Quality Account
2025/26

Welcome

2025/2026 Innovations

During the last year we have continued to embrace innovative and creative ways of working, in our processes, technology and service provision, enabling us to operate in a more efficient and effective way.

For the ward, a welcoming entrance, 2 wet rooms, a quiet room and complementary therapy room, and new tea/coffee and outside seating areas.

Awareness flyers translated into the 12 top languages spoken across our diverse catchment areas.

A GP and family information leaflet to help preparedness for wish for urgent burial for religious reasons, co-designed with local faith leaders.

Co-design workshops created for service development and transformation.

Accessible Information Standard training for a broad range of staff.

Hearing loop technology was installed on the Ward, designed to help people with hearing loss.

We worked with local hospital partners to co-design smoother investigation and treatment pathways for people with advanced cancer.

Growth of Non-Medical Prescribing through focussed work on knowledge, skills and confidence.

Development of a new Enhanced Hospice at Home service model, to support more people in the community with complex end of life care needs.

A new Medication Room on the Ward, with a biometric key safe to improve medicine security.

Installation of solar panels to improve energy efficiency, save on energy bills and future proof the hospice.

Increased signage on the Ward in response to feedback from people receiving care and their loved ones.

Ward bays re-designed to allow more bedside privacy.

Televisions at each bed space that could be watched sitting in bed or out in the chair.

Barriers from the nurses station were removed to create a welcoming environment.

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PART 1

INTRODUCTION

Who we are and what we stand for

Saint Francis Hospice is an expert provider of outstanding palliative and end-of-life care, for over 40 years serving a population of nearly 1 million, spread across Barking and Dagenham, Brentwood, Havering, Redbridge, and parts of West Essex.

Our Vision

is the best care for all at the end of life.

Our Mission

is to ensure that everyone in our community has access to excellent palliative and end-of-life care before, during and after death.

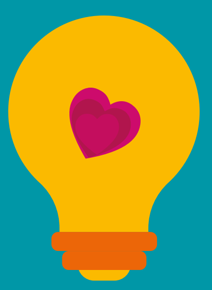
Who we are and what we stand for

All our work is guided by our recently refreshed Values.

Our Values

Compassionate – we are a caring team, kind to each other and put the needs of individuals and their loved ones at the heart of what we do.

Collaborative – we value working in partnership across our communities and are proactive about nurturing relationships with our stakeholders.



Creative – we are forward-thinking, adaptable in our changing world and embrace change and innovative ways of working.

We are Saint Francis Hospice

Proud to be rated **'Outstanding'** once again by the Care Quality Commission (CQC), Saint Francis Hospice is an independent charity and one of the largest hospices in the UK, situated in the beautiful village of Havering-atte-Bower. We provide expert palliative care for anyone with advanced, progressive disease. We support people of all faiths and cultural backgrounds from our local boroughs: **Barking and Dagenham, Brentwood, Havering, Redbridge, and parts of West Essex**.

We provide outstanding care for people at the end of life, in their own homes or at the hospice and our committed team of experts address every person's situation. The hospice has **18 specialist palliative care beds** on its Ward. We also have an active wellbeing and day therapy service which provides one-to-one clinical and therapy appointments as well as group wellbeing activities. **85% of our care is carried out in the community.**

We work **collaboratively** alongside our local healthcare partners including GPs, community nurses and hospital specialists to help manage pain and other difficult symptoms, aiming for comfort, as much independence as possible, and the best possible **quality of life.**

Individuals in our care and the people who love them are embraced by a team of **experienced professionals** who are devoted to making everyone's life the very best it can be. Our aim is that no one is afraid or in pain and **no one dies or grieves alone.**

There are no charges to users of our services. We are funded mostly by the generosity of our supporters - local people, companies and organisations. To provide this dedicated and expert care, the hospice needs to raise nearly £9 million each year in voluntary income.

"She felt completely at peace. She knew she – and all of us – were in safe, compassionate hands."

Running for Lisa

Written by: Peter Salter

On Sunday 22nd March, Lisa's husband Peter and their daughter Abbie ran the Brentwood Half Marathon in her memory. Read on for their heart-felt story.

Lisa was a loving mum and wife and on Sunday 22nd March her husband Peter and their daughter Abbie ran the Brentwood Half Marathon in her memory. Their eldest daughter Beckie supported them every step of the way, along with family and close friends. Here Peter, Beckie and Abbie share why running and raising funds for Saint Francis Hospice means so much to them....

