40 YEARS

Saint Francis Hospice

Caring for you

Quality Account
2023/24

WELCOME

2023/2024 Innovations

During the last year, learning from the most challenging period of the pandemic led to further innovative thinking and service development, enabling us to restart face to face groups and sessions as well as improving technological solutions across the Hospice.

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PART 1

INTRODUCTION

VISION, MISSION AND VALUES

Our Vision

A world where everyone gets the right palliative and end of life support and care for them and their loved ones.

Our Mission

To provide local people with excellent palliative and end of life care and support, before, during and after death.

VISION, MISSION AND VALUES

Our Values

Supportive - We listen to people and value peoples' experiences and use them to give the personal support that is right for everyone.

Compassionate - We are kind and provide a caring and compassionate environment for everyone. We put people at the heart of our actions and words and support people's choices and decisions, helping them feel safe, secure and valued.

Inclusive and Respectful - We are open and transparent and value each person's individuality. We respect everyone and value diversity. We believe our different experiences and knowledge make us stronger. Together we achieve more.

Professional - We are experienced in what we do as a hospice and as a charity. We encourage everyone to give of their best, in providing the appropriate care and expertise to those who need us and support us.

Always Learning - We are open and outward looking, always ready to adapt and change, looking for better ways of doing things, by learning from each other and from the ever changing world around us.

ABOUT SAINT FRANCIS HOSPICE

At **Saint Francis Hospice**, we believe that **everyone has the right** to be the person they are, to **live without fear or prejudice** and so we **welcome people of any ethnicity, age, gender, sexual orientation, faith** and **belief**, or **disability**.

We believe that our hospice is a **better place to receive care**, to work and volunteer when we all feel **included, respected** and **welcomed**. We are committed to **inclusivity** and our approach is **rooted** in our **Vision, Mission and Values**.

As an **independent charity** and one of the **largest adult Hospices in the UK**, we play a **vital role** in our **growing and diverse populations** of **Barking & Dagenham, Havering, Redbridge, Brentwood** and **West Essex**.

We have a **committed team** of **specialist consultants, doctors**, and **nurses** who work alongside other **health and social care professionals** to provide **compassionate** and **comprehensive care** to **all who need it**.

Every donation is essential to us, and we **value every one of our supporters** immensely: **individuals, schools, faith groups, local organisations, trusts and foundations and businesses**, as well as **large corporations**. We are **grateful** to our team of **655 skilled and committed volunteers** who help us - **keeping costs down** and **adding huge value** to the Hospice.

Emily's story about her husband, Mark's care at the hospice

Mark Taylor and his wife Emily were together for 25 years before his death on Valentines Day in 2022. Mark was supported by the Community Team before spending the last few weeks of his life on the Ward. Emily explains how the community team supported Mark so he could stay at home for as long as possible.

"Mark was diagnosed with oesophageal cancer at the beginning of 2018 and in December 2021 a lump came up on Mark's arm. Two weeks before Christmas, Mark had a scan and we found out the cancer had now spread to his muscles and his bones. That was when his oncologist told him he was now terminal, and she was going to refer him to Saint Francis Hospice. Those words were terrifying.

We thought if you are referred to Saint Francis Hospice that it was a place you were sent to die, little did we know how wrong we were. When the nurse came to see Mark, she asked if he would come to the hospice for pain management, but he refused. He said, "If I go in there, I will not come out. I am not ready yet." She sat with him and explained that the hospice was not a place to just go and die, it was a place of respite and to manage pain and symptoms too. The plan for him was to go in for pain management and to then come home.

Those last few days will always be so important to us. We had watched Mark in excruciating pain for so long. He was monitored so closely, and we knew he was pain free. When someone is in pain, you can see it in their face and during those last few days, I could see he was peaceful.

When the time came, we obviously did not want it to happen, but we knew he was not in pain anymore.

Our experience of Saint Francis Hospice is overwhelmingly positive. Mark felt so strongly that if people were unfortunate enough to be told they had a terminal illness, that they should feel relief at being referred to the hospice, without any fear.

CO-STATEMENT BY THE CHIEF EXECUTIVE OFFICER AND ACTING CHAIR.

GRAZINA BERRY CEO

PAUL GWINN ACTING CHAIR

Similar to many organisations, at Saint Francis Hospice 2023/24 was a year of reflection, restoration and recovery post-Covid. We paused to take in valuable learning that everyone experienced and to appreciate how difficult a period this will have been for individuals, families, communities and organisations, such as ours, who carried on finding the best ways to care for people and their loved ones. This has led to more innovative thinking and further building the organisation's resilience. The operating context remained pressured against the backdrop of increasing complexity in people's care needs, difficulty to recruit to specialist roles, escalating service delivery costs, and a tough fundraising environment.

Yet, we are pleased to share with you, our numerous achievements across the core areas of focus, anchored in our values and with safe and effective service delivery, with the best experience for the people in our care always at the forefront.

We not only remained person and community-centric, but amplified this even more, to ensure that our services become even more individualised and culturally sensitive. We supported 2,000 people across our wide-ranging services, seeing a huge rise in demand for bereavement support, occupational therapy, face-to-face and telephone consultations, which reached nearly 15,000. We also cared for more people with diagnoses other than cancer demonstrating the widening in our reach and the effectiveness of our multi-disciplinary teams.

Inclusion and accessibility were at the front of our minds and efforts, as we made tangible progress in widening access to our services across our catchment geography, improving the accessibility of our information materials and communication methods, and developing our offering further. The extension of our 'flagship' bereavement service to children through group work was a noteworthy achievement, as was bringing teams more closely together for collaborative working, harnessing digital technology, while also not losing sight of the ever-important human interactions.

We challenged ourselves 'how do we become even more person-centric?', listening and observing the people we cared for and their loved ones in their homes, which led to the introduction of wellbeing packs, recognising the holistic care needs people have, including emotional and psychological, when they choose to or have no other choice but to remain at home.

We recognised that the quality of the physical environment is of immense importance for individuals in our care and for our teams of staff and volunteers. We developed plans to transform the ward environment so that it becomes more modern, even better equipped and tailored to individuals and their palliative and end of life care needs, while also improving our environmental footprint. We will continue focusing on this major priority in 2024/25.

In 2023/24 the safety of people in our care remained a key priority, as the NHS safety standards were further tightened through the introduction of the Patient Safety Incident Response Framework (PSIRF). The greater focus on learning and whole-system approaches to continually improving practice fit right in, one of our core values being 'always learning'.

Safety and outstanding quality of care provision were key drivers for the clinical effectiveness of our services, which we continued to evolve, by

investing in team development, for example by training our Occupational Therapists as Trusted Assessors.

Funding remained a significant challenge, and while we were fortunate to secure an uplift from the North East London Integrated Care Board, we still needed to raise approximately 66% of funds to run the hospice effectively through retail and voluntary giving. The fundraising and retail teams of staff and volunteers worked relentlessly and creatively to attract the needed income, but with all charitable organisations experiencing a greater need for funds against the pressures of the cost-of-living crisis and vastly increased cost of running services, securing income was difficult.

External pressures provided a real impetus to develop our own solutions to tackling the recruitment challenge, and we were happy to have grown our own talent to support the Crisis and Community Services Teams. We also focused on more efficient ways of working and providing care, one such activity being safe and legally compliant recycling of medication, which we identified as a need against a national shortage of meds.

Organisational improvement was aligned with our focus on meeting the diverse needs of the communities of people that we serve. Recognising that looking after our diverse workforce is essential for outstanding care provision, we made significant progress in our Equity, Diversity and Inclusion initiatives, for example, achieving 95% of our staff being trained in Oliver McGowan and becoming a Disability Confident Employer.

This work will continue in 2024/25, as we look to strengthen collaborative working with our health, community and education partners to meet the ever-increasing demand for our care and support. We will need to ensure that we can attract and retain diverse workforce that is representative of the communities that we serve. Our culture of compassion, inclusion and learning will underpin our efforts to innovate as we launch Virtual Ward services and grow our reach across the communities that we serve.

Thank you for working with us and supporting us in our mission to provide local people with excellent palliative and end of life care and support before, during and after death.

GRAZINA BERRY CEO
PAUL GWINN ACTING CHAIR

PART 2

REPORTING ON OUR PRIORITIES 23/24

PRIORITY 1: PATIENT SAFETY

1.1 THE IMPLEMENTATION OF PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF)

Authors: Tes Smith, Director of Services and Brigid Hardy, Business Manager

How the priority was identified

PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to safety events for the people we care for. This newly launched framework has been developed to aid learning from events and improve safety. PSIRF supports the development and maintenance of an effective safety response system that integrates four key aims. We were required to adopt the PSIRF from September 2023 - a contractual requirement under the NHS Standard Contract. The PSIRF replaces the current Serious Incident Framework (2015).

Aim

To develop and maintain an effective safety event response system that integrates the following aims:

- Compassionate engagement and involvement of individuals affected by safety incidents.
- Application of a range of system-based approaches to learning from events.
- Considered and proportionate responses.
- Supportive oversight, focused on strengthening the functioning of the response system and ongoing improvement.

Progress against the priority

By December 2023 we were ready to transition to the PSIRF and had submitted our policy and plan to NEL ICB and for ratification by the SFH Board of Trustees. Reaching out to and collaborating with other Hospices and acute sectors helped us to develop a thorough understanding of safety profiles and actions in response to analysis of events, using established improvement methods.

Preparation was broken down into phases to ease transition from the old system to this new one, helping to provide detail around discrete activities which enabled us to set strong foundations for the full implementation of the framework. Proportionate training has been embedded within our mandatory training tracker across the organisation. An escalated PSIRF reporting template was designed and adopted to improve the recording and standardisation of events and facilitate collection of findings for learning purposes. The report is concise, written in plain English, uses inclusive language, is anonymised, and is written to inform and learn rather than apportion blame. We will continue to evaluate and develop this format.

Improvement in safety of care is monitored daily, collated, responded to and summarised at the Quality Assurance Management Group meetings. A quarterly report is submitted to Trustees via Clinical Governance Committee meetings. Monitoring focusses on identifying the system factors that contribute to individual safety events and provides opportunities for collaborative learning and improvement.

We updated the language used in the Sentinel event reporting tool model that we use, to enable us to provide the means to identify systems/factors to help us prevent, minimise and best manage events such as falls and pressure ulcers in an individualised, multidisciplinary and person-centred way.

GOING FORWARD

Progress will form part of emergent learning. Individuals continue to be encouraged to be actively involved in self-learning and self-discovery and to build their own understanding of how to maintain and improve safe practices. Full transition is expected to be completed by April 2024. We continue to develop collaboratively with relevant staff and stakeholders and with consideration of wider organisational priorities and improvement work.

PRIORITY 1: PATIENT SAFETY

1.2 The Implementation of the Trusted Assessors course and the impact on people we care for

Authors: Kathryn Owens, Therapies Manager

How the priority was identified

We identified this project as a way of developing our therapies service and extending our ability to serve those that need our support. With a small therapies team it was essential to look at ways we could ensure that we were providing as comprehensive and wide reaching a service as possible.

