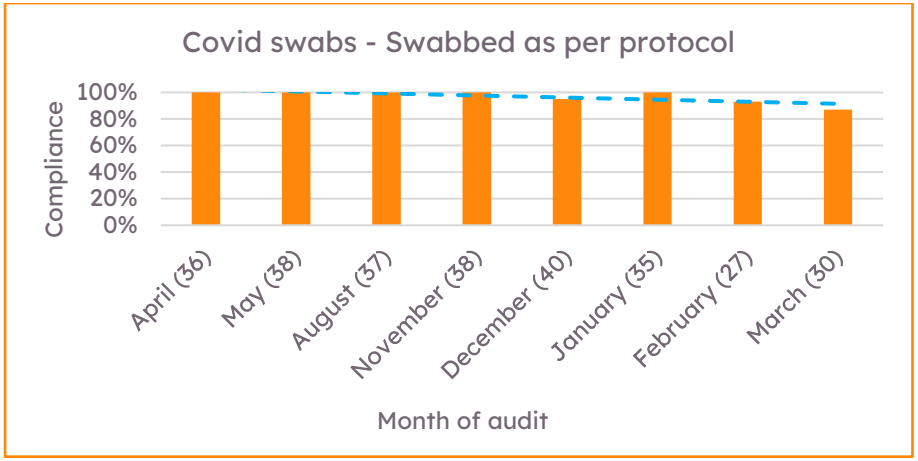

Figure 18 23-24 Covid swab audits

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 over the threshold level are cleaned again with Antichlor.

During the year, our Domestic Supervisor encountered problems with linen supplied by our external contractor. After a period of investigation with the contractor and increased in-house monitoring, there have been no further issues since November 2023. From March 2024 we will reduce the audit frequency to monthly. The chart below shows the number of items swabbed with results below the threshold for action in Green and those above the threshold for action in Red.

All Red items relate to items received from the external contractor, and not to items laundered in house.

