St Helena

Quality Account

2020 – 2021

www.sthelena.org.uk @StHelenaHospice @sthelenahospice

Contents

Acknowledgements

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

Ken Aldred	Chair, Service User Group and Trustee
Lorraine Blanking	Bereavement Team Lead
Nicola Button	Head of Compassionate Communities
Nicky Coombes	Hospice in the Home Matron
Julia Davey	Breathlessness Lead
Sarah Hay	Clinical Compliance Officer
Jenni Homewood	Complementary Therapies Team Lead
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
Sue O'Neill	Hospice Matron
Lisa Parrish	Director of Care
Vickie Peters	Chaplain
Nigel Pie	Chair of the Board of Trustees
Becky Rix	Virtual Ward Manager
Laura Shukla	Head of Clinical Services
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

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 our commitment to excellence in all the services we provide, and we welcome the opportunity to share our progress and priorities in this report.

We take a local leadership role in the provision of education and training in communication skills, and palliative and end of life care. We also contribute to local strategic leadership through the North East Essex Health and Wellbeing Alliance and the End of Life Board.

We organise our service delivery around our 24/7 SinglePoint palliative care coordination centre. SinglePoint coordinates end of life care services across local providers, including GPs, district nursing, Colchester General Hospital, out of hours services, and the East of England Ambulance Service. SinglePoint also coordinates the My Care Choices Register (see page 24), a means of capturing and sharing the care preferences of people in the last year of life.

We have a large community nursing team of specialists who manage a caseload of patients in the local community in their home or care home. An 18-bed Inpatient Unit (IPU) provides specialist palliative care and end of life care.

The charity had two centres for day therapies – one in Colchester, located with The Hospice at Myland Hall, and one at our Tendring Centre in Clacton. The Tendring Centre closed in early 2020 and will not resume as a base for the provision of day therapies.

In addition to these services, St Helena has a Complementary Therapy Team, a Rehabilitation Team, Chaplaincy Team and a Bereavement Service accessible to all and not just those previously known to us. Our specialist palliative care Medical Team works in an integrated way with the hospital palliative care service and provides an on-call service.

"Thank you all for helping... To know he was cared for in his last days is very comforting to me."

1.1.1 Response to COVID-19

In March 2020, St Helena agreed with the Suffolk and North East Essex Integrated Care System to take on a leadership and coordination role for all end of life care delivered outside of hospital in North East Essex during the pandemic. We coordinated the community end of life response on behalf of the North East Essex Health and Wellbeing Alliance, creating a hub and spoke model. Non-urgent hospice visiting ceased, and community specialist nurses, Rehabilitation and Family Support teams joined the SinglePoint team to create an enhanced community rapid response hub. Continuing healthcare funding resources were allocated through the hub, and local voluntary services coordinated relief services for those on the palliative care register. The charity created a 24-hour non-medical prescriber rapid response service in partnership with Anglian Community Enterprise (ACE) to enhance overnight nursing capability and offered bereavement services across the community.

The charity also created integrated spoke teams with weekly virtual meetings between primary care, community nursing and the hospice, and developed a single caseload between the providers to enhance care coordination.

The My Care Choices electronic palliative care coordination system was changed to capture advance care planning discussions about COVID-19 and access granted to senior care home staff. The clinical team rewrote anticipatory prescribing guidance, verification of death procedures, created patient group directives, wrote policies to allow hospice medications to be taken into the community for urgent visits, and supported carers to learn to administer subcutaneous medication. The Hospice IPU was increased by 2 beds and Virtual Ward capacity doubled through a collaboration with a local care provider. Community hospital and hospice beds were merged into an integrated community bed base. Education activity included delivery to colleagues across the community about symptom control and advance care planning.

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

Mark Jarman-Howe

Chief Executive

"I want to thank you very much for the loving care you gave mum in the last two weeks of her life. You gave of yourselves so generously and patiently. Your friendship and support helped not only Mum but us too... You were all so passionate about the work you do."

1.2 Statement from the Board of Trustees

The Board of Trustees is accountable for the quality of care given at St Helena and we take this accountability very seriously. Not only do we seek to ensure that the care given is fit for purpose, but also that, as the requirements of our community change, the services provided, and the care given, change appropriately.

Since our last report, we have re-organised the committees working to the Board and drawn up new Terms of Reference. The Patient and Family Services Committee leads on quality of care, receives quarterly quality reports, and provides a comprehensive quality report quarterly to the Board. The other three committees, Finance, Governance, and Income, look after quality in their own areas, also reporting to the Board.

In the committees, Trustees work alongside staff and management to enact St Helena's strategy, review current activities, policies, and procedures, and develop new ones. This also provides a key opportunity for some of the oversight that is the duty of Trustees. Trustees are also encouraged to spend time "on the shop floor" to get a feel for how the organisation is running. Unfortunately, that has not been possible for the past year, but we hope to start again soon. As we come out of lockdown, we are refreshing our Service User Group, which engages with local people, to ensure we continue to deliver services that are relevant and appropriate to our diverse local community. Also, we are keen to strengthen our relationships with key stakeholders, and we are exploring the best way to

establish a Stakeholder Group to help us achieve this goal.

All committees practice self-reflection and checks of their effectiveness, and this is overseen by the Corporate Governance and Risk Committee, which looks across the whole organisation for compliance with policy and procedures. While risks are held by the committee where they are most appropriately managed, the Corporate Governance and Risk Committee ensures that the assessment and management of risks is carried out correctly.

The greatest assets to our quality of care are our outstanding staff and volunteers. The dedication of those dealing directly with patients and those working behind the scenes is truly humbling. They set themselves, and they achieve, very high standards in all they do, and they do it with care, compassion, and in line with St Helena values. The Board acknowledges and thanks all staff and volunteers for all they do in providing outstanding care in supporting people who are facing incurable illness and bereavement in North East Essex. We fully endorse this Quality Account.

Nigel Pye

Chair of the Board of Trustees

1.3 Executive Summary

This is the first Quality Account produced by St Helena following the outset of the COVID-19 pandemic. In it, we discuss our priorities for rebuilding and renewal: embedding our new model of care, working to deliver excellent personalised care, and developing our Compassionate Communities programme.

We also review our priorities from our 2018-19 Quality Account and offer updates on progress with them.

In Part Three, each area of our clinical operations offers a brief review of the last, tumultuous year. This section includes contributions from our newly created Multidisciplinary Teams: The Hospice and The Hospice in the Home. We also include contributions from Compassionate Communities, and our Bereavement and Breathlessness services.

Part Three also includes reviews from Estates & Facilities and a contribution from our Volunteer Management Team. There are also reports on risks and incidents, information governance, and Safeguarding.

In all these areas, and many more, we review activities during the year, consider the impact of the pandemic, and look ahead to 2021-22.

2.0 Priorities for Improvement in 2021-21

"I would like to thank you all for the care, medical attention, love and support you gave my Dad … and our family during his time at the hospice. From the staff in the kitchen to the nurses, complementary therapists, volunteers and doctors… your care and attention to Dad was amazing. For a time that was so difficult for him you tried to keep his 'normal' for him and made him feel human right until the end."

2.1 Priority One: Embed our revised operating model to ensure we can provide support to local people who need us regardless of diagnosis.

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.

"Just to say a big thank you for all you continue to do in these difficult times. It's tough right now but we will be back, running, walking, jumping, baking & coming together to continue to raise fund for the hospice. Keep smiling, we've got this."

2.2 Priority Two: Support our workforce to deliver excellent personalized care to all our patients

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.

2.3 Priority Three: Develop a Compassionate Community programme

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, see page 24) 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.

2.4 Priorities for improvement from 2018-19

As a result of the pandemic pressures on the organisation, St Helena did not produce a Quality Account for 2019-20. Since 19-20, we have made significant changes to our organisation and operating model, both in response to the immediate crisis, and to its longer term impact. Many of the aspirations outlined for 19-20 have seen substantial progress during that time, while others have become less of a priority. We will update these below so far as we are able. The original text of the priority is presented in *italics*.

"Words cannot really express how truly grateful we were/are for the kind, caring and compassionate care and support you all offered to … our beloved wife, mum, grandmother, sister, aunt and friend during her last weeks of life. Mum could not have received better care in the last few weeks of her life and we are so grateful that you helped mum have a better quality of life before she died… Thank you once again to you all for your wonderful care and support and know that you made such a difference to … at the end of her life."

2.4.1 Priority One: Reaching out based on need regardless of diagnosis or circumstances.

We will work to balance the rising number of referrals we receive with our perennial aspiration of keeping waiting times low. We will ensure that each of our teams is equipped to meet agreed target response times. To achieve this, by the end of the year, we will require all our teams to institute their own standard operating procedure (SOP).

We will develop our Virtual Ward (see Page 24) and continue our policy of providing a 16th bed to help manage wider winter pressures.

We are continuing to provide Gold Standards Framework (GSF) training. A first cohort of care home staff will be accredited by the end of November 2019. We have also begun to provide workshops to a second cohort, and these will be complete by September 2019. Finally, a second cohort of domiciliary care workers will begin in April 2019 and finish by September.

We are currently working with Professor Muir Gray's team at Triple Value Health Care to develop the first atlas of value in end of life care to drive an integrated population-based commissioning model for the future.

Our aim is to have clear set of information on quality and value in end of life care across our community. This is in order to promote ongoing improvement, spending resources on services that people really need from which they can get the maximum benefit'

What we have achieved

During the pandemic, we focused our service provision on responding to the needs of those in crisis or in the very final weeks of life. During the restructure to implement our new operating model, we disbanded some individual teams and their functions were absorbed into two new multidiciplinary teams (MDTs): The Hospice MDT (for inpatient care) and the Hospice in the Home MDT (for community care). As a result of this change, we did not carry on developing SOPs for each of our previous teams.

The Virtual Ward has developed significantly, and now offers 18 beds, with ten of these provided through our partnership with Bluebird Care. The Inpatient Unit (IPU) provides for 18 beds, if required; although this has been limited by the need to follow national Infection Prevention and Control guidance.

GSF accreditation of the first cohort of care home staff (from six homes) was delayed by a year to November 2020 because of the pandemic. Cohort 2 finished their training workshops at the end of September 2019 and attended a pre- accreditation workshop in February 2020. They have been invited for accreditation and are waiting to hear back from the GSF panel. The third cohort of care homes for GSF was due to start in March 2020; however, this has been deferred to September 2021 and will be conducted by video call. A second cohort of domiciliary care agencies completed the GSF programme in September 2019.

'Accounting for Value,' a value report for the 'Die Well' domain in the North East Essex Health & Wellbeing Alliance, was published in April 2020. Subsequently, the North East Essex End of Life Board has developed a strategy and work plan to improve the ten prioritised outcomes for people at the end of life. This focuses on reducing inequalities and delivering the highest value end of life care for the resources available. The ten prioritised outcomes from a consultation in 2019 are as follows:

1. To identify and recognise people in the last 12 months of life.
2. To inform people thought to be within the last 12 months of life and their families of the likelihood of death within the next 12 months sensitively and honestly.
3. To elicit and record people's preferences for care during the last 12 months of life.
4. To respect people's preferences for care during the last 12 months of their life.
5. To ensure people's preferences for care are accessible to all parts of the health and social care system/end-of-life-care system.

6. To treat people at end of life as individuals, with dignity, compassion, and empathy.
7. To control pain and manage symptoms for people during the last 12 months of life.
8. To minimise inappropriate, unnecessary, and futile medical interventions during the last 12 months of a person's life.
9. To ensure that people at end of life have equitable access to flexible 24/7 end-of-life care services, irrespective of the place of care or the organisations providing care.
10. To provide support to families and other carers during and after their loved one's end of life.

A dashboard has been created to demonstrate where these outcomes are being achieved and where resources need to be targeted.

"...thank you to you for the invaluable care you gave to our mum, particularly in the last months of her illness. The most important thing you gave her was control during her illness when really she had little control left. You enabled her to continue to live her life at home, always respecting her wishes and listening to her. She died with us all by her side in the home that she loved. She requested for donations in her memory to be made to the SinglePoint nurses at St Helena which was her final testament to the wonderful care you gave her."

2.4.2 Priority Two Empowering people to plan ahead, share their choices and achieve their wishes.

What we wanted to achieve

As mentioned above, we will further develop our Virtual Ward and continue our policy of providing a 16th bed to help manage wider winter pressures.

We will also develop and widen access to the My Care Choices Register (MCCR) in order to pursue our target that, by 31st March 2020, it holds current data on 1% of the population of North East Essex (approximately 3,500 people).

We also plan to enable ten care homes to access the system directly by the same date.

What we have achieved

See above for comments on the Virtual Ward and Inpatient beds.

Access to the My Care Choices Register continues to improve. At the time of writing (June 2021) there are over 4000 people on the register which represents an increase of 400 people on the previous year.

2.4.3 Priority Three: Providing excellent personalised care to more people in hospice beds and in the home

What we wanted to achieve

We will create a business case for a version of Project ECHO™ for GPs (see Page 33).

We will deliver our 2019-20 education prospectuses.

We will increase our collaboration with other local hospices and providers.

We will continue to prepare for a CQC inspection at some point during 2019-20.

We will deliver a regional palliative care conference.

We will deliver further GP training

What we have achieved

There were three sessions for the pilot Project ECHO™, held between January and March 2020. These concerned Advanced Care Planning, Recognising the Dying Process, and Symptom Management at the End of Life. The sessions were attended by GPs, Advanced Nurse Practitioners (ANPs), District Nurses, and Paramedics.

Project ECHO™ has now been superseded by Community of Practice events, which have been running every 6-8 weeks since November 2020. It is felt that other remote conferencing platforms are now more familiar to both speakers and participants. Topics covered to date include opiates, diabetes at the end of life, anticipatory prescribing, and palliative care emergencies.

The 2019-20 education events detailed in our prospectuses were delivered until March 2020. At St Helena, we cancelled all education events (internal and external) in March 2020, and our practice educators were re-deployed to clinical duties. Between September and January 2021, our priorities were to ensure that staff were up to date with mandatory training, such as basic life support and manual handling, and to offer them the opportunity for reflection with the re-introduction of Schwartz rounds via videocall.

We have continued to collaborate with other local hospices and providers across the ICS.

We have recently refreshed our approach to preparing for CQC inspection and restarted our CQC Working Party.

It was not appropriate to continue plans for the regional palliative care conference during the pandemic; however, we are keen to work with neighbouring hospices to develop something in the next 12 months.

We continue to host and support GP trainees working on our IPU as part of their ST2 rotations. This allows them to gain palliative care experience that they can apply in their future career. Since September 2020, we have also been supporting two GP associates who are gaining clinical experience with us while completing their Diploma in Palliative Care at Cardiff University.

2.4.4 Priority Four: Helping life to go on in the face of dying, death and bereavement

What we wanted to achieve

We will reduce the waiting list for bereavement triage.

We will increase the number of bereavement volunteers we have.

We will reduce the waiting list for counselling and Family Support services.

We will deliver Dementia Tier 2 training.

We will continue to deliver Dementia Friends information sessions.

