St Helena

Quality Account

2021 – 2022

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Acknowledgements

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

Richard Bareham	Head of Finance
Nicky Coombes	Hospice in the Home Matron
Greg Cooper	Head of Compassionate Communities
Niamh Eve	Hospice Matron
Sarah Hay	Clinical Compliance Officer
Mark Jarman-Howe	Chief Executive Officer
Sarah May	IT Information Manager
Wendy Marcon	Volunteer Team Leader
Kevin McGill	Head of Estates and Facilities
Kath Oakley	Medicines Management Lead
Lisa Parrish	Director of Care
Nigel Pye	Chair of the Board of Trustees
Becky Rix	Virtual Ward Manager
Deborah Smart	Operation Medicines Management Lead
Cherie Smith	Social Worker
Kirsty Smith	Tissue Viability Lead
Emma Tempest	Medical Director
David Traynier	Head of Quality & Compliance
Kimberley Rice	Falls Lead
Caroline Vergo	Infection Prevention & Control Volunteer Consultant

Throughout this Quality Account, we have included excerpts from patients' and families' cards and letters. In all cases, they is anonymised and reproduced with only minor edits for length and clarity.

1.0 Statement on Quality

1.1. CEO Statement

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

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

The organisation has a reputation for excellence in the care we provide, and we have an 'Outstanding' Care Quality Commission rating for our charitable services (see page 81 for details). We have developed innovative approaches across an increasingly diverse range of services.

St Helena wants end of life care to be better for everyone across North East Essex, regardless of where they live, how old they are or their diagnosis. We have worked with partners in the North East Essex Health and Wellbeing Alliance to develop a new population approach to end of life care, focused on the 10 outcomes that matter most to people in the last year of life and their families. We are pleased that providers in other parts of the UK have expressed interest in the approach we have championed, and we are always happy to share our learning.

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

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

Our service delivery is organised around two multi-disciplinary teams (MDTs) – The Hospice MDT, which provides Inpatient care (see

page 23) and Hospice in the Home MDT, which cares for people at home and in the community (see page 29). We offer support to patients, family members, and professionals through our 24/7 SinglePoint palliative care coordination centre and end of life care hub. SinglePoint coordinates end of life care services across local providers including GPs, district nurses, the acute hospital, out of hours services, and the ambulance service. It also coordinates the MyCareChoices Register (MCCR), a means of recording and sharing the wishes of people in the last year of life. To read more about SinglePoint, go to page 31 and, for the MCCR, page 43.

In addition, we provide a range of complementary and support services, including spiritual care, through our own teams and in partnership with community groups and other local providers as part of our Compassionate Communities programme. We also provide a comprehensive bereavement counselling service for all adults, and we have recently been commissioned to extend this support to children, regardless of the cause of their bereavement.

Last year was our busiest year ever, supporting a St Helena record of over 4,000 people. We want to do more and are seeking to further strengthen our work to personalise care, widen access, and tackle inequalities in both access and outcomes.

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

Mark Jarman-Howe
Chief Executive

We know this is what you do every day but we want you to know that what you do is amazing and we thank you for making our mum's last few days so comfortable and caring. She passed away so peacefully with us by her bedside so she could not have wished for more

1.2. Statement from Board of Trustees

The Board of Trustees continues to be accountable for the quality of care given by St Helena and we take this accountability very seriously. It is our duty to ensure that St Helena staff provide high quality care, and we proactively seek to develop that care to ensure it remains fit for purpose as the requirements of our community develop and change.

The COVID-19 pandemic has meant that face to face Board and Committee meetings were curtailed, but we implemented video meetings and continued with remote oversight by the whole Board. The Board's committees continued their duties via video and the Patient and Family Services Committee was especially important in receiving and challenging the Quarterly Quality Reports (see page 21 for details) before they came before the Board. Other committees, including Finance & Operations and Governance & Risk maintained their oversight of quality issues.

While the Board is wholly made up of Trustees, the committees are chaired by a Trustee but include relevant senior managers so that Trustees can assure themselves that quality is being delivered and work with senior managers to help address issues. Major issues are reported to the Board, where necessary, for action to be taken, but these committees have powers within the Board approved strategy to act themselves, allowing for more agility. The Board is now meeting face to face again, but the committees are, for the time being, meeting via video, owing to the flexibility this allows. Trustees are once again visiting the operations of St Helena to contribute to their own and the Board's assurance of quality being delivered.

We continue to develop our reporting processes and in addition to the Quarterly Quality Report the Board receives a monthly report from the Chief Executive and uses a dashboard and a Board Assurance Framework that give the Board wider insight and assurance regarding the quality we are delivering. The Governance and Risk Committee annually challenge all Committees and the Board to reflect on their Terms of Reference, confirm they are being fulfilled, and recommend any necessary changes.

The Board acknowledges that the principal reason St Helena can deliver quality care is the

outstanding dedication of its staff and volunteers. Throughout these difficult times they have continued to work to the highest standards in a selfless way and we do not take this for granted. The Board acknowledges and thanks all staff and volunteers for all they do in supporting people who are facing incurable illness and bereavement in North East Essex. We fully endorse this Quality Account.

Prof. Nigel Pye
Chair of the Board of Trustees

1.3. Executive Summary

2021-22 was a year of recovery for St Helena, as we slowly began to return to normal following the COVID-19 pandemic. Life is not yet back to the 'new normal' and references to the pandemic are inevitably scattered throughout this text, but we now have our eyes very much on the future.

In Part One this Quality Account, you will read about our priorities for the coming year. These are working to address inequalities in access to our services by engaging with the local population to co-produce our services, developing the skills of our workforce, and pressing ahead with our Compassionate Communities agenda. We also provide an update on our progress with our priorities from the previous financial year.

In Part Two, we discuss 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.

In Part Three, we will update you on our inpatient care, specifically the changes to our visiting rules and our return to full bed capacity following the pandemic (page 23). On page 29, our Hospice in the Home Matron provides an update on our work caring for people in their own homes with our Clinical Nurse Specialists, our SinglePoint service, and our newly expanded Virtual Ward. On page 34, there is a detailed discussion of the work we do under the banner of Compassionate Communities, including Bereavement Counselling, Complementary Therapies, and our Breathlessness Service.

Elsewhere, we discuss improvements we are making to our buildings (page 49), the return of our volunteers (page 51), and provide a summary of our incidents during the year (64). Towards the end of this report, we summarise the complaints we have received and how we've dealt with them (page 71) and throughout this report we share some of the valued feedback we have received from our patients and their families.

2.0 Priorities for Improvement in 2022-23

2.1. Priority One

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

We will work to use our Inpatient Unit (IPU) capacity to its fullest and serve as many patients and families as we can. We have already increased our Virtual Ward capacity through joint working with Bluebird Care (see page 32), and plan in the early part of 2022-23, to pilot adding another four beds to those we provide directly. This will enable us to see how well this additional capacity can support not only admission avoidance and early discharge for patients of Colchester General Hospital (ESNEFT)[1] who are eligible for fast track funding, but also improved flow from our IPU by flexing the criteria for this service. Once this pilot is complete, we will update our referral criteria and share these with system partners via an updated Access to Services Policy (904).

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

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

To support people after their loved ones' end of life, we will try to reduce waiting times for our

[1] East Suffolk and North Essex Foundation Trust.

Adult Bereavement Service. We will also be launching a Children and Young People's Bereavement Service in Summer 2022 to fill a known gap in service provision.

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

2.2. Priority Two

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

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

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

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

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

Mum died peacefully at home surrounded by her family. It was the support we received from you that enabled us to do this.... Please pass on our thanks to all, we are really grateful for the support you gave us and our large family will forever be supporters of your work.

2.3. Priority Three

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

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

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

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

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

2.4. Priorities for Improvement from 2021-22

2.4.1. 21-22 P1 Embed our revised operating model to ensure we can provide support to local people who need us regardless of diagnosis

What We Wanted to Achieve

'We will work to further embed the revised operating model we implemented as part of our response to the COVID-19 pandemic. During the pandemic, we took on a leadership role for all out of hospital end of life care activity across North East Essex - a significant change to our pre-COVID-19 model of care. This involved: increasing our Virtual Ward capacity, including working with a local care agency; aligning our Clinical Nurse Specialist (CNS) Team to Primary Care Networks (PCNs); providing enhanced rapid response and prescribing capacity; co-ordinating care with the voluntary sector; and acting as the co-ordinator for all local bereavement support. Recognising that many aspects of the revised model

resonated with our perennial priority of reaching out based on need regardless of diagnosis, we consulted with our staff to adopt this approach as our new operating model.

The model creates two Multi-Disciplinary Teams (MDTs). Each will develop its own Standard Operating Procedure, to provide robust processes for supporting teams to provide timely care to patients and their families and ensure our system partners are clear about our service offer. By standardising these processes, we will ensure that we are able to accurately report our teams' activity. We will also seek to define the impact the MDTs have on the North East Essex Health and Wellbeing Alliance Die Well domain, "Outcomes that Matter."

We will work in close partnership with our Alliance partners to support the North East Essex system in avoiding unnecessary emergency admissions and to provide for timely discharge for patients who wish to die at home. We will continue our partnership with Bluebird Care to provide 18 Virtual Ward beds, allowing us to care for more patients at home in their final weeks of life.'

What we have achieved

We continue to act as the co-ordinating hub for all out of hospital end of life care in North East Essex and have embedded our new operating model. Both our MDTS have developed Standard Operating Procedures to ensure consistent working and we have revised our reporting dashboards to reflect the new model. The data helps to demonstrate how our services have contributed towards to the North East Essex Health and Wellbeing Alliance Die Well domain, "Outcomes that Matter".

We have consistently offered 18 Virtual Ward beds and have worked closely with system partners to support access to domiciliary care for patients whose preferred place of care is home. We continue to work with Bluebird Care to deliver Virtual Ward beds and have put in place a Memorandum of Agreement to support this partnership. Staff on our Virtual Ward have cared for over 500 patients with an average length of stay of 10 days. Together with the SinglePoint service, the Virtual Ward and the wider Hospice in the Home MDT have worked to minimise inappropriate, unnecessary, and futile medical intervention during the last 12 months of life.

During the past year, the SinglePoint service has received more than 47,000 calls and supported over 2000 people. Where a rapid response visit has been required, either from a SinglePoint RN or a Non-Medical Prescriber Clinical Nurse Specialist, we have been able to visit in under two hours. This has actively promoted the outcome 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. We also increased the working hours of our Referrals Team to support improved access.

The Community Clinical Nurse Specialist Team has worked with primary care and the community nursing service to manage the end of life caseloads for their population. This proactive caseload management has supported the identification of people thought to be within their last 12 months of life, enabled their preferences to be recorded, and helped manage their pain and symptoms. This approach has also supported families and carers, in accordance with the identified Outcomes that Matter.

We have also supported carers and families after the death of their loved one with our Bereavement Service, which has supported over 750 adults, regardless of whether St Helena had provided care to their loved one.

Our Joan Tomkins Day Centre has re-opened for use by patients and clients, enabling us to offer some face to face sessions and groups, and we have increased the number of volunteers who have returned to support our clinical teams.

She was a beautiful lady who had fought a long fight, but with the care you all gave, enabled our mum the most dignified and peaceful end to her life, and we are eternally grateful for this.

2.4.2. 21-22 P2 Support our workforce to deliver excellent personalised care to all our patients

What We Wanted to Achieve

'Through our Primary Care Network linked Community Clinical Nurse Specialist Team we will provide proactive care to patients on the Primary Care Network (PCN) End of Life caseload, empowering people to plan, share their choices, and achieve their care preferences. This will support a population based model of care. We will work to ensure that PCNs see the information contained within the End of Life dashboard, including care preferences, levels of anticipatory prescribing, and achievement of Preferred Place of Care (PPC).

We will support healthcare professionals to develop advanced communication skills that will support them to empower patients to plan their care.

We will deliver a third cohort of Gold Standards Framework (GSF) training to local care homes, commencing in September 2021.

Working with other local hospices, we will seek opportunities for enhancing our learning and development offer to Alliance partners.

We will re-establish our Service User Group and seek to increase the amount of service user involvement in the governance of our services.

We will continue to prepare for any CQC inspections and ensure our approach reflects the new CQC strategy.

We will offer a suite of Community of Practice sessions to healthcare professionals across the North East Essex Health and Wellbeing Alliance.

St Helena recognises that working with palliative and end of life patients and their families can be both challenging and stressful. We will support the health and wellbeing of our workforce, including by offering clinical supervision for all staff working in patient facing roles, Schwartz Rounds, and team days. These will supplement our existing health and wellbeing provision.'

What we have achieved

We have championed a population based model of care, with our community Clinical Nurse Specialist Team having oversight of the data for their Primary Care Network (PCN) population. Based on this data, we successfully bid for and put into place an additional Clinical Nurse Specialist to work in the most challenged PCN areas to address some of the inequities in outcomes seen within the data.

We have partnered with St Elizabeth Hospice to establish Hospice Education, which will seek to offer education to partners across the Alliance. Unfortunately, because of the constraints within our Learning and Development Team we were unable to deliver a third cohort of Gold Standards Framework (GSF) training to local care homes. As a result, we handed this back to the GSF central team to be delivered to the nine remaining care homes.

The ongoing pandemic has prevented us from re-establishing our Service User Group. We have sought to gain service users' views through other mean; for example, we ran a survey on spirituality needs help inform our future service.

The CQC Working Group's work programme has reflected the regulator's new strategy and we have worked with teams across the Hospice to help them identify how they can evidence the outstanding care they deliver. In addition, the Hospice Matron provides a CQC question of the week to increase awareness and confidence. We have recruited to the new role of Quality Improvement and Patient Safety Matron to enhance clinical leadership across our clinical teams.

Schwartz Rounds have continued virtually, and we have reviewed all patient facing staff's clinical supervision arrangements. Team days for each of the MDTs have taken place, which have included pertinent education topics as well as thank you events to recognise the amazing efforts of our teams throughout the year.

We were particularly pleased to have several posters accepted at this year's Hospice UK conference, with colleagues attending to present them. For more details of these, see on page 20.

2.4.3. 21-22 P3 Develop a compassionate community programme

What We Wanted to Achieve

'We will work to reduce the inequity of access to hospice care, increase the opportunity to carry out and record advance care planning (utilising the My Care Choices Register) and realise the principles of the Die Well domain, 'Outcomes that Matter'.

The development of a Compassionate Community will enable us to put interventions and services in place with partners to address these specific issues and optimise the use of community assets and resources across North East Essex. This will involve working with the statutory and voluntary sectors to deliver services that contribute towards the collective goal of improving outcomes for the end of life population as well as increasing the resilience of the community to better cope with issues related to dying, death, and bereavement.

As part of the Compassionate Community programme, we will identify gaps within local community assets and work with partners to develop, support, and -- where appropriate -- invest in addressing these gaps. We will also work to strengthen existing assets.

St Helena will seek to become a Compassionate Workplace and, having developed a prototype, will work with other local businesses to help them to improve communication with, and support given to, those who may be experiencing issues around dying, death, and bereavement.

We will help local people to go on in the face of dying, death, and bereavement by ensuring timely access to adult bereavement support services.

Recognising a gap in current service provision locally, we will develop a triage and signposting service for families with children who are facing bereavement, while actively working with partners for a full service to be commissioned.'

What we have achieved

Our Compassionate Communities programme has further matured through the year. The work to address inequity of access to Hospice care is being led by an Equality Working Group using a recent Equality Impact Assessment to drive its work, alongside data from the End of Life dashboard. We have also started to develop of a Hospice Equality dashboard.

We have worked with several system partners towards improving outcomes for the end of life population. This has included introducing Outreach Social Prescribers focusing on Black and Minority Ethnic (BAME) and deprived communities, and a personalised care project co-ordinator for care homes residents, particularly in deprived areas, to increase access to the My Care Choices Register (see page 43).

Work is ongoing to establish community networks using existing community assets, to ensure our communities are prepared to care.

We have piloted a Compassionate Workplace training programme amongst our

own staff, which has been well evaluated and will inform the roll out of the programme to local businesses within the area.

Having recognised the gap in service provision for bereaved children and young people we have been able to offer a triage and signposting service for families with children facing bereavement. Working with system partners we have been able to secure funding for a Children's and Young People's Bereavement Service, which will be launched in the summer.

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

2.5.1. Review of Services

During 21-22 St Helena provided the following services:

- Inpatient services – up to 18 inpatient beds with support from the Hospice MDT, which includes the Nursing Team, Care Co-ordinators, Specialist Physiotherapist, Specialist Occupational Therapist, Specialist Social Worker support, Counsellor, and Family Support Workers.
- Community services – acting as the End of Life Hub for North East Essex, co-ordinating all out of hospital care and comprising the SinglePoint Service (24/7 advice, support, and information), Virtual Ward (18 beds) in collaboration with Bluebird Care, and the Community Clinical Nurse Specialist (CNS) Team. The Hospice in the Home MDT consists of the Nursing Team, Specialist Physiotherapist, Specialist Occupational Therapist, Therapy Assistant, Specialist Social Worker support, Counselling, and Family Support Worker.
- The Medical Team, supporting both MDTs.
- The Compassionate Communities Programme encompasses the following services; Complementary Therapies for both inpatients and community patients, Breathlessness Service, Chaplaincy, Safe Harbour project, Personalisation project, and the Bereavement Service for adults.
- Hospice Education in collaboration with St Elizabeth Hospice.

2.5.2. Funding of Services

St Helena is an independent charity, which during 2021-22 provided its services largely free of charge to the end user. At time of writing, Our grant income from the NHS in 2021-22 constituted

approximately 24% of our total income. In addition, a further 3% was received from NHSE to provide support for additional pressures related to COVID-19. The remainder came from voluntary charitable donations, legacies, hospice shops, hospice lottery, and our corporate and community fundraising.

Please note, these figures may be revised, as we are awaiting confirmation of additional funding for the year from Hospice UK.

2.5.3. Clinical Audits

During 2021-22, there were no national clinical audits or National Confidential Enquiries relevant to us.

We didn't manage to get him home but he was happy to stay with you.

Local Audits

The planned annual audit programme for the year began in April 2021, designed by the Clinical Compliance officer together with service leads. During the first two quarters, the majority of Hospice MDT audit work fell to the IPU Senior Sister and the Clinical Compliance Officer because of ongoing staffing and recruitment challenges. Similar staffing problems slowed progress with clinical audit for the Hospice in the Home MDT during this time. This has improved over the course of the year for both MDTs, with almost all programmed audits completed by the end of March 2022, and several new ones introduced. A small number of audits have been brought forward to the new 2022-23 programme, which will begin in April 2022.