Saint Francis Hospice cared for Lisa in her final days. Although her time there was short, she felt completely at peace. She knew she – and all of us – were in safe, compassionate hands. Taking on this challenge together felt like the right way to honour her, to talk about her, and to give something back to the place that held our family through the hardest moments of our lives.

Quietly courageous

Lisa was an amazing wife and mum – loving, kind, selfless and quietly courageous. She always put others before herself, even when she was unwell. She had a warmth and a smile that people naturally gravitated to, and a laugh we can still hear when we think of her. We're incredibly proud of the woman she was and will always cherish the memories we shared.

When Lisa went into Saint Francis Hospice, the support we received was incredible. The team created a calm, peaceful environment at a time when everything felt overwhelming. Even the

smallest gestures meant the world. One of the things we treasure most are the knitted hearts they gave us – one for Lisa, and one for each of us. Abbie and Beckie still hold theirs tight whenever they miss their mum, and it brings real comfort knowing Lisa had hers too.

Caring for us

We were able to stay overnight with her at the hospice, something we will never forget. Being by her side and surrounding her with love meant everything. And even in the toughest moments, the hospice brought gentle smiles – like on Lisa's first day, when the drinks trolley arrived, and she momentarily lit up thinking the Bacardi was for her. She didn't actually have any, but that smile is a memory we'll always hold close.

Saint Francis Hospice didn't just care for Lisa; they cared for us, our extended family and some close friends too. They made sure we were eating, drinking, and felt supported. They gave us comfort not only during Lisa's final days, but afterwards as well. Knowing she passed peacefully, surrounded by her family, has been a huge part of our healing. To us, the staff at **Saint Francis Hospice are real-life angels**.

Running the Brentwood Half Marathon was our way of giving something back so other families can receive the same compassion and care we did. For Peter, training became a space to think, breathe and feel connected to Lisa. Running offers quiet moments to reflect, to process, and to keep her memory alive.

Keeping her memory alive

We were part of a team of eight on the day: Peter, Abbie, Lisa's brother

Paul, our long-time friend Keith, our brother-in-law Andrew, Andrew's son-in-law Jamie, and two friends from our regular Saturday Parkrun group, Kelly and Lisa. Knowing we were running with people who all carry Lisa in their hearts made it even more meaningful.

Our fundraising began with a Bonfire, Burger and Banger Night at home back in November. Around 90 family and friends came together to support us, and through ticket sales, a BBQ, a cocktail bar, raffle tickets and a "Shuffle for Saint Francis" game, we raised over £2,600 in one evening. We were blown away by everyone's generosity and love.

Real life angels

Saint Francis also cared for my Dad in 2022, so supporting the hospice means supporting the people who have supported us. Raising money for them means helping other families who will one day find themselves needing the same compassion and care that we did. If what we do can support even one more person or family, then it's worth every step.

CEO and Chair's Introduction

GRAZINA BERRY CEO

AMANDA HALLUMS INTERIM CHAIR

We are proud to share Saint Francis Hospice's Quality Account for 2025/26 - a year that reflects the very best of who we are and what we stand for.

This year, we cared for 2,945 people across our services – a huge 31% increase on the previous year. Behind every one of those numbers is a person and a family who trusted us at some of the most difficult moments of their lives. That trust is something we never take for granted, and it is the privilege and the responsibility that drives everything we do and all that we achieve.

Across all three of our values of being Compassionate, Collaborative and Creative - we have seen our teams rise to meet a year of both growth and challenge with exceptional dedication.

Our compassion was evident in every interaction: in the knitted hearts given to Lisa's family, in the renewal of vows supported by our pastoral care team, in the OrangeLine calls that continued week after week, long after a loved one had died. It was evident too in the completion of our Ward Development Project - a beautifully refurbished environment designed to offer calm, comfort and dignity to every person and family in our care. We are particularly proud that 92.8% of people cared for by our Enhanced Hospice at Home team died in their preferred place - well ahead of our 80% target, and a testament to the extraordinary commitment of the team.

Our collaborative spirit has been at the heart of some of our most significant achievements. Working alongside BHRUT consultants, we co-designed new pathways for people with advanced spinal cord compression and malignant ascites - avoiding unnecessary hospital admissions and making a real difference to people at their most vulnerable. We worked with faith leaders and the Gardens of Peace to co-design accessible information supporting urgent burial - a deeply meaningful piece of work for many of the communities we serve. And with Healthwatch Redbridge, we strengthened our approach to the Accessible Information Standard, ensuring we better meet the needs of all those who come to us.