Aim

The aim of this service was to maintain Occupational Therapy input, knowing we had service gaps, ensuring that those we care for, both in the ward setting ready for discharge, and those in the community have access to practical support in a timely manner, even with a limited Occupational Therapy service, by use of Trusted Assessors skills.

The objective was to:

- Provide a safe home environment.
- Ensure safe appropriate equipment is provided.
- Enable people at home increasing independence.
- Increase this service to individuals that are under our care.
- Reduce hospital admissions.
- Provide the appropriate equipment in a timely manner.

Progress against the priority

Since team members gained their qualification as Trusted Assessors, they have used their skills daily. The service provided 333 activities during a one-year period (1st January 2023 to 1st January 2024), undertaken by the two Trusted Assessors. During this time, we had a period of ten months without an Occupational Therapist therefore the Trusted Assessor role ensured that service provision continued supporting those we care for.

We have had many compliments of feedback from those we have supported:

- *Daughter thanked the department for the amazing service they received with the wheelchair being delivered so quickly.*
- *Daughter thanked us for our prompt visit when a riser recliner was delivered which made the world of difference.*
- *Really grateful for a shower stool, enabling the first shower in a long time.*
- *Family thanked the team for support in giving family member some independence back.*
- *Daughter said, "I can't believe how quickly our request was responded to. The equipment has made the world of difference".*

GOING FORWARD

This project has been very successful, and the plan is to continue training suitable staff in the Trusted Assessor role to continue this excellent service to those we care for, therefore becoming business as usual.

PRIORITY 2: CLINICAL EFFECTIVENESS

2.1 RECYCLING DRUGS DESIGNATED FOR DESTRUCTION

Authors: Dr Corinna Midgley, Accountable Officer, Joanne Noguera, Head of Ward Services, Victoria Wyke-Joseph, Pharmacist and Salma Begum, Pharmacist.

How the priority was identified

In recent years, national shortages of key medications have been a live challenge, and we have felt that challenge locally. Promoted by the challenge of shortages, schemes have been developed around the country to promote re-use of patients' own medicines which are no longer required and would otherwise have been designated for destruction. At the hospice we must quite frequently destroy medications we have ordered for people to go home with, if their medication needs change or if they die prior to discharge. This includes the destruction of Controlled Drugs, and medicines subject to national shortage, and other medicines being put on the stock shelf inappropriately. Because of this we decided that the hospice should try and see whether we could legally recycle at least some medication.

Aim

To pilot a safe and legally compliant recycling process on the ward for at least some of the unused named patient drugs dispensed from our supplier pharmacy, rather than to continue with the standard destruction of all those medications. With the aim to reduce medicines waste, and to save money for the hospice and the NHS.

Progress against the priority

A standard operating procedure was created within the medicines management policy. Ward sisters were trained on standards required i.e. on what medicines can be recycled and safety standards (such as standards for over labelling of current labels and documentation of what is being put back into stock).

It takes time for the pharmacist and a ward sister to go through the appropriate drugs for recycling. However, they have made time and there has been significant recycling and cost saving, as documented below. The pharmacist has recorded the drugs that have been recycled. Some had been subject to national shortage within the previous 6 months.

Month	Amount saved	Amount saved for Controlled drugs	Total
Jan – April 23	No drugs in quarantine box	£889.26	£889.26
May – Aug 23	No drugs in quarantine box	£247.60	£247.60
Sept - Dec 23	£518.56	£440.07	£958.63
Jan 2024	£44.83	£37.30	£82.13
Total to date			**£ 2,177.62**

GOING FORWARD

- To train more staff on the recycling process.
- To create a SOP outlining the recycled medicine scheme process.
- To build a business case using the data above and additional data to demonstrate what value this scheme adds, but what time it takes. Our aim: to get NHS support to fund a pharmacy technician to continue this and other essential works, freeing pharmacy/nurse time for other duties.

PRIORITY 2: CLINICAL EFFECTIVENESS

2.2 UTILISATION AND DEVELOPMENT OF SPECIALIST COMMUNITY & CRISIS SUPPORT STAFF

Authors: Lesley Burrows, Head of Community Services and Commissioning Lead, and Jane Elmer, Maria Stripe and Evelyn Asiam, Team Leaders

How the priority was identified

The Community Specialist and Crisis Support team (SCCS) is a team of highly skilled and knowledgeable clinical specialists whose focus is on specialist palliative and end of life care. Members have traditionally come from a wide range of nursing career backgrounds. As a specialist service we need staff who are knowledgeable and experienced in complex symptom management and in advanced end of life skills who can exercise a high level of confident decision making and autonomy. In recent years it has been harder to recruit such experienced palliative care clinical specialists into gaps in service.

So that since 2015 we have developed a 'grow our own', model, supporting the development of less experienced nurses to become clinical specialists, though mentorship, teaching and training alongside a competency-based framework for learning, supporting and monitoring development.

However, recruitment of nurses into the workforce is proving challenging. We have thus been required to consider alternative models, and alternative professions for development into specialist palliative care.

Progress against the priority

One key change (2022) has been a move to hospice ward staff becoming our first responders for overnight calls between the hours of 11pm and 7am. A Clinical Nurse Specialist remains on call for complex calls that require immediate support, but this additional layer has enabled our specialists to get a better night's sleep and increase the available daytime community workforce.

Our next aim was to try a different development pathway for a vacant development role we were struggling to recruit to. We developed a job description for a senior staff nurse post for our Specialist Advice Line. The hope was that if we could recruit to such a role, our clinical specialists would be freer to attend to urgent visits and to ongoing complexity. We wanted to make it an attractive one, including skills development.

At the same time, we had approaches by interested paramedics keen to develop palliative care knowledge and skills. We constructed a development role which allowed for identified transferable skills to be nurtured and grown.

Adverts were successful for both an advice line senior staff nurse and a paramedic with interest. Competencies were developed to support the new individuals into these unique posts, and it has been wonderful to see them grow.

GOING FORWARD

During these post pandemic times, and a shifting workforce nationally, developing a new type of post and opportunity hasn't altered the overall landscape but has created a more diverse team, with benefits for all.

Each new role has required strong induction, strong mentorship, progressive documented competencies and regular supervision and appraisal sessions.

PRIORITY 3: PATIENT EXPERIENCE

3.1 LEADING ALONGSIDE LOCAL COMMUNITIES AND PARTNERS IN REDBRIDGE – SUPPORTING BETTER ACCESS TO OUR SERVICES BY INCREASING UNDERSTANDING OF WHAT WE DO

Authors: Bridget Moss, Head of Professional Practice and Education and Jan Scott, Transformation Development Manager

How the priority was identified

A recent service improvement project identified that the hospice was receiving fewer referrals for people from minority ethnic groups than would be expected. For example, evidence from the 2021census demonstrates that 60% of people living in Redbridge (one of the boroughs we serve) do not define themselves as white UK, yet only 23% of the Redbridge referrals we received were from other ethnic groups.

Aim

Our aim is to ensure ease of hospice referrals for people from our whole catchment. We recognised that unfamiliarity with or uncertainty about hospice care would make it harder for people to feel informed or confident to seek palliative/ or end of life hospice care or to accept a referral for our services.

A key priority was to be sure that we were communicating a clear message that the Hospice provides individualised and culturally sensitive care for the differing needs of all people referred to us. We recognised how important it is not only to include provision of language translation, space to pray, pastoral care and choices for nutrition, but also to demonstrate what we do and to share this widely and more effectively.

Another priority was to create a subgroup to focus on widening access and align activity, analysis and learning with our Equality, Diversity, and Inclusion Strategy.

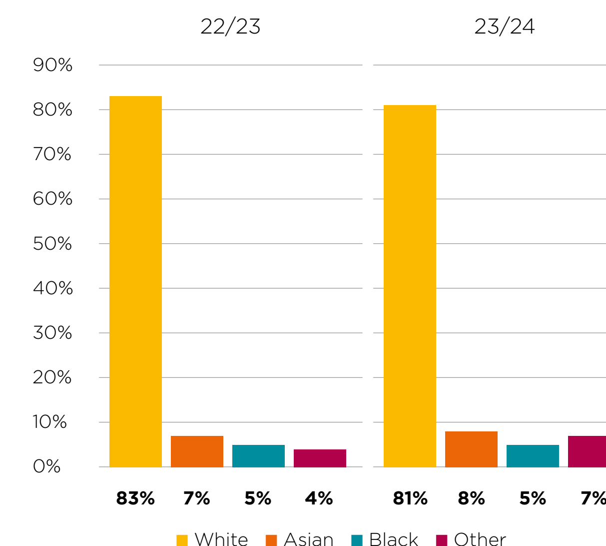
Progress against the priority

Emphasis was initially focused on the borough of Redbridge, but this widened to other boroughs later as the year progressed. In May 2023 we hosted an 'open morning', generously funded by Healthwatch Redbridge, inviting members of the public, health and social care professionals, faith leaders and voluntary and public sectors. The audience, of over 50 people, heard from faith leaders, our health care colleagues and people who had already used our service, and we listened to their expressions of need. Together we were able to explore reasons for lower numbers of referrals and how we could demonstrate we were open to suggestions for development. The impact of this sharing event was outstanding, reflected in the feedback. We heard how important it was for families, carers and loved ones to be included. This has since been prioritised by both the ward and Hospice at Home service.

This year we also presented our care services to other forums, including the Redbridge Faith Forum, Redbridge Mental Health Team for Older People, Havering Asian Social and Welfare Association, Brentwood Ageing Well, social prescribing groups in all areas, Healthwatch events, and many more.

Our Data analyst has provided quarterly reports for referrals received, including a breakdown of age, gender, and ethnicity. This has enabled us to compare referrals demographics against previous quarters. We have already seen an impact this year. We will continue to monitor the changes in referrals borough by borough and now have an ongoing analysis and report mechanism which is monitored closely by our Clinical Governance Committee.

Service User Ethnicity



GOING FORWARD

We continue to learn, we continue to reach out at every opportunity. This year's Dying Matters week theme is 'language around death, dying and grief' and Dementia Action Week will be focussed on reflecting the needs of all people, from all backgrounds, those who have dementia and those at the end of their life.

PRIORITY 3: PATIENT EXPERIENCE

3.2 RESEARCH THE USE OF INTERPRETERS, PURCHASE, AND TRIAL OF INTERPRETING DEVICE IN THE HOSPICE

Authors: Jan Scott, Transformation Development Manager

How this priority was identified

The people we care for cannot always communicate fully with staff because their first language is not English, or because of difficulties with hearing, sight, speech, or a combination of these. In this situation we enlisted the services of an interpreter or signer, which at times could be costly or delay communication between ourselves and the people we care for. We acknowledged that we needed to find other means of communication to enable the person to fully participate in discussions and decisions regarding their care, and express their preferences, wishes and feelings.

Aim

Our aim was to provide a better form of communication which brings equity for people when accessing our services. After researching what devices were available, and identifying a budget, interpreting devices were purchased and presented to the Ward, Hospice at Home and the SCCS team. Our other aim was to provide signers, on site, for people who are deaf, or hard of hearing.