Our Quality Assurance and Audit Group (QAAG) meets monthly to monitor our annual audit programme, quality reporting, and patient experience. Our Clinical Compliance Officer keeps a register of the audit programme and its progress on a dedicated module of our Sentinel electronic reporting system, and during 2022-23 enhancements will be made to the module to improve reporting and monitoring of audit actions.

Below, we present summaries of a selection of clinical audits conducted throughout the year. Audits are listed by their title and reference number.

Hospice UK – Management of Controlled Drugs [02-2122]

This audit, based on a Hospice UK template, was completed by the Director of Care as the Controlled Drugs Accountable Officer (CDAO). Its purpose is to ensure that our management of controlled drugs (CDs) complies

with the Misuse of Drugs Regulations (2001) as amended (2007), The Health Act (2006), and the Controlled Drugs (Supervision of Management and Use) Regulations 2006. This is an annual audit, which is supported by quarterly internal audits completed by the Operational Medicines Management Lead and the IPU Senior Sister. The audit comprises seven topics:

- Adequacy of Premises/Security
- Procurement
- Examination Stock Held
- CD Register, Records and Audit
- Prescribing of CDs
- Administration of CDs
- Destruction of CDs

'CD Register, Records and Audit' scored 91% because a correction in the CD register had not been signed, dated, or signed by a witness. The CDAO reminded the Nursing Team of the importance of this.

'Destruction of CDs' scored 84% because the name of the person destroying and the authorised witness were not recorded (signature only), and the address of the patient for whom the drugs had been prescribed was not recorded. Authorised individuals have been reminded by the CDAO of the need to write their name as well as sign, and to record the address of the patient.

The audit found 100% compliance with the remaining topics. The CDAO will re-audit in one year.

Side Rails Assessment Documentation [27-2122]

The purpose of this audit was to examine how well the newly introduced side rails assessment was being used on the IPU. A weekly care plan was introduced during September 2020, with an assessment completed on admission and re-assessment carried out weekly. This was the first re-audit.

The IPU Senior Sister and the Clinical Compliance Officer audited 12 admissions from May 2021 where length of stay was longer than one week and found that all 12 patients were assessed on admission and re-assessed weekly, as per the care plan instructions.

Re-audit will be in one year's time to ensure we remain 100% compliant.

Visual Skin Assessments [21-2122-1/2/3]

This re-audit was carried out to ensure that visual skin assessments are carried out within 6 hours of admission to the IPU, or that a reason and handover are documented if assessment is not possible on admission. The first re-audit was carried out in October 2020, which found that all required

documentation was thoroughly completed in 9/10 admissions. This was the second re-audit.

All current inpatients (10) on 13/04/2021 were audited, looking at when a visual skin assessment was documented during admission and at the quality of related documentation. The Tissue Viability (TV) Lead found that documentation remained generally of high quality; however, one patient did not have a visual check recorded and two records did not have a nurse named in the handover documentation.

The TV Lead communicated the results to staff along with a reminder of all the elements required for documentation with a plan to re-audit in July 2021.

Reaudits were carried out in July 2021 and February 2022, both finding excellent compliance. As a result, the frequency of re-audit has been reduced to annual.

Pressure Ulcers Quarterly Audit [16-2122-1/2/3/4]

This audit was carried out to determine how well management of pressure ulcers is documented on the IPU. This is a regular audit, carried out quarterly by the TV Lead and the Clinical Compliance Officer.

The results of all four audits for the year showed continuing 100% compliance in all areas and the TV Lead has congratulated the nurses for continuing good documentation.

During the year, an IPU Deputy Sister presented at two IPU team days on identifying pressure ulcers and moisture lesions to improve nursing knowledge.

As a result of the consistently excellent results all year, we have reduced the frequency of the audit from quarterly to half-yearly. Re-audit will therefore be in July 2022.

Hospice UK Management of Medical Gases [32-2122 -1/2]

The purpose of this audit is to ensure that St Helena continues to meet the legislative requirements surrounding the use and storage of medical gases (oxygen). This cycle of the audit was due to be completed in February 2021 (a one year re-audit from February 2020). However, because of on-site restrictions relating to the pandemic and staffing issues, it was completed during August and September 2021.

The audit tool is based on one originally provided by Hospice UK and comprises eight topics:

- Topic 1: Standard Operating Procedures (SOPs)
- Topic 2: Personnel (NB: not completed as relates to pipeline systems which we do not have)

- Topic 3: Ordering and Receipt
- Topic 4: Storage
- Topic 5: Oxygen Concentrators
- Topic 6: Prescribing
- Topic 7: Administration
- Topic 8: Decontamination and Storage

The audit was jointly completed by the IPU Senior Sister, the Non-Clinical and Health & Safety Compliance Officer, and the Clinical Compliance Officer.

The audit identified work to be done surrounding ordering and receipt of oxygen and storage. This was because of changes in practice since the previous audit. The relevant teams were tasked to complete actions to improve compliance in these areas and Topic 3 and Topic 4 was scheduled to be re-audited in January 2022.

January 2022 re-audit

This reaudit focussed on Topics 1,3, and 4 only. It was jointly completed by the Non-Clinical and H&S Compliance Officer, and the Clinical Compliance Officer. The results showed that an improved process for orders and receipt of oxygen had been developed but was not yet in use by the Maintenance Team. The Maintenance Manager was asked to implement the new process, and this was subsequently confirmed by the Clinical Compliance Officer to be in place.

My family and I wish to Thank You All most sincerely for the kindness and compassion shown to my husband ... From the diligence of your telephone staff to the magnificent care, compassion and humour of your nurses... The hurt will go on forever, but, the memory of how ALL of you at SinglePoint assisted at this difficult time will remain with us!

Mental Capacity Assessment Documentation [33-2122]

This annual record keeping re-audit assessed how well mental capacity was recorded during a patient's admission to the IPU. Both the admitting nurse and the admitting doctor should record a mental capacity assessment, and mental capacity should be recorded daily by the nursing staff.

An IPU Deputy Sister audited all admissions from October 2021 (28 patients) and found that assessments were completed on admission and recorded daily for all patients. Where a patient lacked capacity, the reason was clearly documented in the free

text and within the capacity questionnaire. If a Best Interests decision was made, it was not always documented in the assessment who had been consulted (e.g. next of kin) but the information was recorded elsewhere in the patient record.

The SystmOne Manager and the Safeguarding Lead are currently reviewing how consent on the IPU is recorded, following feedback from a Best Interests Assessor who visited the IPU in October 2021, and the care plan may be amended as a result.

Re-audit will be in October 2022, or sooner if required following any care plan changes.

Admission Avoidance – Hospice in the Home [40-2122]

This audit was conducted to examine whether St Helena interventions had avoided patients needing a hospital admission. With the increased strain on healthcare nationally, all healthcare providers have a duty to prevent inappropriate admissions to an acute hospital.

The audit took place over a two-week period. Whenever a clinician made any intervention, they felt had prevented an admission, they informed the auditor. This data was then collated, and each patient's record was reviewed to confirm the patient had not been admitted to hospital within 72 hours of the intervention.

Overall, over the two-week period all 14 patients audited were found to have been spared an acute hospital admission because of an intervention made by the Hospice in the Home Team. After the intervention, all patients were able to remain in their preferred place of care.

DNACPR in the Community [39-2122]

The purpose of this audit was to look at how the community CNS team are evidencing that they are completing Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) forms on our patient administration system, SystmOne. The objective was to ensure that staff take a uniform approach to completing the forms, as well as in St Helena documentation.

The results were mainly satisfactory with a mostly consistent approach to documentation. A few recommendations were made to improve the quality of documentation with a re-audit set for 12 months' hence.

Community FP10 Monitoring [46-2122]

This audit was carried out to ensure that a robust monitoring system is in place for the use of FP10 prescriptions in the community.

Our Quality Improvement and Patient Safety Matron carried out the audit in March 2022 to identify whether the St Helena procedure allowed for the history of a prescription to be traced from receipt of the blank form to when it was prescribed, as per the standards set by the NHS Counter Fraud Authority (2018).

This was an original audit, following a change in monitoring processes implemented during Q2 and Q3.

The audit showed a well-established process for monitoring prescriptions was in place and generally working well. Actions were identified regarding improving record-keeping further, and for the process for changing the prescription safe code.

Re-audit will be in June 2022 to ensure a suitable system for safe security is in place and that record-keeping remains of a good quality.

2.5.4. Participation in Research

Needs Rounds

Our Nurse Consultant has been leading on our current research into implementing Needs Rounds in care homes. The project is led by Stirling University and St Helena is one of six participating sites across England and Scotland. Needs Rounds are an intervention already trialled and positively evaluated in Australia. They involve a palliative care nurse attending a care home regularly to discuss patents identified by its staff. Interventions may include Advance Care Planning, simple symptom management or referral to the Palliative Care Team. Following preparatory workshops, Needs Rounds were implemented in care homes from July 2021. The pandemic has made it a challenging time to introduce a new way of working in this setting. The Needs Rounds will run until June 2022 and the team at Stirling will evaluate the data and hope to report their findings in early 2023.

CHELsea II (IRAS 313640)

St Helena has also been accepted as one of 80 study sites for a national project, led by Professor Andrew Davies at the University of Surrey, looking into the role of clinically assisted hydration at the end of life. This is due to commence late 2022.

We have presented several posters at conferences across several topics and service areas. These are detailed in Table 1, overleaf.

Title	Venue
Evaluating the role of Advanced Nurse Practitioner (ANP), in a hospice Inpatient-unit (IPU) setting, as part of the Medical Team	Palliative Care Congress
Off to war when I didn't sign up. Supporting Hospice staff mental health during a global pandemic	Hospice UK Conference
The evolving role of rapid response Clinical Nurse specialists during the Covid-19 pandemic	Hospice UK Conference
Bereavement services. An adapted model of care during a pandemic	Hospice UK Conference
Outreach Social Prescribers at the end of life	Hospice UK Conference
Hope for the best, plan for the worst? Improving resilience with Business Continuity Planning	Hospice UK Conference
No surprise? Reducing risk through effective contract management	Hospice UK Conference

Table 1 Posters presented at conferences (2021-22)

2.5.5. Use of the CQUIN Payment Framework

St Helena income in 2021-22 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because we are not party to any NHS National Standard Contracts.

2.6. Clinical Governance

In Figure 1 on page 22, we present a schematic of our current clinical governance structure. These groups are fortnightly, monthly, or quarterly as needed, and manage key components of patient safety and clinical quality. All these groups report up to our quarterly Clinical Governance and Compliance Group.

2.6.1. Quarterly Quality Report

Each quarter, our Quality & Compliance Team collates a Quarterly Quality Report. Running between 60 and 80 pages, this report summarises all our patient quality, patient safety, patience experience, and clinical governance activity and developments for the quarter. The Report is tabled before the Clinical Governance and Compliance Group before being presented to our Board of Trustees and sent to North East Essex Clinical Commissioning Group (NEECCG) and the Care Quality Commission (CQC).

Although she was only with you for a short while, you enabled us as a family to be with her during her final days. Your care and compassion is above the role of nurses, and your genuine sympathy shines from you all. Thank you seems such a small word.

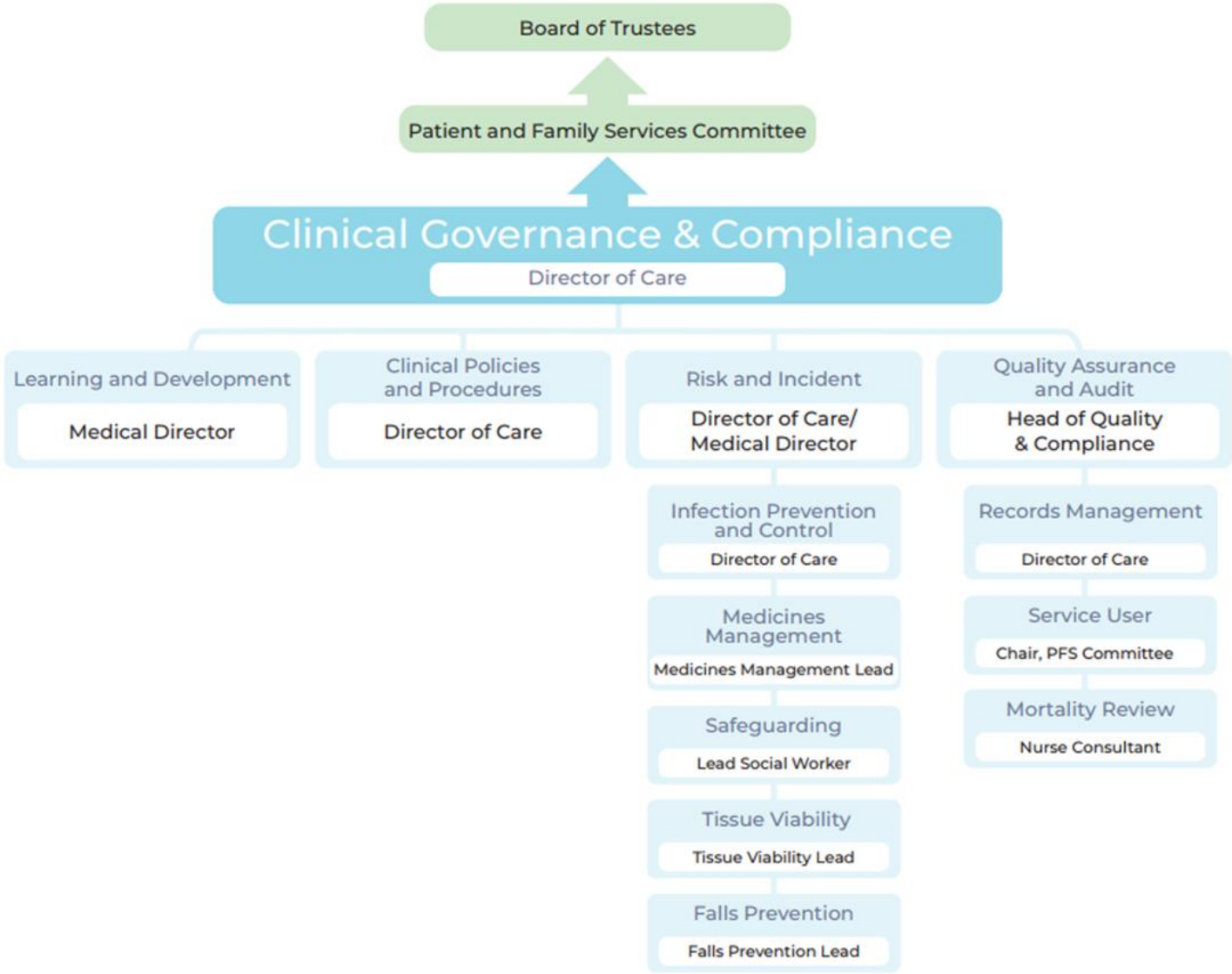

Figure 1 St Helena's structure of clinical governance groups

3.0 Review of Quality Performance

3.1. Overall Referrals to St Helena

Figure 2, below, breaks down the number of people referred to us during the year, the number or referrals received, their age, diagnosis, referral source, and other useful information. This information is for St Helena as a whole, but there are service specific versions in the pages that follow.

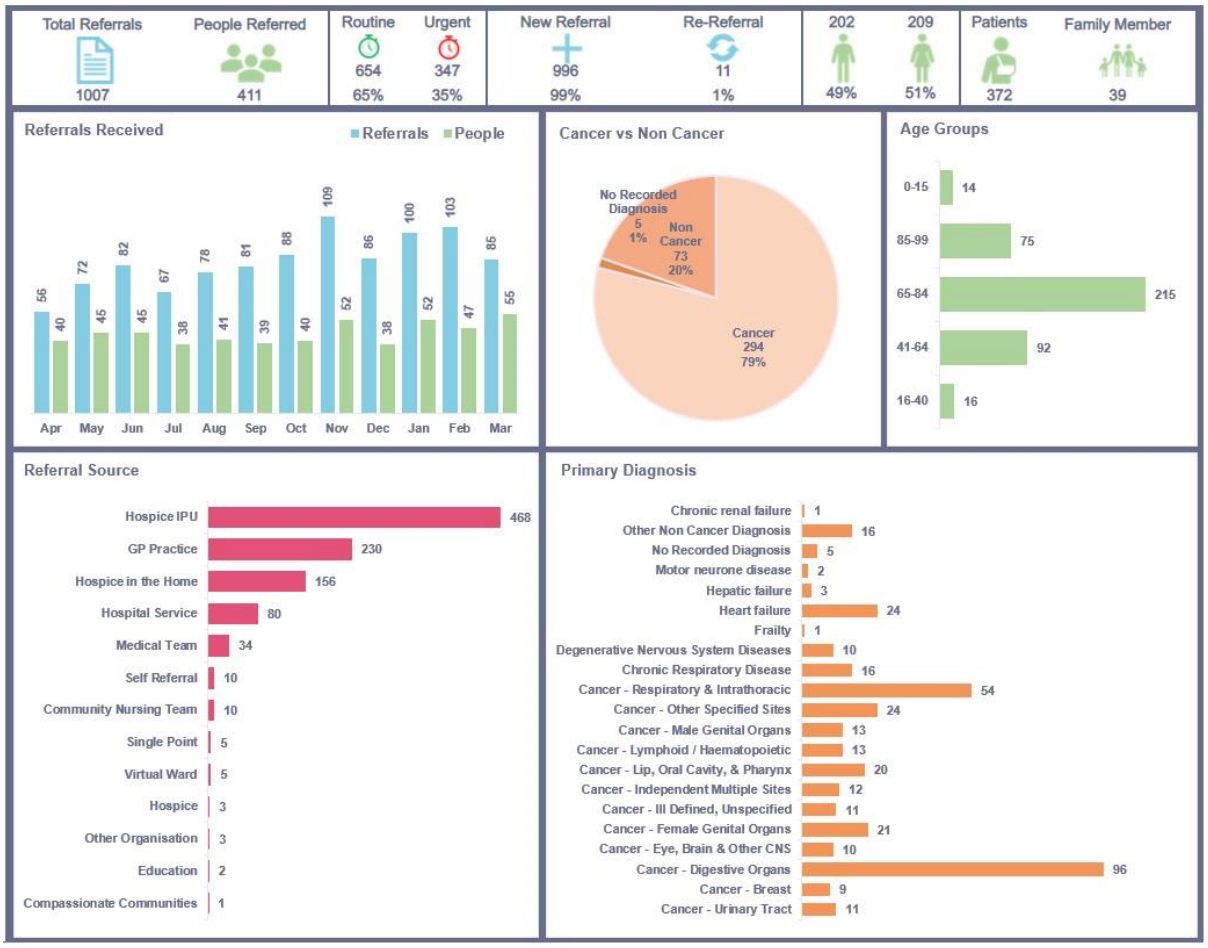

Figure 2 Overall referrals 2021-22

3.2. The Hospice MDT

The last year has been challenging; particularly with further waves of COVID-19 and reduced staffing due to illness and self-isolation. Despite these challenges, the Inpatient Unit (IPU) has continued to provide a high standard of care to our patients.