Our creativity has continued to push the boundaries of what a hospice can offer. We became the first hospice to prepare for piloting remote monitoring technology through the Careport Project, opening new possibilities for proactive, personalised care at home. And across education, we continued to invest in our people — achieving 98% mandatory training compliance and deepening our dementia offer through immersive, experiential learning.

We are deeply grateful to every member of our team - clinical, therapeutic, operational, voluntary and in support areas whose commitment makes all of this possible. We are equally grateful to our partners across the NHS, local authorities, faith communities and the voluntary sector, whose collaboration is essential to the care we provide. And we thank the many individuals, families and supporters whose generosity enables us to continue doing this work, free of charge, for everyone who needs us.

Looking to the year ahead, we are excited and focused. Our priorities for 2026/27 reflect the ambitions of our Five Year Strategy: strengthening our approach to patient safety through improved incident reporting and learning; extending nurse-led competencies including syringe pump training across community and nursing home teams; piloting a hospice-led frailty workshop; embedding digital legacy into our advance care planning conversations; and continuing to develop our volunteer companion programme on the Ward. Each of these builds on the foundations laid this year and takes us further towards our vision: the best care for all at the end of life.

We are so proud of what has been achieved. We are grateful to all who made it possible. And we remain wholly committed to the people and communities we have the honour of serving.

Grazina Berry
Chief Executive Officer

Amanda Hallums
Interim Chair, Board of Trustees

PART 2

REPORTING ON OUR PRIORITIES 25/26

Priority 1: Patient Safety

A Ward Development project has been undertaken to future proof the Hospice Ward and the outstanding clinical services that the Ward provides for the next 5+ years

Authors: Jo Noguera, Head of Ward Services & Steve McClure, Ward Development Project Manager

How was this identified as a priority?

The Ward at Saint Francis Hospice was constructed during the 1980's and has served its purpose well over the last 40 years. Due to age, wear and tear and regulation updates the Ward is now in need of re-development.

The purpose of the Ward Development Project is to refurbish the existing Ward, (currently 24 bed spaces and 18 registered beds) to future proof the facility, ensuring it meets the requirements of the CQC, Health & Safety Executive (HSE), Infection Prevention & Control (IPC) and building compliance regulations and to ensure a positive experience for individuals in our care and their loved ones as well as those working in our care environment.

Aim

This Project set out to ensure that Ward changes continued to meet all key care, health and compliance standards, whilst building on the welcoming and calming environment for those receiving ward care and their visitors, and for those working on the ward.

The Project aimed to ensure that the ward remains fit for purpose for the next 5+ years.