Progress against the priority

One team reported that the language they wanted translated was not available on the device, and one team experienced the device over heating after a period of time. Both of these issues are being reviewed.

However, our community team has been using the pocket talk device, which provides a two-way translation in to 74 languages. enabling a two-way voice translation between the health care professional and the person they are caring for.

The small, handheld device has proved simple to use for our nurses and individuals using our services and is a great addition to improving communication. This is an account by two of the nurses.

"We went to visit a person in his home, his first language was Russian, and it had been noted during triage that he would require a translator. Previously it was a great challenge to arrange a translator and often we had been unsuccessful in being able to book a face-to-face translator having to rely on language line or google translate.

I took along the pocket device that provided excellent translating enabling a two-way conversion from English to Russian and vice versa. It allowed sensitive conversations around death and dying which historically had felt uncomfortable when using a third-party translator. This device allowed us to feel confident that the information we had given had been understood, it allowed family to ask questions.

I was very impressed with how easy this device was to use, and I would encourage my colleagues to try it out. The device even comes with a camera so printed/ handwritten text can be translated meaning we could use this device for people that are unable to verbally communicate."

During the last 12 months the British Signing team have been to the hospice and over a period taught sign language to 20 members of our staff. This was funded by the Jack Petchey Foundation. All the staff members passed their level 1, six of these are going on to do level 2.

GOING FORWARD

We need to monitor the device on the ward and if it continues to overheat, we will return to the manufacturer, meanwhile we will continue to encourage the use of this new piece of equipment and gather feedback from both staff and the people we are caring for.

PRIORITY 3: PATIENT EXPERIENCE

3.3 WELLBEING PACK – SELF MANAGEMENT HELP: RESOURCING A RE-SETTING PACK FOR SERVICE USERS

Authors: Klaire Craven, Complementary Therapist

How this priority was identified

This project was identified when a team member visiting those in the community under our care suggested that at times support is needed within a person's living space that will enable a more comfortable feeling both physically and psychologically.

Aim

The aim of this project was to provide additional wellbeing support to those who are housebound. Some people can be more susceptible to depression and low mood due to being unable to access other wellbeing services. Studies have shown that nature can be very calming, therefore, mindfully engaging in smells, sights, sounds and some activities of the outside world can positively affect a housebound person's emotional, physical, and psychological wellbeing.

Progress against the priority

A Therapy pack was produced giving written suggestions as to how a living space can be "reset" to facilitate feelings of calmness and wellbeing. These included simple tasks i.e. opening curtains to allow natural light and opening windows for fresh air. Optimising any outside views that they may have from their home such as trees and green spaces. Additionally, tips on how to utilise "artificial nature" in the form of photos, screen savers or house plants to make the living space feel greener.

For those able to access a computer, links for videos with nature sounds were also included with written guidance to listen mindfully. This pack included laminated photos of local open spaces such as parks and meadows, an aromatherapy room spray with floral notes called "The Meadow" and a written guided visualisation of walking through a meadow to be used to activate a housebound person's senses to make them feel like they are outside. The pack was given to suitable people, and they were followed up a few weeks later to record progress. The information was very well received – one lady was very emotional as she had been bedbound for a few months and had been unable to see her beloved fox who visited regularly. Knowing how important this was, an image of a fox was laminated and put in her pack.

GOING FORWARD

The nature of this project is extremely specific to a relatively small number of people accessing our services. There have therefore, only been a few referrals. The work outstanding will be to educate other services of its availability, to introduce it to larger numbers. This would enable a greater review. We will continue to provide this for those in the community and to those within the ward setting when appropriate. We will continually review and monitor the response by gathering feedback on satisfaction and reaction.

PRIORITY 3: PATIENT EXPERIENCE

3.4 EXTENDING THE EQUALITY, DIVERSITY & INCLUSION (EDI) APPROACH AND KNOWLEDGE TO INCLUDE NEURO DIVERSITY

Authors: Jenni Aylen, Director of People & Culture

How the project was identified

The Hospice's commitment to ensuring exceptional care for our service users means that we are continually looking at how we can build our knowledge, awareness and understanding to meet the needs of all people that use our services. We recognised from experience our need to learn more about how best to support, adapt and individualise care for people who are neurodiverse. We needed to find or create high quality training for our staff and volunteers. In early 2023 The Oliver McGowan Mandatory Training on Learning Disability and Autism was published and presented as the government's recommended training tool for all health and care staff. This training was developed after the tragic death of a young man, Oliver McGowan. In the training, Oliver's mother Paula McGowan OBE shared Oliver's story, with the help of others with learning disability and/or who are neurodiverse in different ways, emphasising how crucial it is to give time to listen to and learn from people with neurodiversity or learning disability, if we are to find best ways to enable them to express their needs and concerns, and to share health and care information, support and care. This training was what we needed.

We also wanted to ensure that our recruitment and employment practices supported the attraction, retention and development of a diverse workforce and we identified that there was more work we could do to enhance our support for disabled employees and volunteers within the Hospice.

Aim

Our aim was to achieve 95% compliance with the Oliver McGowan training and to become a Disability Confident Employer in 2023, ensuring that our recruitment processes and entire employee journey supported colleagues with disabilities to access and thrive in employment.

Progress against the priority

The learning from the Oliver McGowan training sparked quite a reaction from our staff. Feedback was extremely positive on the exceptional content, which was powerful, insightful and galvanising. We were so thrilled to achieve our target of 95% compliance with this important learning.

We also invested in and achieved our Level 1 Disability Confident accreditation and work is now under way to progress to level 2 in 2024 focusing on support to our volunteer workforce who play such a valuable role within the Hospice and across our retail directorate.

GOING FORWARD

The Hospice is eagerly awaiting the next phase of the Oliver McGowan training from Health Education England, and, in the meantime, we have renewed our commitment to the subject with ensuring that our colleagues undertake this training again in 2024.

Courtney Thomson – Retail Volunteer with learning disabilities and dyspraxia.

"I have learned so many skills since I started volunteering. I can do everything at the shop, and I enjoy interacting with customers when I'm on the till. I love our team – we all get along so well".

PART 3

PRIORITIES FOR IMPROVEMENT FOR 24-25

The priorities for improvement for the coming year were developed in line with our hospice care strategy 2023-25.

PRIORITY 1: PATIENT SAFETY

1.1 TO FUTURE PROOF THE WARD BY ADAPTING THE ENVIRONMENT AND THE SERVICES WITHIN THE HOSPICE WARD, AS WELL AS THE PUBLIC RECEPTION AREAS, ALLOWING THE HOSPICE TO KEEP PACE WITH THE INCREASED AND VARIED DEMANDS FOR CARE WITHIN OUR COMMUNITY INCLUDING MODERN NURSING/ HOSPICE STANDARDS. THIS WORK IS BEING FUNDED BY THE HOSPICE

Authors: Joanne Noguera, Head of Ward Services, and Chris Franklin, Head of Support Services

How was this identified as a priority?

Before the covid-19 pandemic, Saint Francis Hospice planned for a capital build project that was to be a new Hospice build. Due to the circumstances, the board made the decision not to proceed due to the future financial uncertainty caused by the pandemic. From this capital build project, it was agreed that a ward transformation would be required to improve individual care and people's experiences.

What goals are we setting?

To transform our Hospice Ward to enable us to future proof the Hospice and continue to provide outstanding care for the people who access our services and facilities.

What will the impact be?

During construction, the ward will continue to function but at a reduced capacity. Based on this requirement, the construction timeline will be done in 3 phases: Phase 1, Phase 1a and Phase 2. The breakdown of the phasing as follows:

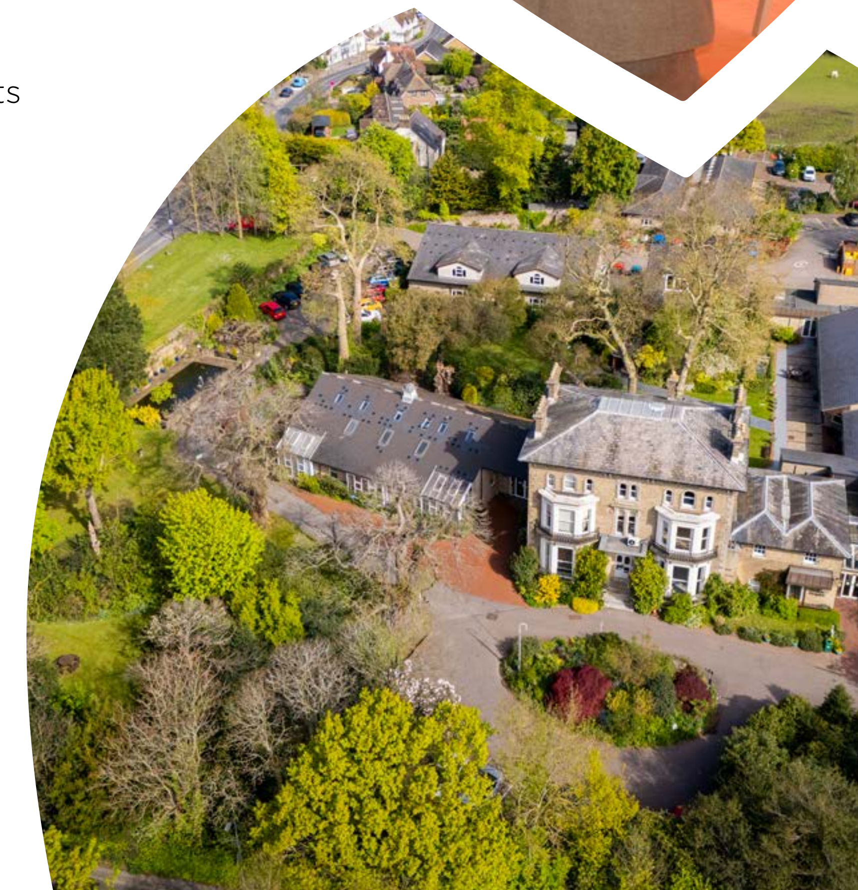
- Phase 1 – Ambulance Bay
- Phase 1a – Reception and North section of the ward
- Phase 2 – South section of ward plus snagging on Ambulance Bay

As highlighted in the project Risk Register, there is a risk of a construction site close to a working Ward. The construction phasing will therefore require extensive planning looking at many aspects such as establishing temporary SOPs, H&S procedures and programming/ scheduling of the works to ensure standards are maintained and there is minimal disruption to the working Ward.

How will the progress be monitored and reported, to include data?

Progress will be monitored and reported through the following lines:

- Programme Manager for the project – working closely with the Project Director, Hospice Ward Transformation Project Manager and the consultants Ingleton Wood
- Reporting to the Steering Groups – Operational and Programme – and the Board
- During construction regular audits to check quality, compliance and timelines/deadlines.