As a result of increased infection control measures during the pandemic, the IPU had 11 of its 18 beds available for admissions through the first part of the year (April-November 2021). In November, all 18 beds were available for patient admissions,

including the four beds in the patient bays. To use the four IPU beds in the bays, patients needed a negative polymerase chain reaction (PCR) swab on admission, another on day five, and weekly thereafter. It was noted that patients were not consistently getting their PCR swabs on admission, day five, and then weekly; and so a risk was raised. This resulted in an audit to monitor patient swabbing and, after several months, overall compliance improved. The need for two negative swabs has meant admissions are slower and it has been difficult to achieve an occupancy of 18 beds.

Figure 3 The Hospice at Myland Hall

During the year, staff completed a weekly PCR test and twice weekly Lateral Flow Device (LFD) tests. In addition, if staff had contact with a person who had tested positive (non-household or household) they were required to isolate for ten days. The COVID-19 Policy was amended several times within the year to reflect changes in national guidance and other developments.

Staff personal protective equipment (PPE) requirements have changed over the year. By the end of the year, all staff at Myland Hall were still required to wear a face mask; however, they no longer must wear a face mask, visor, apron, and gloves when they enter a patient's room. We are now back to using PPE as we

were before the pandemic: for personal care, wound dressings, etc. IPU staff continue to wear full PPE to nurse a COVID-19 positive patients. We have also been able to reduce social distancing from two metres to one. This means that the maximum capacity in rooms has increased, allowing more people to gather.

As guidance has changed, we have also been able to reduce the amount of PPE we have required visitors to wear. They now need only wear to a face mask unless the patient is COVID-19 positive, in which case we require a face mask, gloves, and apron. We have been able to increase the visiting hours for patients to morning and afternoon slots and the duration of visits from 1.5 to two hours. Patients thought to be at end of life remain on open visiting. Visitors are now able to use the lounge, multi faith chapel, and dining room.

Face to face teaching, meetings and handovers are now starting to return. Weekly MDT teaching has remained via Microsoft Teams videocall, allowing staff to participate from home or onsite. They can also watch recordings via our online staff forum, Workplace. We have also been able to welcome back many of our valued volunteers: Complementary Therapists, Pets as Therapy (PAT) dogs, kitchen helpers, Reception volunteers, and the gardeners.

Audits have continued despite the pressures from the pandemic and reduced work force. This continues to evidence our good practice and what we need to improve on. For more details of our audit programme during the year, see page 14. We have restarted staff supervision and surveyed our team to gather their supervision preferences (i.e. group, 1:1, or no supervision). The senior staff continue to provide daily ad hoc advice and informal supervision to support the staff.

As with last year, we have found recruitment a challenge. We remain under established for Registered Nurses (RNs) and Clinical Support Workers. We continue to try to recruit to these roles and have paid special attention to the retention of new and existing staff. We completed an IPU staff survey during the year and have addressed the main themes of the response. Part of the survey highlighted complaints about salaries and a pay review in October 2021 resulted in pay increases and unsociable hours pay for weekends, nights, and Bank Holidays.

The wider MDT staff (Physiotherapists, Occupational Therapists, a Social Worker, a Counsellor, and Family Support Workers) have been adjusting to changes in their roles and working in a reduced workforce. The social worker has taken on more of an advisory role within

the Hospice and focused on projects such as ensuring the IPU is compliant with safeguarding training. The Rehab Team (Physiotherapists and Occupational Therapists) has adjusted to working more autonomously, with minimal crossover between the two Physiotherapists and two Occupational Therapists. The Physiotherapists have helped with the Clinical Support Workers (CSW) achieving their Rehab competencies, which was a new part of the CSW role.

The Family Support Workers have continued to support patients and families on the IPU. One of the Family Support Workers has helped with signposting families for bereaved children. They have also had more interaction with children and families now we have had increased visiting. The Counsellor continues to work across both MDTs and is a good support to the Family Support Workers when a patient needs more structured support or counselling.

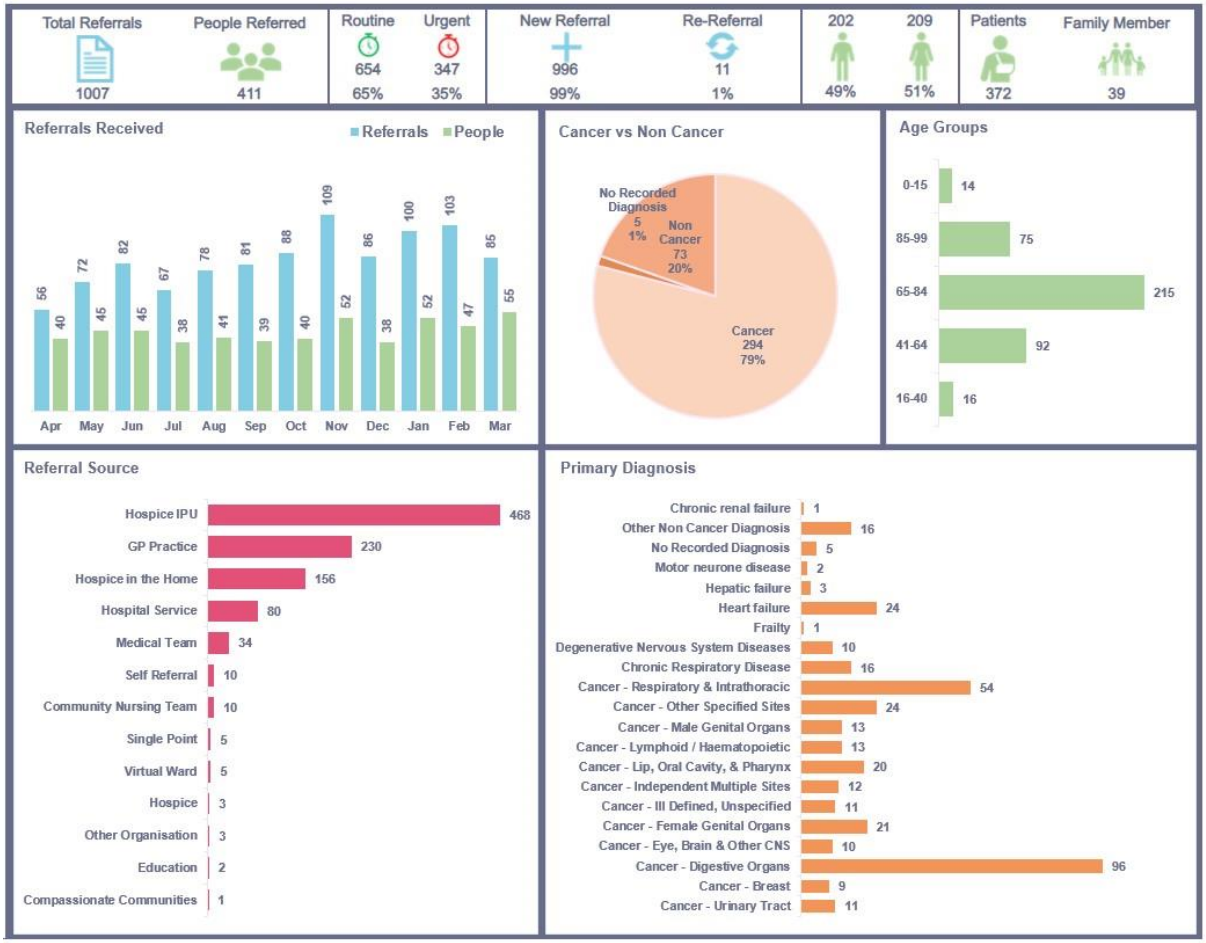

Figure 4 Inpatient referrals, 2021-22

3.3. Medical Team

2021-2022 continued the challenges of the pandemic, even while we tried to return to 'business as usual'. The Team continued to work flexibly to cover whichever of our services had the greatest need. With the help of our regular bank staff, we managed to maintain a 24/7 service. Team members were also very supportive of each other throughout.

At the beginning of the year, we began working with colleagues elsewhere to form an MDT to address the Palliative and End of Life needs of people with Parkinson's Disease. The aim is to increase our reach to people with non-malignant disease by targeting another specific disease group traditionally underserved by hospice services. This has led to an increase in specialist reviews and inpatient admissions for patients in this group. Members of the Medical Team now lead on the workstreams for Chronic Obstructive Pulmonary Disorder (COPD) and Heart failure for the North East Essex End of Life Care Board (NEE EOLCB) on the back of the MDTs for these areas. We continue to support the dementia wards at Essex Partnership University NHS Trust (EPUT) and were pleased that their Tower Ward (based in the Landermere Centre in Clacton-on-Sea) received a national Gold Standards Framework (GSF) Quality Hallmark Award for its delivery of end of life care

It was a pleasure to once again be able to welcome medical students from the University of Cambridge, St Bartholomew's Hospital, and the Royal London Medical School. In May and June we hosted final year students who became doctors in August, and we hope this experience gave them the confidence to talk to patients with a life limiting illness and their families. This time with us is always well evaluated. One student even took the time to play the piano on IPU for everyone, which felt like a return to normal Hospice life. Later in the year, we hosted a medical student for four weeks, who found her placement very beneficial to her training and had lots of positive feedback for our Team.

In July, we commenced the intervention stage of our Needs Rounds as part of a research project with the University of Stirling. For more details of this, see page 19.

August saw a change to how St Helena supports junior doctors who rotate through our Team to experience Palliative Medicine as part of their training. Over recent years we have hosted Foundation Year 1 (FY1) and Foundation Year 2 (FY2) doctors on our IPU. However, as we have increasingly felt that a hospice placement is often not a

suitable first placement for a newly qualified doctor, we have decided to no longer accept FY1s. Instead, we have worked with our general practice colleagues to develop two posts mixing palliative care and general practice. This is the first time we have placed a trainee solely in the Community Team and we hope this will provide great experience pertinent to a career in general practice.

As opportunities for education returned, the Team attended and delivering teaching, internally and externally. This included one of our Advanced Nurse Practitioners presenting a poster at the Palliative Care Congress held by the Association of Palliative Medicine titled “Evaluating the Role of Advanced Nurse Practitioner (ANP), in a Hospice Inpatient Unit (IPU) Setting, as Part of the Medical Team” detailing how we have developed this role.

In early 2022, we welcomed a Specialist Trainee and appointed a new Specialty Doctor. One of our Team has been appointed to a Specialist role. These changes should provide better resilience for the Team, especially on-call cover.

Nationally, Medical Examiners have been introduced to scrutinise Cause of Death certificates and provide greater safeguards for the public. This has been working well locally at Colchester General Hospital and, in March, we commenced a pilot project with ESNEFT to show how this can work in a community setting. This has been successful and now all Cause of Death certificates issued on our IPU have this additional level of scrutiny.

Following appraisals, Team members have identified their own training needs and areas of the service they would like to work on, and we look forward to developing these in the coming year.

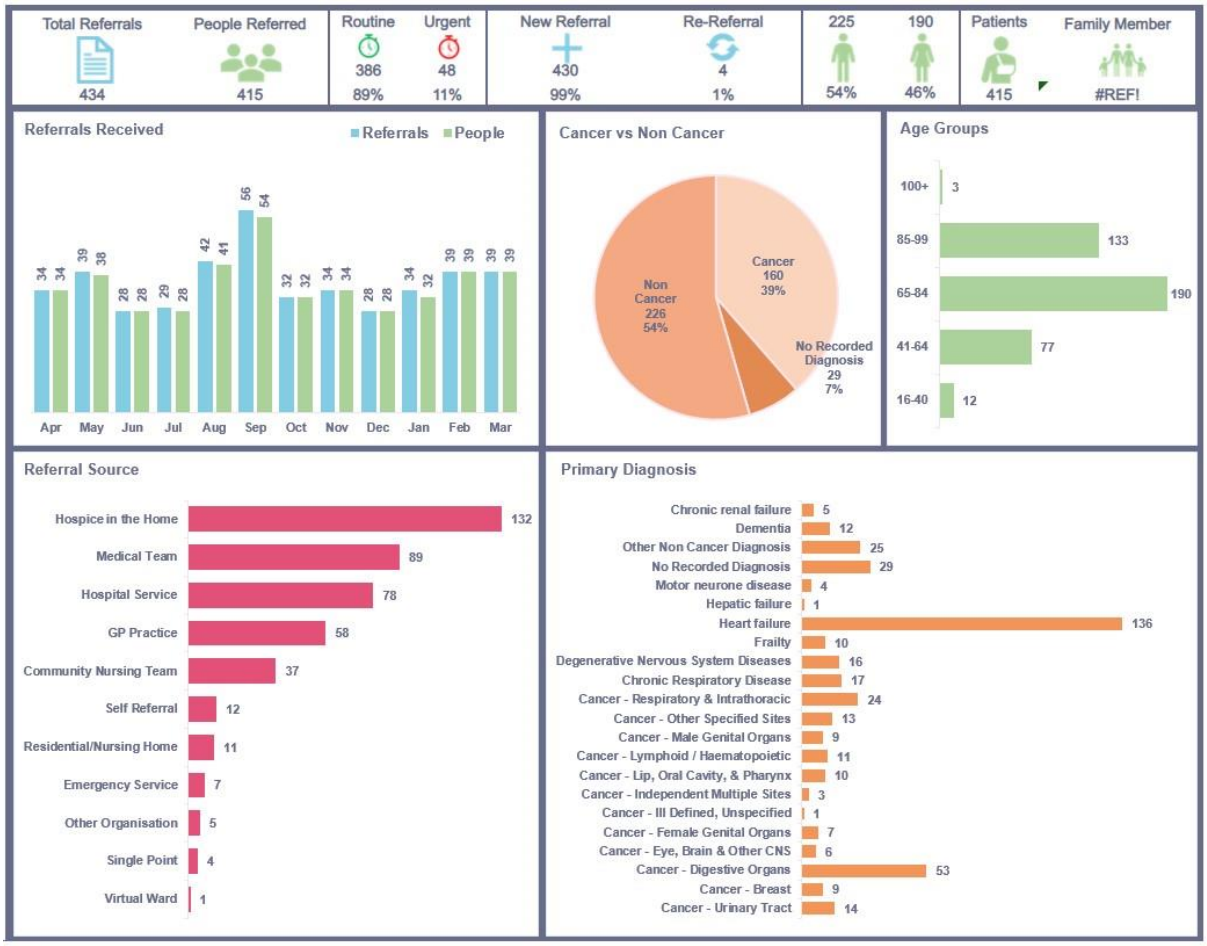

Figure 5 Medical Team referrals, 2021-22

3.4. Hospice in the Home MDT

Hospice in the Home (HitH) is the end-of-life hub for North East Essex. All referrals for the end-of-life hub are triaged by the Referrals Team and allocated to the appropriate healthcare professional. There was a total of 4,124 referrals, 2,543 of which were referred to HitH. HitH is divided into the Primary Care Network Clinical Nurse Specialists (PCN CNSs), the SinglePoint Service, and our Virtual Ward. Each is discussed below.

The HitH service works collaborates with the community nursing service. Community nurses have been spending a week with the HitH service as part of their induction when starting a new role. This has helped promote a more integrated way of working. There are three new palliative community nurses working for ESNEFT covering the Tendring area. They have a CNS allocated as a clinical supervisor and attend MDT meetings (please see below) when appropriate.

I would like to thank each and every one of St Helena staff to whom I spoke to or met during my husband's last difficult days. Their kindness, gentleness and professionalism was of enormous help to myself and my family in fulfilling his wish to stay with us at home. We had no idea the hospice services are so far reaching

3.4.1. PCN CNSs

We currently have eight CNSs, with a vacancy due to maternity leave and general turnover. Despite the role being advertised there have not been any successful applicants. As a result, the Team has reconfigured how it works and so is not completely aligned to the PCNs. Team members continue to have regular meetings with their GP surgeries and some of these continue to be PCN meetings.

Patients are allocated to one of four levels of care and these levels indicate which healthcare professional is a patient's key worker.

Level One – GP. The patient is supported by their usual General Practitioner.

Level Two – District Nurse or Community Advanced Nurse Practitioner. This is for patients with needs that can be managed by PCNs, those with less complex problems, and those going through a normal process of dying.

Level Three – Hospice CNS. This level provides for ongoing specialist palliative care for those with less intense needs or problems that can be managed monthly with input from various non-specialist teams. As part of this level, there will be pro-active planning for future care and the prevention of problems.

Level Four – Hospice CNS, complex care. This top level provides specialist palliative care; i.e. for complex symptoms, holistic needs, and/or a deteriorating patient. Care will involve weekly to twice-weekly telephone or video consultations and SOS; face to face visits if essential.

Patients on any of these levels have access to SinglePoint's 24/7 support.

The CNS Team have increased their face to face visits, with all patients receiving a face-to-face initial assessment, and their CNS establishing from this assessment what ongoing support they need. The CNS Team has received a total of 2,115 referrals.

A new, funded inequality CNS role has commenced. This person supports patients in the most deprived areas in Tendring,

ensuring have equal access to services they require.

3.4.2. SinglePoint

SinglePoint is a phenomenal service that makes all the difference when dealing with a terminal illness

SinglePoint is the central hub for all out of hospital end of life care and is the single point of contact for all for aspects of end-of-life care in the community. SinglePoint operates 24/7 and is supported by call handlers, rapid response senior staff nurses, health care assistants, and rapid response CNSs who are Non-medical prescribers (NMPs) and work seven days a week (but not overnight). Overnight, a rapid response senior staff nurse and Health Care Assistant (HCA) cover SinglePoint, answering calls and providing rapid response visits. If for any reason SinglePoint is unstaffed overnight, calls are diverted to the Community Gateway, run by North East Essex Community Services.

SinglePoint supports patients to meet their preferred place of care (PPC) and prevent needless hospital admission. To achieve this, SinglePoint works closely with NHS 111, the East of England Ambulance Trust, and community nursing services. The service provides rapid response visits from a senior nurse to address severe complex symptoms such as pain, dyspnoea, and vomiting (where these result from advanced life-limiting illness).

The Rapid Response CNS (NMP) Team advises community staff on caring for patients who require urgent or complex care and symptom control, provides rapid assessments where needed, coordinates care, and works to avoid hospital admissions. Where appropriate, and with consent, they will also add patients to the My Care Choices Register.