What we have achieved

We successfully reduced the waiting list for bereavement triage with the introduction of a new triage flow chart. The administration team now follow this when allocating clients to either an appropriate professional's caseload or a waiting list. Where there is doubt or the flow chart is not suited to a client's referral, qualified Counsellors or the Team Lead will review and make the allocation. Since the pandemic, Counsellors have been providing support on the phone rather than in face to face sessions, and this has also reduced waiting lists.

We were not able to increase the number of bereavement volunteers and, given the changes in the types of clients we are seeing, we do not feel it is appropriate to pursue this currently.

Our Counselling and Family Support services are now part of the two MDTs, which means patients and families can access them more promptly.

Dementia Tier 2 training was delivered to St Helena staff in January 2020 and was well received. We were unable to offer further dates because of the pandemic. We were also able to offer one session of Dementia Friends.

2.5 Mandatory statements relating to the quality of the NHS service provided

2.5.1 Review of Services

During 20-21 St Helena provided the following services:

- Inpatient services – up to a maximum of 18 beds with support from the Hospice MDT, which includes the Nursing Team, a Specialist Physiotherapist, a Specialist Occupational Therapist, a Social Worker, a Counsellor, and a Family Support Worker.
- Community services – acting as the End of Life Hub for North East Essex and comprising the SinglePoint Service (24/7 advice, support and information), Virtual Ward (18 beds), and the Community Clinical Nurse Specialist (CNS) Team. The Hospice in the Home MDT consists of the Nursing Team, a Specialist Physiotherapist, a Specialist Occupational Therapist, Therapy Assistants, a Social Worker, a Counsellor, and a Family Support Worker.
- The Medical Team, supporting both MDTs.
- Complementary Therapy
- Breathlessness Service
- Chaplaincy
- Bereavement Service for adults.
- Education and Training Practice Educators.
- Safe Harbour Service

2.5.2 Funding of Services

St Helena is an independent charity, which during 2020-21 provided its services largely free of charge to the end user. Our grant income from the NHS in 2020-21 constituted approximately 21% of our total income. In addition, a further 16% was received from NHS England to provide support for additional pressures related to COVID-19.

The remainder of our income (63%) came from voluntary charitable

donations, legacies, our shops, our lottery, and our corporate and community fundraising.

Please accept my thanks and appreciation for all the help and kindness you have given me over the past few months. I couldn't have done it without you. You have helped me continue my life with quality there have been times when I gave felt that the stepped decline was part of the slippery slope but you have shown me that with good pain control you can still have quality of life and enjoy your time with your family and friends. For this and more I truly thank you.

2.5.3 Clinical audits

During 2020-21, there were no national clinical audits or National Confidential Enquiries relevant to us.

Local Audits

We had largely suspended our clinical audit programme at the beginning of the year in response to the pandemic, except for our programme of infection prevention and control audits, which we have expanded throughout the year. These are detailed on page 37.

During the second quarter of 2020-21, the Clinical Compliance Officer worked with the Ward Sister to produce a revised programme of clinical audits for the IPU. This revised programme began in September 2020. The Clinical Compliance Officer also worked with the Operational Medicines Management Lead during Q2 to introduce new medicines management audits on the IPU.

During Q4, the Clinical Compliance Officer worked with the Hospice in the Home Matron to build a new programme of clinical audits for the community services, to begin from April 2021. This work is ongoing.

In normal times, our Quality Assurance and Audit Group (QAAG) meets monthly to monitor our annual audit programme, quality reporting, and patient experience data. We suspended QAAG during the first wave of the pandemic but reinstated it in September 2020.

During the year, we also shifted from managing our audit programme on a spreadsheet to a dedicated module of our Sentinel system. This module was designed and built by our Clinical Compliance Officer. This will improve monitoring and allows for more sophisticated reporting.

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

Patient Locker Audit June 2020 [12-20/21] and re-audit October 2020 [12-1-20/21]

This observational audit examined patients' own medication lockers on the IPU to ensure that all were clean and contained the correct medication for the correct patient. This was an original audit.

A Deputy Sister from IPU and the Operational Medicines Management Lead manually checked nine patient lockers on 16th June 2020 against a set of questions agreed prior to the audit.

The audit found that medicines were not being quarantined when not in use and so quarantine bags were purchased.

Re-audit in October 2020 found improvements in locker tidiness and

quarantining of medicines no longer in use. Some patient medicines were found to be labelled incorrectly or not labelled at all. The Operational Medicines Management Lead continues to work with the nursing staff on this during drug rounds.

Visual Skin Assessments July 2020 [16-20/21] and re-audit October 2020 [16-1-20/21]

This original audit was carried out at the request of St Helena's Risk and Incident Group (RIG) following an incident where we could not document that we had given an inpatient a visual skin assessment until day five of their admission.

The audit examined 10 admissions between 15/06/2020 and 26/06/2020, 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 was generally good, and if the admitting nurse was unable to visually assess the skin on admission (for instance, because the patient declined), it was usually documented that the assessment was handed over to a named nurse to carry out later that day. If a patient declined assessment, this was clearly documented. On three occasions, there was no same day assessment and no documentation explaining why.

Following the original audit, the TV Lead worked with the SystmOne Manager and a skin assessment tool (ASKIN) was introduced to reduce the chance of assessment being missed. The Tissue Viability Policy (133) was also amended to clarify the documentation procedure for skin assessments on admission.

Re-audit in October 2020 found an improvement, with all required documentation thoroughly completed in 9/10 admissions.

Patient Story Documentation [15-20/21]

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

15 patient records were audited against the prompts given on the Patient Story care plan. The results showed that the Patient Story care plan was not always being completed daily in cases where it has not been launched on admission.

The audit also showed that the quality of the psychosocial data entered was much improved since the previous round. Patients were being named in data entries and there was a reduction in inappropriate use of the care plan.

Recommendations from this audit included commending nursing staff on the good data entry that is often completed, reminding them to launch the Patient Story care plan on admission, and to only use it to capture the appropriate psychosocial information. The button to launch this care plan on admission was also made more visible to decrease the chances of it being missed during the admission process.

Re-audit was planned for May 2021.

Quarterly Controlled Drug Check July 2020 [14-20/21]

This new audit was designed to be carried out quarterly to support our annual 'Management of Controlled Drugs' audit. It was completed for the first time in July 2020 by the Operational Medicines Management Lead and the Director of Care, examining the Controlled Drugs Registers for accuracy against a set of agreed questions.

Two annotation errors were noted during the audit but neither required any action to be taken.

MCA Documentation October 2020 [18/20/21]

This 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 RN from the IPU audited all admissions from September 2020 (23) and found that assessments were completed on admission and recorded daily for all patients. Where a patient lacked capacity, the reason was clearly documented, and if a best interest decision was made it was clearly documented who was consulted (for example, the patient's next of kin). These results show a great improvement from the previous audit in June 2018.

Re-audit was scheduled for one year.

Hospice UK Management of General Medicines September 2020 [21-20/21]

This is an annual audit carried out to ensure that St Helena's management of non-controlled medicines meets the requirements of the Medicines Act (1968), Misuse of Drugs Regulations (2001) and the Health Act (2006). The audit tool was adapted from a Hospice UK tool and comprises the following topics:

1. Standard Operating Procedures (SOPs).
2. Purchasing and Supply of Stock Medicines.
3. Storage and Destruction of Medicines.
4. Prescribing Medicines.
5. Administration of medicines.
6. Patients' Own Medicines.
7. Non-medical Prescribers.

The audit was carried out on 30th September 2020 by the IPU Matron, Operational Medicines Management Lead, and the Clinical Compliance Officer. Compliance had improved further since the 2019 audit with 100% compliance recorded in all seven topics.

Re-audit will be carried out in September 2021.

Graded Pressure Ulcer Care Plan Documentation October 2020 [17-20/21]

The purpose of this audit was to monitor how well the graded pressure ulcer care plans used on the IPU were being completed. The previous audit

was completed in November 2019, with a plan to re-audit in April 2020 and, from then, quarterly. These plans were then postponed because of the pandemic. This was the second re-audit.

10 patient records were audited against a set of questions agreed by the Tissue Viability Lead.

The results show a huge improvement since the previous audit. Most care plans were launched and re-named on the same day the ulcer was identified, and the quality of the free text documentation had improved.

Actions for this audit were to update the graded care plan instructions and re-audit was scheduled for January 2021.

It's been tough enough with covid, bad weather and then the most painful [thing] of losing your mother to cancer... you were amazing and thank you for letting me be the daughter and not the nurse at end of life

Pressure Ulcer Management on IPU [11-1-20/21]

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 Tissue Viability Lead and the Clinical Compliance Officer.

The results showed consistently good results in all areas, and the TV Lead congratulated the nurses for continuing good documentation.

Re-audit was scheduled for January 2021.

Bowel Care Documentation December 2020 [24-20/21]

The purpose of this audit was to examine how well the Bowel Care care plan was being completed on the IPU. This care plan is used by the nursing team to record bowel care daily. This was an original audit.

An RN from the IPU audited the records of all patients admitted in November 2020. It was found that the care plan was being completed appropriately 100% of the time.

Re-audit was scheduled for one year to ensure that compliance remains high.

To Do Lists January 2021 [25-20/21]

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

The audit was postponed in March 2020 because of the pandemic. A new audit lead recommenced the audit from July 2020. This report covered seven monthly audits between July 2020 and January 2021.

Compliance was generally good, and staff have been reminded of correct processes where relevant. Audits will continue monthly, and a further report will be produced in July 2021.

End of Life Drugs March 2021 [30-20/21]

Since January 2021, the Operational Medicines Management Lead has been formally auditing the register of end of life drugs taken from IPU stock

for use in the community, to ensure that drugs given are documented appropriately. Previous audits of the register have not been formally recorded.

The January audit of medication showed that there was no SystmOne documentation of drug administration on 10/23 occasions. This was discussed with staff and results for February and March were much improved with no documentation in 1/9 occasions in February, and all documentation correct in March.

2.5.4 Participation in research

After the first wave of the pandemic, we evaluated the service provided to all COVID-19 positive patients we had cared for on the IPU. We did this to try to understand this particular patient group and share our learning with hospice colleagues throughout the UK. This work described the disease trajectories seen in patients with different functional statuses and raised important questions about the ethics of undertaking COVID-19 swabs on patients in the last days of life. This was presented to the Hospice UK Clinical Echo and as a poster presentation, “Experience of COVID-19 in a Hospice Inpatient Unit: Characteristics, Symptoms and Ethical Issues”, at the Palliative Care Congress held virtually in March 2021.

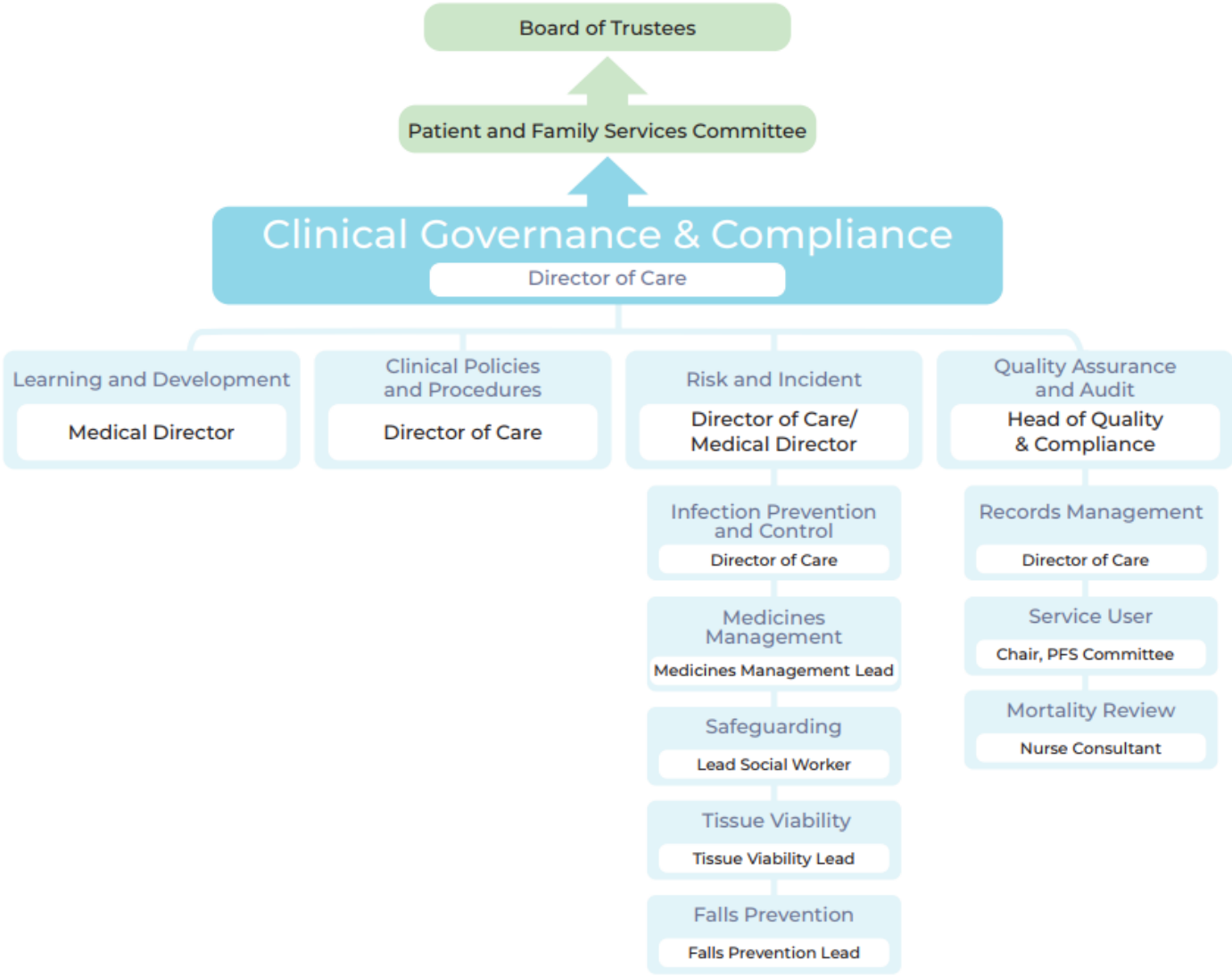
We also presented a poster entitled “Demonstrating How Being Available for Advice Enhances Patient Care,” which looked at the Medical Team’s availability for consultation to a wide range of health care professionals, both internally and externally.

St Helena is one of six hospices working with a team at Stirling University to look at the implementation of needs rounds in England and Scotland. A needs round involves a palliative care nurse attending a care home regularly to discuss patients identified by the care home staff. Interventions can include education or guidance with Advance Care Planning, simple symptom management or referral to the palliative care team for a holistic assessment. Needs rounds have been implemented successfully in Australia and the team hope to replicate their success in England and Scotland. The initial timelines for the project were affected by the pandemic, but the project is now underway with a series of workshops. We have identified four local care homes who have agreed to take part. The needs rounds themselves are due to commence in the summer.