PRIORITY 1: PATIENT SAFETY

1.2 MEETING THE ACCESSIBLE INFORMATION STANDARD (AIS) UTILISING OUR EDI POLICY WITH A SPECIFIC LENS ON INDIVIDUAL CARE RECIPIENT INFORMATION WITH A FOCUS ON REGULATIONS.

Authors: Jan Scott, Transformation Development Manager

How was this need identified?

The Accessible Information Standard (AIS) is a requirement for providers of NHS care to meet the information and communication needs of people with disabilities, impairments, or sensory losses. The CQC monitors how providers implement the AIS and expects providers to involve people with accessible information needs in reviewing and improving their services. It covers the needs of people who are deaf, blind, or deafblind, or who have a learning disability.

It can also support people who have aphasia, autism or a mental health condition which affects their ability to communicate. When appropriate, AIS also must be considered in its application to their carers and parents.

What goals are we setting?

We want to ensure that our services identify and meet the information and communication needs of all people with a disability or sensory loss. We will consider: how do we record, highlight, and share this information with others when required and gain people's consent to do so?

We will seek accessible ways to communicate with people when their protected and other characteristics make this necessary to reduce or remove barriers.

We will focus on these 5 steps:

Identify

How do the services enable guidance and any other disability related information or communication needs? How does the service find out if people have any of these needs?

Record

How do we record identified needs clearly? What systems are in place as part of the assessment and care planning process?

Flag

How do we highlight people's information and communication needs in their records? This could be in paper or electronic records. The chosen method must make it possible for all staff to quickly and easily be aware of those needs.

Share

Sometimes we will need to share details of people's information and communication needs with other health and social care services. This means that other services can also respond to the person's information and communication needs. How do we gain consent to share?

Meet

Evaluation: how do we make sure it meets people's needs? How does the service make sure that people receive information that they can access and understand? How does the service arrange ongoing communication support if people need it?

What will the impact be?

People using our service will:

- Be able to contact (and be contacted by) services in accessible ways, such as via email or text message
- Receive information and correspondence in formats they can read and understand. For example, in audio, braille, easy read or large print.
- Be supported by a communication professional if needed to support conversation or use appropriate devices. This would include a British Sign Language interpreter.
- Get support from health and care staff and organisations to communicate. This should include help to lip-read or use a hearing aid or loop

How will the progress be monitored and reported, to include data?

We will look at these five steps by talking to staff and people using the service.

Wherever possible, by peer review, service user and our CQC inspectors will review the assessment and care plan of at least one person using the service who is affected by AIS. These will be selected as part of our usual inspection evidence-gathering.

In addition to inspections, we will also monitor how we are meeting AIS through annual Provider Information Requests/Collections.

PRIORITY 2: CLINICAL EFFECTIVENESS

2.1 HOSPICE AT HOME RAPID RESPONSE - EXTENDING REACH AND ACCESS

Authors: Simone Sims, Hospice at Home Team Lead.

How was this identified as a priority?
We have identified that Although we reach a lot of people in our catchment areas, we'd like to be able to adapt our service to reach many more. During the covid-19 pandemic we learned that not everyone needs a 3 hour set visit, nor does everyone want a 3 hour visit; so, we discussed how can we be more flexible and more personalised to each individual need whilst remaining responsive and providing crisis intervention to those we care for.

What goals are we setting?

- Communicate our changes with key workers, district nursing teams and GP practices.
- Shorter visits, team to trial 2-hour visits to enable us to reach more people every day.
- On our initial visit the team to adapt the language they use to explain the service offer, expressing we provide individualised care for everyone regardless of their faith or culture.
- Respond to crisis calls from other health professionals, district Nurses, GP's and acute hospitals in a timely manner.
- Work with the iCare team to create activity codes and status codes which reflect crisis visits and calls which will enable us to run reports.

What will the impact be?

- More individuals will be supported in their own homes and in the place of their choosing.
- Ability to respond rapidly to crisis calls and crisis interventions.
- Provide a more flexible personalised service.

How will the progress be monitored and reported, to include data?
Crisis visits and referrals will now have a code attached to enable us to report on.

All visits will be entered onto iCare.

PRIORITY 2: CLINICAL EFFECTIVENESS

2.2 CREATE A VIRTUAL WARD MODEL TO DELIVER A HIGH QUALITY OF SPECIALISED CARE IN AN INDIVIDUAL'S HOME

Authors: Jo Noguera, Head of Ward Services and Jan Scott, Transformation Development Manager

How was this identified as a priority?
It was recognised through the Ward Transformation planning that we would be required to reduce the capacity of the Ward to enable us to complete the work in 2 phases. This would impact on the number of beds. We would need to reduce the number from 18 to 11 for a period. Throughout the pandemic, we learnt that other hospices within the area developed Virtual Wards and we know that BHRUT was also successfully piloting this.

What goals are we setting?
By September 2024, we will offer virtual consultations and provide Ward services in the comfort of an individual's home. We aim to grow the service alongside our specialist Community Team and Hospice at Home team.

What will the impact be?
We aim to be able to offer the same care we would offer on the Ward but in the comfort of the individual's chosen place of care. We hope that providing the same level of care at home will reduce the impact of individuals being transferred through different care environments. We will also be able to serve more individuals under Saint Francis Hospice services.

How will the progress be monitored and reported, to include data?
Through Audit. We will create Power BI reports to record the number of individuals we are able to admit to the virtual ward and through use of OACC be able to monitor our effectiveness.

PRIORITY 2: CLINICAL EFFECTIVENESS

2.3 INCREASE ON SITE VISITS / CONSULTATIONS IN PEMBERTON PLACE WITH A VIEW TO EVALUATE, REVIEW AND INCREASE THIS WITHIN 6 MONTHS THEN 12MONTHS.

Authors: Evelyn Asiam and Jane Elmer, Specialist Community & Crisis Support (SCCS) Team Leaders.

How was it identified as a priority?

At times we do have waiting lists for face-to-face clinics and assessments. As part of reducing the waiting time for the people who require a home visit and on-site clinics, we will design smarter ways of working to improve our services

What goals are we setting?

To increase the number of face-to-face onsite visits that we offer at the hospice to at least twice a week with a view to increasing the numbers with growth over 6 months and 12 months.

What will the impact be?

More individuals will be seen in a timely manner in a clinic setting, helping to avoid delays to face-to-face assessments and improving individual's quality of life and experience. The individual could be seen by multiple health care professionals during this visit on site – it will save resources for the organisation and may provide a gentle introduction to hospice services (a foot in the door process). The more individuals that we see onsite at the hospice will also reduce travel time for staff.

How will the progress be monitored and reported to include data?

Through Audits and using iCare data reports. We will conduct a 6-month review in December 2024 and 12 month review in March 2025.

PRIORITY 2: CLINICAL EFFECTIVENESS

2.4 EXPLORING OUR PRACTICE AND LEARNING FROM AUDIT: DO WE DO ENOUGH TO SUPPORT PEOPLE WITH ADVANCED ILLNESS WHO ALSO HAVE A LEARNING DISABILITY OR NEURODIVERSITY DIAGNOSIS?

Authors: Dr Corinna Midgley, Medical Director and Katy Marling, Clinical Nurse Specialist.

How was this identified as a priority?

National LeDeR reports continue to flag that people with a learning disability who develop an advanced or progressive illness don't get timely access to the care they need. There is often an underestimation of vulnerability concerning communication, understanding, choice, recognition of distress, attention to inclusive advance care planning, and the support of family and carers.

Previous Saint Francis Hospice audits have looked at people we cared for with a learning disability and what we did, but the focus was mainly on numbers served, service used and (if they went on to die) where people died. All our staff have completed Oliver McGowan mandatory training. We felt strongly that we must look again more carefully at what we do and what care we give, looking more widely, and at neurodiversity too.

What goals are we setting?

To do a retrospective audit of people with a learning disability referred for palliative care support: did we see and support according to our own standards (which are in line with national standards)? To also audit people with a diagnosis of neurodiversity: to learn from them whether we met their needs.

To seek out the narrative from the notes: What did we do well? What should we have done better? What can we learn?

What will the impact be?

We think there will be learning that we can implement to ensure that people with a learning disability or a diagnosis of neurodiversity get the care they need. As a result, we will improve the accessibility of our services.

How will the progress be monitored and reported, to include data?

We will do two audits, one for people with a learning disability, a second for people with a neurodiversity diagnosis; structuring a template to pull as much from the narrative as we can in all effort to learn. The audits will be presented to the hospice audit group and more widely, if possible, along with recommendations for change if we identify that change is needed.

PRIORITY 3: SERVICE USER EXPERIENCE

3.1 WIDEN THE REACH AND SUPPORT FOR BEREAVED PEOPLE, UTILISING RESOURCES AND OFFERS OF SUPPORT

Authors: Shahina Haque, Family & Individual Support Services Manager and Karen Freeman, OrangeLine Project Manager.

How was this identified as a priority?

We have identified a need which has been recognised by an increase in requests for support from people in our community who are bereaved.

What goals are we setting?

- To acknowledge, address and reduce social isolation
- To build resilience, and coping strategies for those bereaved, lonely, and isolated
- To create a community support that is accessible and independent of the Hospice
- To address the mental health of those vulnerable in the community and signpost them accordingly
- To build working relationships with outside organisation and work collaboratively
- To access external venues to deliver these projects. For example, the new St George's Clinic and The Meeting Place Café in Havering, The Pipe Major in Barking and Dagenham and the Merry Meade Tearooms in Brentwood.

What will the impact be?

- Normalising grief, and loss and destigmatising mental health
- Individuals building reliable and trusting relationships and building on their support network
- Reduction in accessing medical support for mental health needs, such as low mood because of bereavement
- Strengthening networks professionally
- Reducing social isolation

How will the progress be monitored and reported, to include data?

- Quantitative data around numbers of attendance
- Feedback /evaluation forms

PRIORITY 3: SERVICE USER EXPERIENCE

3.2 INCREASE THE USE OF CO-DESIGN AND CO-PRODUCTION APPROACHES IN DEVELOPING AND TRANSFORMING SERVICES

Authors: Jan Scott, Transformation Development Manager

How was this need identified?

The feedback we currently receive is in written or digital form, using the iWantGreatCare system, which covers all our clinical and therapeutic services. This information is shared across the site to the relevant teams and is monitored by the Individual Experience Management Group (IEMG) and reported to Clinical Governance on a quarterly basis. However, we don't have regular real time verbal feedback which we feel would be beneficial to the transformation of our services.

What goals are we setting?

We aim to recruit more people, who have used our services, to become members of IEMG. In the past this has proved very useful in service development. Our aim is to recruit 3 people, on a rolling basis, so that we have up to date knowledge of people's experiences when they, or their loved one, have been cared for by the hospice. This will create a co-design approach where we can work together in a collaborative way to create solutions. Co-design aims to harness the collective wisdom and insights of everyone involved, especially the end-users, to innovate and solve problems effectively.

As we start to develop our Hospice Strategy for the next 5 years, we will endeavour to have this as a permanent strand for gathering information and knowledge to reflect people's experiences and determine the development and transformation of care.