The Hospice in the Home MDT Physiotherapist, Occupational Therapist, and Therapy Assistant work closely with SinglePoint and the CNS Team. They typically support patients who receive Level 3 and 4 support. The Physiotherapist and Occupational Therapist meet regularly with the Community Rehab Team, discussing complex patients and offering support where required.

Counsellors and a Family Support worker provide psychosocial support to patients, families (including children) and carers. The aims of the service are:

Ensure patients and carers are offered psychological support appropriate to their needs and, where possible, to offer choices to meet the individual needs of patients and carers.

Provide a blended service using video or telephone contact where a home visit is not essential.

Provide confidential emotional support in an empathetic and non-judgemental environment to family members coping with a dying relative.

A member from each discipline of the HitH team attends a daily MDT meeting. The role of the MDT meeting is to present patients with specialist palliative care needs who are new to the service or who have ongoing complex specialist palliative care needs. The rationale of this is:

- to benefit from the expertise and perspective of the wider MDT.
- to aid learning and development.
- to enhance teamwork and communication.
- to ensure patient care is transparent and peer-reviewed.

During the year, SinglePoint received a total of 47,421 calls, and supported 2,297 people with 1,580 face to face contacts. The number of face to face visits we have been able to make has been diminished by the pandemic but our focus in the coming year will be to bring this number back up.

3.4.3. Virtual Ward

The Virtual Ward (VW) comprises a Clinical Nurse Manager, a Senior Staff Nurse, an administrator, and ten Healthcare Assistants (HCAs). We receive referrals from many different sources within the community, the Hospice, and the Hospital. We continue to provide twice a day personal care to patients in the home who are within the last few weeks of their life. We also have a rapid response team from the care agency Bluebird working with us who can provide care up to four times a day for patients in the last six weeks of life. This has meant that we are able to support more patients in the community to be able to be at home with their loved ones as their lives end. Our carers not only provide care for the patients but valuable support to the families. We received a great deal of positive feedback from relatives for our service.

We meet (via Microsoft Teams) three times a week with the Colchester General Hospital Discharge Team and Palliative Care Team and with the Continuing Health Care Commissioners to discuss hospital patients who want to go home to receive end of life care. We try to accommodate as many patients as we can, but if we have no capacity then the commissioners arrange a care package for them. This joint working has enabled us to ensure that patients are discharged home with the appropriate care in place. Our service also accepts patients

known to the Hospice for crisis care to bridge gaps before an ongoing care package can be provided by either Adult Social Care or the Commissioners.

We have recently been informed that we can increase our capacity with an extra four beds and extra hours from Bluebird. We are also changing our referral criteria so that we can support patients in up to the last twelve weeks of life. This will allow us to support more patients within the community to enable them to die in their preferred place of care and avoid unnecessary hospital admissions.

As a family, we cannot express how grateful we are for the service we received. The care and support our family member received was of the highest quality and we cannot thank the ladies who came to support him enough. He was far from the easiest patient, he could have been described as having a sense of humour or in the carers words 'he has character' but despite this they still ensured he was clean, comfortable and had everything he needed. They also ensured that as a family we were listened to and provided us with lots of support through a very difficult time. They made everything so much easier for us and nothing was too much to ask. This service meant that he was able to stay at home for his final days surrounded by his loved ones, exactly as he would have wanted.

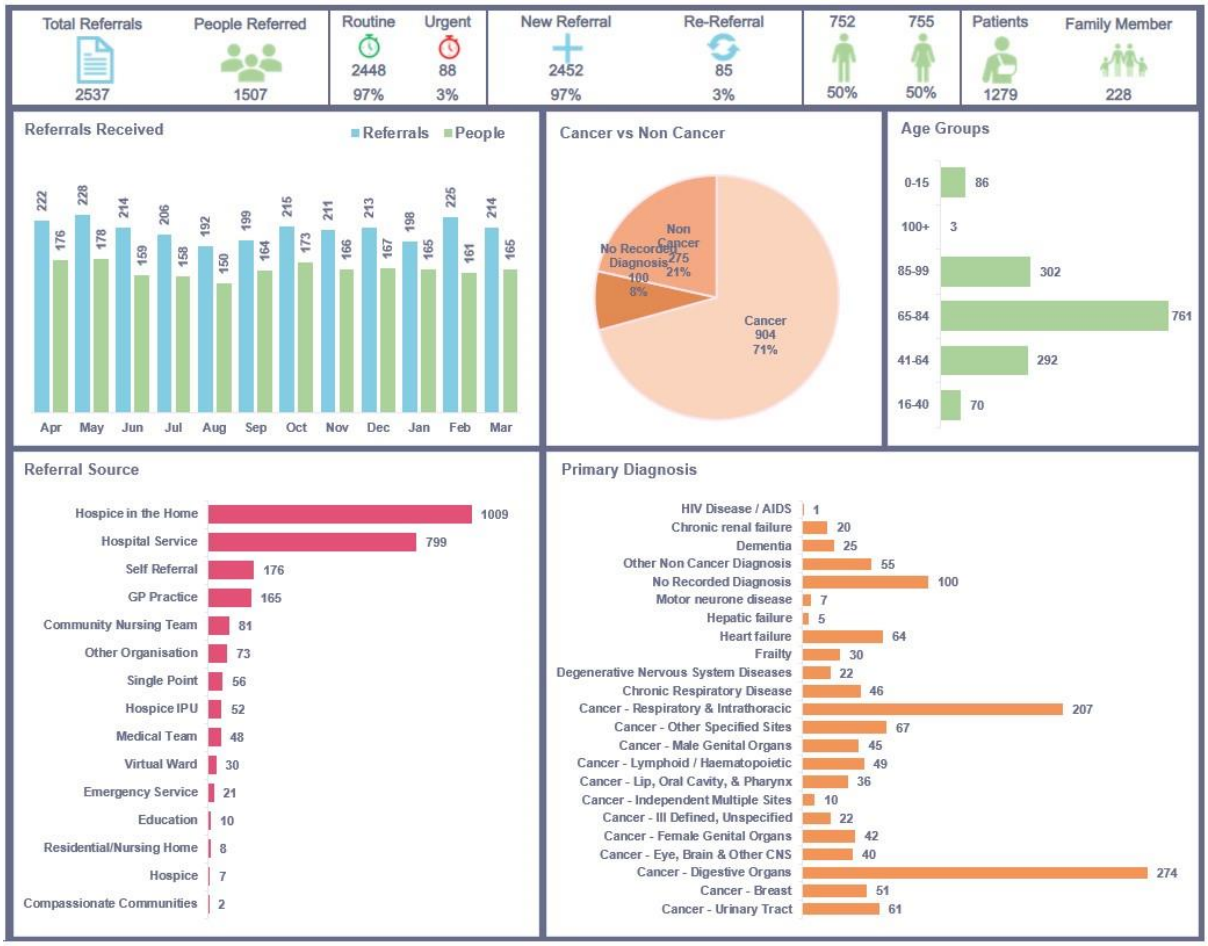

Figure 6 Community referrals, 2021-22

3.5. Compassionate Communities

St Helena's Compassionate Communities service provides essential care to people and their carers, who are experiencing death, dying, and loss. This includes a Bereavement Counselling Service for children and adults; management of chronic breathlessness for people with life-limiting illness; and person-centred spiritual, mental, and emotional support from our Chaplaincy and Complementary Therapies teams.

The Compassionate Community service also collaborates with local healthcare providers, community partners, and service users, to address inequalities in the uptake of Hospice services, through targeted outreach support via social prescribing and personalised care, and the Safe Harbour Project. These key services and outreach projects are described in more detail below.

A Compassionate Communities model also recognises that everybody has a role to play in supporting each other during times of health crisis and personal loss and that together they can make a difference. It encourages asset based community

development by working with local communities and developing relationships with existing networks, for example community groups, places of worship, and local businesses. These organisations are assets that contribute towards improving the experience of those at the end of their life, as well as increasing the resilience of the community to cope with issues related to death and dying.

Our Compassionate Communities approach to end of life care and bereavement support is progressing as planned, with services provided by the Hospice connecting with community networks to improve care and bereavement support for everyone. This has been enabled by the formation of local networks that promote information and resources and cooperate to identify and fill gaps in community care.

3.5.1. Bereavement Service

The Bereavement Service counsels and supports bereaved adults across North East and Mid Essex, irrespective of the cause of death. The Service consists of a manager, administrative coordinators, qualified counsellors, support workers, Bereavement volunteers, and placement students.

All our counsellors are registered with the British Association of Counsellors & Psychotherapists (BACP) and the service manager is also a member of The Association of Bereavement Coordinators (ABSCO). All staff and volunteers complete regular mandatory training and continued professional development.

The Service uses the four tier model for psychological support specified by the National Institute for Health and Clinical Excellence (NICE), and we use this for triaging clients and allocating them to staff. As a result of the pandemic, we moved from face to face work to telephone or video counselling sessions but have more recently resumed our face to face counselling support.

We feel the quality and effectiveness of our services have remained high and that they continue to be sought by potential clients and health professionals.

At the outset of the pandemic, we saw referrals decrease markedly, in line with other bereavement services in the East of England, but referrals began to increase steadily in 2021 and reached very high levels towards the end of that year. Our waiting list peaked at almost 200 people, the majority of whom required a Level 3 counselling intervention. To help reduce waiting, we successfully applied for funding

from North East Essex Clinical Commissioning Group (CCG) and recruited an additional 1.5 Whole Time Equivalent (WTE) Counsellors. Staff members returning from long-term sickness has also helped us reduce the caseload.

The Bereavement Service has also been tasked with developing a service suitable for bereaved children and adolescents and has received additional funding from the CCG to support 1.5 WTE child/young person Psychotherapists. We expect to receive this funding in each of the next four years. The new service will commence in July 2022.

During the year, the Bereavement Service supported four students from Colchester University Centre throughout their placements until they achieved their qualifying hours in March. Two of these students have asked for voluntary counselling positions from September 2022.

The service manager has also organised a placement pathway for Master's students from Essex University. Students who have completed the first year of their Master's and have been deemed competent to undertake practical support will care for bereaved clients. This is a mutually beneficial relationship and will add to the current list of training providers with whom the Service has a relationship. These students will begin their placements in October 2022.

3.5.2. Breathlessness Service

The Breathlessness Service provides intervention, education, and support for patients experiencing the often distressing symptom of breathlessness (dyspnoea) and/or associated symptoms of fatigue and anxiety at the end stage of their disease.

The Service currently consists of a Specialist Senior Staff Nurse (0.6 WTE) and Specialist Occupational Therapist (0.4 WTE), who was recruited in May 2022, following a year with no substantive occupant.

During the pandemic, all face to face clinics and groups were suspended, and the Service ran virtually via phone or video consultation. This provided an opportunity to experiment with remote working and support, which worked better than anticipated from both the clinician's and patients' perspectives.

The Service has in 2022 resumed face to face support and we will continue to offer a mix of both face to face contacts and phone or virtual consultation, based on patient need. We are also starting group therapy sessions in June 2022 and will look to collaborate with other peer-to-

peer groups offering similar services; for example, the group run by the British Lung Foundation, 'Breathe Easy'.

From our very first video consultation you have been so professional, supportive and extremely knowledgeable. As you know the last 12 months have been a rollercoaster of events, you have definitely seen me at my best and worst but you have always been able to provide me with a listening ear and I am so grateful to you and the service that the hospice provide.

3.5.3. Chaplaincy Service

The Chaplaincy Team leads on spiritual care within the organisation, raising the spiritual awareness and responsiveness of all staff.

The Team works across the organisation to meet the spiritual, pastoral, and religious needs of all patients, families, and staff. We have adapted our service to fit within the COVID-19-safe ways of working and, when lockdown restrictions prevented visiting, staff spent additional time sitting with patients who were lonely. We have served patients in the community by offering telephone support where possible.

Staffing requirements for this service are currently being reviewed, as we have been without a Lead Chaplain for some time. The Chaplain continues to support patients and their families on the IPU and within the community, and we have seen an increase in the number of funerals and internments of ashes.

The number of chaplaincy volunteers is low, so we aim to recruit more in the coming months. Some positive progress has been made through discussions with ESNEFT Chaplaincy and Butterfly Volunteer services regarding opportunities to collaborate.

A spirituality consultation period concluded at the end of Q4, with 60 respondents giving feedback on survey questions including:

- What does inner peace at end of life mean to you?
- What form of spiritual support do you think would be most useful to you in the last year of your life?

This feedback will now be reviewed and inform proposals to develop the Service to ensure that it best supports the local population.

3.5.4. Complementary Therapies

The Complementary Therapy (CT) service provides treatments that can be given alongside medical care to help manage wellbeing and health and optimise quality of life and quality of death. They focus primarily on the individual and their emotional, mental, spiritual, and physical health and may be helpful in treating symptoms such as pain and muscular tension, stress, hormone imbalances, depression, poor sleep patterns, lack of focus, lifestyle management, and anxiety. Although often referred to as pampering treatments, they provide a therapeutic experience that has an effective and noticeable positive outcome by helping manage symptoms. Effective pain relief and symptom control may help making medical and life-changing processes seem less frightening and often help the patient to better accept their situation and make the most of the time they have left.

Our CT service is available to our own patients, their families/carers, and clients of the Bereavement Service. The therapies are provided by dedicated and professionally qualified Complementary and Beauty Therapists who volunteer with us and includes PAT dogs. The Service is led by a professionally qualified CT Team Lead. We provide treatments in the Joan Tomkins building, on the IPU, and to patients in their homes.

After dealing with another year of restrictions caused by the COVID-19 pandemic, the CT Service is making positives strides to increase our service provision. We reinstated face to face support, seeing 192 people and providing 468 treatments. The most popular treatments are massage, followed closely by reflexology, aromatherapy, and reiki. We also support wellbeing by providing relaxation on-line links, and products such as aromatherapy inhalers.

Developing our Compassionate Communities links has been interesting, and the CT team lead has been part of the team facilitating the Compassionate Workplaces project. This project aims to increase the resilience of the community to cope better with issues related to death and dying and for local businesses to become more informed about the impact death and dying has on their employees. A toolkit has been developed to support this and the training is currently being delivered to all St Helena line managers. The same training will then be provided to our community workplaces and employers.

Together with St Helena's Learning and Development Team, the CT lead and education

practitioner has provided training through Provide and Essex County Council. This training was for care home managers and workers on how to implement 'Namaste Care,' a person-centred, multi-sensory support for those with advanced dementia. This was extremely popular and generated some excellent feedback and links to St Helena and further sessions are planned.

Finally, the CT Team lead continues to provide wellbeing and mental health information and support and guidance for staff and volunteers, including occasional treatments from our volunteer therapists.

Can't thank you enough for all the wonderful treatments you gave me.

3.5.5. Safe Harbour Project

We established the Safe Harbour Project to make good end of life care more accessible to minority, vulnerable, and hard to reach groups.

Over the past year, our Outreach Clinical Nurse Specialist had 410 contacts with 33 patients to support them in their end of life care. These patients included members of the BAME community and those with drug addiction, mental illness, and learning disabilities. In supporting these patients, links were built with other members of the multi-disciplinary team, which will serve to improve end of life care for members of these groups in the future.

The focus of the outreach role changed towards the end of 2021, with the CNS taking a sabbatical period of three months and then retiring at the end of the financial year. This resulted in a decreasing caseload that enabled the CNS to support and upskill the rest of the CNS Team in preparation for their departure.

We have now recruited a new Safe Harbour Project Manager, who is focused on continuing to deliver project aims and objectives, aligned with the collaborative compassionate communities approach that we have integrated across St Helena. This will include continuing to develop our cooperation with partners including Colchester's homeless charity, Beacon House, and Refugee Action. The Project Manager will also continue to tackle the issues in the Learning Disability Charter, specifically the high level of preventable deaths amongst patients with learning disabilities (LD). They have also produced some safe and appropriate DNAR documents for LD patients.

3.5.6. Outreach Social Prescribing

The overall aim of the Outreach Social Prescribing project is to improve outcomes for end of life patients within BAME and deprived communities. The number of patients from BAME and deprived communities accessing end of life support is lower than other sectors of the community, but we believe that by adopting the social prescribing and Compassionate Community methodologies we can encourage and enable more of them to access the support and care they need. These inequalities must be addressed if we are to improve outcomes for people at end of life and increase community resilience to cope better with issues related to death and dying.

This project commenced in September 2021 and has been delivered in partnership with local Community Voluntary sector agencies Community360 in Colchester and Community Voluntary Services Tendring. They have acted as host employers for two Social Prescribers, both contracted as 0.8 WTE posts and funded by the Masonic Trust and the End of Life Board for nine months.

To fully understand the need for, and barriers to accessing, end of life services requires building up a trusted relationship with the communities and this in turn requires dedicated time to listen and fully understand. By being introduced by, and working in partnership with, leaders who are trusted within their communities, our Engagement Officers will be in a better position to gain an understanding of the issues.

Working through the pandemic proved to be a big challenge for the project, exacerbated by changes in staff within the host agencies, but we have started to see a real upturn in engagement and referrals in Q4 (126) compared to Q3 (49). This has been stimulated by a Personalised Care directive from the North East Essex End of Life Board to provide support for people in care homes and additional funding for this purpose has extended the life of the project for a further three months.

3.5.7. Personalised Care Project

The My Care Choices Register (MCCR) proved an especially crucial tool during the pandemic for coordinating people's end of life care preferences (see page 43 for more details). Those registered are likely to be cared for in their Preferred Place of Care (PPC) and their chance of dying in hospital (which 96% of registrants do not want) is much less than for those

who do not record their preferences.

The Personalised Care project is focussed on enabling conversations with people in care homes thought to be in the last year of life, targeting areas with lower levels of access to the MCCR and deprivation. It also aims to enhance the personalised care aspects within the end of life programme and address known inequalities locally. It is hoped that feedback from these conversations will also be used to inform the End of Life Board's care planning.

The project was funded by the Alliance End of Life Board for an initial three months, which enabled us to recruit a Project Coordinator. The project's initial target was to add 100 people to the Register, a target already met. As a result of its success, we have since received an additional six months' funding to extend this post to the end of September 2022.

Throughout these very difficult months you all made a difference with a smile, a nod, a gentle move and tender touch and wise words.

3.5.8. Addressing Inequalities

We established the 'Addressing Inequality at EOL' working group to ensure that we take a strategic approach to embedding this agenda. This will build on the Equality Impact Assessment produced as a support document for the recent the NEE CCG application for Children's Bereavement Service funding.