2.5.5 Use of the CQUIN payment framework

SH income in 2020-21 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 structure

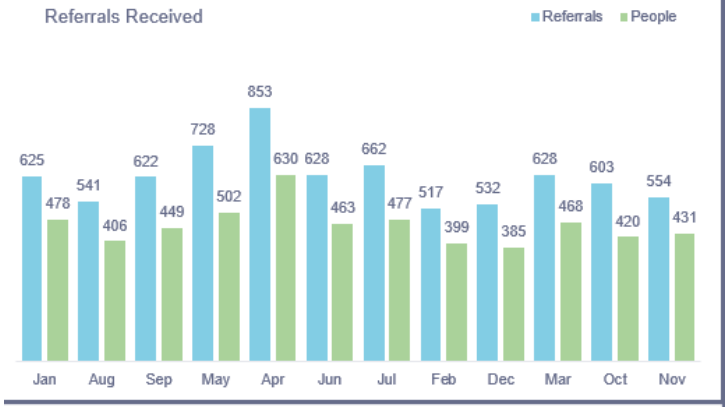


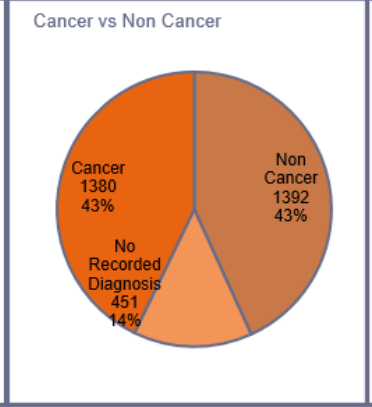
3.0 Review of quality performance

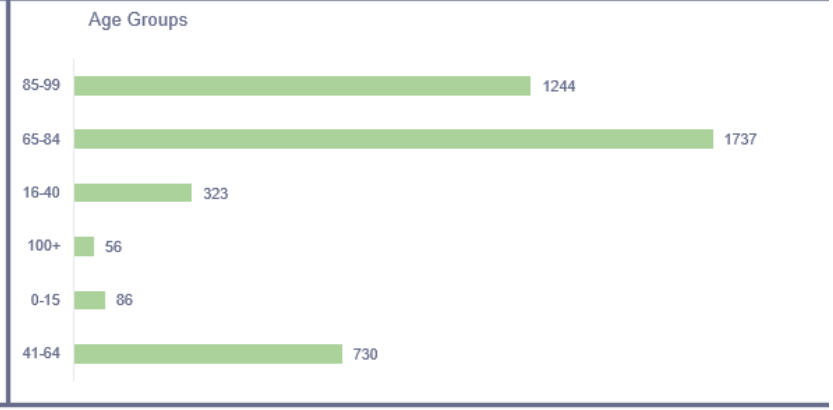
“I cannot begin to tell you the difference, the twice daily visits made to Mum and I. I promised my mother, that she would stay at home and I would look after her, which was important to both of us, but as she became more frail, it because increasingly more difficult to give her the level of care she deserved, during the day and then at night. The virtual ward team were a lifeline to me, having someone at the end of a phone 24/7, to help me cope with Mum's increasing health issues. It removed much of the worry and stress from my shoulders, I no longer felt alone and I was able to honour the promises I had made to my mum. Your wonderful help and support, enabled Mum's final weeks to be dignified and pain free, which is all you want for your loved one. You can not put a price on what you do for families, who are caring for someone, who is terminally ill, even more so, during the current COVID-19 pandemic, which has only compounded families distress and heartache. You are a beacon of light, in very sad, dark and distressing days, the caring does not stop when your loved one dies, you are there for grieving families in the future, to guide them through the grieving process, which can be overwhelming at times.”

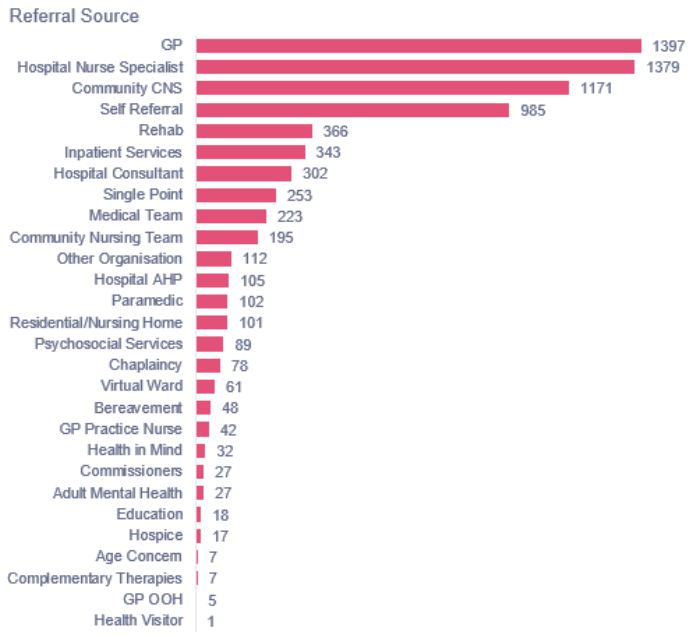
3.1 Overall referrals to St Helena

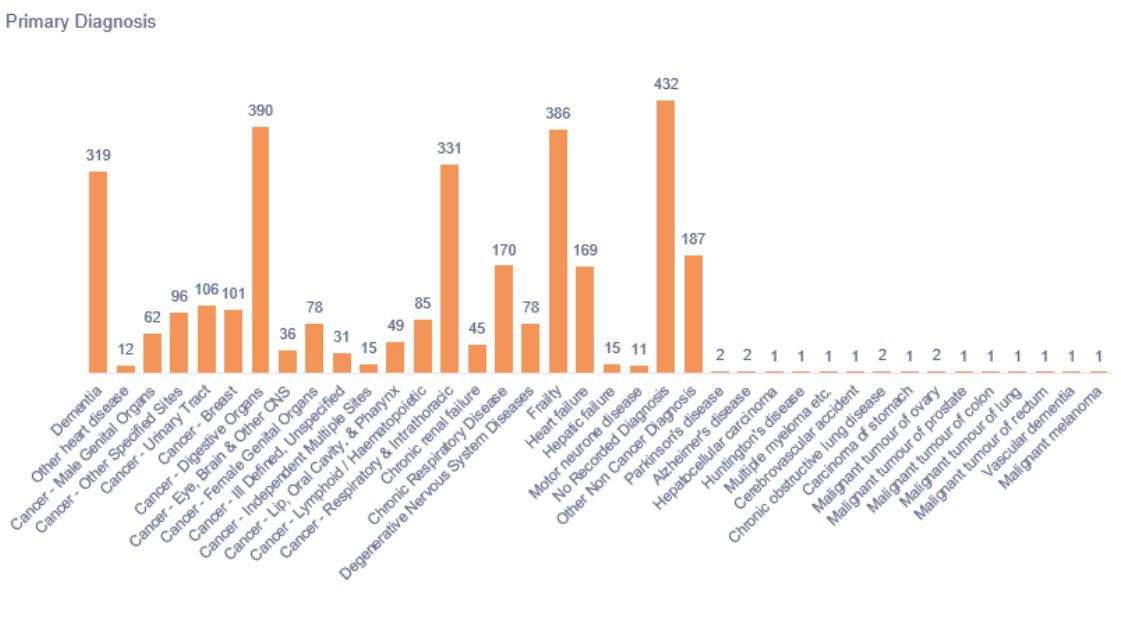
Total Referrals	People Referred	Routine	Urgent	New Referral	Re-Referral					Patient	Family Member	Current Open Referrals	Current Active People	
7493	4165	6797	663	6956	537	5107	2386	1714	2451	3223	942	1747	1142	301
		91%	9%	93%	7%	External	Internal	41%	59%					











3.2 The Hospice MDT

Inpatient occupancy continued to safely accommodate up to 11 patients from our usual 18 bed occupancy.

Visitors were able to book a 90 minute visit each day until the lockdown was announced in November when we unfortunately had to restrict visiting again except for those patients thought to be in the last week of life. Booked visits were reinstated after lockdown. Where possible we have continued to ask visitors to enter bedrooms using outside doors rather than walk then through the unit, complete a Lateral Flow Test prior to visiting, and most importantly not to visit if they are unwell.

Ventilation, social distancing, and correct donning and doffing of personal protective equipment (PPE) has continued with the support of our Infection Control Consultant and key staff following government guidance. Reduced occupancy has provided a little extra time in everyone's day for changing PPE between patients, hand hygiene, and additional cleaning between care, medications, comfort checks, meals, and companionship for patients in the absence of family and friends.

We created a "wobble room" for staff who need to have a "wobble" (see page 32 for details). Wellbeing tips and online courses for staff have been available to assist with staying connected for those in work and those working from home. We greatly valued the support of our "meet and greet" volunteers to assist with spacing visitors, providing visiting agreements, and instructing on correct use of PPE.

We continued to complete weekly environmental cleaning audits and improved our cleaning schedules to include additional cleaning of high touch surfaces around the individual patient bed space. Supported by the Domestic and Estates & Facilities teams, we kept maintained PPE supplies and began work to outsource our laundry service.

Nursing each person alone has been very foreign to our usual practices and community spirit, but we have attempted to compensate with technology, such as phones and iPads.

The COVID-19 Safety Champion has supported the team in complying with social distancing, hand hygiene, and correct use and disposal of PPE by staff and visitors. We also provided additional socially distanced safe spaces for staff to have comfort breaks.

The Care Co-ordinators and the Pharmacist continued to play a pivotal role in achieving a timely discharge for patients once they were fit to return home again. We replaced the role of Healthcare Assistant with Clinical Support Worker. We have developed additional competencies and training and provided further online resources to assist learning and development needs. Training and lectures via Microsoft Teams or Zoom have become the new normal.

Interviewing via Teams has become usual practice in new appointments. There have been challenges recruiting into, Physio, Nursing and CSW roles over the past year. We have seen staff move on to new roles or retire over this past year. Some staff members have

been unable to work because of COVID-19.

The year has been a challenge for many of our patients, families, staff, and volunteers. Our commitment to provide palliative care to those who need us most has continued with courage and continuous compassionate care.

"Thank-you all so much for looking after our mum so well for the 12 days she was with you... She absolutely loved her time with you and we know she felt safe."

3.3 Medical Team

The pandemic has been a challenging time for staff, requiring them to work flexibly to cover whichever services have had the greatest need. Early in the pandemic, our junior doctors were redeployed back to Colchester General Hospital, and this was briefly repeated in 2021. During the second wave we also supported the acute trust with increased Consultant hours. The team have had to embrace remote working and technologies such as video consultations.

Following on from the Nurse Consultant role, the Medical Team have welcomed 2 ANPs to their team. Initially born out of necessity, because of the redeployment of junior doctors during the first wave, this role has proved invaluable on the IPU, providing expertise, leadership, and continuity for both Medical and Nursing teams. We hope the ANP's specialist knowledge will complement our returning junior doctors' medical skills to enhance patient care. Their working pattern has also allowed us to plan routine admissions six days a week instead of five. We are excited to develop this role further.

The pandemic also saw the opportunity to increase the amount of support we receive from our Pharmacy Technician. This has allowed us to improve and strengthen our medicines work and look further afield to support our community teams and community hospital colleagues.

Dr Emma Tempest continues to lead the Team and is now Medical Director for St Helena.

Dr Katherine Oakley is now Training Programme Director for the Eastern Deanery, responsible for specialist trainees working towards becoming Specialist Palliative Care Consultants.

We continue to support three junior doctors on four-month placements at the Hospice. We have identified that this is a difficult placement for newly qualified doctors, and so from September 2021, we will cease supporting Foundation Year 1 doctors. This has, however, given us the opportunity to work with the local GP training scheme to develop a six-month post, which will be split between St Helena and a GP practice. We will take two trainees at a time, who will each be with us two days a week.

We also have two GP associates who started with us in September 2020. They gain clinical experience with St Helena while undertaking the Palliative Care Diploma at Cardiff University. These posts have been successful in the past in producing GPs with specialist knowledge and a close working relationship with the clinical teams at St Helena.

We continue to work to support specific patient groups with non-cancer diagnoses. GSF accreditation has been successfully obtained by Essex

Partnership University Trust and the team continues to support their weekly MDT meeting for patients with dementia. In addition, we have developed MDTs for heart failure and Chronic Obstructive Pulmonary Disease (COPD), and this year will lead on workstreams within the Alliance on these areas, using data from the End of Life Dashboard to demonstrate an improvement in outcomes.

From September 2020 we have reintroduced weekly teaching sessions, which are available to all clinical staff via Microsoft Teams.

From November 2020 we have worked closely with community colleagues to offer regular Community of Practice sessions.

3.4 Hospice in the Home

"As a family we would just like to thank you all for the excellent support and care you have shown to our father … during the past few weeks. Dad could not have received any better care and attention. The nurses who attended to him every day have been absolutely fantastic. Nothing was too much trouble for them and the genuine warmth they showed towards dad was beautiful to watch… The work you all do is amazing and is such a valuable service to both the patient and their families when they need it the most."

At the start of the pandemic, Hospice in the Home (HitH) quickly became the end-of-life hub for North East Essex, coordinating the efficient use of resources across the system to ensure timely access to out-of-hospital care. The hub became the single point of access for the newly formed Primary Care Networks (PCNs). These include GPs, District Nurses, and Clinical Nurse Specialists.

All referrals for the PCNs' end of life care come through the HitH Referrals Team and are then allocated to the appropriate healthcare professional. The Team processed 4,943 referrals during the year. The HitH Team cared for 2,870 patients (not including those on the Virtual Ward – see below) and made 29,485 individual contacts, of which 7,720 were face-to-face.

3.4.1 Clinical Nurse Specialists (CNS)

There are 11 CNS's, and each member of the team is allocated to a PCN. The CNS's hold regular PCN meetings online to enhance and co-ordinate care.

Each PCN divides cares into four levels, which determines which healthcare professional will case manage a patient.

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 Clinical Nurse Specialist (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.

This scheme makes clear to all who should be case managing a given patient. Patients at all levels of care also have access to our 24/7 support line, SinglePoint (SP), and the scheme enables SP staff to know which level of care a given patient is receiving when they call.

Initially during the pandemic, the CNS team were providing essential face to face visits and were encouraged to provide virtual consultations to patients. The face to face visits have gradually increased, as CNSs can now exercise more discretion about which type of support a patient needs.

3.4.2 SinglePoint

"To all the wonderful ladies from and working with SinglePoint, Virtual Ward and the nurses. A massive thank you for all the support and help through the day and night, being there for our mum."

SP is our 24/7 advice and support line. It is supported by call handlers and rapid response senior staff nurses 24/7, and, seven days a week, healthcare assistants and rapid response CNSs who are also non-medical prescribers (NMPs).

SP supports patients to achieve their Preferred Place of Care (PPC) of home and prevent unnecessary hospital admission using telephone support, signposting or rapid/ crisis visits.

The total number of incoming calls into SP over the last year was 45,670. Since COVID-19, the team has worked very closely with the community nursing service, GPs, paramedic crews and the hospital teams to provide support when needed.

The Rapid Response CNS 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 admission. Where appropriate, and with consent, they will also add patients to the My Care Choices Register (MCCR, see page 24). The Rapid Response CNS team has also increased its support for care homes, which have proved a locus for COVID-19 outbreaks.