Our aim will also be to request that staff and volunteers record comments, in real time, when they hear people's wishes, thoughts and ideas so that we can have a shared vision and tailor services accordingly.

What will the impact be?

By following this route of co-design, it will promote positive relationships between us and the people using our service, demonstrating a commitment to listen and respond. We hope it will foster trust and transparency and allows people to witness the direct

impact of their contributions, 'you said, we did'. This approach bridges gaps between stakeholders and ensures that the design process is an open, shared journey towards a common goal.

How will the progress be monitored and reported, to include data?

We will maintain detailed records of the process, and any decisions made, and feedback received. We will communicate outcomes with all participants and stakeholders, being transparent about how their input was incorporated. IEMG will monitor feedback bi-monthly with regular reports going to Clinical Governance. Regular reporting of 'you said, we did' will be displayed around the hospice.

PART 4

PARTICIPATION IN CLINICAL AUDITS

PARTICIPATION IN AUDITS

Authors: Tahnee Howard, Practice Education Facilitator

Saint Francis Hospice believes that Audit of the practices and services it offers ensures it develops, maintains and supports a culture of evidenced-based practice in the management and delivery of services within the Hospice.

Audit activity is reported:

- Monthly at the Quality and Care team meeting
- Quarterly at the Clinical audit group and the Clinical effectiveness group

1. Annual Audit Programme

An annual cycle of audits measures our service against both recognised national standards of excellence and organisational standards, using both in-house generated tools and tools developed by Hospice UK (national charity for hospice care) enabling us to assure our standards and benchmark services against standards of excellence for a wide range of health, safety and care delivery principles. Many of the Hospice UK audit tools are under review and update, we continue to use the tools we have until updates are completed. We completed 11 annual audits last year.

2. Short Observational Framework Inspections (SOFI's)

An annual cycle of SOFI's are carried out particularly evidencing care standards on the ward and across the hospice. These SOFI's are tools that can also be used to highlight things we continue to do well and achieve, but also any new areas of concern or gaps for improvement. These improvements then become learning objects and tailored support can be provided to this area of need. The Hospice responds quickly and effectively to these findings from the Audits and SOFI's to ensure the highest possible practices remain. Through these audits we can present evidence of excellent practice alongside implementing change and driving actions. The SOFI's are aligned with CQC (Care Quality Commission) key lines of enquiry. 23 SOFI's were completed in the past year.

3. Specific tailored Quality Improvement Audits

Members of the Multi-Disciplinary Team are encouraged to consider aspects of service improvement in the form of Quality Improvement Projects, this is supported by the Clinical Audit group via a process to facilitate the design of audits supporting projects by benchmarking and then assessing change delivered by the project interventions.

The Clinical Audit Group meets bi-monthly and is open to any member of staff; during the past year it has received presentations by 7 groups who completed audits as either baselines to inform QIPs (Quality Improvement Projects) or audits to evaluate outcomes of QIPs.

Highlights included the 'Night Owl project' which led to a poster presentation at the Annual Hospice UK conference last November.

Audits and SOFI's completed this year

AUDIT No. 16	Hospice UK - Bereavement support
AUDIT No. 17	Hospice UK - Medical Gases
SOFI No. 5	Environment supports privacy and dignity
SOFI No. 18	Hand Hygiene - IPU
AUDIT No. 12	SFH in house - Resuscitation Policy Audit
AUDIT No. 14	Hospice UK - Nutrition & Hydration
AUDIT No. 15	Hospice UK - Pain Management
SOFI No. 22	Uniform/dress code: Domestic
SOFI No. 32	Hand Hygiene. Domestic
SOFI No. 29	Controlled Drugs Check - **six monthly**
AUDIT No. 4	Hospice UK - Self assessment, accountable officer
SOFI No. 19	Nutrition
SOFI No. 24	Documentation - Personalised framework for the last days of life
SOFI No. 31	Medicines Safety Thermometer Audit - **quarterly**
AUDIT No. 10	Hospice UK - General Medicines
AUDIT No. 11	Hospice UK - Controlled Drugs
AUDIT No. 8	Hospice UK - Admission telephone CNS
AUDIT No. 9	Hospice UK - Ongoing support CNS
SOFI No. 9	Reception area
SOFI No. 23	Maintenance and renewal
SOFI No. 27	Diabetic Management
SOFI No. 30	Fall Toolkit IPU
SOFI No. 20	Whistle Blowing
AUDIT No. 1	Hospice UK - Infection prevention IPU
SOFI No. 4	Mental Capacity
SOFI No. 7	Informed consent – IPU
SOFI No. 31	Medicines Safety Thermometer Audit - **quarterly**
SOFI No. 2	Care plans – IPU
SOFI No. 12	Safeguarding people who use services
SOFI No. 25	Catheter care
SOFI No. 8	Assessment of risk within clinical and non-clinical areas
SOFI No. 21	Uniform/dress code: Hands on clinical
SOFI No. 13	Using clinical equipment
SOFI No. 14	Discharge Planning

QUALITY PERFORMANCE OVERVIEW

Author: Tes Smith, Director of Services, CQC registered manager and Caldicott Guardian.

During the last twelve months, hospice services cared for 2,000 people in comparison to 2,092 the year before equating to a 4% decrease. This is due to a more thorough approach by the referral's hub when assessing referrals for appropriate care. The next stage will be to concentrate efforts into converting more appropriate referrals onto service.

Our ward admitted 359 people, many requiring pain and symptom control. 29% of people were discharged home and the average length of stay on the ward was 12 days in comparison to 10 days in 2022-23. This we have identified as due to more complex admissions and people with multiple issues to resolve which necessitated a longer length of stay.

This year, the overall number of people with a noncancer primary diagnosis increased to 37% an increase from 34% the year before. This is a positive outcome as we strive to demonstrate that our care services reach far beyond a person with a diagnosis of cancer.

1,238 people were cared for by our Specialist Community and Crisis Support (SCCS) team, a decrease this year by 1%, this due in part to the more intense work with those already on the service. The number of face-to-face visits and telephone consultations increased by 3.5% totalling 14,777. This increase is due to the use of digital checks using the Universal Care Plan and the East London Patient Record which has been significant in gaining information to better assess the individual. The average length of care delivered by our Clinical Nurse Specialists team was 26 days, caring for people with a 32% non-cancer diagnosis, similar to the year before.

Our Hospice at Home team made 4,897 home visits compared to 4,724 in 2022-23 (an increase of 4%). The total number of people cared for was 639 compared to 632 (an increase of 1%). 44% of people they cared for had a non-cancer diagnosis compared to 42% the year before indicating that health professionals who refer are understanding that we care for people without a cancer diagnosis as this has been steadily rising over the past 2 years.

Pemberton Place, our day therapy and outpatient facility numbers are lower than the previous year, due to lower levels of group activity and fewer staff in post, they are now steadily increasing as staff numbers improve and new groups for physiotherapy, exercise, pastoral care, complementary and creative therapy are commencing robustly.

In total, people received 1,142 sessions of complementary therapy, an increase of 27% in home visits. 1,175 activities for individuals requiring occupational therapy (an increase of 156%, this is due to a full complement of OT therapists) and 2,445 sessions of physiotherapy (an increase of 57%, again due to an increase in therapist numbers).

The number of adults receiving bereavement counselling has increased to 618 an additional 41% compared to the year before, partially due to more volunteer working back on site. In addition, 87 children received bereavement counselling from our Child and Family Therapists compared to 65 in 2022-23.

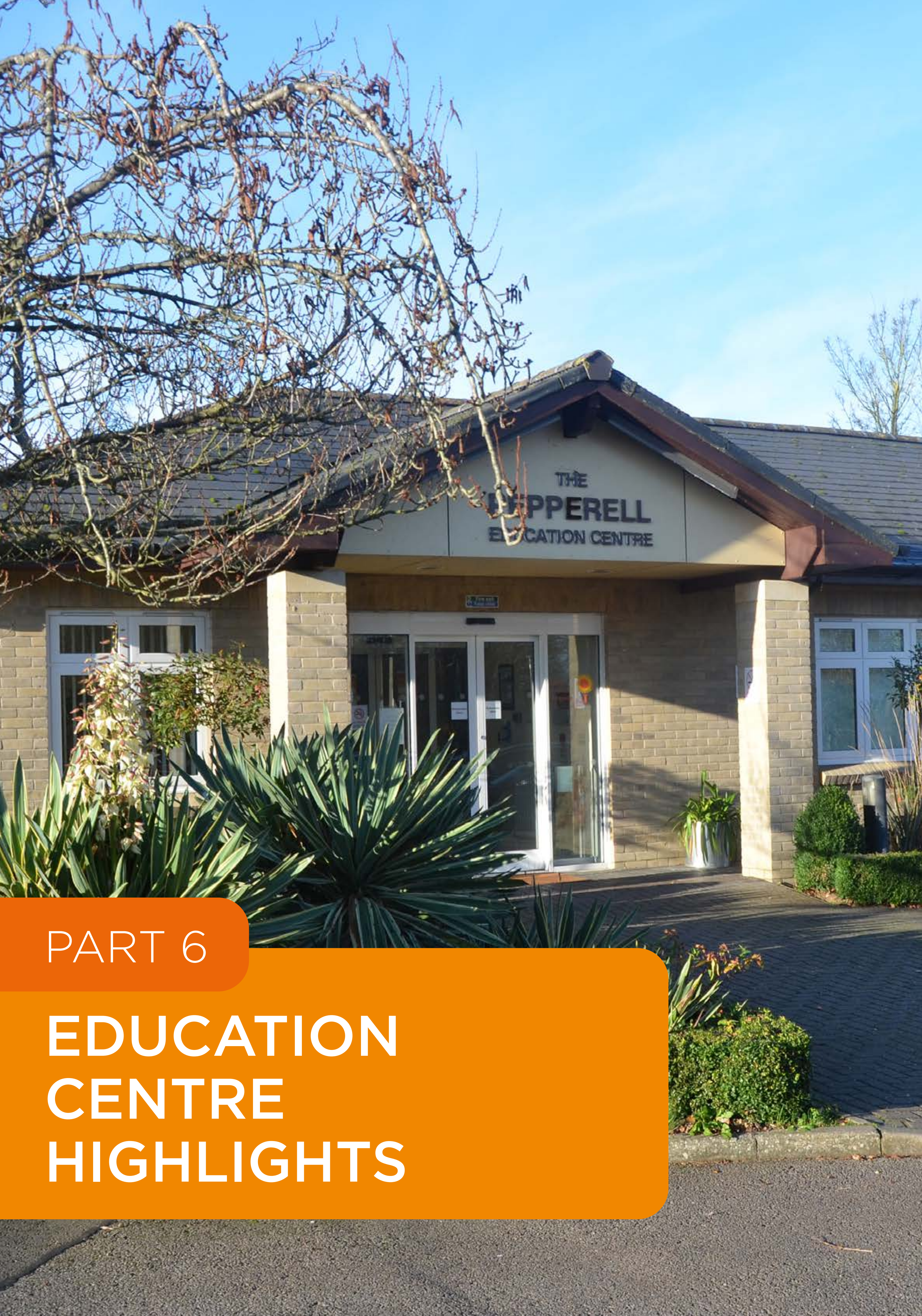
The Family and Individual Support Team delivered an outstanding 4,706 activities the previous year, this year this has increased to 5,246 an increase of 11%. This is in addition to their business-as-usual social work and safeguarding interventions, and Pastoral care who supported 614 people this year, both at the hospice and at home.