We endorse the Hospice UK Report, "Equality in Hospice and End of Life Care; Challenges and Change," which highlights the hospice sector strategy to 'open up' hospice care. The first of its four pillars is to 'tackle inequality and widen access to hospice care.' The report identifies four key priorities:[2]

- timely access to care for non-malignant conditions,
- support appropriate to individual needs,
- improved understanding of unmet need in local populations; and
- better collaboration and joined up working across health and care systems

The working group will function as a community of practice that shares a focus on improvements in practice, active learning

[2] Hospice UK (2021). "Equality in hospice and end of life care: challenges and change," London: Hospice UK, p. 7.

through the process of inquiry, and a commitment to support implementation. It will support a Compassionate Community approach that brings professional and community assets together to deliver better health outcomes.

We are committed to addressing inequalities at end of life in collaboration with local healthcare providers, community partners, and service users, through targeted outreach support and interventions. As such, St Helena is also working with a cross Alliance working group, established by the end of life Board, that will focus on delivering the goals of the NHS Equality Delivery System (EDS2):[3]

- Goal 1 – Better health outcomes
- Goal 2 – Improved patient access and experience
- Goal 3 – A represented and supported workforce
- Goal 4 – Inclusive leadership

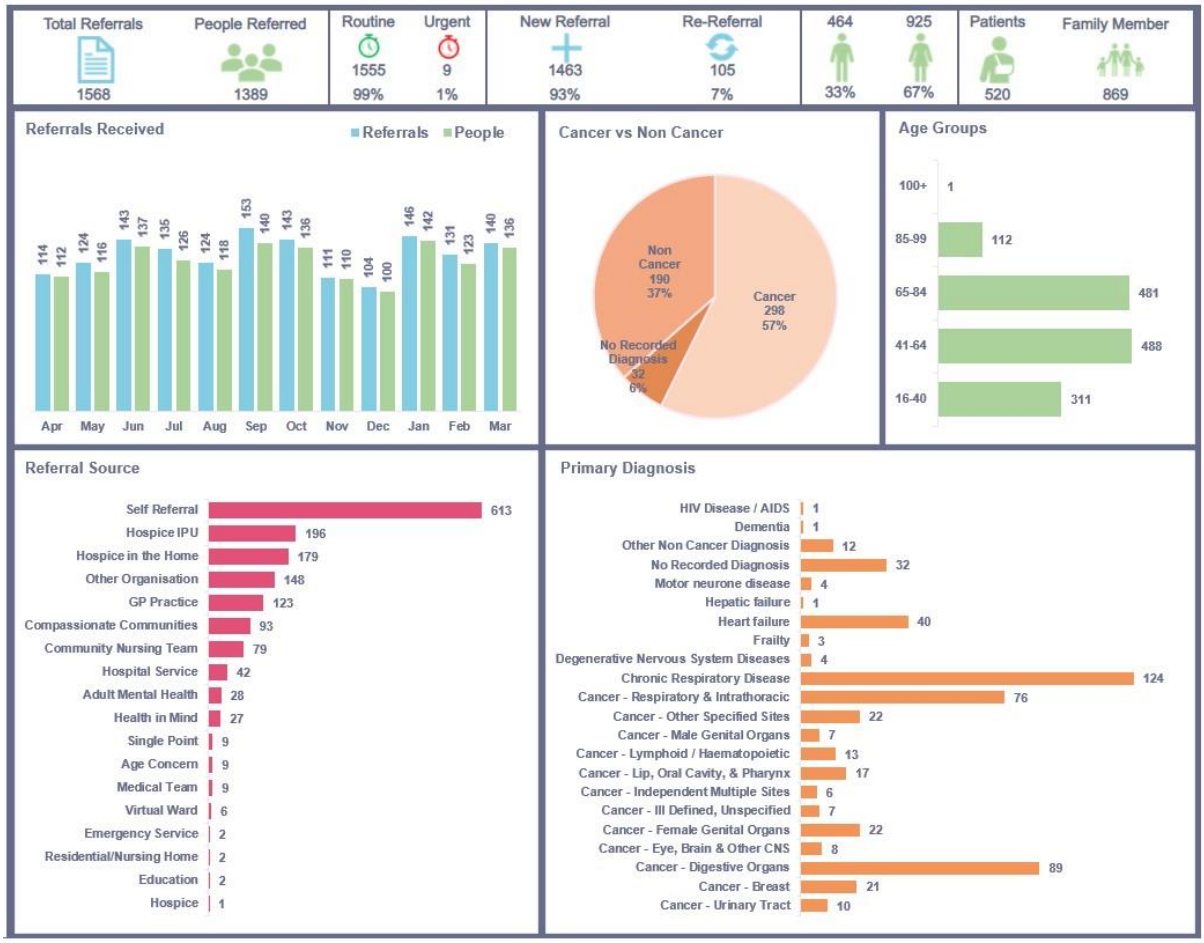

Figure 7 Compassionate Communities referrals, 2021-22

[3] NHS (2013) "A refreshed Equality Delivery System for the NHS; EDS2 Making sure that everyone counts," pp. 18-35.

3.6. MyCareChoices Register

Despite the pressures of the ongoing pandemic, local clinicians supported over 50% of people who died in 21/22 to record preferences for their future care.

Data quality was audited, and improvements put in place to ensure records were contemporaneous and accurate. This led to an apparent fall in the total number of people on the Register in March 2022, as records for people who had died, but had incorrectly remained active on the Register, were removed. The fields on the Register have been expanded to include free text on what is important to the person and what they would and would not want to happen if they were more unwell. This supports more holistic care planning. Projects to increase access to advance care planning in areas of deprivation and within care homes are working to address the inequality in access to the Register (see page 39 for details).

There are now 3585 people in North East Essex with a My Care Choices Register entry, including 898 people with a primary diagnosis of frailty and 830 with dementia.

In March 2022 only 21% of people on the Register had died in hospital, compared to 76% of people who died without an entry.

3.7. Safeguarding

During the year, St Helena saw an increase in safeguarding concerns resulting in complex case management and some referrals to adult social care. Complex case management consisted of discussing the safeguarding concerns in the daily multi-disciplinary team meeting and developing a clear plan of action. Action may involve assessing a patient's mental capacity and, at times making, a Best Interests decision to safeguard them or working alongside a patient to give them choice and control over their life, even if they make an unwise decision and the potential for harm continues. St Helena has recognised an increase in domestic violence with both female and male patients as victims. Our role has been to carefully assess individual risks with patient and together devise a clear safety plan (sometimes with the perpetrator as well). Where needed, we also involve partner agencies. To aid this, we have created a new safety risk plan in our patient administration system, SystmOne.

We have seen a mixture of safeguarding concerns that have required referrals to adult social care. There have been several referrals raised against third parties, such as care homes or domiciliary agencies, involving

potential neglect resulting from inadequate staffing levels during the pandemic. Some of these referrals have illustrated that care staff have not always recognised end of life care needs or responded promptly to patients experiencing pain or distress.

During the year, we were also required to raise a safeguarding referral against St Helena after an inpatient made an allegation of restraint and expressed concern that domiciliary care did not arrive following their discharge. This allegation led to the local authority requesting an in-depth internal investigation as part of a Section 42 enquiry. Social Care concluded that the allegation of restraint was unfounded, but the concern in relation to care not arriving was upheld. We have learnt lesson from this and changed certain processes, both of which we have communicated to staff. Social Care have now closed the referral.

We have changed the safeguarding structure at St Helena to having one lead for adults, children, and Prevent, and three safeguarding deputies, one in each of the clinical areas. We have developed safeguarding champion roles to embed safeguarding across the organisation and have started to recruit to these positions. We are strengthening our safeguarding culture around the maxim that safeguarding is 'everyone's business.' We have created a Safeguarding Workplace group for all hospice staff, and we regularly post Hot Topics, national and local safeguarding news, and educational items.

St Helena's safeguarding poster has been refreshed to be more user friendly and identifies the Safeguarding Lead and deputies. Our Communications and Marketing team are assisting in developing safeguarding boards in all three clinical areas to provide user-friendly information on mental capacity, deprivation of liberty, and – soon -- liberty protection safeguards.

Now we are coming out of the pandemic, we aim to re-introduce a face to face induction programme for all new clinical staff, which will cover St Helena's safeguarding structure, policies, documentation, and local statutory referral pathways and processes. We have planned Bespoke Trustee training that includes the Charity Commission's 10 safeguarding actions, and how to recognise and report abuse. We are arranging training sessions for all Trustees and the Chief Executive to attend.

In collaboration with NEE CCG and the Local Authority, we have made substantial changes to our Adult Safeguarding Policy & Procedure (008). As a result, we have reviewed the levels of training we provide to all employees and volunteers against

the "Adult Safeguarding: Roles and Competencies for Health Care Staff 2018; Intercollegiate Document."[4] We are in the process of looking at various training packages to deliver the training required. We currently are not compliant with the recommended adult and children training levels, and therefore have two live safeguarding risks logged on our Risk Register with a plan of action to work towards compliance. As a result of the safeguarding workload, we are exploring additional external support to assist with revising the Safeguarding (Children) Policy (009a) and Safeguarding (Children) Procedure (009b), which are now past their review dates. We also plan to adopt the Intercollegiate training framework, as outlined in the most recent edition of "Safeguarding Children and Young People: Role and Competencies for Health Care Staff."[5]

3.8. Education & Training

In April 2021, our Practice Educators were able to return to their roles, having previously been seconded to other services during the pandemic, and work with teams to define competencies and identify training needs. Initially, their focus was on socially distanced learning including signposting staff to online resources and producing their own videos.

As we were able to reintroduce some face to face sessions (initially one to one or small groups), were relaunched practical sessions such as Manual Handling and Basic Life Support.

Until September last year, our training rooms (Beeches) on the Myland Hall site had been used to house our SinglePoint Service. Returning them to training rooms has facilitated more face to face teaching sessions, including Team days, and these have been good for staff morale as well as education. It has also allowed us to offer some in person teaching to health care professionals from outside St Helena.

Over the course of the year, we have developed a blended approach to delivering training, hoping to take the best of virtual and face to face formats. For instance, we have split our Advance Care Planning (ACP) and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions training into an online session,

[4] Royal College of Nursing (2018), "Adult Safeguarding: Roles and Competencies for Health Care Staff; Intercollegiate Document".

[5] Royal College of Nursing (2019) "Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff; Intercollegiate Document".

which covers the knowledge element, and small group face to face sessions for practical roleplay. We continue to review and develop our methods, but a hybrid approach will increase access, make use of the wealth of online training available, and maximise engagement.

We suspended appraisals during the pandemic but reintroduced them during Quarter 4 of 2021-22. These has been a valuable opportunity to evaluate the learning and training needs of both individuals and staff groups, and this will form the basis for planning and promoting learning and development in the future.

Since the autumn we have joined forces with St Elizabeth Hospice in Ipswich to become "Hospice Education" a single provider of Palliative and End of life training and education for East Suffolk and North East Essex. We think this will allow us to draw on the wealth of expertise at both sites to offer a wide range of opportunities to staff working at the two hospices and across the local healthcare Alliances. The new team has worked hard at integrating, sharing experience, and co-producing sessions. The official launch was delayed by the impact of Covid in early 2022, finally happening April 2022.

3.8.1. Mandatory Training

St Helena requires staff to complete various modules of eLearning during induction and to refresh these at regular intervals. We manage this training using a third party, cloud-based system called MyLearningCloud, which provides reporting and automatic reminders when staff when training is overdue. Non-compliance is pursued at staff supervision and, if persistent, results in disciplinary action. In the two tables that follow, we present our training compliance as it stood at the end of 2021-22, broken down by clinical and non-clinical staff.

Clinical

Course	Compliant	Non-compliant	Compliant (No.)	Non-compliant (No.)
Cyber Security Awareness	100.0%	0.0%	135	0
Display Screen Equipment	97.5%	2.5%	78	2
Document and Record Keeping	98.2%	1.8%	110	2
Domestic Abuse	100.0%	0.0%	10	0
Equality and Diversity	100.0%	0.0%	136	0
Fire Prevention and Awareness	96.2%	3.8%	131	5
Food Hygiene Awareness	100.0%	0.0%	65	0
Health and Safety Awareness	95.4%	4.6%	130	6
Infection Control	95.6%	4.4%	114	5
Lone Working and Personal Safety Awareness	97.3%	2.7%	73	2
Manual Handling	95.9%	4.1%	121	5
Data Protection	97.7%	2.3%	133	3
Mental Capacity Act	98.4%	1.6%	128	2
Safeguarding Adults	100.0%	0.0%	136	0
Safeguarding Children and Young People	100.0%	0.0%	136	0
Safeguarding (Combined)	100.0%	0.0%	272	0

Table 2 Mandatory training compliance (clinical)

Non-clinical

Course	Compliant	Non-compliant	Compliant (No.)	Non-compliant (No.)
COSHH	100.0%	0.0%	24	0
Cyber Security Awareness	100.0%	0.0%	185	0
Display Screen Equipment	98.8%	1.2%	163	2
Equality and Diversity	99.5%	0.5%	184	1
Fire Prevention and Awareness	99.5%	0.5%	184	1
Health and Safety Awareness	99.5%	0.5%	184	1
Infection Control	100.0%	0.0%	18	0
Lone Working and Personal Safety Awareness	95.5%	4.5%	22	1
Manual Handling	98.8%	1.2%	163	2
Data Protection	98.3%	1.7%	182	3
Safeguarding Adults	98.3%	1.7%	182	3
Safeguarding Children and Young People	97.8%	2.2%	181	4
Safeguarding (Combined)	98.1%	1.9%	363	7

Table 3 Mandatory training compliance (non-clinical)

3.9. Freedom to Speak Up

Freedom to Speak Up Guardians (FSUG) are a product of Sir Robert Francis' 'Freedom to Speak Up Review' following the Mid-Staffordshire NHS scandal. Local guardians support staff to raise concerns about care -- anonymously if necessary -- and so help foster a positive culture of continuous improvement in patient care.

Since April 2021, we have had a team of three guardians: the Head of Quality & Compliance, an Advanced Nurse Practitioner, and a Trustee. All three have completed online training.

During the year, only one communication was received. This did not become a 'freedom to speak up' matter, but the Lead Chaplain at the time provided pastorale care.

3.10. Quality of the Environment

Social Distancing Measures and Keeping premises COVID-19 secure

During the year, we maintained social distancing rules, supported by signage, floor stickers, regular updates to teams, and bulletins and updates on our online staff forum, Workplace. We made several adjustments to our COVID secure arrangements; specifically, reducing room capacities when national restrictions increased because of the Omicron variant.

We manage COVID risk management controls, including risk assessments for physical premises, using the Risk Register module of our Sentinel information management system, under the supervision of our IPC Group.

We recruited a Volunteer Social Distance Champion to audit our premises weekly and advise staff on proper social distancing. We also created a specific training presentation on social distancing for new recruits.

During Quarter 4, we were able to relax some guidelines, particularly across non-clinical sites, and phase out the social distancing audits. The Infection Prevention and Control (IPC) Group designated the Myland Hall site as a healthcare setting, so type 2R mask restrictions remained in place.

Personal Protective Equipment and Covid Testing

The Estates Team continued to order, store, and distribute PPE for the Myland Hall site throughout 2021-22. During this period, the PPE hub based at St Elizabeth Hospice in Ipswich was shut down, and stocks are now provided directly to site by NHS Supply via a third party supplier. The Team also managed the supply of PCR and LFD, ensuring sufficient stocks were always held on site to support surge testing during potential outbreaks.

Patient, Visitor and Workforce Safety

Parking at our Myland Hall site has been a longstanding problem for patients and families. During the year, we have invested significantly to improve facilities and create an additional 13 spaces. We have also improved the lighting, making our carparks safer for pedestrians, especially during the winter months. We have also erected “No idling” posters across the site, particularly around Inpatient bedrooms near to parking spaces, to improve air quality.

In March 2022, we commenced work to repair the Farmhouse window frames, which are listed

structures. Once complete, this will improve ventilation in our Farmhouse offices.

Teams. We present the results of this in Figure 8, above.

The action plan resulting from this audit identified 37

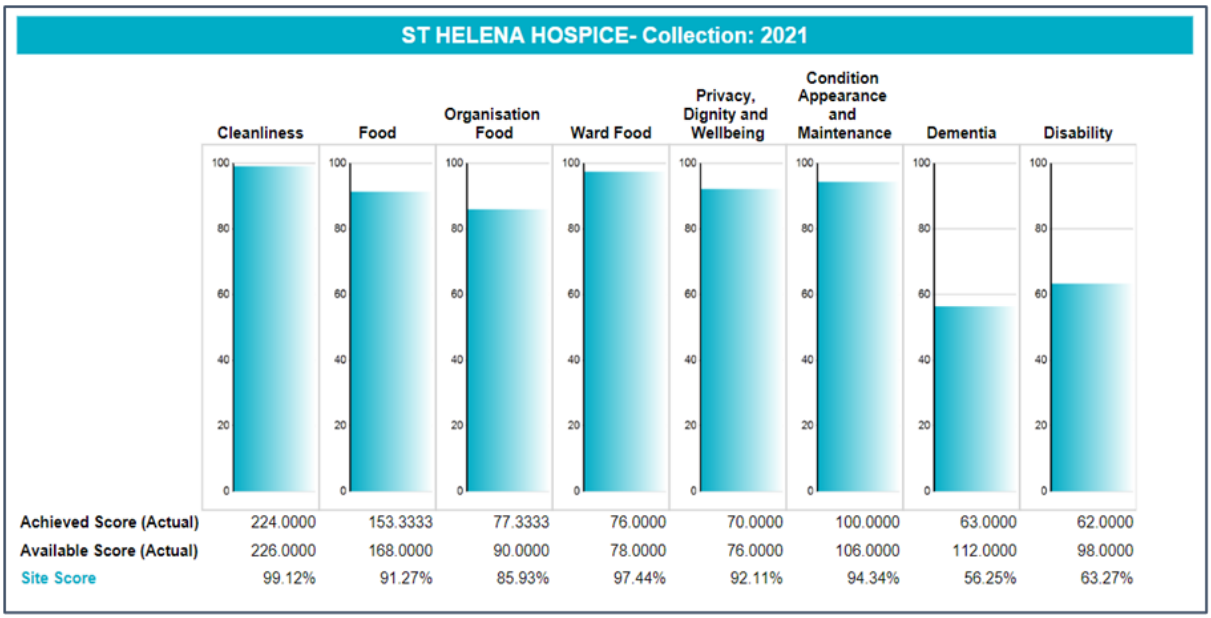

Figure 8 PLACE lite score summary

Patient Led Assessment of the Care Environment (PLACE)

The NHS PLACE assessment programme was frozen during the pandemic and has not yet been reinstated. Instead, providers have been encouraged to take part in "PLACE lite" assessments, which have the same rigour as the full assessment, but focus on a single location. Given the pause since the last full audit, we decided to carry out an annual assessment across the full healthcare estate in June 2021. We conduct PLACE assessments with a group that is 50% service users, volunteers, or Trustees, and 50% from the Estates and Facilities and the Quality and Compliance

improvements, all of which we have completed or are in progress. One of the key items was to replace worn carpet in our IPU corridors. The Senior Management Team approved expenditure for this project, which is scheduled to commence in Quarter 1 of 2022. Another notable improvement was to install Hearing Induction Loops to improve the experience for persons hard of hearing (see Figure 9 on page 51).