The Hospice in the Home MDT also has a Physiotherapist, Occupational Therapist, and Therapy Assistant who work very closely with SP and the CNS Team. Typically, they support patients who are receiving Level 3 or 4 support.

Psychosocial support to patients, families (including children) and carers is provided by counsellors and a family support worker. The aims of this service are to:

- 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.

"Dear SinglePoint, As a family we wanted to thank you all for the professional care you gave to my mother during her final journey. Our family is grateful for your care, kindness and concern for our mum. You all greatly assisted wher peaceful transition and gave comfort to us all."

3.4.3 Virtual Ward

The Virtual Ward Team comprises a Clinical Nurse Manager, an Administrator, a Registered Nurse, and nine Health Care Assistants. Prior to the COVID-19 pandemic, we were only able to offer four beds, but we are now able to offer 18 beds for patients in the last two weeks of life, for crisis intervention to avoid hospital admission, or to bridge the gap until a care package is in place. We can offer a twice a day care package and also support families in their time of need.

We accept referrals from various sources, including SP Clinical Nurse Specialists, SP Registered Nurses, the Community Clinical Nurse Specialist Team, GPs, District Nurses, the Hospice in the Home Rehab Team, the Hospice IPU, and other Community services.

Since April 2020, we have been working with Bluebird Care to offer a rapid response service for up to four visits per day for six weeks. Where patients require support for more than six weeks, we refer on to Continuing Healthcare to source an ongoing care package.

3.5 Compassionate Communities

Compassionate Communities is a model being used in various ways across the country. The model encourages us to work with local communities and develop 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. Matters addressed may include practical support around the home, understanding cultural wishes or providing emotional support to an individual's friends and family.

We hope that by developing a Compassionate Community model, we can support our local population to make the best use of the assets within their area and so improve even more their outcomes at end of life.

Currently the project has 4 key areas of work:

1. Firstly, to plan for the period post COVID-19 when our patients and families may want or need to access group support again, such as group bereavement support or peer support from those with the same diagnosis
2. Developing an online portal to allow those at end of life to connect with others in the same position and find support available to them within their community
3. Implement Compassionate Workplaces. We hope to work with local business to help them improve how they support their teams when someone is experiencing issues related to

death, dying and bereavement
4. Build on the work of the Social Prescribing model locally to include a focus on end of life and supporting those communities who do not traditionally access hospice care. Social prescribing is where individuals are signposted to local voluntary sector organisations for support; for example, they may have issues accessing their hospital appointments, so they could be supported to use a community transport scheme.

Five services from within the Hospice have been aligned to the Compassionate Communities model, where we see a potential for them to expand under it. Of course, this will not be possible without the support of our dedicated volunteers.

These services include;

- Bereavement
- Breathlessness
- Chaplaincy
- Complementary Therapies
- Safe Harbour

We will develop the Compassionate Communities approach throughout the year.

3.5.1 Safe Harbour

We suspended the Safe Harbour Project during most of 2020. The Outreach Clinical Nurse Specialist was redeployed into a rapid response role in line with the St Helena COVID-19 strategy. However, we have continued to receive referrals from patients from hard to reach groups and these are still rising. We have now reinstated the role and placed it under the remit of Compassionate Communities (see page 23). We will continue to focus on the work we started with patients with learning disabilities and those with chronic mental health problems. The plan for 2021-22 is also to look at how we can reach Black, Asian and minority ethnic groups and ensure we are doing all we can to support the LGBTQ+ community.

3.6 My Care Choices Register

The My Care Choices Register (MCCR) has proven an especially crucial tool during the year of the pandemic for coordinating people's end of life care preferences. At its peak, during the summer of 2020, 58% of end of life patients in the local system were on the MCCR. At the close of 2020-21, over 4200 people have an entry.

Senior care home staff can now access the Register to support their residents and training on this is being delivered across the region. Clinicians have worked hard to recruit and now over 1,400 local care home residents have a record.

Those registered are likely to be cared for in their Preferred Place of Care at the end of life 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.

3.7 Bereavement Service

"I am writing to say how much I appreciated the bereavement support I've had over the past few months. I completely understand why it couldn't be face to face support, and was happy for phone support. [You] were so caring and professional, friendly, calm and so supportive... so easy to talk to. I feel as if the clouds have lifted."

The Bereavement Service counsels and supports bereaved adults across North East and Mid Essex, irrespective of the cause of death. The service comprises a service manager, five counsellors, two support workers, three administrators, 15 volunteer support workers, and four trainee/volunteer counsellors. 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.

In 2019, the service adopted the four tier model for psychological support specified by the National Institute for Health and Clinical Excellence (NICE), and we use this for triaging and allocation to staff.

As a result of the pandemic, we moved from face to face work to telephone or video counselling sessions. The Team was initially reticent and feared that some of our vulnerable clients would suffer; however, the change was met with understanding and telephone sessions have proven popular with the majority. We were delighted with this response and intend to continue offering telephone support to most of our clients once the pandemic is over. We feel the quality and effectiveness of our services have remained high and that they remain sought after by individuals and professionals. During 2021 our service held two virtual, counsellor led groups with weekly themes pertinent to grief that is experienced by loved ones bereaved by suicide. Feedback suggests these were well received.

Most volunteering for the service ceased during the first lockdown. Some volunteers have now returned and are being supported by the Service Manager and Volunteer Services Team to undertake their mandatory training.

At the outset of the pandemic, we saw referrals decrease markedly, in line with other bereavement services in the East of England. Referral numbers began to increase in January 2021 and are now slightly above service average. Demand for counselling support has increased; we believe because of external healthcare professionals becoming more aware of our reputation, particularly for caring for people who have lost loved ones to sudden or traumatic death or mental ill health. The increase in demand (and waiting times) has prompted us to reduce sessions from 50 to 35 minutes and to increase the number of calls staff make per day. We hope that additional funding may become available to enable us to increase our staff of counsellors and the length of sessions. Our waiting lists for all counsellor led services are approximately 4-8 weeks.

We look forward to another year of supporting bereavement needs in the community.

3.8 Complementary Therapy

The Complementary Therapy (CT) service offers treatments to support patients and their families and carers through periods of anxiety and stress associated with illness. We take a holistic approach to sustaining the whole person, easing their symptoms, improving their sleep, and providing general comfort in a therapeutic and compassionate environment. Patients can also use our therapies safely alongside any medical treatments they might be receiving. The CT service also supports those who access St Helena's Bereavement Service. Therapies are provided by dedicated and professionally qualified complementary and beauty therapists, who work on a voluntary basis. The service is led by a professionally qualified CT Team Lead. The Team also includes volunteer chiropodists and our Pets as Therapy (PAT) dogs.

During the pandemic, we initially suspended face to face therapies and treatments while the Team Lead was redeployed to SinglePoint. The Lead supported staff by helping (along with Chaplaincy) to create a 'wobble room' for staff to find some respite from the pandemic. We accompanied this with a 'wobble' booklet, sent to those furloughed and working from home. We also supplied staff with aromatherapy inhalers to manage their stress, anxiety, fatigue, and grief during this time.

Support for patients and families/clients had to be adapted while face to face services were suspended or restricted. We did this by sending aromatherapy inhalers to patients and families, as requested by the CNS team and the nurses on IPU, as well as those within the patient and family counselling service. In October 2020, the CT team lead was able to provide treatments to patients on the wards and has continued to do so, adhering to the strict infection and prevention control measures.

Despite all the changes and restrictions that were in place during 2020-21, the service managed to provide 117 complementary therapies sessions for patients or their families/clients.

The CT Team Lead also provides wellbeing and mental health information, support and guidance to staff and volunteers. Courses have been arranged for line managers in managing mental health at work and additional Mental Health First Aiders have been trained. St Helena has also joined Working Well Essex, who will provide various wellbeing support and activities. Regular information and webinars are made available for all staff.

In November 2020, there was a restructure and Complementary Therapy became part of Compassionate Communities (see page 23). The team are looking forward to developing this great service.

The process to bring the volunteer team back to their roles has started, and we look forward to their fantastic support for our patients and families.

"We are and will forever be truly grateful for all your hard work to care for our wife and mother … The warmth, compassion

and love you showed her during those long 10 weeks was inspirational. … adored you all so very much and you made her final weeks as comfortable as possible. She never wanted to last as long as she did at the end but she was determined to spend them at St Helena. Her decision was thoroughly vindicated as we are now left with lovely memories of visiting her in a safe and comfortable environment - which is what she wanted. The Hospice will be close to us and we'll hold it always in our hearts. Thank you for giving her the dignifty and care she deserved."

3.9 Breathlessness

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

During the pandemic, all face to face clinics and groups were suspended and the service was run virtually via phone or video consultation by the RN (who happened to be on the shielding list). This provided an opportunity to experiment with remote working and support. This worked better than anticipated from both the clinician's and patients' perspectives.

A virtual 'Breathe Happy' Group was also commenced and has had some success, although it only reaches a few patients because of varying degrees of IT capability among patients.

As a result of restructuring, the Breathlessness Service now sits under Compassionate Communities. The service will continue to offer the direct, one to one patient contacts and some of the previously delivered Breathlessness education programme. We will look to offer a mix of both face to face contacts and phone or virtual consultation, based on patient need.

In terms of peer support groups, we will look to collaborate with other groups offering similar services; for example, the group run by the British Lung Foundation, 'Breathe Easy'.

Staffing requirements for this service are currently being reviewed, and we are seeking further external funding to increase capacity.

3.10 Safeguarding

The St Helena social worker continues to support staff with various safeguarding concerns; including working with the Police and local adult and children's services. We aim to adopt a preventive safeguarding aproach with patients in the last few days of life, which can involve complex family dynamics. In these situations, the social worker gathers all the necessary information and devises safety plans to resolve concerns, often without having to refer to the local authority (which may not be ideal in last few days of life).

In March 2020, at the outset of the pandemic, St Helena saw an increase in safeguarding referrals, as vulnerable people were left with reduced support services and patients and families reached crisis point. St Helena also completed a re-structure, which provided for one social worker to support staff in safeguarding, mental capacity, and deprivation of liberty.

Safeguarding posters have been updated to reflect the organisational changes and information relating to the six safeguarding principles staff need

to adhere to (Empowerment, protection, prevention, proportionality, partnerships and accountability) have been re-issued to the various teams.

We are currently reviewing our children and adult safeguarding policies to ensure they are up to date and in line with Essex County Council safeguarding policies and procedures.

Unfortunately, face to face safeguarding training ceased during the pandemic, but all staff continued to undertake their mandatory children and adult safeguard training online. The social worker has continued virtual safeguarding training at the appropriate level with Essex Safeguarding Boards for both adults and children. She has also recently commenced monthly clinical supervision with an operational manager from adult social care, thereby giving her a rich source of knowledge and expertise within safeguarding and current legislation. Our quarterly Safeguarding Group meetings will resume shortly.

"We cannot put into words how grateful we are for all you did. From the first phone-call, everyone on the phones, just one call and you were there for us. You took all the worry from us, and made us able to focus on mum. Every nurse, every carer, every Virtual Ward call, was handled with compassion and care. We could not have coped without every one of you. You helped make mum's last days with us dignified and peaceful."

3.11 Chaplaincy

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.

In the past year, we have sought to adapt our service to fit within the current COVID-19-safe ways of working. We have served patients in the community by offering telephone support where possible. We have also continued to have an active presence in The Hospice and, when lockdown restrictions prevented visiting, we have spent additional time sitting with patients who were lonely.

We have made use of technology by providing a weekly virtual religious service and set up a group for isolated patients within the community.

The Chaplaincy Team has sought to help support staff where possible through providing mindfulness sessions and helping (with the Complementary Therapies manager) to create a 'wobble room' for staff to take some time out when needed.

Chaplaincy is actively involved in St Helena's Compassionate Communities project (see page 23), contributing to the Compassionate Workplace project and Dying Matters week. We are currently putting things in place to assist a local charity to provide support in schools around spirituality at end of life and to launch some initiatives involving working with external organisations to help our patients live well before they die.

This past year, we have seen an increase in the number of patients requesting to get married. This has been complicated by infection control restrictions at the local Registry Office, but with the assistance of some helpful

local clergy, we have not yet let anyone down.

3.12 Education and training

At the beginning of the pandemic, we suspended all training and redeployed staff with clinical skills. When it became clear that this would be for a prolonged period, we made the difficult decision to reduce the number of staff within the Team, leaving two Practice Educators as we restructured to our new model of care (see page 4).

During the first wave, training focused on updating staff around rapidly changing government guidance. We developed new resources on changes to procedures around verification of death and death certification and to support staff's understanding of correct use of PPE and other infection control measures. From July 2020, a fortnightly Microsoft Teams live event was established to help keep staff abreast of the ongoing situation and evolving national guidance.

From September 2020, the Medical Team made a weekly online teaching session available to all clinical staff.

From November 2020, St Helena staff contributed to Community of Practice sessions led by the Alliance End of life board, aimed at GPs and community nurses.

One practice educator returned to post in November 2020, with the second joining her in January 2021. Unfortunately the second wave meant further redeployment to clinical roles and a further suspension of face to face training.

Our priority on restoring our Practice Educators was to ensure staff were up to date with mandatory training, in particular Manual Handling and Basic Life Support. Following the restructuring, they are working closely with Inpatient and HitH Matrons to identify specific training needs, support with clinical supervision, and help staff to complete agreed competencies for each role.

Other specific projects have included:

- Provision of online resources for blood transfusion annual update.
- Provision of online resources for nurse verification of expected death.
- Promotion of the nutrition and hydration policy.
- Supporting the launch of the newly developed standard operating procedures for medicines management.
- Circulating and signposting to online resources.
- Circulation of monthly updates from East Anglian Children's hospice Library department.

Our Practice Educators have also taken time to reconnect with contacts in local nursing homes, to offer support and signpost them to online resources. St Helena is a regional training centre for the Gold standards Framework (GSF). Our commitment to training a third cohort of nursing homes for GSF accreditation remains and we have plans to offer this from September 2021.

The need for staff to have an opportunity to share and reflect was identified and both Practice Educators are now trained as Schwartz Round facilitators. Alongside our existing facilitators they have reintroduced

Schwartz rounds in a virtual format. We have also extended this to Bluebird Care staff with whom we partner to provide our Virtual Ward (see page 21).

3.13 Freedom to Speak Up Guardian

There are currently 670 Freedom to Speak Up Guardians (FSUG) in 442 organisations across the UK. Freedom to Speak Up Guardians provide an alternative route to support workers to speak up. They ensure those who speak up are thanked, that the issues they raise are responded to, and that the person speaking up receives feedback on the actions taken. They also work proactively to support organisations to tackle barriers to speaking up.

At the onset of the lockdown, we furloughed our Staff Development & Freedom to Speak Up Guardian and the Head of Quality & Compliance took over in her absence. During that time, the FSUG dealt with two instances of staff wanting to 'speak up,' in both cases raising concerns about reorganisation and restructuring. The Guardian took these concerns to the appropriate level of management and, without revealing the identities of those who had spoken up, obtained a response with which both were satisfied.

Since April 2021, we now have a team of three guardians: the Head of Quality & Compliance, the lead Chaplain, and a Trustee. All three have completed online training.