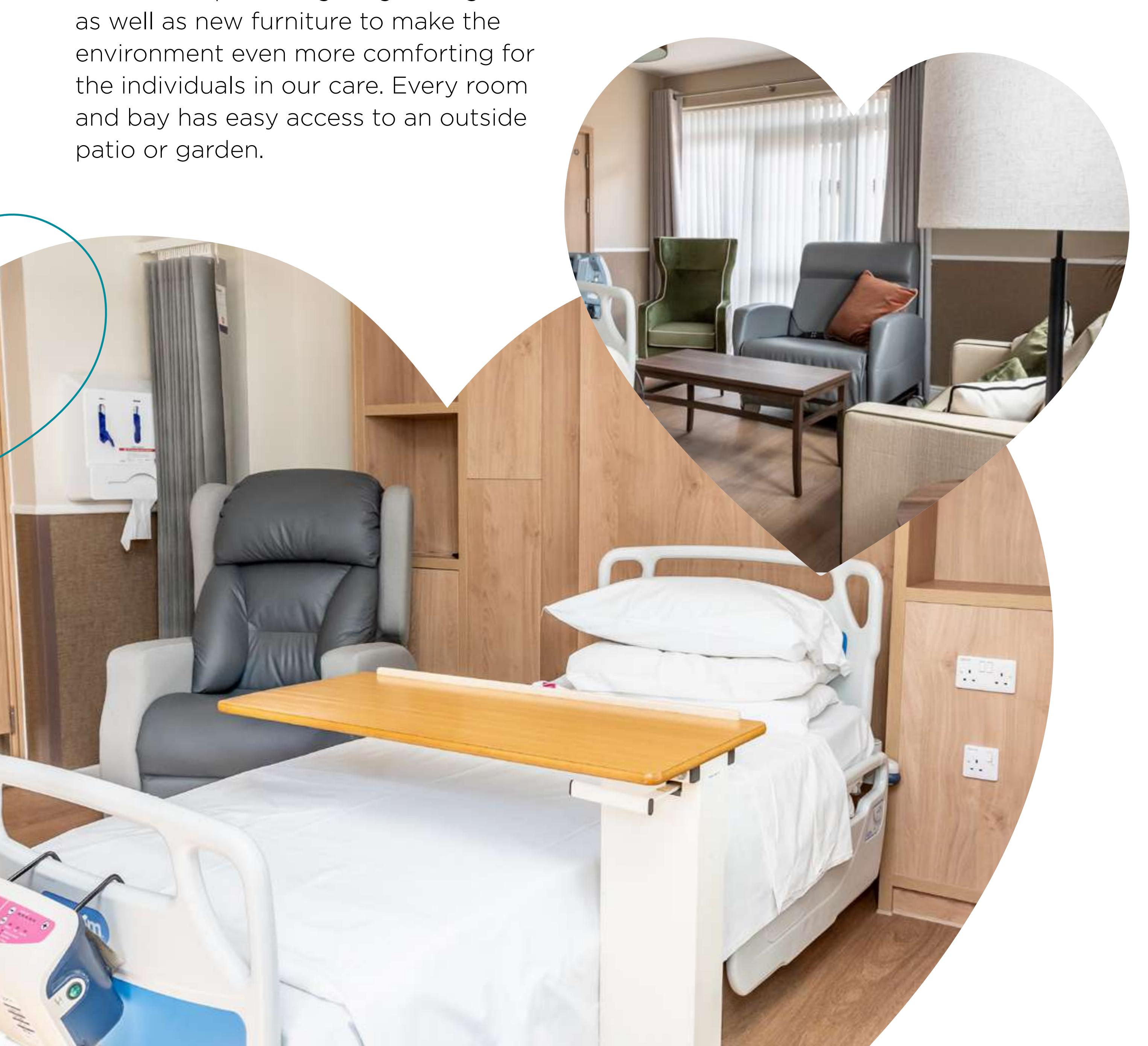
Progress against the priority

The Ward Development Project was completed on the 23rd March 2026.

The Ward has now been totally refurbished including, adding additional hoists to improve manual handling for the care teams, redecoration of the existing bare brick walls with cleanable and protective coverings to be compliant with IPC, a new medication room with biometric key safe to improve the security of medicine management, revised access to external areas ensuring that individuals can make the best use of the external spaces whilst they are in our care, improved lighting throughout, as well as new furniture to make the environment even more comforting for the individuals in our care. Every room and bay has easy access to an outside patio or garden.

Going forward

The hospice Ward will continue to provide outstanding care within a calm and comforting environment. The improved Ward area allows individualised care for the person staying on the Ward and their loved ones.



Priority 1: Patient Safety

Meeting the Accessible Information Standard (AIS) utilising our EDI policy with a specific lens on individual care recipient information and regulations.

Author: Jan Scott, Transformation Development Manager

How was this identified as a priority?

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. This will support 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 carers and patients.

Aim

We want to ensure that our services identify and meet the information and communication needs of all people with a disability or sensory loss.

In collaboration with Healthwatch Redbridge, we will provide learning for 10 members of staff, who represent front line services. In addition, one member of staff will become a champion in this field of work to roll out learning to relevant teams, this person will initially be supervised by the lead at Healthwatch Redbridge. The first learning event will be held in June 2025.

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.

Progress against the priority

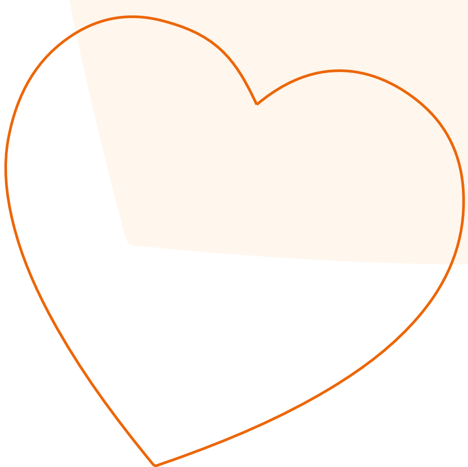
We commissioned Healthwatch in Redbridge to deliver the overview and impact of the AIS, this covered the Legal and Policy content of the standard in detail, the need for the standard, case studies discussion and a self-assessment framework. 12 members of staff, from across the hospice teams, attended the workshop and a champion was identified to ensure the learning could then be escalated further.