The PLACE lite assessment programme was reinstated for March 2022, where the Joan Tomkins Centre was assessed. This identified 18 improvement actions of which 13 are so far complete.

The next PLACE lite assessment is due in Q1 of 2022-23.

Staff Health and Wellbeing

We kept our 'Wobble Rooms' open for the majority of 2021-22 but phased them out as usage dropped significantly during Quarter 4. These rooms allowed staff to reflect in a quiet and respectful space and so help manage stress resulting from the pandemic.

Figure 9 An induction loop in use in our Joan Tomkins Centre

Throughout the year staff also had access to fresh produce from the Fair Share initiative, which was particularly beneficial when stocks from supermarkets were limited by supply chain difficulties.

During Quarter 4, we reviewed our Inpatient menus following feedback from the Staff Voice Forum. We added healthier meals, such as baked potatoes with fresh fillings, at a subsidised cost and the uptake has been encouraging. To ease pressure on staffing changing facilities, we also converted a meeting room to an additional changing room with two extra cubicles and a hanging rack.

As the pandemic subsides, we plan to reinstate a larger welfare area in the Learning & Development Centre during Quarter One of 2022-23.

Tendring Centre Vaccination Programme

Our Tendring Centre in Clacton continued to host the CCG Vaccination programme throughout the year, with over 100,000 vaccinations being provided. The programme ended in March 2022 and the St Helena Estates and Facilities Team co-ordinated the site's closure in partnership with the Suffolk and North East Essex CCG team. This included donating spare PPE to local charities and to a field hospital in Ukraine.

3.11. Volunteering at St Helena

St Helena is fortunate to have many dedicated volunteers who contribute a great deal of time to the charity, bringing skills, interests, and individual experiences that complement

and support the care we offer to our patients and families.

It has been a difficult two years since the start of the pandemic, which has impacted on how much volunteers have been able to carry out their roles. most of the Retail teams have returned, there are many in patient facing roles who have yet to re-join us.

To ensure the safety of volunteers, patients, and staff, the Volunteer Services Teams has done a lot of work over the past two years to ensure that volunteer completed health questionnaires, and COVID Pass letters were collated for those in patient facing roles. We carried out more than 700 initial risk assessments (documented on Sentinel risk management system) and, more recently, updated them line with current guidelines.

We are continuing to work with line managers to regularly review volunteers in their teams and respond to any recruitment requirements. Our aim is to target volunteer recruitment ensuring the right volunteers are recruited into roles to support service requirements where needed and to return volunteer numbers to pre-pandemic levels or higher.

The restructure of Patient & Family Services in 2020 and, more recently, the sale of our Tendring Centre in Clacton has meant that some volunteer roles ceased to exist. This caused a slight decline in volunteer numbers, as most of these volunteers are deciding not to transfer to alternative roles within the organisation. The leaver numbers during the year include those who we have not been able to contact since March 2020 and have removed from the volunteer database.

Having had a reduced presence in the local community because of COVID, we are working with the Marketing Team to focus on social media and online platforms for recruitment. The positive results of this are evident in that recruitment, particularly in Retail teams, continues to increase despite us not being out and about in the community for face to face engagement.

We now have the highest number of Retail volunteers we've ever had. Working closely with the Retail Management Team, we analyse capacity reports to prioritise recruitment for those shops with the highest need so that we can specifically target our approach.

We have updated our volunteer processes to make recruitment and onboarding a smoother journey so that we handle applications even more efficiently, thereby ensuring volunteers feel involved and valued from the beginning. We will soon be reintroducing Volunteer line manager training to ensure that all our Volunteers receive the calibre of support they deserve.

We continue to support volunteers to complete their mandatory training and Disclosure and Barring Service (DBS) checks, and we have restyled our monthly compliance reports to volunteer line managers to aid them in keeping their volunteers compliant. The Skills Pathway, evidence based learning, is open to all volunteers to participate in and, despite the lockdowns, we had 19 Retail volunteers certify in 2021.

We increased our communications with volunteers increased during the pandemic and received some very positive messages and feedback. We will continue to communicate effectively, so that volunteers feel included and up to date on relevant information, thereby making them confident ambassadors for St Helena.

We are delighted that, after a two-year hiatus, we could bring back our Volunteers Thank You Day and Long Service Awards. We had five volunteers in 2021 who completed 40 years of dedicated service, which is a fantastic achievement. They each received a ruby engraved vase as a thank you for their contribution over so many years.

Volunteer statistics 2021-22

- 246 Volunteers left the organisation.
- 226 new starters joined the organisation.
- By end of year, we had 779 Volunteers.
- We benefited from an estimated **140,000** hours of Volunteering during the year.

During the coming year, we plan to continue improving the Volunteer experience, and maximise our volunteer skill set in all areas of our services.

You have always been incredibly polite, respectful & professional, despite my many tantrums & general misbehaviour! We always felt well supported by you & you helped us through dad's illness – thank you. Most importantly, you empowered us so dad achieved his wish to pass away at home – again thank you.

3.12. Quality Markers

3.12.1. Tissue Viability

Although pressure ulcers are inevitable when caring routinely for patients who are near the end of their lives and have weakened skin, we record all pressure ulcers, regardless of origin or severity, as incidents on our Sentinel system. It is our standard that all patients be assessed for ulcers within six hours of admission. Table 4, below, shows all the ulcers reported this year broken down by the time it took us to assess the patient.

Time to assessment	No.
Within 6hrs	195
6-24hrs	27
24-48hrs	2
Grand Total	224

Table 4 Pressure ulcers by assessment time

Our IPU nurses report all pressure ulcers to the Tissue Viability (TV) Lead, who then investigates them and determines whether all appropriate safeguards were in place. If not, we deem the ulcer 'avoidable.' Table 5 show how many ulcers were deemed avoidable, broken down by whether they were new or present on arrival (POA).

Origin	Unavoidable	Unknown	Grand Total
New	104	0	104
POA	119	1	120
Grand Total	223	1	224

Table 5 Pressure ulcers by origin and avoidability

Completing investigations promptly has been a challenge at times during the year because of staffing issues. This has meant that investigations have not always been completed in the ten working days standard timeframe. The TV Lead continues to monitor this.

During Quarter One, we recommenced the quarterly Tissue Viability Group following a hiatus during the pandemic.

During Quarter Two, we gave a training presentation, "Pressure Area Care: Identifying Pressure Ulcers and Moisture Lesions" at the IPU Team Days and as part of the MDT teaching schedule. We also updated our IPU Tissue Viability Policy (133) so that the Safeguarding Lead is notified of all Category 3 and 4 pressure ulcers. This promotes discussion between the TV lead and the Safeguarding Lead as to whether a SETSAF (adult safeguarding concern) needs to be raised.

During Quarter Three, we made the evidence based decision to cease using pillows to elevate

heels, and in Quarter Four, we purchased Repose wedge cushions to support heel offloads in bed to minimise pressure damage.

Pressure area documentation has been outstanding in the last year, and this has been reflected in the excellent results in all three TV documentation audits (see page 14 for details of clinical audits). We have therefore felt able to reduce the frequency of two of these audits from quarterly to six-monthly. We will do the same for the third if the April 2022 audit continues to show excellent results. The TV Lead has thanked the staff for their ongoing high standard of documentation and vigilance around pressure ulcers and moistures lesions.

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

3.12.2. Falls

Falls cannot be prevented in terminally ill patients, as human behaviour can sometimes be unpredictable. Pain, fear, confusion, emotional distress, hallucinations, and disorientation to a new environment can often add to the physical changes associated with the falling patient. However, safeguarding our patients is paramount and as a result we are always looking at the data we collect to prevent or reduce the risk of falls.

All patients admitted to the IPU receive a holistic assessment that also includes Manual Handling, falls risk, and bedrails assessments. We review these assessments regularly during the patient's stay. As patients with terminal illness may vary day to day, we will reassess them if their risk of falling changes. All patients are asked to call for assistance when mobilising to the bathroom or getting out of bed; however some patients forget to call, they want to remain independent, or they do not want to bother people. There are posters in every room reminding patients to "call don't fall."

Our Falls Lead analyses our falls data quarterly to see if there are any ways of reducing the risks and improving our practice. This data comes from the falls incident reports, which staff are required to submit within 24 hours of each fall being detected. Staff have been 100% compliant in completing these reports so that they can be investigated and then referred to the Risk & Incident Group for review. During 2020-21, we closed 65 falls incidents. Below, we present selected statistics.

Harm level	No.
1 - No Harm	39
2 - Low Harm	24

Harm level	No.
3 - Moderate Harm	1
4 - Severe Harm	1
Grand Total	65

Table 6 Falls by harm level

39 of the falls recorded caused no harm, while a further 24 resulted in low harm requiring some basic first aid. The two incidents resulting in moderate or severe harm necessitated a hospital admission. These events were thoroughly investigated, with the severe harm fall logged with our CCG as a Serious Incident. A comprehensive investigation found it to have been unavoidable. Where necessary, we took to ensure best practice and quality of care.

although she only needed to use the service for a short period of time, she felt that everyone treated her with respect and like a long lost friend.

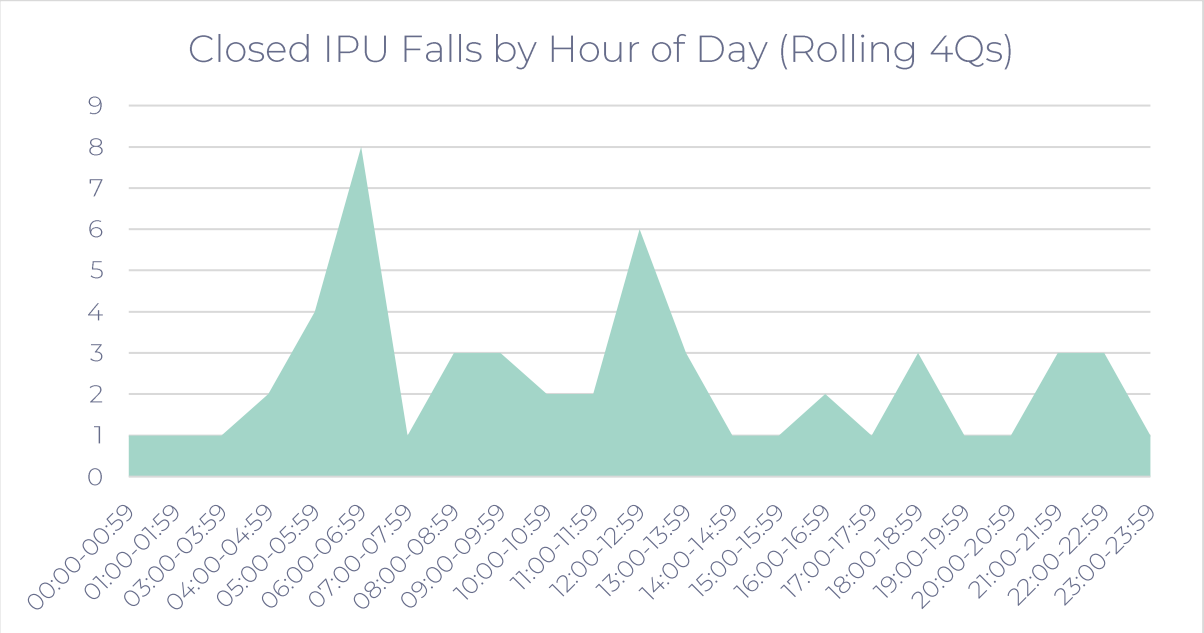

Figure 10 Falls by hour of the day.

We break down falls by the hour of the day they occur, and this is shown in Figure 10, above. Please note that we could not establish the time of some falls because they were unwitnessed by staff and the patients did not know, so these are excluded from the chart. As can be seen, falls peak between 06:00-08:00 hrs and 12:00-14:00 hrs, which we associate with the activities of daily living for our more mobile patients.

Did fall involve toileting?	No.
Yes	26
No	36
Unknown	3
Grand Total	**65**

Table 7 Falls by toileting

26 of the 65 closed falls involved toileting. We use grab handles and toilet seat raises to assist with transfers on and off toilets and all likely fallers are encouraged to call for assistance. Urgency to prevent soiling often makes patients rush and more likely to fall, especially if they get up quickly and their blood pressure falls, which can make patients very light headed or dizzy. Blood pressure changes are monitored regularly, and medications are always reviewed by the Medical Team.

Origin	No.
Bed	33
Chair	5
Commode	1
Standing / Mobile	20
Toilet	3
Transferring	3
Grand Total	65

Table 8 Falls by origin

As can be seen in Table 8, above, 33 falls occurred when patients rose from their bed. Patients often forget that the edge of the mattress is soft and bed rails are not used often as they can cause potential falls risks if the patient is agitated confused. We now have low rise beds, which can be lowered to minimise harm should a patient slip. This also makes transferring to and from the bed to the chair easier for shorter patients.

Bed rails in use at time?	No.
No	64
Yes	1
Grand Total	65

Table 9 Use of bed rails

Bed rails may be more of a hazard and need to be risk assessed before use. They cannot be used to keep a patient in bed a safely without their consent. If a patient does not have capacity, a mental capacity assessment needs to be completed and a Best Interests decision made before bed rails can be used. These decisions must be discussed first in the Multidisciplinary Team and be clearly documented to

evidence there was no inappropriate deprivation of liberty.

Cognitive impairment?	No.
Acute confusion/ delirium	28
None	37
Grand Total	65

Table 10 Falls and cognitive impairment.

As can be seen in Table 10, above, confusion and agitation contributed to 28 of the 65 falls closed during the year. Unfortunately, these are afflictions commonly associated with end of life, even with modern medications.

No. of falls during present admission	No.
No data	9
2	9
0	29
1	15
3	2
5	1
Grand Total	65

Figure 11 Falls during admission

The number of falls in one admission is variable and depends on the patient's condition. A person with a brain tumour and impaired memory is very likely to forget they are less mobile and to have challenging behaviours that them to fall repeatedly during their admission. Where we can, we provide 1:1 care to reduce the risk of these patients wandering and falling.

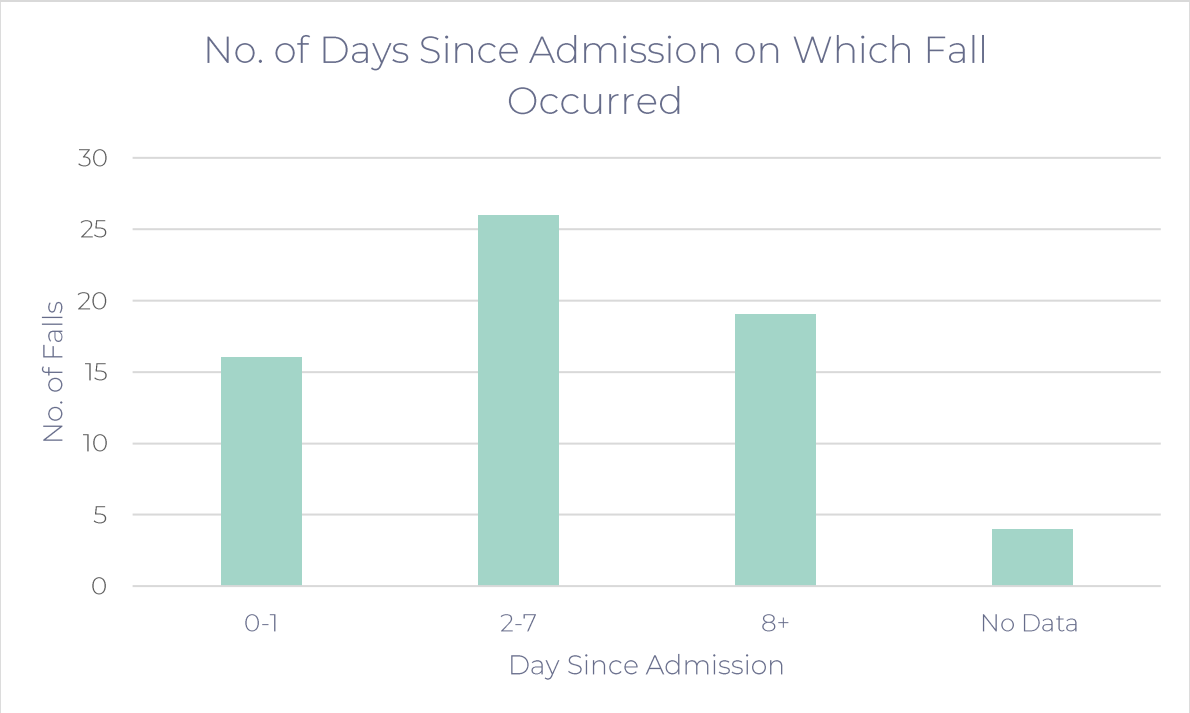

Figure 12 Falls by days since admission.

Finally, in Figure 12, we see that 16 of the falls occurred on the first day of admission. This may have resulted from disorientation in a

new environment, a change in the size of the bed or the patient's condition. 16 falls occurred during nights 2-7 and 19 after eight or more days. These later falls might have resulted from deterioration in the patient's performance status or medical condition.

The Falls Group, with the support of IPU Matron, continues to look at the data and meets quarterly. The Group comprises the Falls Lead, the Physiotherapist, the Discharge Coordinator, a Clinical Support Worker, the Manual Handling team, the IPU Matron, and the Quality Improvement and Patient Safety Matron. Over this last year, the Group has reviewed the Inpatient Unit Prevention and Management of Falls Policy and Procedure (055) and has been influential in discussing procuring equipment helpful to the at risk patient. We are currently working with the Estates and Facilities Team to see if we can improve the use of sensor mats and the call system to alert staff if an at risk faller is trying to get out of bed. With the use of integral bed sensors, low rise beds and appropriate seating, we hope to reduce the number of falls. We are currently researching seating on the IPU and propose to purchase riser recliner chairs with integral pressure relief and sensors, which can be used in the chairs to reduce falls risk and improve tissue viability.