"I am writing this letter as a small gesture of my appreciation for the wonderfully expert and kind help our family received from all St Helena, SinglePoint and Virtual Ward staff during my wife's final illness. I confess I was just about on my knees. [Your] prompt, decisive and expert intervention saved the day and faithfully continued throughout the little time … had left. Before she lost her power of speech, … told me I must write to you with her personal thanks…"

3.14 Quality of the environment

Keeping premises safe during COVID-19

At the outset of the pandemic, ahead of the first lockdown, we converted our former Activities Room to a two-bed bay. We also converted various meeting rooms to socially distanced office space.

At the beginning of lockdown, we supported the new, more stringent visiting policy by securing our Inpatient Unit terrace and putting up new signage.

As we ceased day therapies activities in our Joan Tomkins Centre, we were able to take advantage of them being empty by refurbishing rooms and adding infection control compliant flooring. These rooms also helped later with storage pressures, including PPE and excess furniture removed from socially distanced offices. We were also able to convert one room to a socially distanced meeting space.

Our Health and Safety Team worked with Human Resources to support staff to work from home safely; for example by providing display equipment and guidance. We also redeployed staff from Retail and elsewhere in Patient and Family Services to strengthen our

Domestic and Infection Prevention & Control activities.

We reshaped our Maintenance Team into two, to provide six day a week cover. This also allowed us to continue with projects such as replacing a fire escape pathway, redecorating certain areas of the IPU, and upgrading carpet to altro flooring.

Personal Protective Equipment and consumables

Establishing and maintaining PPE stocks was a key priority during the initial stage of the pandemic. For instance, a Facebook appeal to dentists helped secure stocks of a particular face mask until national and regional suppliers improved their capacity. We had already built up stocks in advance of a 'no deal' Brexit, which assisted with initial shortages. From then on, we accrued a five week supply to hedge against a potential collapse in the supply chain. Later, we maintained one month's supply at minimum and, in many instances, three months' supply of consumables. We benefited greatly in this effort from support from our Infection Prevention & Control Volunteer Consultant, Caroline Vergo, whose knowledge ensured we didn't waste money on unnecessary or unsuitable stock. We also worked with other hospices to collect and distribute supplies from Hospice UK.

Social Distancing Measures and the evolution towards COVID Secure workplaces

We introduced social distancing ahead of national guidance by encouraging staff to work from home (and owing to several who were required to shield). We later used draft government guidance to adapt work areas to be 'COVID secure,' becoming an early adopter of social distancing floor markings, and using signage, training, and workplace risk assessments. This later fed into a Social Distancing Policy (909). While the tape and signage detract from St Helena's traditional, 'homely' feel, it is worth it to change behaviour and remind people that there is still a risk to be managed. The Health & Safety Manager issues regular updates to staff.

When national guidance evolved, our Human Resources Team issued a health questionnaire to all staff, which became the basis for individual staff risk assessments. The Quality & Compliance Department supported this with a bespoke risk assessment form on our Sentinel risk management system.

In September 2020, we appointed a volunteer receptionist as our first Volunteer Social Distance Champion. Their audits have led to improvements such as:

- Increased Perspex screening in Main Reception.
- A dedicated PPE station in the main entrance.
- Perspex screens in the dining room.
- Closure of the main entrance to reduce contact with the public.
- Additional, secure welfare areas for staff.

Infection Control

Infection control has been even more important during the pandemic. We have increased deep cleaning and supported barrier nursing with portable PPE and sanitisation supplies. The

Infection Prevention and Control Group has convened meetings throughout the pandemic, and we have significantly increased auditing. We have also developed a new infectious waste policy and facilities to support community staff.

Staff Health and Wellbeing

Maintaining staff wellbeing during a difficult year has been a priority for us. We established a 'Wobble Room' with the aid of our Chaplain and Complementary Therapies Manager, which provide soothing music and lighting and various mindfulness activities. As anxiety levels were high, we organised regular meetings to keep staff informed on national guidance and developments. We also surveyed staff to understand their views on how they could best be supported. Where needed, Estates & Facilities staff safely transported potentially COVID-19 positive staff to testing centres.

Our Mental Health First Aider continued to help and advise staff throughout, and we have since expanded that team to five. Finally, a request for donations, ensured that staff received kindnesses such as Easter eggs, toiletries, and free meals.

Site Security

We have recently updated our CCTV to a new, cloud based system with much greater functionality, allowing real time surveillance of key areas. We have also issued lone working devices to our community, evening IPU, and domestic staff on late shifts.

Myland Hall Car Park improvements

In March 2021, we began work to add 15 spaces to our front car park. We have also begun improving lighting at our middle and front car parks.

Patient Led Assessments of the Care Environment (PLACE) Assessment

Last year. the NHS deferred PLACE assessments and no new dates have been set. We will still be carrying out a 'PLACE lite' assessment later in 2021.

Tendring Centre Vaccination Centre

From December 2021, we have made our previously mothballed Tendring Centre in Clacton available as a COVID-19 vaccination centre. This required considerable work by the Estates & Facilities Team to make the site suitable after its period of disuse. An average of 1,000 patients a week have been vaccinated at the Centre and, to date, over 30,000 people have used it.

Figure 1 St Helena Tendring Centre operating as COVID-19 Vaccination Centre

3.15 Volunteering at St Helena

St Helena's volunteers are an integral and valued part of the organisation, and, as with so many other charities, the pandemic has had a vast impact on volunteering with us. The first lockdown forced us to close our shops, so most of our volunteers could no

longer carry out their roles, and many had to shield or chose to self-isolate.

In May 2020, the relaxation of lockdown to include non-essential shops allowed us to launch our initial 'Bringing Back Volunteers' Project (BBV). This involved asking volunteers to complete health questionnaires, checking how many were on the government's list of 'clinically vulnerable' or 'extremely clinically vulnerable,' and carrying out risk assessments.

Lockdown and social distancing seriously affected our Retail operations, in which 500 volunteers are involved, whether in sorting, pricing, till work, or general customer service. Volunteers in patient facing roles were asked to step down to reduce infection risks. This placed more pressure on IPU and catering staff. Some temporary volunteers were recruited to assist in the kitchen, and staff who would otherwise have been furloughed were redeployed to roles such as Ward Helpers and Reception.

Where we are now

When the Government announced the easing of lockdown in April 2021, the number of criteria that marked people as 'clinically vulnerable' or 'extremely clinically vulnerable' increased. This required refreshing our individual risk assessments.

Once redeployed, staff started to return to their normal roles and more volunteers were asked if they would be willing to return. There has been a slight increase in numbers, but they are still low in non-retail roles.

We are now liaising with non-retail line managers to gradually bring volunteers back on a service needs basis and ensuring that no volunteer returns without completing their health questionnaires and risk assessments where required.

Many volunteers chose not to renew training or Disclosure and Barring Service (DBS) checks while they were unable to continue in their roles. As part of the BBV projects, we are ensuring that all volunteers are compliant with mandatory training and DBS checks before they return.

Volunteer numbers for the past financial year (1st April 2020 – 31st Mar 2021) as follows:

- On 31st March 2020, we had 847 volunteers.
- Between 1st April 2020 to 31st March 2021, 158 volunteers left the organisation with 40 stating COVID specifically as the reason
- Recruitment was reinstated in June 2020, and we recruited 106 new volunteers up to 31st March 2021
- On 31st March 2021, volunteer numbers were down to 795

During what has been a very difficult period for everyone, while some have decided not to return following lockdown for their own personal reasons, most volunteers have remained loyal. There have been frequent communications to volunteers keeping them informed about how the pandemic has affected St Helena, the processes required for returning to their roles and information on health and wellbeing. We introduced a virtual Friendship Group where volunteers could meet their colleagues and we acted as a go between to reunite volunteers with their colleagues so that

they could engage in social activity for their mental well-being.

Our plans for 2021 – 2022

We continue to work with line managers to increase the number of active volunteers. We will continue to ensure that active volunteers returning to their roles complete the relevant health questionnaires and risk assessments are in place where required, and that all volunteers are compliant with training and DBS checks.

We plan to review volunteer roles following our restructuring and the pandemic, and because of our reduced presence in the community, we will liaise with the Marketing Team to take a more online approach to recruitment.

The Volunteer Services Team will always support both volunteers and line managers to ensure our volunteers receive the best experience throughout their volunteering time at St Helena, from beginning to end.

"I wanted to write and thank the hospice for everything that they did for my father when he was dying last spring. The service provided by SinglePoint was extraordinary. The speed with which everything was provided for my father to be looked after at home was astonishing. Equipment and carers were put into place for me, making such a difficult tie a little easier. Every person who came into Dad's home was kind, respectful and compassionate. The nights were often problematic but there was always someone at SinglePoint to help. When my father was admitted to the Inpatient Unit for the final few days of his life he was treated similarly well. This year has been a huge challenge to many people and being the sole visitor to my father was very hard. I was grateful to find myself in slightly familiar surroundings with outstanding nurses, support staff and volunteers. My father had a great sense of humour, really up until the end and the nurses and carers responded equally. Despite having consumed very little in the days prior to being admitted, when asked if he would like anything, he replied "some soup and a gin and tonic please". Impressively, this was duly brought out but sadly not touched. I have always known that the hospice does great work and now I have witnessed it first hand and will be forever grateful for the care we received."

3.16 Quality markers

3.16.1 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.

Our IPU nurses report all pressure ulcers to the Tissue Viability Lead, who then investigates them and determines whether all appropriate safeguards were in place. If not, we deem the ulcer 'avoidable.'

During the year, we have suffered disruptions to our reporting and investigation because of COVID-19. That said, we were able to address the backlog on incidents during Quarter Two. At the beginning of the pandemic, we simplified our IPU care plans to alleviate some of the pressure on staff, but we were able to revert to the standard plans by the beginning of

June last year, restoring the quality of documentation. During August, the graded pressure ulcer care plans were reviewed to be more user friendly, and a body map was added. A further care plan for moisture lesions was introduced. The pressure area monitoring care plan now incorporates a full skin assessment tool (ASKIN tool). These changes were all made to further improve pressure ulcer documentation.

IPU now has a reference grading tool for each computer on wheels, so this has helped to standardise practice. We also now have the specific dressing requirements for each grade of ulcer on the care plans to ensure the correct dressing is used.

Overall, our standard of documentation improved over the course of the year, evidencing the high level of care we provide for patients with this problem.

3.16.2 Falls

We strive to prevent our patients falling and recognise the challenge of keeping seriously ill patients safe while promoting independence, rehabilitation, privacy, and dignity. As 'Patient Safety 1st' put it in 2009, 'a patient who is not allowed to walk alone will very quickly become a patient who is unable to walk alone.'[1]

Despite our best efforts, however, falls do occur within the hospice. All our IPU nurses are educated in falls prevention and, when patients do fall, how to assess risk and prevent any further injury. This includes taking a falls history as part of the admission process.

Our Falls Lead analyses fall incidents reported through our Sentinel system. They determine whether a falls plan had been created and correctly followed and all reasonable precautions put in place. Based on this, falls are categorised as 'avoidable' or 'unavoidable.' The Falls Lead checks that all necessary actions were carried out following the fall; for example, that the patient was seen by the Medical Team if needed and that we fulfilled our duty of candour by informing the patient's family/carers.

The Falls Lead also determines whether any further precautions are required; for instance, using a 'low rise bed', or moving a patient to a different room where they can be monitored more closely.

During the year, we reported a somewhat higher incidence of falls than usual, likely the result of admitting more patients who were less mobile. Naturally, the COVID-19 pandemic has resulted in changes to IPU, principally reduced occupancy of the bays (because of the need to isolate patients pending negative swab results).

IPU now has three beds with integrated pressure sensors, which can be used to alert staff when they are vacated. These potentially offer a slightly earlier warning than bedside pressure sensor mats, and without some of the disadvantages: wires (trip hazard), their one year operational lifespan, and themselves being a falls

[1] Patient Safety 1st (2009) "The 'How to' Guide for Reducing Harm from Falls", p. 6, available at https://www.rcplondon.ac.uk/file/927/download?token=tq5LdXuy. Accessed 18/04/2016.

risk when some patients try to step around them.

"Thank you for being a lifeline of help and support… your empathy and compassion gave Dad a safe haven during dark days."

3.16.3 Medicines Management

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

Medicines errors are reported via Sentinel and analysed by the Medicines Management lead for prescribing errors and by the IPU matron for administration errors. External errors are reported to the appropriate agency.

Our Controlled Drugs Accountable Officer (CDAO) also reports controlled drug errors quarterly to our Local Intelligence Network.

As with every other part of the organisation, the Group had to act in response to the pandemic. This action included:

- Agreeing a new medicines authorisation chart for patients dying of COVID-19 in the community
- Implementing emergency drug boxes in Clacton and on IPU for the use of community hospice team and Anglian Community Enterprise (ACE) prescribers to ensure timely access to drugs in the community.
- Writing new guidance on alternative drugs and routes of administration in case of shortages of common end of life drugs during the pandemic - this was shared locally and with Hospice UK at their request.
- Agreed with ACE to allow prescribing rules changes to reduce delays in patients receiving time-critical medication.
- Our senior pharmacy technician becoming End of Life lead for the community hub and increasing her hours on IPU.

Other, non-COVID-related activity includes:

- Writing new standard operating procedures (SOPs) to improve standards of medicines management on IPU
- Produced an education alert about the management of constipation.
- Several audits of electronic prescribing.
- Approved label printer for IPU to improve safety of re-labelled medication.
- Improvement to VTE prescribing following a national alert.
- Instigation of daily fridge monitoring and CD checking and documentation.
- Agreement for St Helena Hospice to take over responsibility for community prescribing of alfentanil with Colchester General Hospital dispensing. This is to reduce the risk of errors in response to local concerns.
- Medicines Management Group now reviews reports on missed doses and on monthly IPU budgeting.
- SOP for transfer of controlled drugs.

- Implemented a single Simplified Opioid Conversion Chart.
- SOP for controlled drugs records – monitoring, length and security of storage, record of destruction.
- Self-administered medications (SAM) audit, including information provision to patients.
- Implementation of risk assessment questionnaire for all patients admitted to IPU to determine need for lock boxes to store injectable anticipatory medicines on discharge.
- Formalised audit of emergency End of Life drugs on IPU.

"My family and I, owe the virtual ward team a huge debt of gratitude, for the wonderful care they gave, not only to … but to my aunt and I, in the final weeks of her life. Mum always looked forward to seeing her team of Angels…"

3.16.4 Infection Prevention & Control

For most of the year 2020-21, the IPC focus was on the COVID-19 pandemic and ensuring the ongoing safety of patients and staff.

The IPC Consultant was available online and on site, meeting with staff from all disciplines individually and in groups from the IPU, SinglePoint, the Virtual Ward. and Therapies. Nursing, Medical, Allied Healthcare Professionals, Facilities, Domestic, Administration and Catering Staff were all provided with information relating to the virus, mode of transmission, the chain of transmission and how to break it, the appropriate use of PPE and safe donning and doffing. This advice was in line with National Guidance from Public Health England and staff were updated whenever that guidance changed. In addition, staff likely to be involved with patients undergoing Continuous Positive Pressure Ventilation (CPAP) or Non-Invasive Ventilation (NIV) were trained and fit tested for filtering facepiece (FFP3) respirators, initially by a professional external company. Since then, in-house trainers have been trained and adequate numbers of staff are now fit tested.