Firstly, we reviewed what we had already achieved during the last 12 months, this included a new portable hearing loop, British Sign language training for 24 staff members, providing easy read material in certain areas and creating an accessible website.

We then focussed on how information and communication could be improved. This included how we ask people what their preferred communication needs are, could our referral form be improved for people to complete, can we communicate by 'text' more efficiently, create a VIP sticker, or flashing screen on our iCare data system to highlight people who require accessible information and to review the current correspondence we currently use. This will be led by our AIS champion.

Going forward

Going forward we will complete self-assessments to check how well we are doing to ensure accountability, organised roles and responsibilities.



Priority 1: Patient Safety

1.3 Priorities for Improvement – Non-Medical Prescribing (NMP)

Author: Jane Elmer, Hospice Community Team (HCT), Dr Pippa Russell, Hospice Consultant, and Kemi Aregbesola, Specialist Pharmacist

How was it identified as a priority?

In September 2019, the hospice was granted authority for our Clinical Nurse Specialists (CNS) to train as Non-Medical Prescribers (NMPs). This was so that when our nurses are called to visit someone in crisis and they find urgent need for new medications to gain rapid symptom control, they can prescribe them.

We were given funding to support CNS training. We had gradually trained most of our CNSs, but recognised the need to build knowledge, skills and confidence further as non-medical prescribing was not being heavily used.

Aim

To update Non-Medical prescribing standards, to give each nurse specialist an initial target of a minimum of 2 prescriptions a month, to build knowledge, skills and confidence through a quality improvement project, using the knowledge and skills of our specialist pharmacist and consultant team, to support learning through practice and feedback.

Progress against the priority

All of our NMPs were asked to submit 2 'dummy' prescriptions per week in response to a real life scenario, over a period of 4 months. These were reviewed by our pharmacist. The pharmacist gave confidential, individualised feedback, which was hugely valued by the team.

The result was an improvement in both prescriptions (now of the highest standard/issue free) and in the self-rated confidence score of each CNS, from an 6.6/10 to 8.7/10.

Overall prescribing in crisis situations increased with the increasing confidence in competence, to prescribing successfully.

For example, in 2024/25 43 NMP prescriptions were issued; in 2025/26 131 NMP prescriptions were completed, 67 in Q4 (at least a 300% uplift and rising).

Going forward

We are now developing pre-populated MAAR charts to help speed our support for district nurses for more simple crisis scenarios. We are campaigning now to be able to electronically prescribe. There is a project in development for our District Nurse NMPs to be able to do so; we hope to be included in that project. This would make such a difference in terms of speed of delivery.

Priority 2: Clinical Effectiveness

2.1 Upskilling clinical workforce in preparation for extending nurse-led care.

Author: Jo Noguera, Head of Ward Services

How was this identified as a priority?

It is recognised that we are providing care and treatment to more people earlier in their illness journey. This often means a need for enhanced clinical interventions, and as a result, our nursing team will be required to enhance clinical competencies. Within supervision and appraisals, nurses working on the Ward have identified and requested the need to improve and enhance their clinical skills to be able to provide enhanced nurse-led care and treatment for the individuals they are caring for.

Aim

To enhance the reach and clinical offer to underserved communities and neighbourhoods within the geographical footprint of Saint Francis Hospice (SFH) by offering outpatient services, within individuals own homes or the Ward setting. To increase the number of avoidable admissions to secondary care for individuals requiring IV antibiotics, to upskill the nursing workforce in areas such as clinical examination skills, phlebotomy and IV competencies to also strengthen career progression and achieve higher levels of retention within the SFH workforce.

Progress against the priority

12 nurses successfully completed a clinical history taking and physical examination course in October 2025. This has helped improve assessment on the Ward and in the community. In addition, we have undertaken Capital Nurse IV modules on e-learning which allows the theoretical competencies to be achieved. We are exploring the options of simulation within the Education Centre to gain the clinical competencies. The policy to support this is close to completion.

Going Forward

The registered nurses will be fully competent in IV competencies and phlebotomy adding to their skill portfolio. The data will demonstrate the number of hospital avoidances as a result of interventions from SFH service teams and Ward 'day-case' admissions.