It is now six weeks since Dad died, and much of our time has been taken up by the administrative procedures following his death. However, we have also had time to think, and appreciate how easily the 'caring community' helped us to cope with his last days. From when I dialled in on Saturday morning until the following Wednesday when he died the NHS and the hospice swung into action so efficiently and caringly.

3.12.3. Medicines Management

Our Medicines Management Group supervises an ongoing programme of auditing of our prescribing and administration on the IPU and investigates all incidents that are reported. This Group, under the leadership of one of our Palliative Medicine Consultants, regularly analyses and codes our medicines incidents to look for causes and trends.

Medicines errors are reported via Sentinel and analysed by the Clinical Medicines Management Lead for prescribing errors, and by

the IPU Matron for administration errors. When we detect an error made by a third party provider, we report it to them. Our Controlled Drugs Accountable Officer (CDAO) also reports controlled drug (CD) errors quarterly to our Local Intelligence Network.

An increase in medicines errors on the IPU prompted an extraordinary meeting, held with the Hospice MDT Matron, Quality Improvement and Patient Safety Matron, Senior Sister, and Operational Medicines Management Lead. Various actions were undertaken to address errors, and they have decreased as a result. The Group continues to review the ongoing situation regarding the COVID-19 pandemic, and amends policies as appropriate.

Activity by the Group this year included:

- Lock boxes – policy finalised and now being used on IPU and in community.
- Discharge medication documentation ('TTO') on SystmOne – working party meeting regularly
- Missed dose audits – performed quarterly to ensure there are no ongoing issues with delays in medication
- Policy updates: new Clostridium Difficile and Unexplained Diarrhoea Procedure (044) as per NICE guidance (in line with ESNEFT); updated Anaphylaxis Policy & Procedure [021] with new advice from the Resuscitation Council.
- Review of electronic prescribing – what we have learnt and areas for improvement.
- Agreement with ESNEFT regarding delivery of medications directly to patients at home – implemented in November 2021.
- St Helena has taken over responsibility for prescribing all community Alfentanil and Lanreotide – prescribing caseload created to ensure timely prescriptions for outpatients.
- Ongoing audits on Self Administration of Medication (SAM) and provision of patient information.
- Implementation of new Standard Operating Procedures: CD Destruction in Patients' Homes; CD Destruction Within IPU; FP10 Record Keeping (and updated databases); EOL Medicines in the Community; Administration of Medicines (including CDs) in a Patient's Home; Return of Unused Medicines Including CDs to a Community Pharmacy;

Transport of CDs in the Community.

- Implementation of specific patient counselling for patients discharged on concentrated opioid liquids -- oxycodone and morphine -- now documented on the TTO by Pharmacy and in the notes by the Care Co-ordinator during discharge process (joint initiative with ESNEFT).
- Implementation of 'call back' system for new medications in the community, ensuring patients receiving new medication get appropriate information on doses and what to do with stopped medicines.
- Implementation of SystmOne template allowing community staff to record collection and delivery details of medicines to patients' homes.
- Stock list review, ensuring missed doses are addressed appropriately by stock holding on IPU.
- Flammables drugs/products – leaflets available for patient information on topical medication.
- Increased support for community staff from Operational Medicines Management Lead along with a designated medicines management link CNS.
- Working towards new anticipatory prescribing templates for GPs – Medicines Management Group to trial the template prior to roll out.
- Use of emergency steroid cards agreed.
- Agreed future benchmarking of opioid prescribing/errors with St Elizabeth Hospice, Ipswich.
- Opioid induced constipation treatment flowchart agreed and added to policy.
- Community patient group directions (PGDs) agreed, and training sourced and added to My Learning Cloud.
- Updating syringe driver compatibility charts – being updated as new charts are being released.

The outcome is heart-breaking but you made it so much easier for us both.

3.12.4. Infection Control

Throughout the year, we nursed all patients admitted to the IPU in either single rooms or as the single occupant of a four bedded bay. Our IPC consultant advised that patients of the same gender who had negative swabs on admission and day 5-7 could share a bay if required and this occurred where deemed appropriate.

We cared for four COVID-19 inpatients during the year. Their COVID status was either known at the time of admission or identified from the swab taken on admission. There were identified cases of transmission within the IPU during the year.

The IPC Consultant and Director of Care facilitated feedback sessions for staff following the two outbreaks of COVID dating from the previous reporting year (January and February 2021). These outbreaks coincided with the then national peak and mirrored, on a much smaller and more controlled scale, what was happening in acute hospitals and nursing and residential homes across the country. The feedback sessions were open to all staff at Myland Hall. Three, hour-long sessions were held in June 2021 and a further two sessions in July 2021. During these sessions, we shared information about the management and decision making involved in the outbreaks and the external reporting and scrutiny, together with discussion and Q&A.

Our IPC Consultant strongly advised that all patient facing staff working for St Helena should be vaccinated for their own protection as well as that of patients. The vaccine provides some protection against severe disease and helps reduce the risk of ongoing transmission. We implemented this advice ahead of the Government deadline and it is also now a requirement for all new patient facing staff to be vaccinated or provide evidence of same. This remains our policy despite the Government's subsequent change of policy.

The increasing numbers of staff affected during Quarters Two and Four (both formally reported as a 'period of increased incidence') reflected the high case numbers circulating within the community, together with the increased transmissibility of the latest dominant variant (Omicron). The fact that there was no transmission identified within the Myland Hall setting in the 2021-2022 reporting year testifies to the effective IPC measures employed by staff to keep themselves and the patients safe.

During the year, we adjusted our visiting restrictions as detailed in the IPU report on page 23, above. At the January 2022 IPC meeting, it was agreed that, because of the efficacy of the vaccination programme and the requirement for evidence of a negative LFD test when visiting, visitor PPE requirements could be amended. From then on visitors are asked to wear only a surgical mask and to sanitise their hands. They no longer need to wear apron and gloves unless undertaking direct care tasks for the patient. This was communicated to the community

via social media and explained to visitors on arrival.

The wearing of surgical fluid-repellent face masks and full-face visors, in addition to single use gloves and aprons, by all staff having face to face patient interaction was discussed at the February 2022 IPC meeting. It was decided that the time had come to revert to the use of gloves and aprons for standard IPC reasons; e.g. when dealing with a known infection (of any kind), blood or body fluids. The routine use of fluid-repellent face masks continues as per the national guidance for healthcare settings. These, plus full-face visor, gloves, and aprons would be used for any known COVID-19 positive patient or on a risk assessed basis; for example, if a patient were symptomatic but the result of screening was not yet known. We have briefed in-house trainers in the use and fit testing of FFP3 respirator masks and have been fit testing staff. Records are kept on the date of fit testing and the brand of respirator mask fit tested to each staff member. Such masks may be worn by staff when caring for a COVID-19 positive patient if they choose and are mandatory if aerosol generating procedures are being performed, as per the national guidance.

At the March 2022 IPC meeting it was decided that, following discussion with the affected staff, the Perspex screens at the reception desks in Myland Hall could be removed. People will still be wearing face masks, decontaminating hands, and encouraged to have windows ajar to allow sufficient ventilation, so any perceived IPC benefits of the screens were thought negligible.

The COVID-19 Policy (150) is reviewed and updated whenever new national guidance requires it.

The IPC Consultant 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. During Quarter Three the IPC Consultant gave two educational updates to staff of Bluebird Care. The sessions were particularly focused on *Clostridium difficile* disease, IPC issues and patient management, but also covered wider issues including COVID-19. The IPC consultant has also supported other local hospices.

We have been working throughout the last quarter to align cleaning practice with the National Standards of Healthcare Cleanliness 2021. We have also been working to improve compliance with Health Service regulations relating to healthcare laundry, to ensure that routine, high volume items are collected and laundered by a commercial laundry service. The aim is that only the delicate, special and non-bulk, non-high-volume items such as slings, hoists, slide sheets or

special velour throws should continue to be laundered in St Helena's own laundry, i.e. items that would get destroyed or lost in the industrial laundry process. We have introduced some additional practices and procedures to the workings of the laundry room, including the weekly testing via contact plates of certain surfaces and clean and dry linen. This provides assurance that linen is being laundered to an acceptable standard via the machines and not being re-contaminated during the drying and folding process. Results are reported monthly to the IPC Group. This scrutiny of the in-house laundry facility helps to provide assurance about safety and best practice compliance.

We now display the results of selected IPC audit at the entrance to the IPU as an additional reassurance to all who work, visit or are patients at St Helena.

I have many years of experience in dealings with Health Professionals and [you have] stood out for me as one of the best.

3.13. Risks and Incidents

All incidents and risks affecting Patient & Family Services are managed by our fortnightly Risk & Incident Group (RIG). Incidents 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 review by RIG and actions assigned where necessary. Actions are a part of the electronic record and are tracked automatically.

Risks are logged and 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.

Below, we present a table of the incidents we closed during 2021-22.

	The Hospice	Family Support	Estates & Facilities	Medical Team	Hospice in the Home	Clinical Secretariat/ Reception	Complementary Therapies	Grand Total
Abuse	2	0	0	0	1	0	0	3
Verbal Abuse	2	0	0	0	1	0	0	3
Accident	78	0	7	0	3	0	0	88
Injury	4	0	1	0	0	0	0	5
Moving and Handling (load)	0	0	3	0	0	0	0	3
Moving and Handling (patient)	5	0	0	0	0	0	0	5
Other	3	0	3	0	1	0	0	7
Slip Trip or Fall (Non-patient)	1	0	0	0	2	0	0	3
Slip Trip or Fall (Patient)	65	0	0	0	0	0	0	65
Clinical Incident	244	0	0	2	30	0	0	276
	2	0	0	0	0	0	0	2
Clinical Admin Error	1	0	0	0	2	0	0	3
COVID-19 Patient	3	0	0	0	0	0	0	3
Inadequate clinical care	0	0	0	0	6	0	0	6
Inadequate record keeping	1	0	0	0	4	0	0	5
Injury	1	0	0	0	0	0	0	1
Medical / Nursing Notes not available	0	0	0	0	1	0	0	1
Medicines error	34	0	0	2	6	0	0	42

	The Hospice	Family Support	Estates & Facilities	Medical Team	Hospice in the Home	Clinical Secretariat/ Reception	Complementary Therapies	Grand Total
Notifiable infection	2	0	0	0	0	0	0	2
Other	18	0	0	0	10	0	0	28
Pressure Ulcer(s)	181	0	0	0	1	0	0	182
Unsafe Discharge	1	0	0	0	0	0	0	1
Communication	3	0	0	0	12	0	0	15
Other	1	0	0	0	9	0	0	10
Rudeness/ Poor Conduct	2	0	0	0	3	0	0	5
Confidentiality/IG	1	0	0	1	3	0	0	5
Data Protection	1	0	0	1	2	0	0	4
SHH ID Card (Lost)	0	0	0	0	1	0	0	1
Cybersecurity	1	0	0	0	0	0	0	1
Hacking	1	0	0	0	0	0	0	1
Environmental/ Facilities	5	0	2	0	0	0	0	7
Hygiene/Infection Risk	1	0	1	0	0	0	0	2
Legionella	2	0	0	0	0	0	0	2
Other	2	0	1	0	0	0	0	3
Equipment / Device Failure	3	0	0	0	0	1	0	4
Equipment Malfunction	1	0	0	0	0	0	0	1
Lack of Adequate Equipment / Resources	2	0	0	0	0	0	0	2
Other	0	0	0	0	0	1	0	1
IT (Failure)	2	0	0	0	2	0	1	5

	The Hospice	Family Support	Estates & Facilities	Medical Team	Hospice in the Home	Clinical Secretariat/ Reception	Complementary Therapies	Grand Total
Breakdown	0	0	0	0	1	0	0	1
Loss of internet service	1	0	0	0	1	0	0	2
Misuse	1	0	0	0	0	0	1	2
IT (User Error)	0	0	0	0	2	0	0	2
	0	0	0	0	2	0	0	2
Patient Bay/Room Closure	1	0	0	0	0	0	0	1
Legionella	1	0	0	0	0	0	0	1
Police Investigation	1	0	0	0	0	0	0	1
	1	0	0	0	0	0	0	1
Safeguarding (Adults)	0	0	0	0	6	0	0	6
Financial/material	0	0	0	0	1	0	0	1
Neglect	0	0	0	0	1	0	0	1
Other	0	0	0	0	3	0	0	3
Physical Abuse	0	0	0	0	1	0	0	1
Safeguarding (Children)	0	1	0	0	0	0	0	1
Other	0	1	0	0	0	0	0	1
Security (inc. Theft)	2	0	1	0	0	0	0	3
Intrusion	0	0	1	0	0	0	0	1
Keys Missing	1	0	0	0	0	0	0	1
Patient Absconded	1	0	0	0	0	0	0	1
Welfare concern (volunteer)	0	0	1	0	0	0	0	1
Grand Total	343	1	11	3	59	1	1	419

Table 11 All closed Patient & Family Services incidents.

Notes

- Abuse We recorded three incidents of verbal abuse, all of which were suffered by our staff.
- Notifiable infection One was patient with salmonella, the other refers to two outbreaks of COVID-19, which we were required to report as a single incident because of their proximity in time.
- Hacking This was an attack against the systems of our CCTV contractor. We logged the incident at the time they notified us before it became clear that we were not affected.
- Police investigation The subject of this investigation was a patient's family member, following an incident of threatening behaviour to our staff and a patient being taken off site without our knowledge.
- Intrusion Intruders entered a skip on our premises with the intention of stealing scrap metal.

3.14. 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 Office (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 our 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

As well as our DPO, our Director of Care serves as our Caldicott Guardian, tasked solely with ensuring the protection and proper handling of patient information.

Confidentiality & IG incidents

During the year, we closed five incidents, all minor. Three of these involved the accidental sending of confidential information to the wrong person, either within St Helena or to another clinical professional. Another incident involved lost ID cards. The fifth incident involved confidential information being accidentally sent to us by a third party provider. 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.

IG Walkthroughs

During much of the year (COVID restrictions permitting), we have conducted monthly IG walkthroughs of our three main Myland Hall sites: the Inpatient Unit, the Joan Tomkins Centre, and the Learning & Development Centre. During these walkthroughs, a member of the Quality & Compliance Team checks for infractions, such as confidential information visible in public areas/ noticeboards, passwords on display, confidential material left on unattended desks, and computers left logged in. We also randomly select a couple of members of staff to ask them questions such as how they would report an IG incident and who the DPO and Caldicott Guardian are. Compliance has been strong throughout the years with only a handful of minor issues detected.

I have tried all week to find the right words to express my thanks for what you have done to help her, my family and I over the last few weeks. Thank-you is not enough for what you have all done. Her 3 visits meant everything. During this time, you made her feel welcome, happy and safe. Most importantly you all befriended her, gave her hugs and made her smile

3.14.1. 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 most recent assessment on 24th June 2022, while this Quality Account was in production. Our organisation code is 8A784

The public can verify our status by visiting https://www.dsptoolkit.nhs.uk/OrganisationSearch.

Our history of assessments is illustrated, below. In addition, we are CyberEssentials accredited.

Organisation code: 8A784

Address: MYLAND HALL, BARNCROFT CLOSE, COLCHESTER, ESSEX, ENGLAND, CO4 9JU

Primary sector: Other (including charities and NHS business partners)

Publication history

Status	Date Published
21/22 Standards Met	24/06/2022
20/21 Standards Met	14/06/2021
19/20 Standards Met	25/09/2020
18/19 Standards Met	23/05/2019

Figure 13 DSPT publication history

3.15. 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.

3.16. Complaints and Feedback

3.16.1. Complaints

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. In Figure 14 on page 77 we show all complaints about us reported during the year by month reported. Below that, in Figure 15 on page 77, we break down those same complaints by where or not we upheld or rejected them. This information is current to the end of the financial year.

Below, we summarise all the complaints that were made about St Helena care during the year. 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

122

The wife of a patient complained that, when she and her daughter arrived at our inpatient unit, there were no staff to greet them, and they could not access the building. As the wife and daughter had been informed that the patient was near death (and had in fact died before they arrived), this caused needless distress. This distress was compounded by the nurse in charge not supporting them as well as they would have wished.

We upheld the complaint, apologised to the complainant, and offered a face to face meeting. The staff involved were also asked to reflect on the incident.

149

We received a complaint from the daughter of a patient, expressing concerns about multiple elements of their care. These included staff not being proactive enough in controlling pain, that we refused to work with an unregulated care provider when the family decided our approved partner was too expensive, that we did not complete a continence referral, that we failed to supply catheter bags, leaving the family to source their own supplies, that we gave wrong medication, and failed to provide anticipatory medications.

We provided the complainant with an extensive investigation report. In it, we partially upheld the complaint regarding pain control, finding that while we

made clinically correct decisions, we did not communicate the rationale for them effectively.

Regarding our refusal to work with an unregulated care provider, we passed on feedback from North East Essex Clinical Commissioning Group, which made clear that personal care is a regulated service, and that St Helena was not at liberty to work with a provider not regulated by the Care Quality Commission. We therefore could not uphold this element of the complaint.

Regarding the incomplete continence referral, we found that our staff had failed to complete it, for which they took full responsibility. We also found that there had been supply problems. We therefore upheld these two aspects of the complaint.

Our investigation into the alleged failure to provide anticipatory medications in a timely fashion and provision of incorrect medicines, we found that communication problems between the GP Practice and SinglePoint led to unacceptable delays and incorrect provision. We therefore upheld this aspect of the complaint.

We made a full apology to the family and provided and extensive report of our findings. This contained several recommendations, including:

In case of clinical deterioration leading to end of life, the dying process should be explained to the family including the possibility of terminal agitation and its management

In complex clinical situations, regular follow ups should be made at least every day or more frequently.

To discuss with D/N team and family when a concern had been raised with appropriate explanation and reassurance

To consider changing essential medications (steroid in her case) as injections where appropriate early on when we think about anticipatory medications.

Practically, GPs and our team complete the authorisation for anticipatory medications as a hard copy and will leave at patient's home. To consider documenting the authorised medications in detail as we won't have record in SystmOne.

To consider getting advice and support from medical team as the team is on call24/7

Given the number of organisations involved in the complaint and the issues with co-ordination of care raised we also recommended that the case be brought to the North East Essex End of Life Alliance Board.

185

We received another complaint which referenced multiple concerns over an inpatient stay, a Community CNS, and our SinglePoint service. These

concerns included a change of CNS and a resulting gap in care, multiple instances of communication, and poor cleanliness on our IPU. There was also a complaint that Virtual Ward Care had been presented as being the same as inpatient care and that a call to SinglePoint had not been returned.