Throughout, the IPC Consultant has advised Estates & Facilities staff about PPE and the appropriateness (or not) of any donated items or consumables; e.g. alcohol-based hand rub or items obtained from outside the usual supply chain. This was particularly important in the early stages of the pandemic when supply could not be guaranteed via the usual NHS supply chain. The hospice has been fortunate to benefit from huge support from individuals and businesses. This has meant that we have always been able to secure sufficient safe and appropriate supplies for the protection of staff and to ensure the continued safety of patients, even when shortages of items were being widely reported in other locations.

St Helena opened to controlled visiting for those indicated to be at the end of life early in the pandemic and this was extended in Quarter 2 to 'routine' visiting for all patients by an appointment only system for one person to visit for a maximum of 90 minutes per day. This was controlled and managed and deemed important for the emotional wellbeing of patients and their loved ones. At a time when there was national concern about the lack of access and visiting in nursing and residential homes, St Helena was

able to safely manage the situation with the help of volunteers to meet and greet and advise about the donning and doffing of the PPE (aprons, masks and gloves). Sadly, in December, when the variant strain of COVID-19 was identified as being prolific in the South East and reported to be approximately 50% more transmissible, visiting was once again restricted to those deemed to be at the end of life only. These restrictions were eased in early March 2021 in line with the acute sector and on a pre booked basis for all patients and generally limited to one visitor per patient. This is being kept under review and restrictions will be further eased as and when the local and national situation permits.

All patients admitted to the IPU during 2020-21 were nursed either in single rooms or as the sole occupant of a four bedded bay. They were swabbed for COVID-19 on admission and routinely on day 5-7 of the admission. Over the course of the year, 36 COVID positive patients have been cared for in the IPU.

In late January 2021, the IPC Consultant was informed that two members of IPU staff had tested positive for COVID-19. There were no links identified between the two staff members (they did not work or take breaks together) but, as a precaution, the IPC Consultant advised that all inpatients should be screened. This identified one individual who had been an inpatient for several weeks, had previously only had negative screens and had not had any visitors. This finding met the criteria for identifying an outbreak and the Clinical Commissioning Group and Public Health England were informed. Staff testing was increased from twice weekly Lateral Flow testing (LFT) to daily testing plus weekly Polymerase Chain Reaction (PCR) testing and patients continued to be tested weekly. The outbreak was formally closed on 1st March 2021, 28 days after the identification of the last positive case. In total, 10 IPU staff, one volunteer, and the patient mentioned previously tested positive as part of this outbreak, which was managed according to procedure.

In early February, an outbreak was identified among Virtual Ward staff who care for patients in their own homes. Four staff were affected, but there was no link between any of the Virtual Ward and IPU staff, so this was classed as a separate outbreak. Working links between the four Virtual Ward staff members were identified. This outbreak was also formally reported, and procedure followed, and it was formally closed on 4th March 2021, 28 days after the last reported positive case.

The above outbreaks coincided with the peak in national figures for COVID-19 cases 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 IPC Consultant has been working with staff to prepare them for any CQC visit, since all hospices will now be assessed according to the same criteria as acute hospitals, unlike nursing and residential homes. Work has been undertaken to improve compliance with Health Service regulations relating to healthcare laundry to ensure that routine, high

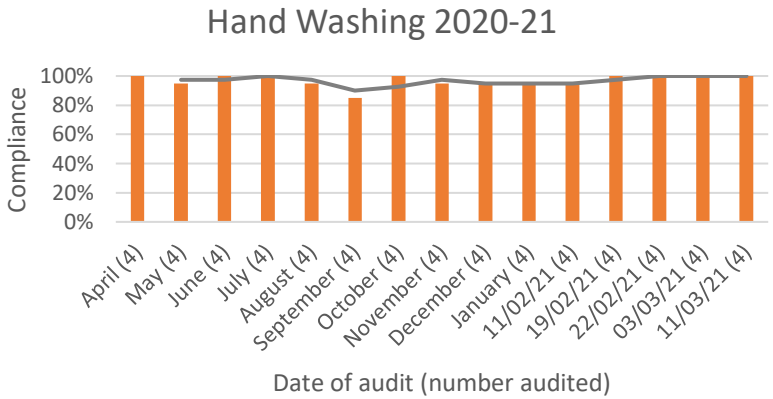
volume items are collected and laundered by a commercial laundry service. The aim is to ensure that only the delicate, special and non-bulk, non-high-volume items are laundered in St Helena's own laundry e.g. slings, hoists, slide sheets, and special velour throws (i.e. items that would get destroyed or lost in the industrial laundry process). Because of several problems with the laundry contractor, this is still work in progress. The advice of a healthcare laundry specialist is currently being sought.

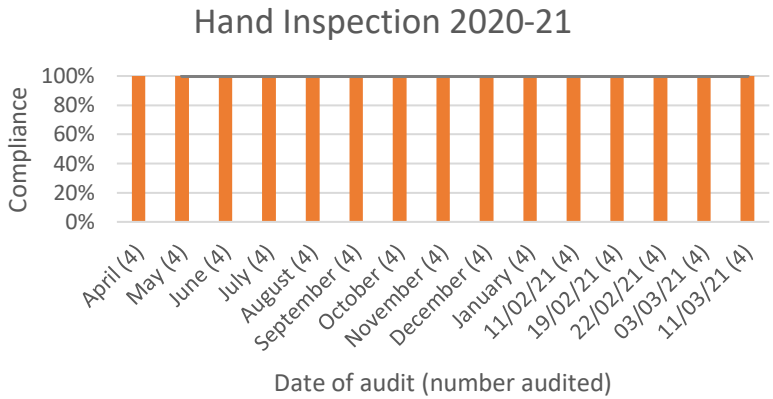
In general, IPC at St Helena has been updated and regulated to bring it in line with NHS acute trusts with regard to application, reporting and assurance. Policies have been updated to reflect national guidance and practice has been amended in line with best practice; e.g. dynamic mattresses are now sent off site for professional decontamination between each patient use. Only bedding that can be laundered via an automated process is now used, as opposed to duvets which could only be surface wiped. This rigor regarding the correct application of IPC has been achieved without detriment to the relaxed, welcoming atmosphere for which The Hospice has always been known. There is further work to be done but service users, staff, volunteers and visitors can be confident that St. Helena provides a safe and comforting environment for staff, patients and families.

IPC audit reports for this period are shown below with text explanation where required.

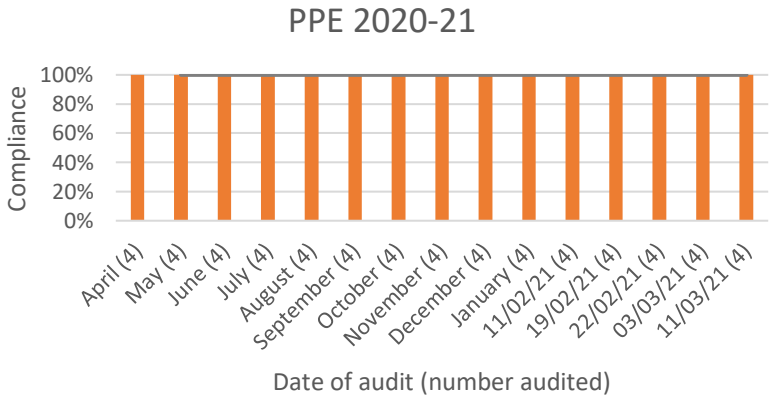
"Thank you so much for your kind thoughts which are much appreciated as is all the help you have given us these past few weeks. I have comfort in the fact that … stayed in his own home until the end which is what he wanted and passed away very peacefully and without pain."

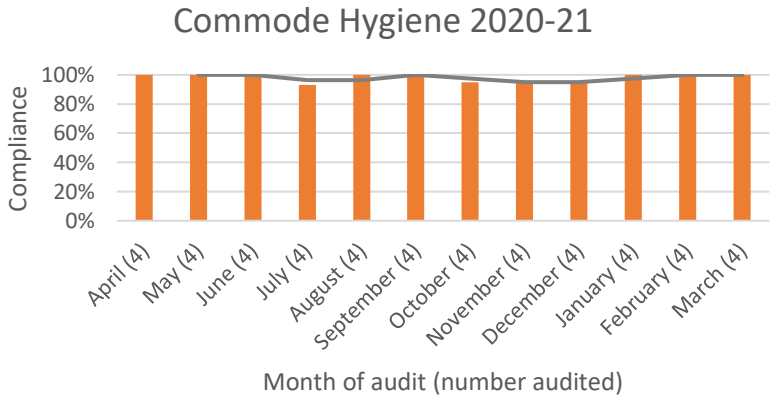
Hand Washing and Hand Inspection



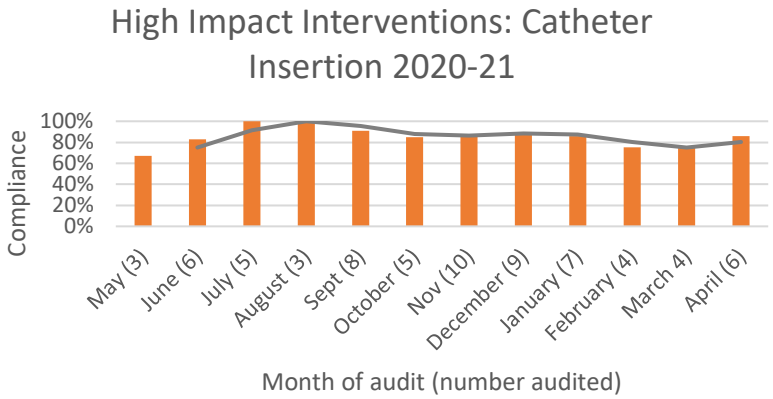


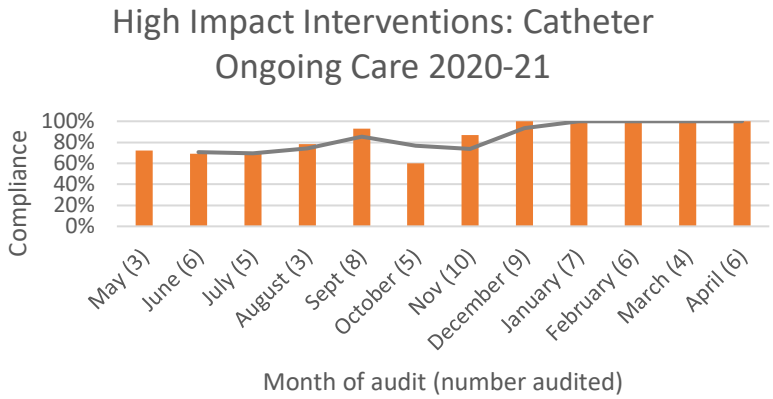
PPE and Commode Hygiene





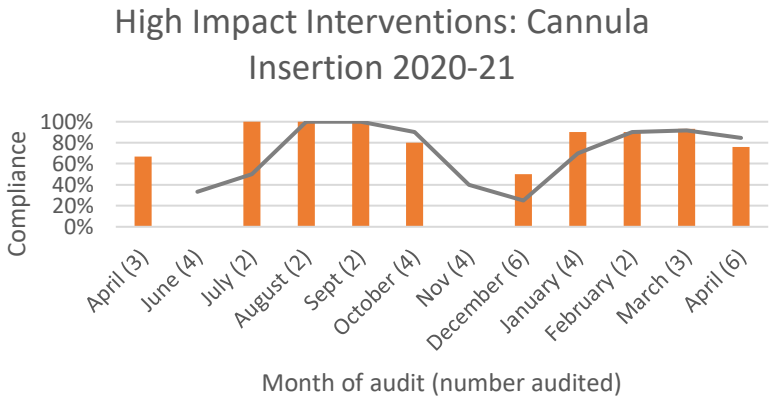
High Impact Interventions: Catheter Insertion and Ongoing Care

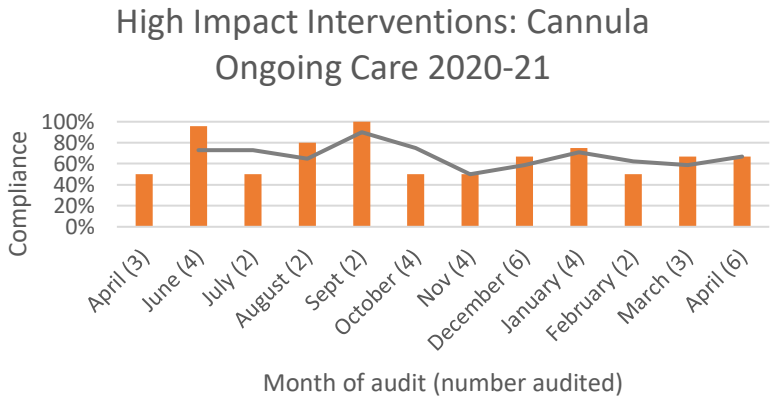




NB. There were no catheter insertions in April 2020.

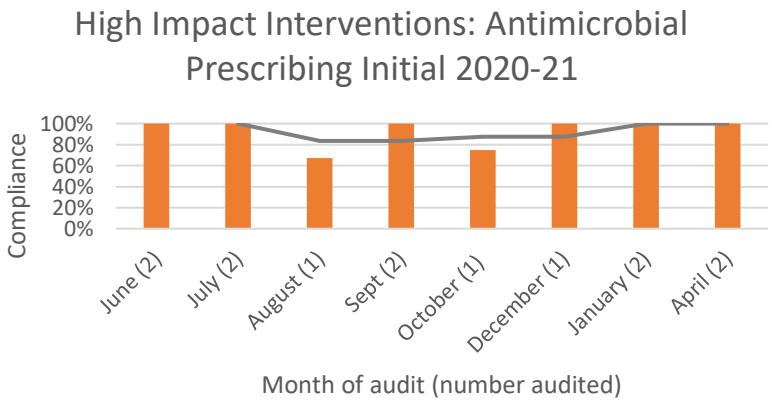
High Impact Interventions: Cannula Insertion and Ongoing Care

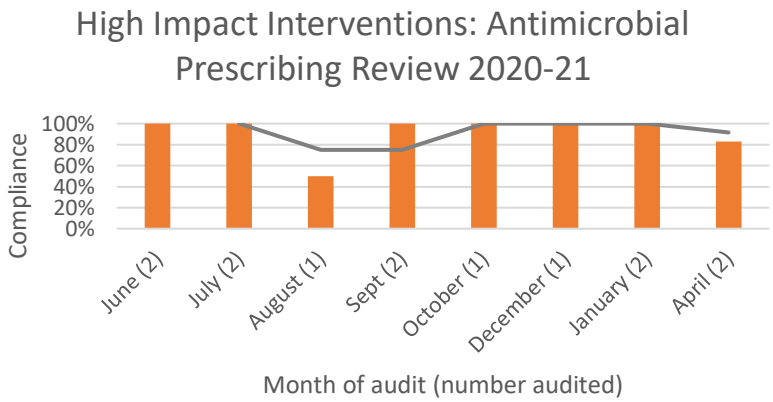




NB. There were no cannula insertions in May 2020.