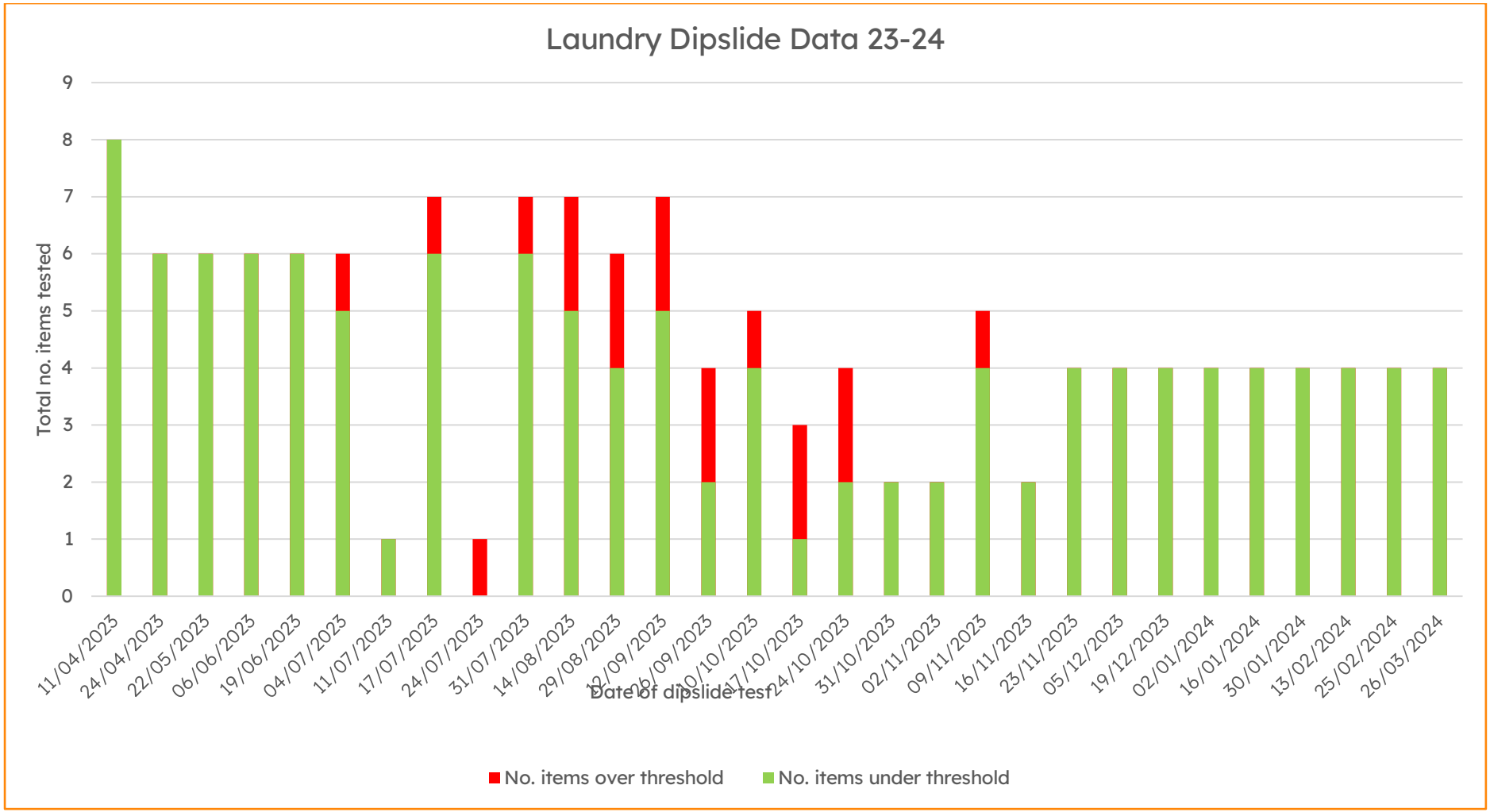

Figure 19 2023-24 laundry dipslide compliance.

3.18.1.5. 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.

88% of people admitted to our IPU during 2023-24 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.

3.19. Risk and Incident

All incidents and risks affecting Patient & Family Services are managed by our weekly 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.

…myself and my family were so comforted knowing [he] spent his last few days at such a wonderful caring place and had so much love and support for him and also all the family. Each and every person we met there had time to help us through the pain of losing a person we all loved…

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 2023-24, we continued with a substantial overhaul of our risk management system and the results of this have been very encouraging.

During the past year, we have also been preparing to roll out the NHS Patient Safety Incident Response Framework (PSIRF), which has replaced the 2015 NHS Serious Incident framework. We will go live with the PSIRF during Q1(24-25) and public our PSIRF plan and policy on our public website.

3.19.1. 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 Medical Director serves as our Caldicott Guardian, tasked solely with ensuring the protection and proper handling of patient information.

3.19.1.1. Confidentiality & IG incidents

During the year, we logged 20 incidents, all of which were minor and mostly clerical errors such as misfiled documents, emails sent to incorrect addresses, documents left unattended in open areas, and smartcard readers left unattended.

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.

3.19.1.2. 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 2023-24, compliance for the location spot checks was generally very good, with some minor infractions picked up and reported as incidents (e.g. smartcards left in readers). Compliance for the staff questions was a little lower and more variable, although some of this variability is explained by a change in our Caldicott arrangements in Q4.

We have judged compliance good enough now that, for 2024-25, the checks will become quarterly.

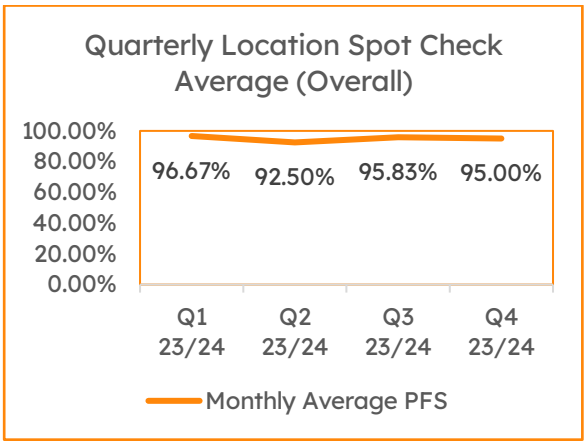

Figure 20 2023-24 Location spot check compliance.