This year we have added the data for our help line, 'OrangeLine'. In the last 12 months the staff and volunteers have supported 614 people, receiving, and making 2,626 telephone calls and 831 face to face activities. This unique service is available to anyone in the community who require emotional support, or people feeling lonely and isolated. Options for individuals include regular phone calls, face to face support or joining the many groups now available throughout our catchment area.

Overall, this is an incredible year of providing services to an increasingly complex and diverse cohort of people who need our help. With recruitment challenges and seeing changes to other services in primary and acute care - I remain immensely proud of all our services and all they deliver.

Activity based on the National Council for Palliative Care: Minimum Data Sets criteria	2023/24	2022/23	2021/22
OVERALL SERVICE			
Patients cared for by the Hospice	**2000**	2092	2153
% Patients cared for with non cancer primary diagnosis	**36.8%**	34.0%	33.0%
% Patients cared for with cancer primary diagnosis	**63.2%**	66.0%	67.0%
INPATIENT UNIT SERVICES			
Total number of admissions	**359**	371	391
Total number of patients cared for	**313**	322	336
% New patients	**78%**	72.0%	78.0%
% Occupancy	**79.1%**	78.3%	81.0%
DIAGNOSIS			
% Inpatients cared for with non cancer primary diagnosis	**17.9%**	19.0%	19.0%
% Inpatients cared for with cancer primary diagnosis	**82.1%**	81.0%	81.0%
OUTCOME OF INPATIENT STAYS ENDING			
% Died	**69.4%**	62.0%	62.0%
% Discharged to home (including care home)	**29.2%**	37.7%	36.0%
% Discharged to an acute hospital	**1.4%**	0.0%	2.0%
% Discharged to another setting	**0.0%**	0.3%	0.0%
Average length of stay (days)	**12.4**	10.1	10.9
SPECIALIST COMMUNITY & CRISIS SUPPORT SERVICE			
Total number of patients supported	**1238**	1257	1599
% New patients	**79%**	93.5%	75.8%
% Patients with non cancer primary diagnosis	**32.8%**	32.5%	33.6%
% Patients with cancer primary diagnosis	**67.2%**	67.5%	66.4%
Number of face-to-face or telephone consultations with patient or relative /carer	**14777**	14287	17737
Number of face-to-face/telephone consultations/digital records checks with a health professional	**18533**	12906	13053
Average length of care (days)	**25.59**	77.6	105.4

Activity based on the National Council for Palliative Care: Minimum Data Sets criteria	2023/24	2022/23	2021/22
HOSPICE AT HOME			
Total number of patients cared for	**639**	632	585
% New patients	**89%**	80.0%	83.3%
% Patients cared for with non cancer primary diagnosis	**44.1%**	42.0%	37.4%
% Patients cared for with cancer primary diagnosis	**55.9%**	58.0%	62.6%
Total number of visits	**4897**	4724	4582
% Patients who died at home (including care homes)	**82%**	84.0%	97.6%
Average length of care (days)	**8.49**	7.35	6.27
BEREAVEMENT SERVICE			
Total number of clients			
Adult	**618**	438	398
Children	**87**	65	96
Total	**705**	503	494
Number of support/counselling telephone or face-to-face consultations (including health professionals)	**5246**	4706	4274
BEREAVEMENT SERVICE			
Number of Referrals	**244**	438	398
Number of Telephone Calls	**2626**	65	96
Number of Face to Face Activities	**831**	503	494
SPECIALIST MULTIDISCIPLINARY SUPPORT SERVICES			
Number of face-to-face consultations with patient or relative/ carer by service:			
Pastoral care support	**614**	675	583
Complementary therapy	**1142**	1536	2174
Family & Individual Support Services	**1453**	1283	2525
Occupational therapy	**1175**	459	1714
Occupational therapy equipment	**465**	316	507
Physiotherapy	**2445**	1553	2296



EDUCATION CENTRE REVIEW

Authors: Bridget Moss, Head of Professional Practice and Education

Education activity has echoed this current time of transition as we see the need for care rise and new ways of working and learning become more established, alongside the skill development required to enable this. There has been a real sense of moving forward, often at pace, with a corresponding requirement to reflect and be responsive as needs arise. Our aim is to always to provide care to the highest standard through evidenced-based, quality-assured learning and development.

In-house Learning and Development

Mandatory training (eLearning and face to face) continues to include Infection Prevention and Control, Fire Safety, Moving and Handling, Safeguarding and Basic Life Skills. This year we have achieved a mandatory training completion rate of 97%. Mandatory training has included new learning, including Patient Safety Incident Response Framework. This training delivers specific knowledge and helps all staff to learn from events that identify where improvements can be made by investigating and gaining insight from individual experiences. There has been a national drive to improve understanding about end-of-life care needs for people with learning disabilities and autism and the required Oliver McGowan mandatory training has been implemented this year.

Wider care-focused training has continued with Clinical Skills study days. A new initiative of Roundtable sessions began this year, to offer opportunity for reflection and discussion on current issues and their application to practice. This year's Digital Skills Programme year has included bespoke sessions and specific skill development across the organisation to build digital literacy and capability for the use of technology to enhance all levels of care and service provision. Communication skill development continues to be part of the offer for all staff who require this as a central part of their role. Last year we recognised the Equality, Diversity and Inclusion training needed to be improved, and the new learning module is now embedded as part of our offer. Feedback from the learning has been good and has generated discussion and reflection.

The work as part of the Hospice UK Quality Improvement project on Resilience Based Clinical Supervision,

as part of a group of 40 Hospices, continues to have a focus this year. We remain committed to addressing wellbeing needs of the staff delivering care. It has been possible to support staff to attend conferences and present our work this year, including the Hospice UK Conference in November 2023.

University partnerships

Our partnership with London South Bank University (LSBU) remains strong, and we have delivered three specialist modules that form part of the master's degree in Palliative and End of Life Care. Each student cohort has included hospice clinicians and teaching is delivered in person and virtually. Throughout the year, we have continued to support and provide a good learning environment for cohorts of student nurses on placement, from different universities, as well as paramedics, district nurses, and social work students. We have been able to respond to the increased number of requests for clinical placements, particularly from community colleagues.

Bespoke Commissioned Education

Strengthened partnerships and joint working of last year has been significant this year. Syringe pump training has been provided for NELFT community nurses and for care home staff, as well as wider support to care homes. We have delivered Advanced Communication Skills Training to a neighbouring hospice as well as to hospital bereavement and mortuary staff in Mid & South Essex. An Essential Palliative Care course has been delivered, and accessed by external and internal colleagues, and will be continued next year. The collaborative End of Life Care training for domiciliary care workers has continued and this year included delivery for staff who support adults with learning disabilities.

PART 7

FEEDBACK FROM THE PEOPLE WE'VE CARED FOR

FEEDBACK FROM THE PEOPLE WE'VE CARED FOR

Feedback

To ensure delivery of our services to the highest possible standard, we continue to request and receive feedback from people who use our services and their families, loved ones and carers. We positively encourage suggestions and comments to enable us to improve and appraise the services we provide. This process is solely undertaken via iWantGreatCare to individuals supported across all our service areas.

Our aim is to encourage feedback from people to provide meaningful, honest and independent reviews on the services they/or their loved ones had received. We use this feedback to assist with improving services – and as a quality indicator of what we are doing well and how we can improve.

Through investment in iWantGreatCare, we can monitor and utilise feedback via a system that is simple to use and gives people a choice of options on how they would like to respond. These options include completing the survey using our website, or by using a simple app, in person on site, or by telephone in person. This system, already used successfully by many NHS and Hospice care providers. enables us to respond where possible and share learning.

iWantGreatCare provide us with reports each month with the feedback received which is analysed by the Individual Experience Management Group (IEMG), reported to Clinical Governance quarterly, and shared with our Healthwatch partners. Three podiums, with secured iPads, are placed in the Ward, Orange Café and Pemberton Place (our day services centre). This allows people to give 'real time' feedback on the care and service they have received that day. In addition, we continue to send iWGC paper copies to our service users, which they return in a stamped addressed envelope, and which includes information on how they can complete the survey digitally on our website.

We continue to receive feedback on available services from the people we've cared for including their carers, family, loved ones and visitors. We continue to gather feedback from people we have supported on our Ward (also engaging in views on Care from the Outcome Assessment

and Complexity Collaborative (OACC) Suite). Our Hospice at Home team continue to gather real-time feedback from people we supported in the community. We have received feedback from bereaved people via a feedback form within their offer of bereavement support from the Hospice. We acknowledge that we continue to improve on the number of feedback comments received.

QUESTIONS ASKED OF ALL PEOPLE WHO ACCESSED OUR SERVICES APRIL 2023 – MARCH 2024

- In the year 2023-2024 we received 459 iWGC reviews compared to 262 last year – a 57% increase.
- This year negative experience has reduced from 3.5% last year to 1.5%.
- This year positive experience has increased from 93.6% last year up to 95.9% this year.
- The increase in number of reviews received has not increased the % of negative experiences.

During 2023-2024 and beyond, we continue to utilise this method of collection of views and suggestions via iWantGreatCare using a variety of IT based processes such as podiums, hand-held devices, QR codes on letters, business cards and compliment slips.

Each year **iWantGreatCare** award a Certificate of Excellence to the most highly-recommended clinicians and providers across the country, in recognition of outstanding care and patient reviews. This year our Specialist Community and Crisis Support team won this prestigious award for Saint Francis Hospice. The quantity and quality of feedback received for this team was outstanding.