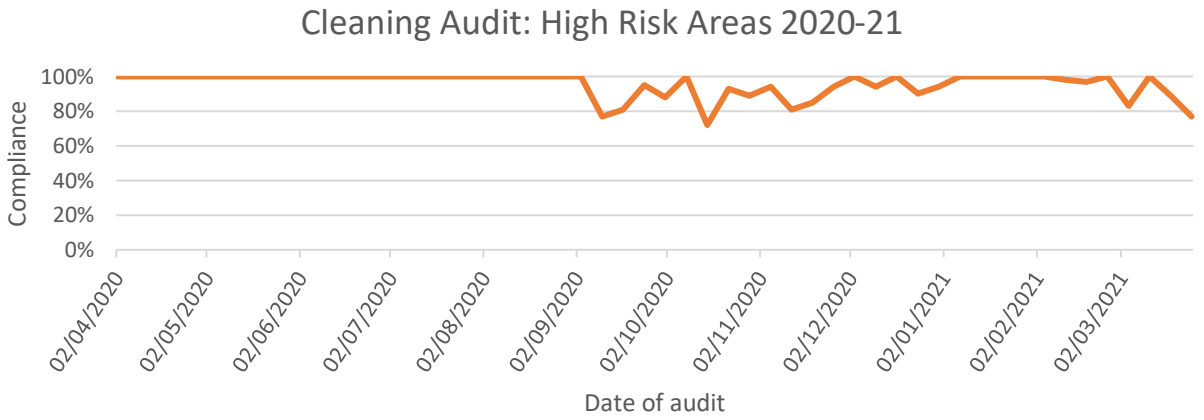
High Impact Interventions: Initial Antimicrobial Prescribing and Review





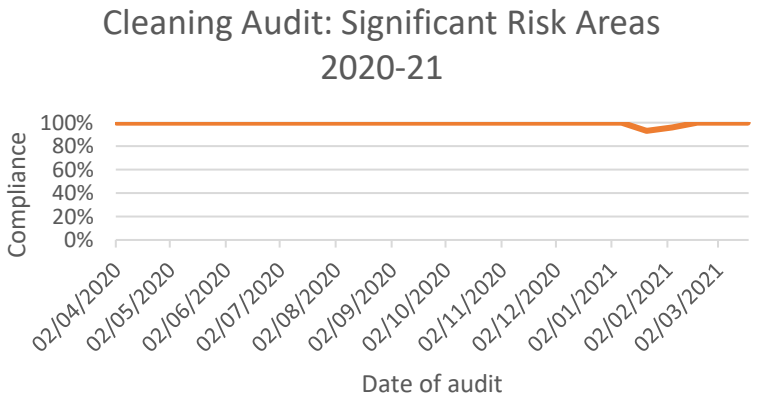
NB. There were no patients on antibiotics on the day of the May 2020, November 2020, February 2021 or March 2021 audits. In October 2020, a community entry affected the audit results.

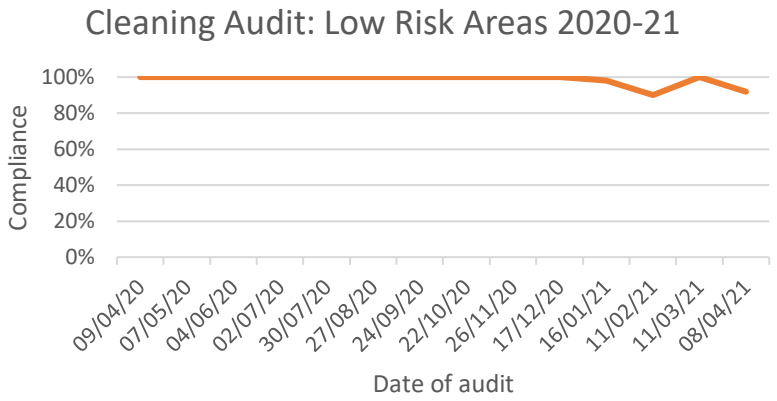
Cleaning Audit – High Risk Areas (Weekly)



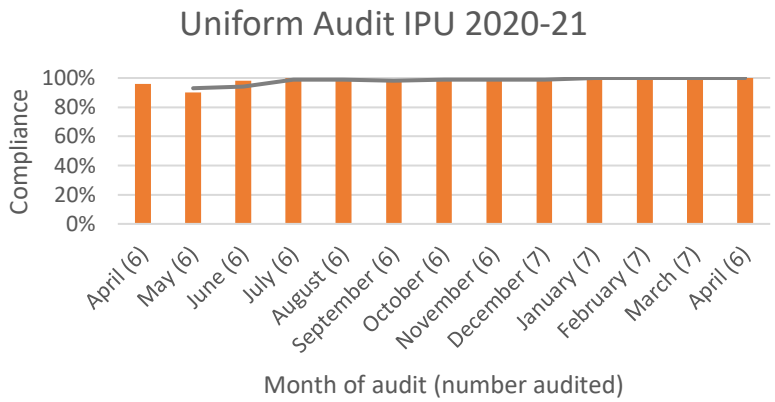
A trend analysis of the cleaning audit scores reflect that the most frequent areas of non-compliance tend to be related to high level and low level cleaning. Awareness of this issue became more prevalent during the Autumn when national guidance showed that regular ventilation helps with reducing COVID transmission, so some low and high areas which previously may have not required a daily wipe down to pass the audit were now showing up as non-compliance on a regular basis. This was further exacerbated by some staffing pressures felt by the domestic team during the Autumn and Winter period where long term sickness within the team had a detrimental impact on the domestic weekly establishment. Also, regular weekly feedback to the domestic team on the Cleaning Audit scores and actions, and discussing areas that require more focus appears to be helping with domestic team's understanding of the IPC process and overall scoring

Significant Risk Areas (Fortnightly) and Low Risk Areas (Monthly)





Uniform Audit (IPU)



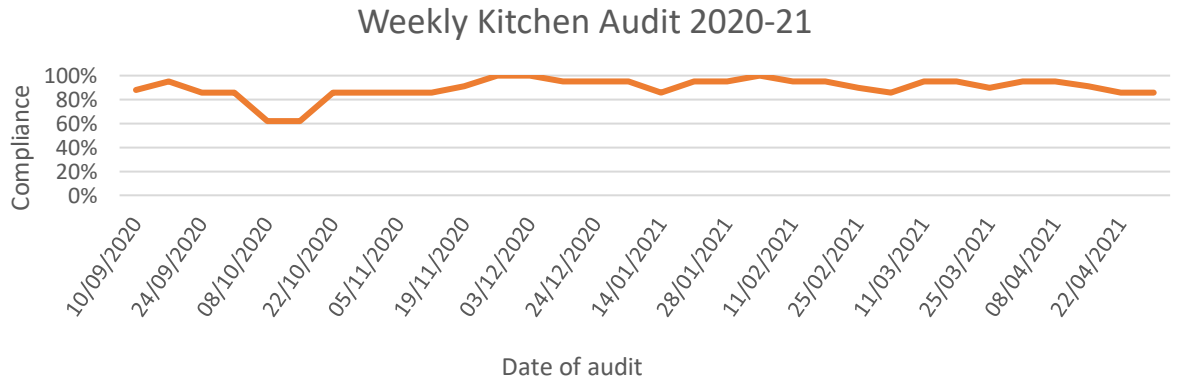
A uniform audit for Hospice in the Home was started in March 2021 and March's audit showed 93% compliance.

NB. This audit was started in June 2020.

Infection Surveillance

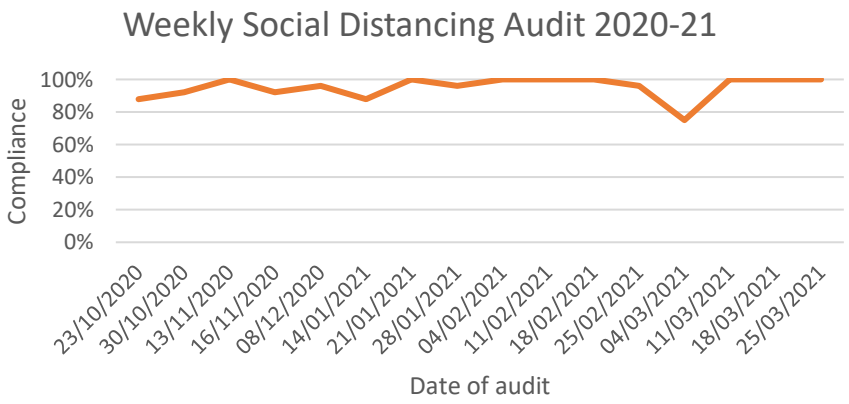
Month/Year	Catheter Associated UTI	Clostridium difficile	MRSA bacteraemia
June 2020	1	0	0
July 2020	0	0	0
Aug 2020	1	0	0
Sept 2020	0	0	0
Oct 2020	0	0	0
Nov 2020	1	0	0
Dec 2020	2	0	0
Jan 2021	1	0	0
Feb 2021	0	0	0
March 2021	0	0	0

Weekly Kitchen Audit



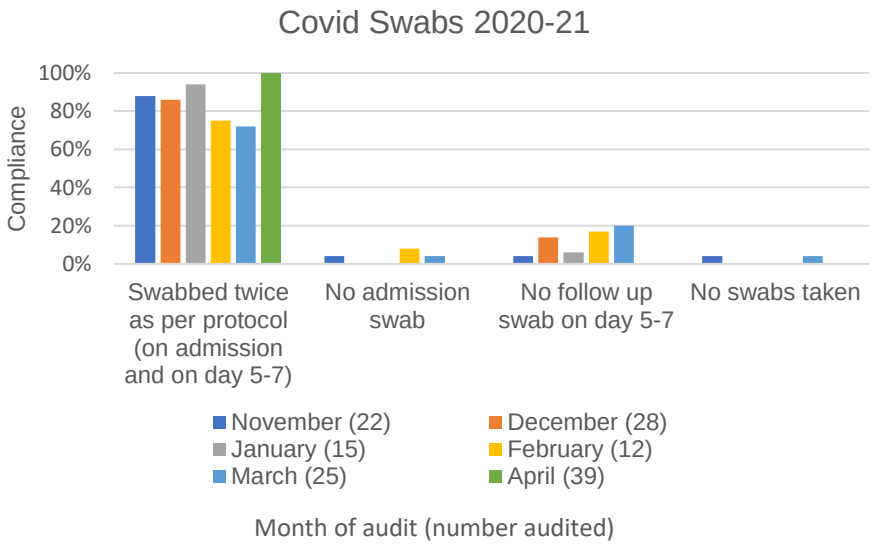
NB. This audit was started in September 2020.

Weekly Social Distancing Audit



NB. This audit was started in October 2020.

Covid Swabbing



NB. This audit was started in November 2020.

3.17 Risks and Incident

"The son of ... who died yesterday in the ambulance on the way to IPU was very appreciative of all the support that... SinglePoint gave. He was so grateful. He said he will not stop telling everyone how wonderful we all are."

Our Risk and Incident Group (RIG) meets fortnightly and is chaired by either the Director of Care or the Clinical Director. The Group reviews all investigated incidents and monitors compliance with actions. It also monitors complaints and risk.

Incidents and complaints are reported and managed via our online Sentinel system. It is our policy that all incidents are reported within 24 hours of occurrence and that no more than ten working days elapse between the incident being logged and a completed investigation and recommendations being available to the RIG.

We define an incident as 'any event or circumstance arising during [St Helena] care that could have or did lead to unintended or unexpected harm, loss or damage'.

While regrettable, incidents and errors are inevitable in healthcare. Simply 'counting the number of incidents reported by an organisation does not tell you how safe they are and should not be used to make isolated judgements about the safety of care.' As understanding the prevalence of incidents is an important part of safety and risk management, in cases of doubt, the presumption should always be to report. This way, we can build a more accurate picture of adverse events within the organisation.

In response to the pandemic and the anticipated change in workflows, we adjusted our incident and complaint reporting process. From March to June all Patient and Family Services incidents and complaints were reported directly to the Head of Quality & Compliance, who then triaged them according to severity, and referred them on to the appropriate member of staff to investigate. At the same time, we disabled overdue reminders for actions relating to incident. During that period, we logged 53 incidents, including 15 COVID-19+ tests for staff.

We also suspended our governance meeting structure, which caused delays in closing existing incidents. The exceptions to this were our Infection Prevention & Control Group, which continued to meet, and our Risk & Incident Group, which began to meet virtually (and with reduced attendance) after a few weeks. During the same period, we also rolled forward the review dates on all low-priority risks on our Risk Register. During the initial phase of the pandemic, we managed 11 COVID-19 related risks.

During the second quarter of 202021, we began to move back to normality. Incident and risk management returned to how it was before the lockdown.We have reinstated our key governance groups and a revised chart can be seen on page 16.

During the year, we also updated our Incident Management Policy [013], Being Open and Duty of Candour Policy [012] and made a minor revision to our Serious Incident Policy [014].

In December, thanks to restored staffing in our Quality & Compliance

Department, we were able to begin weekly compliance checks for incidents and complaints that have been open more than a month, allowing us to improve our performance.

3.18 Information Governance

The COVID-19 pandemic prompted substantial organisational changes at St Helena and a number of these have had IG implications. Additionally, there were temporary changes to data protection law around patient care, to give providers additional flexibility to respond rapidly to demand and to promote cooperation between organisations.

The most notable legal change has been the activation of provisions under the Regulation 3(4) of the Health Service Control of Patient Information (COPI) Regulations 2002, which was invoked by the Secretary of State for Health and Social Care on 20th March 2020. This notification sets aside the common law duty of confidentiality, which ordinarily prevents the processing of patient identifiable information without consent for reasons other than direct patient care, with respect to any activity that is part of the national response to COVID-19. This does not remove our obligations to comply with the GDPR, but fortunately our lawful basis is clearly established under Article 9(2)(i): processing for reasons of public interest in the area of public health. The COPI authority is currently scheduled to expire on 30th September 2021.

The Phoenix Partnership (TPP), which provides our patient administration system, SystmOne, enabled users to set the implied consent override option on community patient records, allowing records to be shared where it is not possible to obtain consent and it has not been explicitly refused. This functionality was enabled by TPP with the written permission of National Data Guardian, as set out in a letter to TPP dated 30th March 2020. The NDG has cautioned, however, that only registered and regulated health and care professionals should make such record access decisions 'in the best interests of their patients and it must be a matter of professional judgement and responsibility whether they need to use this "break-glass" facility.' This authority currently expires on 30th June 2020 but is likely to run concurrently with the COPI Regulations.

- During the period, we initiated a project to broaden the use of the My Care Choices Register to care homes across North East Essex, taking advantage of the additional flexibility offered by the COPI provisions. We were also advised by the Head of Information Governance and Data Protection Officer for Essex CCGs that responsible and proportionate information sharing during the COVID-19 pandemic can occur without a formal data sharing agreement.
- To protect our staff better, we introduced Skyguard, a tracking and 'panic button' system for community lone working. As this involves tracking data and collecting personal medical information from community staff (to assist the emergency services), we had to ensure a

separate policy document and transparency notice, to comply with the Data Protection Act 2018.