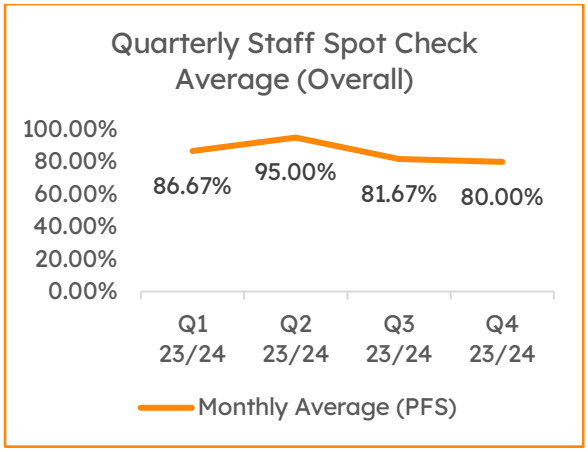

Figure 21 2023-24 Staff spot check compliance.

3.19.1.3. 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 2023-24 on 17th May 2024. 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 2023-24 DSPT certificate

3.20. 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.
We will be updating our policy during 2024-25.

3.21. Complaints and compliments

3.21.1.1. 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.

266 This complaint was initially investigated and closed during Q1 (21-22). 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, which was sent to the complainant in February 2022 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. In April 2022, having received no reply, we closed the complaint.

In October 2022, the Complainant contacted us to request an independent

investigation. We facilitated this and the investigation was conducted by a Consultant in Palliative Medicine at Mid and South Essex NHS Trust and Farleigh Hospice. The Consultant's finding supported the findings of our initial investigation.

We informed the Complainant of the results this second investigation, apologising for our original failings and once again offering them the opportunity to meet in person with the Medical Director of the Director of Care. 28 day later, and after having receive no response, we re-closed the complaint.

We partly upheld this complaint.

414 The wife of a patient contacted us to complain that they had called SinglePoint to request support with the patient's pain and poor sleep but had not received a promised call back.

Our investigation found that there had been poor communication internally and made several recommendations, including reminding SinglePoint staff not to use SystmOne tasks for urgent messages and refreshing them on the importance of comprehensive pain assessments. We sent our findings to the Complainant and offered them a face to face meeting.

We upheld this complaint.

232 This complaint, which concerned call bell response and a bruise the patient had sustained, was originally logged in 2021 but reopened for a second time in August 2023 at the request of the Complainant. Although the Complainant was content with our investigation and response, they did ask to meet our staff again, as they were still unhappy with the event. After reviewing, we were unable to provide any additional reassurance to the Complainant.

415 The parent of a patient cared for by our Hospice in the Home Team was distressed that one of our CNSs had used insensitive language while giving them advice following the patient's death.

Our investigation found that our CNS gave clear advice, we nonetheless acknowledged that the language used caused distress.

As a result of our investigation, we partially upheld the complaint and took several actions in response around better communication and documentation of sensitive subjects.

433 This complaint was about our Inpatient service. The Complainant felt that care had been hard to obtain, that they were continually asked to give information they had already given, and that the information they received from us was inconsistent. They also felt that they were not listened to when discussing the patient's mental state, and about the arrangement to move the patient to a nursing home.

Our investigation found clear failings in planning the patient's discharge, compounded by poor communication with the patient and the family. There was also a missed opportunity to visit the patient sooner, resulting in a possible delay to admission and assessment of their mental state.

We upheld this complaint and apologised to the family. As a result, we developed a formal process for deciding whether to apply for Continuing Healthcare (CHC) funding, and better training for staff in this area. We also revised our SOP around discharge and reminded staff about the importance of good communication.

439 The family of one of our community patients complained that we had failed to manage their pain or recognise that

they were imminently dying, thereby denying the family the opportunity to say a proper goodbye.

Our investigation concluded that we had managed the patient's pain well up until the final 24hrs of their life and that we missed an opportunity to increase the dosage of pain medication. We also concluded that we had missed an opportunity to discuss the patient's deterioration.

We upheld this complaint and apologised to the family. We also made four recommendations to our Hospice in the Home MDT to review how pain is managed, and a fifth to review our SinglePoint shift pattern.

443 We received a complaint involving several elements, including that we offered no physical support to an inpatient when they were entering or leaving IPU, that the admission process was too lengthy, that our staff used inappropriate language, that we hadn't provided overnight pain relief, and that a senior nurse had shown a poor attitude.

We upheld, or partly upheld, every element of this complaint and apologised to the family. As a result, the Matrons made 13 recommendations for improved practice, including reminding staff to use their observation skills when carrying out initial assessments, discussing the importance of appropriate language, reminding staff of the importance of observation at night, and reviewing our processes related to the answering machine in SinglePoint to ensure callers are aware of the process for responding to messages being left.