Priority 2: Clinical Effectiveness

2.2 Improving pathways in advanced illness: Co-designing a smoother investigation and treatment service for people with advanced disease.

Authors: Dr Corinna Midgley, Dr Pippa Russell Hospice Consultants, and from BHRUT Dr Pauline Leonard Oncology Consultant, the Acute Oncology Team and Dr Meera Kirby Consultant Hepatologist.

How was this identified as a priority?

Suspected spinal cord compression and suspected malignant or advanced liver disease ascites are two palliative care crisis scenarios which can lead to extended waits in hospital Emergency Departments (ED) whilst examination, investigations and treatments are processed. Our hospice and our local hospital trust, BHRUT (Barking, Havering and Redbridge University Hospitals NHS Trust) were concerned how stressful the BHRUT busy EDs were for people with advanced disease. Experience had shown us that journeying to and being in the ED environment could be very tough, with protracted waits for necessary processing, which is incredibly hard for people who are very unwell. We were aware of local (and national) stretch in EDs, with congestion a regular feature.

We wanted to make the pathway to diagnosis, and, if needed, treatment and care reliably easier.

Aim

To create local agreed pathways for smoother assessment, investigation and if needed, treatment for malignant spinal cord compression and advanced recurrent ascites.

Progress against the priority

The creation of best pathways has been a collaborative process with discussion, ideas, testing and review. We have gained confidence that people can be held comfortably at home or in the hospice pending planned review by (in the case of suspected spinal cord compression) next day acute oncology team, and (in the case of suspected ascites), planned hospice ultrasound, with an interim immediate treatment plan (e.g. high dose steroids; analgesia; care support, as needed catheterisation) pending planned transportation to either BHRUT Sunflower Suite (for suspected compression) or the hospital or hospice (for suspected ascites) for evaluation.

Over this year the ED has been successfully avoided, whilst investigation and treatment has been achieved, with positive feedback from the service users concerned. We have also worked with our therapies teams to develop clear guidance for mobilisation/movement prior to and post treatment, allowing for more confident moving and handling.

Going forward

We will be finalising pathways into both our hospital and our hospice systems in Q1 of the 2026/27 year and will then share our learning and the pathways with GPs and District Nurses as well as with specialist palliative care teams. We hope to have a community portable ultrasound machine by the end of Q1, and to gain access to human albumin solution. The ultrasound will be useful for investigation; human albumin solution will be useful in the treatment of ascites, allowing for more treatment in the community/hospice rather than in hospital.

Priority 3: Patient Experience

3.1 Increase the use of co-design and co-production approaches in developing and transforming services

Author: Jan Scott, Transformation Development Manager

How was this identified as a priority?

During 2024-25 a priority was agreed to increase feedback received from individuals using our service, which was only being received in writing or digitally using the iWantGreatCare system covering all our clinical and therapeutic services. This information is shared across the hospice to the relevant teams and is monitored by the Individual Experience Management Group (IEMG) and reported to Care & Quality Committee on a quarterly basis. However, we didn't have regular, real-time verbal feedback which would be beneficial to the transformation of our services.

Aim

Our aim was to recruit people to attend a co-production workshop, so that we have up to date knowledge of people's experiences when they, or their loved one, has 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, solve problems and create better end of life experiences for people in our care.

As we start to implement 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 inform the development and transformation of care.

We will 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.

Progress against the priority

For co-production to become part of the way we work, we created a culture where the following values are the norm:-

- **Create a culture of openness and honesty**
- **Progress 'you said, we did' to 'we said, we did'**
- **Create a commitment to share decisions**
- **Create a culture in which people are valued and respected**
- **Use clear communication and simple language**

The practical steps we took to make co-production happen in reality:

- Via the Individual Experience Management Group, we received agreement from senior leaders to champion co-production
- We opened a fair approach to recruit a range of people who use/have used our care services, taking positive steps to include underrepresented groups
- Put systems in place that recognise the contributions people make
- Identified areas of work where co-production can have a genuine impact, and involve people in the very earliest stages of developing services
- Inserted a question into the reception sign-in facility to seek permission to contact Ward visitors to agree contact from us for future engagement.
- Attended our Dementia Support group creating a co-design workshop environment to seek people's views. Outcomes included the need for more disabled parking spaces, a wider selection of lunch choices and quiet closing waste bins in Pemberton Place.
- Attended our 'Friendly Faces' bereavement support groups creating a safe environment for feedback.