- We renewed our CyberEssentials Certification and published our Data Security and Privacy Toolkit self-assessment for 19-20 (the deadline having been delayed until September 30th).
- We have created a new Information Assets Register and an electronic form for Data Protection Impact Assessments. Both these projects extended the use of our Sentinel system.
- During the year, our IT department began work to meet the DCB1596 secure email standard, which we hope will be complete by the end of 2021. Certifying to this standard will allow us to send and receive emails directly between our internal email system and NHS Mail. This will improve security. We have also allocated an internal email address to our incident and complaints management system.
- We have modernised our CCTV system and, as part of this, we are refreshed our Data Protection Impact Assessment.
- We have been preparing to participate in the Health Information Exchange (HIE), an online portal, which allows clinicians to access patient information from multiple providers more effectively.
- In November, we produced a new Information Governance Policy (900) for the organisation. We have also introduced a new Information Classification Policy (911), which will be applied to Patient and Family Services in due course.

3.18.1 Data Security & Privacy Toolkit

Each year, St Helena publishes a DSPT self-assessment, to demonstrate our high standards of information governance. We published our most recent assessment on 14th June 2021.

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

Our history of assessments is illustrated, below.

ST HELENA HOSPICE (COLCHESTER)

Organisation code: 8A784

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

Primary sector: Charity / Hospice

Publication history

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

3.19 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.

"...my Counsellor, was wonderful throughout and professionally identified and worked with me on each area of concern as it appeared and it transpired that I did indeed need professional support to help me through this incredibly difficult time when my Brother was stranded at his home in Canada and unable to visit the UK due to Covid-19. I cannot thank ... enough for her cheerful, caring support throughout and also for her depth of knowledge on all aspects of life and death which is absolutely amazing! She has shared with me coping strategies and also provided comfort in that my thoughts and feelings are absolutely normal during the bereavement process which is a relief to know! My Partner, Andrew, asked me 'can Lindy move in with us to help us both?'"

3.20 Complaints and feedback

3.20.1 Complaints

In line with national guidance from NHS England/Improvement and the Parliamentary and Health Service Ombudsman (PHSO), we paused our complaints process in March 2020, but began to return to normal during June that year. This move anticipated the national 'unpausing' of complaints scheduled for the 1st of July 2020. We ensured that all existing complainants were informed of the pause in writing and kept up to date with developments. Below, we present a summary of the complaints we closed during 2020-21 and the actions we took because of them.

Complaint 114

A lady complained about the care given to her mother by one of our Clinical Nurse Specialists. Her complaints consisted of several parts. Firstly, that the CNS's visits were too brief and, secondly, that she appeared confused regarding days and times. There was also a complaint, on one occasion, the CNS left a note to say that she had attempted to visit and telephoned, and that she was unable to return to visit later that day and was not available until the following week. Another complaint was that the daughter had requested an assessment for oxygen and wanted the CNS to visit with a pulse oximeter but was instead advised to request this from her mother's GP. Finally, the complainant was upset that the CNS made no further contact following her mother's death.

During our investigation, our CNS reported that most of her visits had been 30 to 60 minutes, which is what we would expect, dependent on need. Regarding the issue of being confused over dates and times, our CNS acknowledged that she had once rung in error and rang on one occasion to propose an earlier or later time for her visit. She did not recognise this to be an issue at the time but asked for her apology to be passed on.

Regarding the attempted visit and the phone call, the CNS acknowledged it would have been better to have called the complainant's mobile number and recognises that this did not support her to build a trusting relationship with her and her mother. We expressed regret that the CNS was unable to visit the same day, but this was not possible as she was also attending university during this period. We noted in our response that our SinglePoint service would have been able to provide emergency support, but we could not confirm that the CNS had told the family this at the time.

On the matter of the pulse oximeter, our CNS reported to us that she informed the family that CNS's do not have routine access to these devices, and we confirmed to the complainant that a GP visit would have been more appropriate.

Finally, on the lack of contact follow the patient's death, our investigation found that our CNS had booked in time to call the complainant within our standard of two weeks, but that she was told before she could make the call that the complainant no longer wished to have contact.

We apologised to the complainant, passing on the CNS's regret, and informing her that the CNS would be receiving clinical supervision to address some of the issues raised.

The complaint was upheld.

Complaint 115

The wife of one of our patients made various complaints about one of our CNSs. These were that the CNS had made several comments she and her husband found to be inappropriate, and that the CNS informed them that he would attempt to access records they assumed were private.

On the matter of the inappropriate comments, our CNS responded that they felt it appropriate to discuss worst case scenarios but recognised that this might be upsetting and apologised that he had not seen that they weren't ready for the conversation. Regarding other comments allegedly made, the passage of time resulting from the COVID-19 pandemic meant that our CNS could not recall precisely what they had said but apologised for any unintentional offence caused.

On the matter of accessing private records, our CNS clarified to investigators that this would have been up to date treatment plans and not full records. We also reminded the complainant that patients are routinely asked for their consent for us to share records to expedite treatment.

We and the CNS extended our apologies for any distress or confusion caused.

The complaint was partially upheld.

Complaint 118

We received a complaint that was substantially about the conduct and communication of one of our CNSs. Specifically, the complainant felt they had provided poor communication, a lack of warmth and insight, and poor organisational skills.

Our investigation found that these points were valid, and the CNS is now receiving clinical supervision and additional support.

The complaint also expressed their understandable distress about having been offered a bed for their loved one after they had died. We apologised for this mistake, which we had made because of an administrative error.

The complaint was upheld.

Complaint 131

We received a complaint about the care provided to one of our patients on IPU. The complaint was complex, but a summary of the allegations is as follows: a social worker used inappropriate language about a family member while speaking to the patient, we failed to notify next of kin in a timely fashion, we attempted to prevent a family member from visiting, we allowed guests into the patient's room following their death against the wishes of the patient, that we admitted the patient too soon, and that we allowed family members to photograph the patient's body after death.

We conducted a thorough investigation and sent the report to the family and the CQC. We upheld the first two parts of the complaint, agreeing that the social worker had used inappropriate language and that we hadn't contacted the next of kin soon enough.

We found that there had been no attempt to prevent visitors to the patient while they were alive, other than to observe COVID-19 restrictions. Nor did we welcome or sanction visitors after death; however, we do accept that visitors entered the room without seeking permission and we will be reviewing our security as a result.

We could not accept responsibility for the actions of family members who were alone with their loved one's body, and so could not uphold that aspect of the complaint.

Finally, we could not uphold the allegation that we had admitted the patient prematurely. A review of the case notes found this to have been clinically appropriate.

We partially upheld the complaint.

"Thankful to … for talking during a difficult time. I was isolated during lockdown and it helped to speak with a friendly and wise woman. My life felt in turmoil and it has since because of various factors improved a great deal. We spoke on the phone and it felt unformulaic and often light hearted. Thank you…"

Complaint 135

We received a complaint from a lady regarding the care we had given to her husband on our IPU. There were three components to the complaint. First it was alleged that a medicines error would have occurred, if not for the complainant's intervention with the consultant. Secondly, the door to the patient's room was closed against their wishes. Thirdly, a nurse told the patient that he would be an inpatient for more than a week, which was felt to be insensitive because he was intending to stay only for a few days.

On the first point, our investigation found that the patient did have an allergy to dexamethasone and that this was not flagged on the record. While our Medicines Management Lead would have reviewed the record, she cannot state with certainty that she would not have prescribed it and so we upheld this portion of the complaint.

On the matter of the door, it was standard practice at the time to close doors while waiting for COVID-19 swab tests; however, on very warm days we had relaxed this rule. Unfortunately, overnight staff had not been made aware of the patient's preferences at handover. We therefore upheld this portion of the complaint.

Finally, while inpatient stays can typically last 7-10 days, we accepted that this information should have been conveyed to the patient in a more sensitive way.

We sent a letter of apology to the patient's wife.

Complaint 140

This complaint had five components. Firstly, the complainant felt that we had not listened to her concerns about her loved one. Secondly, the complainant felt that our Care Coordinator had wanted to 'get rid' of her loved one to a nursing home. Thirdly, it was alleged that Care Coordinator and the Advanced Nurse Practitioner had asked 'loaded questions' and 'used their body language' to persuade the loved one to accept this discharge to a nursing home. The fourth component of the complaint was that the complainant had not been told that our IPU is a short stay unit and thought that their loved one had been admitted for End of Life care and so would not be discharged. The final component was the Complainant's belief that they had not been given an accurate prognosis by a doctor.

Our investigation found that the patient's move to the nursing home caused distress to the family, not least because of the visiting restrictions resulting from the COVID-19 pandemic. There were clearly errors in communication that meant that it was not made clear to the family that, should the patient's condition stabilise during their admission, we would need to arrange discharge. The opportunity to communicate this was missed by our staff on several occasions. Furthermore, the communication in relation to discharge was not consistent from all members of the team, adding to the family's distress and confusion.

The investigator made several recommendations to ensure practice is improved within this area and individual members of staff have reflected on the episode, to ensure they improve their practice.

Complaint 145

A family complained because we had informed them of their loved one's death by mistakenly contacting their granddaughter, which caused distress. We partially upheld this complaint, and our investigator made several recommendations to improve practice around recording contact details. We reminded all staff of the importance of recording telephone numbers correctly and the need to only speak to individuals listed on the record.

Complaint 147

We received a complaint that someone had tried to contact our SinglePoint but the call was not answered and so they contacted the district nurse service instead.

Our investigation found that we were suffering from reduced staffing on the night in question, but this does not account for two calls being missed. We apologised to the Complainant for this lapse in our service and we have improved our process for checking for missed calls and escalating staffing problems.

Complaint 178

We received a complaint from a client of our Bereavement Service, which comprised three elements. Firstly, the complainant stated that their sessions were ended abruptly and that she only agreed to this because they believed they had a poor relationship with their counsellor. The second element of the complaint was that the complainant stated that they had heard a television or radio during a session. Thirdly, the complainant felt that the counsellor made inappropriate comments and judgements about them, which made them feel uncomfortable and embarrassed.

Our investigation found that it was unclear from the notes who had chosen to end the referral; however, it seemed unlikely that it would have been the client, so we upheld this aspect of the complaint. We also found that the counsellor's record keeping had been inadequate, so this was addressed with them. We also upheld the complaint regarding the background noise, which we think came from an open window in the counsellor's residence. Finally, as there was no documentation of any inappropriate comments in the record, and the counsellor denied having made any, we could neither uphold nor reject this aspect of the complaint.

As a result of the complaint, the Bereavement Service Lead wrote to her team, reminding them of the need to maintain a domestic environment conducive to therapy sessions and of the importance of documenting explicitly who has decided to end a referral early and why. A further reminder was issued to staff about the general importance of good record-keeping.

Complaint 189

The relative of a patient cared for by our SinglePoint service objected to one of our Healthcare Assistants describing their father as 'Ok' during a visit. The Complainant felt that, as the patient was dying, this was an inappropriate description which they had found upsetting.

We upheld this complaint and both staff on the visit were asked to reflect on appropriate communication. Although not raised by the complainant, our investigation also found that staff needing to answer work calls during the visit may have contributed to their distress.
This has led to a new procedure where phones are left in the car, but security of staff is still protected using PeopleSafe lone working devices.

3.20.2 Unsolicited comments

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.

"Sadly, today was my last session with the wonderful … my counsellor. In the short time I have been speaking with her she has become a friend. I looked forward to my weekly hour, where the jumble of thoughts running around in my head, started to fall into line with the guidance of Lucy. My first few sessions were mostly me just crying my eye's out. I could not see a future and would have been quite content to end it all… thank you for your time, knowledge and experience, helping me put some order in my life. You will never appreciate the warmth I felt when you said 'hello' on a Thursday, the instant weight off my shoulders from a few considered words."

3.20.3 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

Feedback declined markedly during the year, owing to a combination of factors, including having to reduce bed occupancy, admitting patients who were closer to end of life, having to restrict visiting, restricting community services, and suspending therapy services. We have reproduced several comments received via IWGC and cards and letters throughout this Quality Account.

3.21 What other say

3.21.1 CQC inspection report

St Helena is registered with the Care Quality Commission to provide the following regulated activities:

- Personal Care
- 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

3.21.2 Statement by Healthwatch

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. In this case, we have limited feedback about services provided by the Hospice, and so offer only the following comments on the St Helena Quality Account.

- HWE is encouraged that during COVID St Helena coordinated the community end of life response on behalf of the North East Essex Health and Wellbeing Alliance, creating a hub and spoke model. Non-urgent hospice visiting ceased and community specialist nurses, rehabilitation and family support teams joined the SinglePoint team to create an enhanced community rapid response hub. This truly shows community working together.
- HWE also recognises the combine work creating integrated spoke teams with weekly virtual meetings between primary care, community nursing and the hospice, and developed a single caseload between the providers to enhance care coordination.
- HWE recognises that the My Care Choices electronic palliative care coordination system was changed to capture advance care planning discussions about COVID and access gained to it for care home staff.
- HWE recognises St Helena's inpatient unit was increased by 2 beds and virtual ward capacity doubled through a collaboration with a local care provider. Community hospital and hospice beds were merged into an integrated community bed base.
- HWE recognises St Helena will work in close partnership with Alliance partners to support the North East Essex system in the avoidance of unnecessary emergency admissions and timely discharge for patients who wish to die at home. They will continue working in partnership with Bluebird Care to enable the provision of 18 Virtual Ward beds to enable more people to be cared for at home for their final weeks of life and provide up to 18 inpatient beds.
- HWE is encouraged to see that St Helena will work to ensure that PCNs have visibility of the information contained within the End of Life dashboard

including the recording of care wishes, level of anticipatory prescribing and achievement of preferred place of care.

- Finally, HWE recognises the value placed on workforce and that they recognise that the nature of working with palliative and end of life patients and their families can be both challenging and stressful. They will support the health and wellbeing of their workforce including an offer of clinical supervision for all staff working in patient facing roles, Schwartz Rounds and team days alongside building on their existing health and wellbeing offer.

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

Sam Glover

Chief Executive Officer, Healthwatch Essex

22nd June 2021

3.21.3 Statement by the St Helena User Group

St Helena's Service User Group (SUG) comprises volunteers who have had some experience of the hospice services, either directly or indirectly, which they use to assist the clinical and administrative teams to develop and maintain quality, relevant services. Unfortunately the COVID-19 lockdowns and restrictions have prevented most activity, and the Group has not been able to meet since February 2020. During that period, the service model has significantly changed and the SUG is in the process of being refreshed, so that it more closely represents the new services. However, the existing group members have been kept abreast of the hospice activities and challenges during the past year and wish to congratulate the management and staff on maintaining an excellent and much valued service to patients and their family members in very difficult circumstances. This report is evidence of that commitment to quality and to caring for those in receipt of the hospice services.

Ken Aldred

Chair, Service User Group

3.22 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

St Helena

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

St Helena Hospice is a company limited by guarantee.
Registered in England and Wales Number 01511841.
Registered Charity Number 280919.
Registered Office: Myland Hall, Barncroft Close,
Colchester, CO4 9JU.