447 This complaint came from the family of a former inpatient and concerned their belief that, once deceased, we moved them too quickly to the funeral directors, that we did not call the family a week after the patient had died, and that we did not also contact the family on the day of the funeral.

We did not uphold this complaint, as we believe the patient was moved to the funeral directors appropriately, and we had no existing practice of communicating with the family in the manner described.

449 A complaint came from the family of one of our community patients, which comprised the following elements: they did not feel their CNS was caring or that the CNS knew what to do when the patient was in pain, and that, when the patient was admitted to hospital, the CNS stated that 'they are... not my problem'.

As a result of our investigation, we upheld this complaint. There were missed opportunities for our development CNS to follow up on the patient and more effectively manage their pain. In addition, the development CNS could have provided more support to the family, especially when they were concerned about the patient's discharge from hospital. In response, we have increased the support given to the development CNS about the management of uncontrolled symptoms, the importance of face to face contact, and asked them to make clear to patients that they are in a junior role and will be supported by more senior staff.

465 We received a complaint to SinglePoint from a residential home manager with respect to one of their residents. The complaint concerned the length of time it took to obtain the correct authorisation for anticipatory medications, set up a syringe driver, and control the patient's symptoms.

Our investigation found that the delay in the patient receiving medication was not solely SinglePoint's

responsibility, but that we had missed an opportunity to set up a syringe driver earlier. As a result, our Hospice in the Home matron recommended a change to process at shift handover, and we apologised for the distress caused.

We partially upheld this complaint.

470 A complaint was made by the wife of a patient about a call to SinglePoint during which a nurse had laughed at her concerns. The Complainant reported that they no longer felt confident about phoning.

Our investigation found that the nurse in question did laugh, but that this was not intended to be dismissive or unkind, and that this was a miscommunication.

As a result of this complaint, HitH staff have been reminded of the need for sensitive communication, call reviews have been recommended, and the nurse in question has had their advanced communications skills training reviewed.

We partially upheld this complaint.

477 One of our CNS team was subject to a complaint that they had cancelled a visit and had to rearrange, was unaware of the patient's medication and advised an increase in one they were no longer taking, was impolite to the Complainant and their children, and advised that the patient was not suitable for a profiling bed and that incontinence pads should not be used.

Our investigation found no evidence to support any of the substantive components of the complaint, but we apologised for any perceived impoliteness.

We partially upheld this complaint.

… to have a place at your lovely Hospice was a godsend. He was calm and peaceful there and on all levels of staffing we were met with kindness and courtesy.

It truly is a peaceful haven for patients and families…

3.21.1.2. 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 Clinical Quality Group. 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.