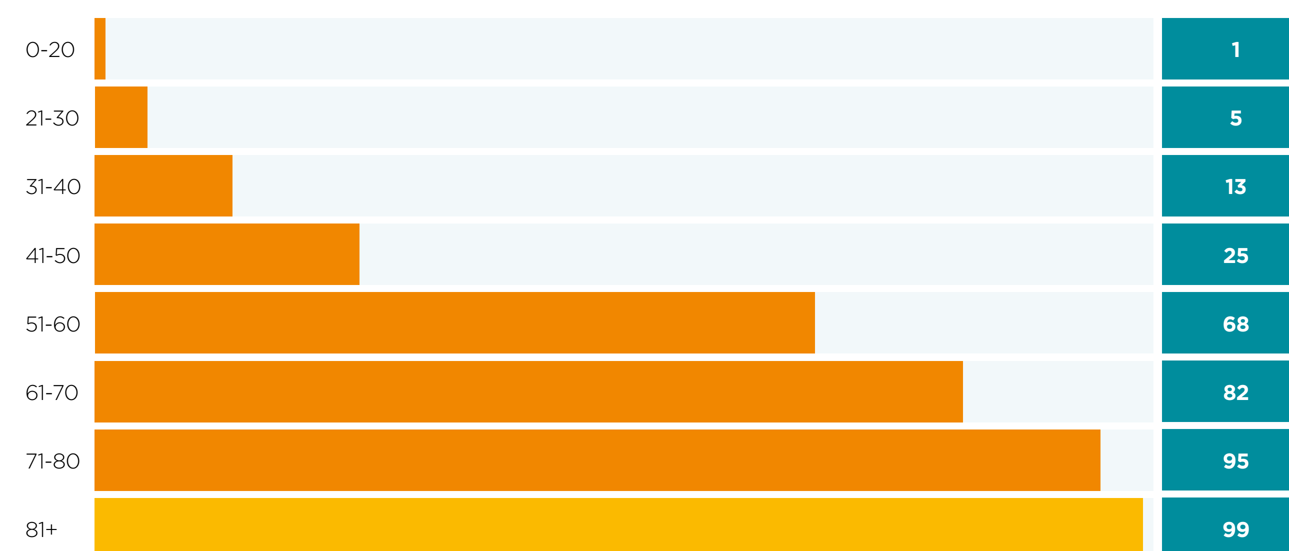
ADULT SERVICES

SERVICE NAME	THIS PERIOD		LAST 6 MONTHS	QUESTIONS									
	Respsonses	Average Score	Average Score	Experi-ence	Dignity/ Respect	Involve-ment	Informa-tion	Staff	Caring	Trust	Support Staff	Support	Trust Staff
BEREAVEMENT SERVICE													
The Hall	29	4.93	4.982	▼ (red)	▶ (green)	▼ (green)	▼ (orange)	▲ (green)	▶ (green)	▶ (green)	▶ (green)	▲ (orange)	▲ (green)
COMPLEMENTARY THERAPY SERVICE													
The Hall	0	–	–	▲ (green)	▲ (green)	▲ (green)	▲ (green)	▲ (orange)	–	–	–	▲ (green)	▲ (green)
FAMILY SUPPORT SERVICES													
The Hall	0	–	–	▲ (orange)	▲ (orange)	▲ (orange)	▲ (orange)	▲ (red)	▲ (orange)	▲ (orange)	▲ (orange)	▲ (red)	▲ (orange)
HOSPICE AT HOME TEAM													
Community Services - Saint Francis Hospice	70	4.96	4.98	▲ (orange)	▼ (orange)	▼ (orange)	▼ (orange)	▲ (orange)	▶ (green)	▶ (green)	▲ (green)	▲ (orange)	▲ (orange)
INPATIENT UNIT (IPU) TEAM													
The Hall	48	4.89	4.89	▲ (green)	▼ (red)	▲ (orange)	▲ (orange)	▲ (red)	▲ (green)	▲ (green)	▲ (green)	▲ (red)	▲ (red)
MEDICAL TEAM (DOCTORS)													
The Hall	1	4.43	–	–	–	–	–	–	–	–	–	–	–
OCCUPATIONAL THERAPY SERVICE													
The Hall	0	–	–	–	–	–	–	–	–	–	–	–	–
ORANGELINE TEAM													
Community Services - Saint Francis Hospice	41	4.84	4.83	▼ (orange)	▼ (orange)	▼ (red)	▼ (red)	▲ (orange)	▲ (green)	▲ (orange)	▲ (orange)	▲ (red)	▲ (red)
PASTORAL CARE TEAM													
Community Services - Saint Francis Hospice	0	–	–	▲ (green)	▲ (green)	▲ (green)	▲ (green)	▲ (green)	–	–	–		
PHYSIOTHERAPY SERVICE													
The Hall	5	5.00	5.00	▼ (red)	▼ (red)	▶ (green)	▼ (red)	▲ (orange)	–	–	–	▲ (green)	▲ (orange)
PSYCHOLOGIST													
The Hall	0	–	–	▲ (green)	▲ (red)	▲ (red)	▲ (green)	▲ (green)	–	–	–	▲ (green)	▲ (orange)
REFERRALS HUB TEAM													
The Hall	0	–	–	▲ (red)	▲ (red)	▲ (red)	▲ (red)	▲ (red)	–	–	–	▲ (orange)	▲ (red)
SOCIAL WORKER													
The Hall	0	–	–	–	–	–	–	–	–	–	–	–	–
SPECIALIST COMMUNITY CRISIS SUPPORT TEAM (SCCS)													
Community Services - Saint Francis Hospice	115	4.84	4.84	▲ (orange)	▲ (orange)	▲ (orange)	▲ (red)	▲ (red)	▲ (orange)	▲ (green)	▲ (green)	▲ (red)	▲ (red)
UNKOWN													
Community Services - Saint Francis Hospice	1	4.57	4.57	▼ (red)	▲ (green)	▲ (red)	▲ (green)	▲ (green)	–	–	–	▲ (green)	▲ (green)
VIRTUAL WARD													
Community Services - Saint Francis Hospice	1	4.57	4.57	–	–	–	–	–	–	–	–	–	–
YOUNG ADULT GROUP													
The Hall	0	–	–	–	–	–	–	–	–	–			

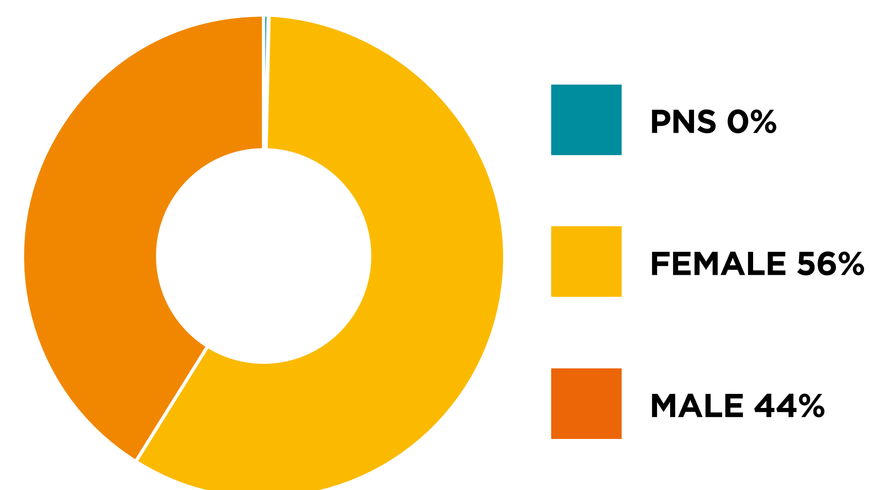
Key: Direction of arrow indicates improvement, decline, or same vs previous period

▲ (green) TOP 1/3 SERVICES | ▲ (orange) MIDDLE 1/3 | ▲ (red) BOTTOM 1/3, — NO DATA FOR COMPARISON

REVIEWS BY INDIVIDUAL'S AGE



REVIEWS BY INDIVIDUAL'S GENDER



PNS 0%

FEMALE 56%

MALE 44%

In 2023-2024, we have expanded our data platform to include ethnicity and long-standing conditions. This information provided invaluable evidence when researching our widening access strategies regarding ethnicity and conditions to inform Equality, Diversity and Inclusion policy. As with Widening Access, our aim is to reach all people in all communities.

WHERE WE COULD ATTRIBUTE AN IMPROVEMENT ACTION TO A COMMENT, WE ENSURED WE DID

The Individual experience management group have continued to meet regularly during 2023-24. The members span the spectrum of the Hospice and include external partners from the four Healthwatch groups across our area.

You said...
"It would be helpful to have a flow chart to give to families after someone has died."

We did...
We devised a flow chart with help from the Medical Director and the Medical Examiner for families and carers to follow if needed when someone dies.

You said...
"the nurse call button could be more effective on the ward."

We did...
Installed a new nurse call system which is more efficient and allows us to provide data for monitoring purposes.

You said...
"We need to have a digital device on reception to assist receptionists with safe signing in of visitors".

We did...
IT supplied a device for people to sign in which also gave us data on the number of visitors on site. For example, how many people stayed overnight. It also allowed us to go paperless.

You said...
"English is not my first language; I don't understand what the nurses and doctors are saying to me".

We did...
Extended our interpreting facility to include a mobile device for use with all nursing teams.

You said...
"I use sign language because I have a hearing impairment".

We did...
20 members of staff completed the British Sign Language course level 1, supported with funding from Jack Petchey, six of them went on to complete level 2.

You said...
"I would like opportunities to develop my role at the hospice".

We did...
We have developed a Preceptorship group to provide a structured framework for newly qualified nurses.

COMPLIMENTS AND COMPLAINTS

Compliments
In 2022/2023, we received 3086 compliments compared to 2152 last year, across our Hospice and relating to all the services we offer.

Complaints
We encourage people to share their feedback with us and we take all complaints seriously. Complaints guide us to look at areas that we need to work with and identify themes as we learn and share from complaints. In 2023-24 we cared for 2,000 people (excluding bereavement services), of whom 14 raised a service related complaint (0.7%), equating to 26% of the overall complaints received.

Revised Complaints, Comments and Compliments Policy
Our Complaints, Comments and Compliments Policy has been reviewed and updated. This means the way we classify, manage and respond to complaints will change. The revised policy was approved by the Board of Trustees on 28th February 2024. We are in the process of preparing for the implementation of the new policy and are currently developing the required infrastructure, training and communications.

Once implemented the following will be revised to reflect the changes in the Complaints, Comments and Compliments Policy:

- Complaints, Comment, Compliments Leaflet
- Website
- Mandatory Training Module
- Communication to the workforce to provide an update on the changes made to the policy and procedures.
- We will be rolling out some updates and provide additional training where necessary.

A change in the way we are reporting on complaints will include some of the new elements including if the complaint has been upheld, partially upheld or not upheld.

A SELECTION OF COMMENTS FROM ACROSS THE ORGANISATION

"I would like to thank your team for all the support that you gave to Mum in the nursing home, it enabled me to go home for a few hours, and the nurses were so lovely, spending time talking to me and my sister and ensuring Mum had the right medications etc. It's truly a wonderful service, given that the care homes are so busy, and didn't always have the staff available to care for mum on a one-to-one basis. I must say that the Nursing Home were also brilliant and cared for Mum with real kindness and generosity."

Education, May 2023 (contributor to Nursing Times Student Awards 2024)

"Thank you for your help. Sessions have gotten me to a place where I can now navigate my next moves in life. I have been helped through sessions to identify my feelings."

Family and Individual Support Services, May 2023

"Dear St Francis Hospice Care Team. Thank you.... everyone of you..... for helping Lee get through such a challenging time of his life, for never giving up on him, for giving him comfort and relief when needed. And thank you for treating us (family and friends) with kindness and respect. May long you continue... to offer and give support, the incredible work you do to help so many."

Ward March 2024

We were both so pleased to be referred to SFH. Only referred on Monday and the visit from SCCS and the Doctor yesterday was amazing. They listened and explained things so well and they did not rush the visit. Very grateful for the time they spent with us.