Our investigation found that there had been a gap in care and that our staff failed to properly follow-up on progress following a visit. We therefore upheld that aspect of the complaint. We also found that there were several problems during the patient's inpatient stay that resulted in them feeling isolated and that the care we provided did not meet our standard. We also raised the issue concerning cleanliness with our domestic staff. Considering this, we upheld the IPU related aspects of the complaint.

We also found that we had not adequately explained the setup of our Virtual Ward and that the call to SinglePoint had gone answered, although we could not ascertain why. We therefore upheld these aspects as well.

We offered a full apology and face to face meeting to the complainant.

205

We received a complaint from the son of a patient who expressed, among others, the following concerns. Firstly, that having been informed that his mother would receive our care, there was a period of six months following initial assessment, during which time they heard nothing from us. Secondly, that they had regularly asked for but had not received a visit. Thirdly, that the patient had been coerced into a hospital admission when she should have been receiving hospice care. Lastly. that the patient need not have had an admission, had she been provided with oxygen sooner.

On the first point, our investigation found that the changes we had been compelled to make to our caseload management in the weeks running up to the first wave of COVID-19 meant that we did not provide the continuity of care we should have. This was not the level of care we aimed to provide.

On the matter of not providing a visit, our investigation found that most of the support we provided was via telephone and that there did not appear to be an indication that a home visit was needed. However, face to face contact might have provided greater emotional support and our staff could have been clearer about the level of support they were able to offer.

Regarding the perception that the patient had been coerced into a hospital admission, our investigation found that it was

appropriate for us to have the patient assessed by her GP before making a referral and that GP had documented that the patient wanted admission to Hospital and had capacity to make this decision.

Finally, concerning the question of whether a hospital admission could have been prevented had the patient been given oxygen sooner, our investigation found that the care we provided was appropriate and, until admission to hospital, there was no indication the patient needed oxygen.

We offered a full apology and face to face meeting to the complainant.

206

We received a complaint from the daughter of a patient, which consisted of three components. Firstly, that the patient had not been allocated a CNS. Secondly, that she had been left in pain with no visit from the hospice, and thirdly that several calls to SinglePoint had resulted in the complainant being directed to other services, leaving her feeling very alone and not knowing what to do.

Our investigation found that the patient had been allocated a CNS but that the language used by a member of our team had caused confusion and misunderstanding. On the matter of the patient being left in pain and inappropriate signposting to other services, our investigation found that our staff had directed the patient/daughter to other services when they should have taken steps to address the patient's pain themselves. This was not acceptable, did leave the patient in pain, and did not provide appropriate support to the daughter.

We identified several recommendations from the investigation, notably that we needed to reinforce to staff that the service should be helping patients and families with their issues and not simply signposting to other services. It was also recommended that we remind staff to access the on call medical team when there is uncertainty as to how a patient should be managed.

We offered a full apology and face to face meeting to the complainant.

207

This complaint concerned restrictions to visiting imposed during the COVID-19 pandemic. The complainant felt that we had been initially too rigid in declining to allow the visit of a family group to a patient. After this decision was revised, there was a further miscommunication between the family and our IPU staff as to the size of the party and whether a

particular family member had been given permission attend.

Our investigation found that we should have taken more time to accommodate the visitors, but we could find no evidence that a particular family member's visit had been agreed in advance. We partially upheld the complaint and apologised for the distress caused.

222

This concerned our Bereavement Service. A client asserted that our communication with them was abrupt and inappropriately informal. The complaint was made to the Head of Service and then escalated to the Head of Partnerships with an additional complaint about the Head of Service, and then escalated to the Chief Executive with an additional complaint about the Head of Partnerships.

We apologised to the Complainant, and we have reviewed our standard form communications.

254

We received a complaint from a person wishing to refer their son to our bereavement counselling service, following the death of the child's father. Since 2020, St Helena has not offered bereavement counselling to children unless they have lost someone in the care of St Helena. Unfortunately, a member of staff was unaware of this when signposting the complainant to our service. This problem was subsequently compounded several months later, when the complainant was signposted to the service again by another charity, based on out of date information held by on the Child Bereavement Network's national map of services.

We apologised to the complainant for the incorrect signposting and the out of date information and informed them that we had asked the Child Bereavement Network to correct their information. We also informed the complainant about the efforts we have been making to commission a children's bereavement service, which should come to fruition in Q1 (2022-23) when we begin a new service with CCG funding.

266

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

was confusion around the patient's condition.

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

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

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

278

We received a complaint from the son of a patient after a member of staff unintentionally disclosed a password that had been established with the family to ensure that care details were disclosed only to authorised people.

We immediately changed the password and apologised for the error. The complainant was satisfied with this outcome.

279

The daughter of a patient complained that a member of our IPU team had been overheard via home CCTV making insensitive and inappropriate comments about her. We upheld this complaint and issued the staff member with an informal written warning. At time of writing, we have not heard whether the Complainant is satisfied with our investigation.

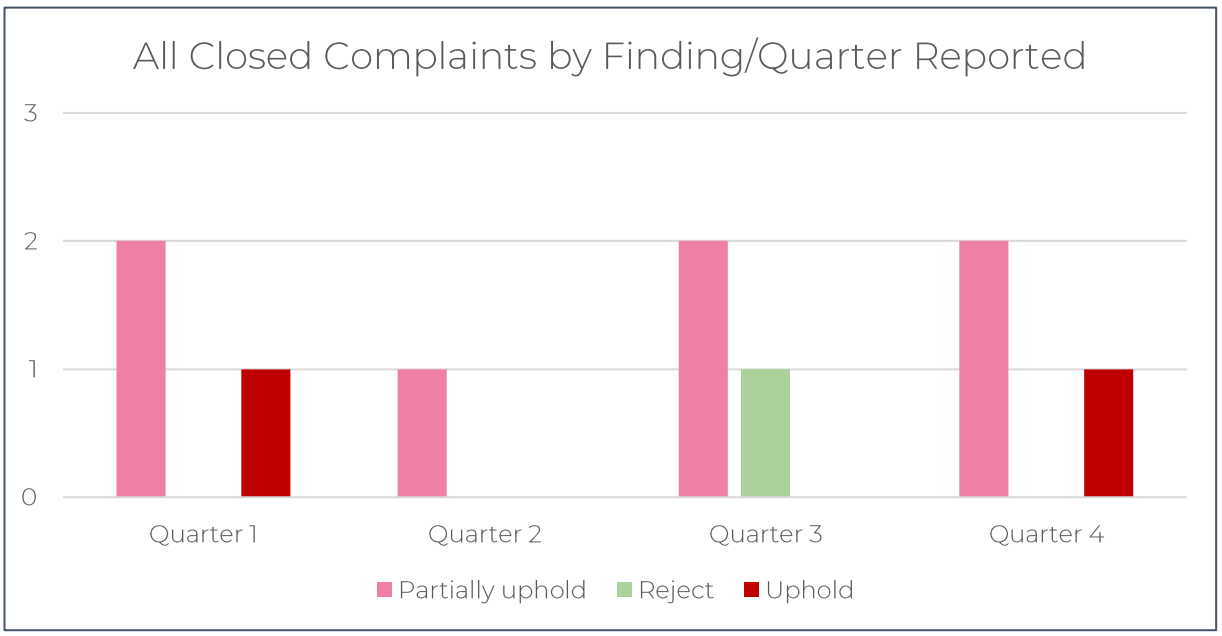

Figure 14 All closed complaints by finding/quarter closed.

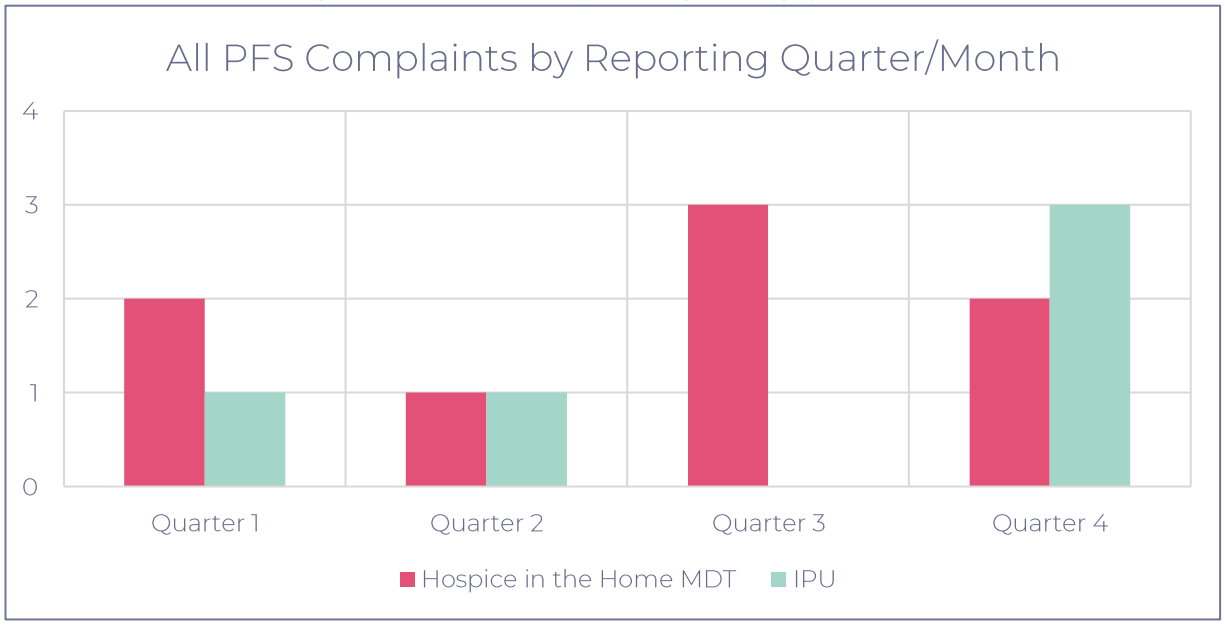

Figure 15 All PFS complaints by reporting quarter/month

3.16.2. Cards and Letters

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

staff can view the feedback received.

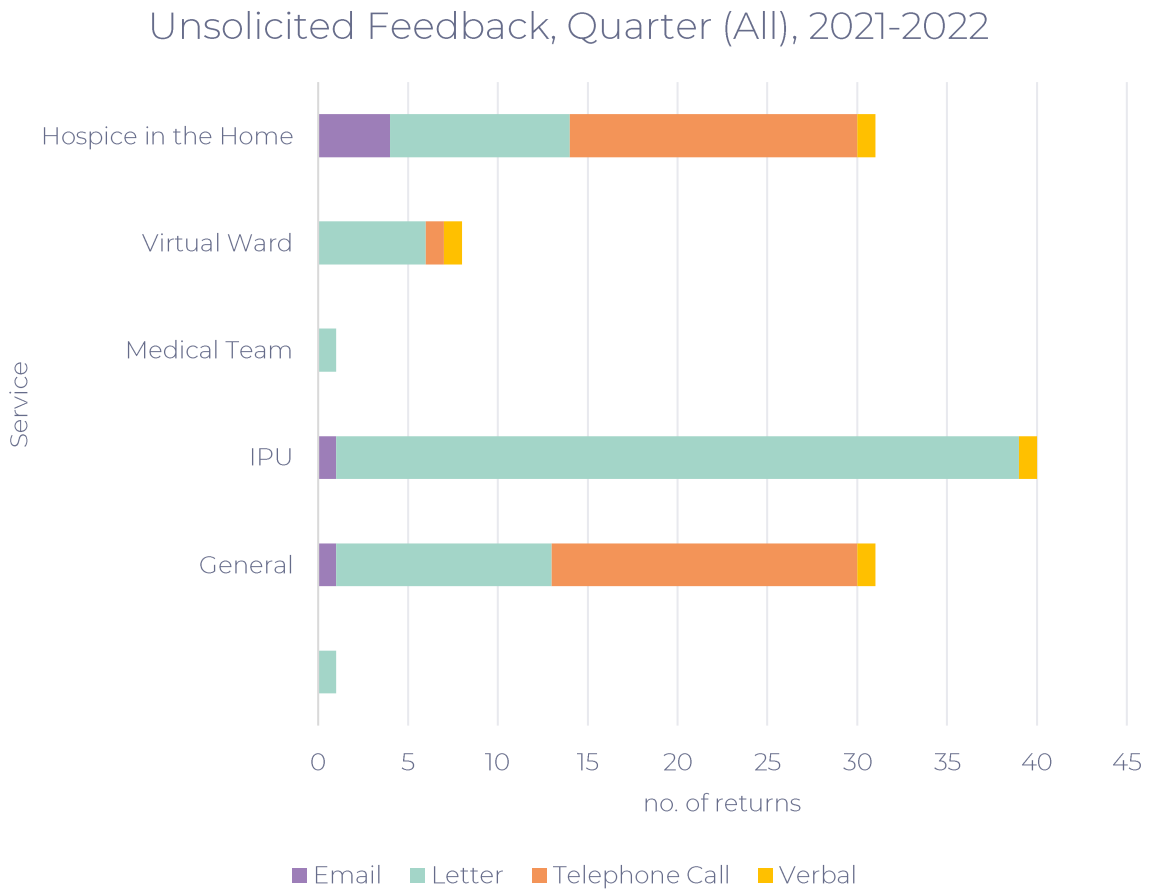

Figure 16 Cards & letters.

3.16.3. iWantGreatCare

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

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

The feedback is analysed using the iWGC management interface and a report of the comments received is presented to our monthly Quality Assurance and Audit Group (QAAG) alongside unsolicited comments received via other avenues. Following the organisation restructure during the year, we reviewed our services to reflect the new model of care. Our current iWGC services are Bereavement, Breathlessness, Chaplaincy, Complementary

Therapies, Hospice in the Home – SinglePoint, Inpatient Unit, Virtual Ward.

QAAG looks for themes and trends and responds as appropriate to any negative feedback. These monthly reports allow us to reach more quickly to what our constituency is telling us, thereby making us a more responsive organisation. Moreover, because the website is hosted externally, we can assure transparency. While the system has safeguards in place to protect against mischievous or vexatious comments, we cannot censor or suppress genuine and legitimate criticism (although we can respond to it on the website)/ to view all our comments on the iWGC website, please visit https://www.iwantgreatcare.org/hospitals/st-helena-hospice-1

The number of comments received has increased throughout the year, following a period of marked decline during the Covid pandemic, but has not yet reached pre-pandemic levels. Services are working hard to promote iWGC to continue to increase numbers. A summary of our results for 2021-22 can be seen in Figure 17 on 80.

This Charity couldn't be closer to our hearts as the level of care we received for our lovely husband, dad and grandad was second to none. They went above and beyond in every way possible to make his final weeks as comfortable as they could possibly be. They accommodated not only him but also the whole family by allowing us to stay by his side day and night for however long we wanted so he was never alone even at his last breath, something we will always be grateful for. Even after he passed the care and support that was offered by St Helena's Hospice was beyond compare.

St Helena Hospice

Date
01 April - 31 March

Your average score for all questions this period

1 2 3 4 5 **4.93**

Reviews this period

155

Your Experience Scores

5 star score	% Positive experience	% Negative experience
4.86	**97.4%**	**1.9%**

Adult Services

Service Name	This period		Last 6 months	Questions						
	Responses	Average Score	Average Score	Experience	Dignity/Respect	Involvement	Information	Caring	Trust	Support staff
Adult Bereavement Service St Helena Hospice	-- (26)	4.96	4.98	↓	↑	↑	↓	↓	↓	↓
Breathlessness St Helena Hospice	-- (32)	4.83	4.92	↓	→	↓	↓	↓	↓	↓
CNS(EC) St Helena Hospice	-- (3)	5.00	5.00	↑	↑	↑	↑	↑	↑	↑
Chaplaincy St Helena Hospice	-- (0)	--	--	--	--	--	--	--	--	--
Complementary Therapies St Helena Hospice	-- (8)	4.95	4.95	↓	→	→	↓	→	→	→
Hospice in the Home St Helena Hospice	-- (18)	4.99	4.99	↓	→	→	→	→	→	→
Inpatient Unit St Helena Hospice	-- (21)	4.88	4.86	↑	↓	↓	↓	↓	↓	↓
Virtual Ward St Helena Hospice	-- (47)	4.98	4.98	↓	↑	↑	↑	→	→	→

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

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

Figure 17 2021-22 IWGC summary

3.17. What Others Say About Us

3.17.1. 2017 CQC Inspection Report

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

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

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

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

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

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

3.17.2. Response from Healthwatch Essex

Figure 18 Samantha Glover

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

We recognise that Quality Accounts are an important way for local 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 Hospice. In this case, we have received quality feedback about services provided by the hospice, via target engagement and the information and guidance service, this supports the following comments on the St Helena Hospice Quality Account.

- Healthwatch Essex are pleased to see the priority areas for this period reflect the needs not only on the individual at end of life but also those who support them. Priority One: Embed our revised operating model to ensure we can provide support to local people who need us regardless of diagnosis.- Is much more inclusive. Priority Two: Support our workforce to deliver excellent personalized care to all our patients- is vital following the challenging two years we have had with COVID and system redesign. The 'wobble room' is an excellent example of how the hospice are doing this. Priority Three: Develop a Compassionate Community programme - Is a great way of involving the wider community and voluntary sector in this stage of life.

- We are pleased to see that good progress has been made against the priority areas for 2018-19. It is a shame to see GSF accreditation was delayed, and we hope this is able to progress in the following year.
- It is good to see the increased collaborative working and the Multidisciplinary approach continued and expanded.
- Although it is not good to see the number of complaints that you have received it is positive to see how you are taking the learning from both complaints and complements and amending practice as a result of these.

Healthwatch Essex were pleased to work with St Helena last year to fed into the North East Essex End of Life Board, as this work continues we look forward to producing a report to continue to support the fantastic work St Helena deliver.

Samantha Glover
Chief Executive Officer, Healthwatch Essex
June 2022

3.18. Contacting St Helena

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

Mark Jarman-Howe,
Chief Executive Officer
St Helena Hospice
Barncroft Close
Colchester
CO4 9JU

Tel. 01206 931450

Email:
mjarmanhowe@sthelena.org.uk

You picked us up when we were down and shared our tears and fears. You gave a wife a bed to cuddle her husband when he was dying and made room for a daughter to be with her dying dad so she could hold his hand. The compassion you shared with us made the very worst situation the best it could be and for this we will always be truly grateful for your care and support.

www.sthelena.org.uk
Telephone: 01206 845 566

St Helena Hospice is a company limited by guarantee.
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Registered Charity Number 280919.
Registered Office: Myland Hall, Barncroft Close,
Colchester, CO4 9JU.