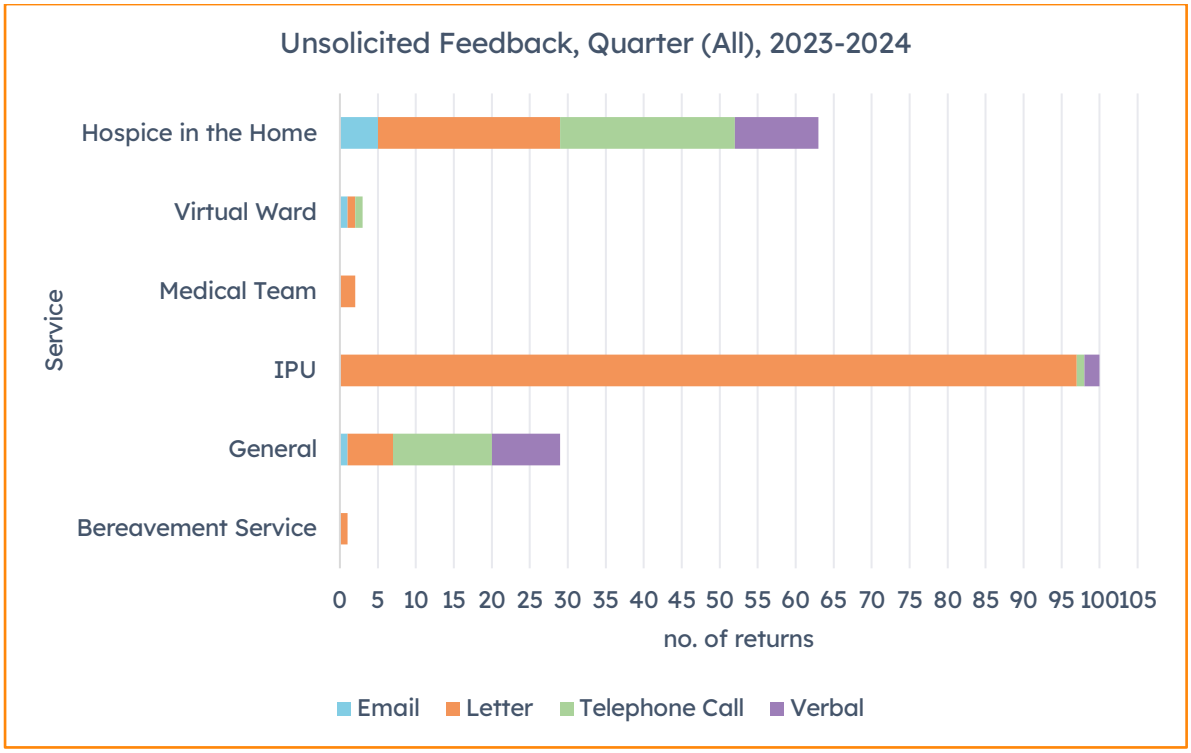

Figure 23 2023-24 cards and letters.

3.22. iWantGreatCare

During the year, we chose not to renew our contract with iWantGreatCare, who provided our previous patient feedback system, opting instead for a new method to gather this important data. This is called Synapta and is provided by AlwaysOnMobile. We will roll this out during the first quarter of 2024-45 and report the first batch of data in next year's Quality Account.

Synapta will enable us to send electronic surveys to respondents' smartphones and will allow for more sophisticated analysis of the results.

3.23. What Others Say

3.23.1.1. 2024 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 February 2024, when we underwent a one-day unannounced visit. Following this inspection, we were once again rated 'Outstanding' –the highest rating that the CQC can give. This continues the rating we were given following our previous inspection in 2017. The CQC summarise their findings as:

'Throughout the assessment, we received positive comments and feedback from people who used the service, relatives, staff, and health professionals. All patient's felt safe, well cared for and knew who to contact should they need to. They reported they were involved in the planning of their care and were kept informed of what would happen next. Patients felt staff delivered care that enabled them to remain well and independent physically, emotionally and mentally. They were supported to live as they wished, and care was coordinated with staff working to support patient choice. Comments included, "Staff are very approachable", "Staff are phenomenal, they are people of peace", and one patient reported his experience had "surpassed my expectations".[17]

Figure 24 CQC rating details

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

3.23.1.2. 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

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

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

- It is positive to see that the co-production process with service users and carers is being further developed by refreshing the points in patient pathways at which feedback is collected. Embedding the collection of patient voice into regular practice is important in improving services.
- It is wonderful to see the impact of the Safe Harbour project in connecting with marginalised communities and we look forward to seeing the future work in known areas of deprivation, as it is important that everyone has access to hospice services.
- Staffing is a challenge in many areas of the NHS, so it is unsurprising that St Helena have experienced short staffing this year. However, it is positive that they have been able to grow their own bank staff.
- The My Care Choices Register (MCCR) has been widely adopted, with almost half of the eligible population registering. It enables people to have a say in their care, and 85% of dying people with a MCCR entry are cared for in their preferred place of care. Hopefully this number will continue to grow to allow everyone to have their say.
- Training the incoming workforce is important in preparing services for the future, so it is great to see the proactive approach in offering placements to students.

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

Samantha Glover
Chief Executive Officer, Healthwatch Essex
June 2024

3.23.1.3. Response from Suffolk & North East Essex Integrated Care Board

The Suffolk and North East Essex (SNEE) Integrated Care Board (ICB) confirm that St Helena Hospice have consulted and invited comment regarding the Annual Quality Account for 2023/2024. This has been submitted within the agreed timeframe and SNEE ICB are satisfied that the Quality Account provides appropriate assurance of the service.

SNEE ICB have reviewed the Quality Account and the information contained within the Quality Account is reflective of both the challenges and achievements within the organisation over the previous twelve month period.

SNEE ICB look forward to working with clinicians and managers from the service and with local service users to continue to improve services to ensure quality, safety, clinical effectiveness and a good service user experience is delivered across the organisation.

This Quality Account demonstrates the commitment of St Helena Hospice to provide a high quality service.

Lisa Nobes
Chief Nursing Officer
Suffolk & North East Essex Integrated Care Board

3.24. Contacting St Helena

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

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