SCCS, October 2023

1) "Teamwork, positive attitude." 2) "I will take loads of new skills away from this placement, particularly the care of end-of-life patients and how to ensure patients and family are fully supported during all care needs. 3) I think it was a great learning experience I'm really grateful for the opportunity to have had a placement here at saint Francis, I really enjoyed it. I have had an amazing insight into palliative care which is an essential part of nursing that I can then take into practice. 4) This placement has taught me loads. I'm so much more confident in dealing with the passing of patients and feel better equipped to interact with their loved ones. I've also learned a lot about myself and feel that I have grown mentally and gained resilience which will benefit me going forward. 5) Everything, it's changed how I look at my own life. Encouraging me to value everyone in my life. Care is very real here. 6) Holistic care. Everywhere you work in nursing talks about holistic care, but I've never seen it achieved like it is here. Whether i pursue palliative care in my career or not, the skills I've learnt around holistic care will stay with me and will make me a much better health care professional in the long term. 7) Very well structured and excellent care."

Education, May 2023 (contributor to Nursing Times Student Awards 2024)

"Lady who went to the Romford Friendly Faces group last week said they all met early and had breakfast together. They have set up a WhatsApp group and are talking to each other on that. They are planning to go out to dinner soon and they will continue to meet every Tuesday morning - that's an important part of her week. She says that the men are all gentlemen and one is giving her lifts to and from the group. She said it's the best group she has ever been to. She doesn't know what she would have done without it."

OrangeLine January 2024

"I am extremely impressed by the care offered throughout. Thank you for your understanding and professionalism the staff clearly understands my vulnerability."

SCCS, 2024

My wife was looked after to the very end, not only her, but our family too.

Ward, 2024

"Having had problems sleeping the team prescribed a mix to use at bedtime. It worked!"

Complementary therapies, 2024

I was really made to feel that I was not a number I was a person.

SCCS, 2024

"St. Francis were involved in my husband's care for the last four days of his life. From the first introduction visit to the first visit all nurses were knowledgeable, kind, and respectful. They all provided great support. Thank you."

Hospice at Home, 2024

"The lady who came to see me was really nice and reassuring. I felt that she cared about what I thought."

SCCS, 2024

"Extremely patient and sympathetic staff. Reliable service and excellent communication at all times."

Family & Individual Support Bereavement Service, 2024

"Exceptionally kind and caring people who have so much empathy."

Referrals Hub, 2024

"The member of staff that came to our home was kind and caring."

Referrals Hub, 2024

PART 8

STATEMENTS FROM OUR PARTNERS

COMMENTS FROM PARTNERS

CATHY TURLAND
Chief Executive Officer
Healthwatch Redbridge

"We have continued to work closely with our colleagues at St Francis Hospice this year. The hospice has also become a member of our Healthwatch Redbridge Community Network which encourages organisations to work together and share information.

As an active member, SFH has regularly attended our Marketplace Events and shared information about their services with many diverse communities across the borough. Meetings such as this have encouraged organisations to support each other, and we were pleased to see SFH working with One Place East, a disabled people's organisation, to support the development of their leaflets in easy read and accessible formats.

We are very pleased to see one of the priorities for improvement in 2024-25 will look at increasing awareness of the Accessible Information Standards for people with particular communication support needs. We would be delighted to support the hospice to develop a model that will support patients and carers accessing their services and we look forward to seeing the results of this work."

SCOTT TATUM
Engagement Manager
Healthwatch Essex

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

We recognise that Quality Accounts are an important way for Saint Francis Hospice 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 Saint Francis Hospice. In this case, we have received no additional feedback, and so offer only the following comments on the Saint Francis Hospice Quality Account:

- We are pleased to see the implementation of the Trusted Assessors Course, developing their therapies service and extending the ability to serve those that need their support.
- It is encouraging to see that Saint Francis Hospice have a commitment to supporting better access to their services with a determination to increase understanding of what amazing work they do. Using innovative methods such as open mornings linking in with the community, public sector, faith leaders and voluntary services demonstrates a passion to listen and gather feedback to improve services and listen to their expressions of need.
- We are pleased that Saint Francis Hospice has enabled the implementation of the Oliver McGowan Mandatory Training on Learning Disability and Autism, with 95% of staff trained which is a great achievement. It is positive to know that Saint Francis Hospice have instigated a commitment to enable this training again in 2024.
- It was encouraging to see a safe and legally compliant recycling process implemented on the ward which reduced medicines waste and saved money for the hospice and the NHS.
- It is positive to see an increase on compliments during 2023/24, but 14 service level complaints could be improved upon in the next year. It is refreshing to see the board

sign off on a new Complaints, Comments, and Compliments Policy which should help reduce the number of complaints for 2024/25.

- Listening to the voice and lived experience of patients, service users, staff, and the wider community, is a vital component of providing good quality care and Healthwatch Essex supports the encouraging work of Saint Francis Hospice.

GLADYS XAVIER RN FFPH
Director of Public Health and Commissioning
London Borough of Redbridge

Overall the quality account provides a clear and digestible report of the way in which St Francis Hospice has reviewed and improved the quality of the hospice service they provide. It clearly articulates their vision, mission and values and case studies illustrate these.

Patient Safety: this section provided information on how the hospice is meeting the requirements to implement the new Patient Safety Incident Response Framework, and several projects where they have managed workforce uncertainties including how they have managed a service gap in occupational therapy through training more of their staff in the necessary skills and the development of a training pathway for specialist staff in the community. The report also noted a pilot in safe and legal recycling of drugs, an important measure to avoid waste and adopt a safe procedure that could safeguard against national drug shortages.

Of particular interest was the work done to encourage and support awareness in various minority ethnic groups of the role and availability of the hospice, given fewer referrals from these groups. The work done to communicate that the hospice provides culturally sensitive care will hopefully have the desired effect and it is a positive move that this will be kept under review by the Hospice's Clinical Governance Committee. Another positive is the move to provide more accessible information to patients through the use of language translation devices and training staff in BSL.

The identified priorities for improvement in the next year focus on a significant building project, meeting the requirements for the Accessible Information Standard and trialling new ways of working to reach more of those who can benefit from the hospice through virtual wards and more focused home visits. The proposed focus on ensuring that the hospice also meets the need of those with a Learning Disability or neurodiversity diagnosis is welcome given the rising awareness nationally that these are groups of people who have not received the best care in the past.

Audits and clinical governance around these was clearly articulated in the account as were the very positive patient feedback that is received by this hospice.

IAN BUCKMASTER, MA FCG
Executive Director & Company Secretary
Healthwatch Havering

"Thank you for asking us to comment on your Quality Accounts. As always St. Francis Hospital has been undertaking very special and important work, that makes a real difference to members of the community for whom every day counts. The new Quality Statement is very comprehensive and covers all aspects of care, education, working with staff, patients, relatives, friends and volunteers.

We were pleased that SFH have been able to re-open services stalled by the pandemic., such as in-person groups and outpatient activity taking place at the Hospital.

The Trusted Assessor programme is an excellent example of how team members gained their qualifications and have used their skills daily. So far, the service has provided 333 activities undertaken by two of the Trusted Advisors and feedback has been very positive.

- Daughter thanked us for our prompt visit when a riser recliner was delivered which made the world of difference.
- "Really grateful for a shower stool, enabling the first shower in a long time." A grateful family

Priority 1 Patient Safety – meeting the Accessible information standards

We are delighted that this is a first priority. At Healthwatch we have been working closely with the Deaf community and have recently published a report for the Havering Place Based Partnership – 'Deafness – is not a Barrier' - AI standards also support people with aphasia, autism or a mental health condition and are as relevant to family and friends.

We look forward to working with you this year."

DR GILES THORPE
Executive Chief Nursing Officer
Mid and South Essex Integrated Care Board

As a commissioner of Saint Francis Hospice services locally, Mid and South Essex Integrated Care Board (MSEICB) welcomes the opportunity to comment on this quality report.

MSEICB is commenting on a draft version of this quality account, however, to the best of its knowledge, the information contained within this report is accurate and is representative of the quality of services delivered. Any queries will have been fed back to Saint Francis Hospice prior to publication for consideration of inclusion, along with any missing data in the final report.

MSEICB is pleased to note the progress that Saint Francis Hospice has made against the priorities for improvement that it set out last year. MSEICB can see that steady progress is being made to achieve these priorities and measures are in place to continue to drive their achievement.

MSEICB acknowledge the priorities that Saint Francis Hospice have set for 2024/25 as part of the four-year strategy:

Patient Safety

- To future proof the ward by adapting the environment and the services within the hospice ward, as well as the public reception areas, allowing the hospice to keep pace with the increased and varied demands for care within our community including modern nursing/ hospice standards. This work is being funded by the hospice.
- Meeting the accessible information standard (AIS) utilising our EDI policy with a specific lens on individual care recipient information with a focus on regulations.

Clinical Effectiveness

- Hospice at home rapid response-extending reach and access.
- Create a virtual ward model to deliver a high quality of specialised care in an individuals' home.
- Increase on site visits/ consultations in Pemberton Place with a view to evaluate, review and increase this within 6 months then 12 months.
- Exploring our practice and learning from audit: do we do enough to support people with advanced illness who also have a learning disability or neurodiversity diagnosis.

Service user experience

- Widen the reach and support for bereaved people, utilising resources and offers of support.
- Increase the use of co-design and co-production approaches in developing and transforming services.

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

In conclusion, MSEICB considers the Saint Francis Hospice Quality Report for 2023/24 as providing an accurate and balanced picture of the reporting period. MSEICB will continue to seek assurance on performance and delivery of care by regular monitoring through agreed contract processes.

GLOSSARY

BAME: Ethnic minority groups

BHR: Barking, Havering and Redbridge

CBE: Commander of the British Empire

CAG: Clinical Audit Group

CCG: Clinical Commissioning Groups

CMP: Clinical Management Plan

CNS: Clinical Nurse Specialist

CQC: Care Quality Commission

CQUIN: Commissioning for Quality and Innovation

CSU: Commissioning Support Unit

DNACPR: Do Not Attempt Cardiopulmonary Resuscitation

EOLF: End of Life Framework

GP: General Practitioner

GSF: Gold Standards Framework

GSL: General Sales List

H@H: Hospice at Home

ICB: Integrated Care Board

IEMG: Individual Experience Management Group

iPOS: Integrated Palliative Outcome Scale

IPU: Inpatient Unit

KLOE: Key Lines of Enquiry

LSBU: London South Bank University

MDT: Multi-Disciplinary Team

NICE: National Institute for Health and Care Excellence

NELFT: North East London Foundation Trust

NMC: Nursing and Midwifery Council

NMP: Non-Medical Prescribing

OACC: Outcome Assessment Complexity Collaborative

PP: Pemberton Place (day therapy unit)

POM: Prescription Only Medicine

PSIRF: Patient Safety Incident Response Framework

QIPP: Quality, Innovation, Productivity and Prevention

SCCS: Specialist Community and Crisis Support Service

SFH: Saint Francis Hospice

SOFIs: Short Observation Framework Inspection

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