- Held our first co-design workshop with people who had visited their loved ones on the Ward and have planned to repeat with our Neuro group at the end of May. So far all have been well received and evaluations have proved positive.

We are regularly reviewing and reporting back on progress to the Individual Experience Management Group, including suggestions for future development across the hospice, and aim to move 'you said, we did' to 'we said, we did.

Going forward

We will continue to connect with people who have used or visited our services and agreed to future contact to attend co-design workshops.

Ensure that everyone understands what co-design is and how to make it happen and build it into our work programmes until it becomes 'how we work'.

Priority 3: Patient Experience

Dementia – Consolidated Progress and the Future

Author: Mark Gilbey-Cross, Quality Improvement Lead

How was this identified as a priority?

This piece of work was identified as a priority within the new Saint Francis Hospice Five Year Strategy 2025–30 to increase access to Hospice services from underserved communities, through building an understanding of the areas of unmet need in each 'place', and what their clinical care needs are.

Aim

The aim was to consolidate the excellent and innovative dementia work already undertaken at Saint Francis Hospice. We will develop a new Hospice-wide Dementia Project Group to ensure complete internal collaboration and alignment of dementia workstreams. We need to identify areas of dementia care and support that can be improved, extended or introduced, internally and externally. To also consider the dementia related learning and development needs of the organisation.

Progress against the priority

Dementia remains a key priority within our SFH 5-year strategy, particularly in relation to improving access and strengthening the quality care we offer to people living with dementia across the communities we serve.

Over the past 7 months, we have developed a SFH Dementia Framework and Action Plan aligned to the NHS Live Well Dementia Pathway. This gives us a clear structure for our dementia work and helps ensure we are not duplicating services already available within our local communities but instead complementing and strengthening what exists.

A cross-organisational Dementia Project Group has been established bringing together staff and volunteers across the hospice. The group provides a space to share ideas, review current practice, refine the framework and collectively move forward agreed actions. As part of this work, SFH branded literature is currently being reviewed to ensure it is dementia-friendly, accessible and supportive for individuals and their carers and loved ones.

A significant step forward has been the introduction of Tier 1 Dementia Awareness training as mandatory for all staff and volunteers, across all roles and levels. This ensures a consistent baseline understanding of dementia throughout the organisation. In addition, two staff

members have completed Dementia Interpreter training and "DIET" Immersive Experiential Dementia Training focused on the dining and nutrition experience, enabling us to deliver this training in-house and deepen the understanding of the lived experience of dementia.

On the Ward, we will be introducing 10 pre-filled MP3 players each containing specific music genres. We know music can be incredibly powerful for people living with dementia – supporting reminiscence, reducing anxiety and agitation, and providing comfort and connection at the bedside.

We've also submitted a grant proposal to fund wipeable headphone and storage cases, which will make the mp3 players safer and easier to use in a clinical setting. Once the Ward refurbishment is complete, the full set will be handed over for staff to access easily as part of everyday care. It's a simple intervention but one that can make such a meaningful difference.

Going forward

A further proposed development within the framework is the introduction of Namaste Care onto the Ward and those supported in the community by the Hospice at Home team. The project plan is complete, and we are currently awaiting confirmation of trust and grant funding to enable implementation. We already have one Namaste Train the Trainer in post and plan to train two further trainers to ensure sustainability and wider roll-out. The project would embed structured, sensory-based and person-centred approaches into everyday care, alongside development of a Night Owl volunteer model to provide overnight companionship and comfort.

Overall, this work reflects steady practical progress in strengthening our dementia offer and ensuring we are well positioned to continue developing this priority.

Priority 3: Patient Experience

In support of the frequent wish for urgent burial for religious reasons: Co-designing GP and family information leaflets with local faith leaders to aid GP and family preparedness after death.

Authors: Dr Pippa Russell, Hospice Consultant and Medical Examiner, Mohamed Omer, Co-founder of Gardens of Peace, Ilford, with Muslim, Jewish and GP community engagement.

How was this identified as a priority?

Our local community includes many for whom urgent burial is important for religious reasons. The relatively new Medical Examiner service provided some new process challenges for GPs, leading at times to unintended obstacles to smooth death certification (a requirement before burial can occur). This has been seen by our local faith leads, and by our hospice too.

We saw an opportunity to try to help and support families and loved ones to achieve a timely burial. Urgent burial is not always possible, but this project aimed to help by ensuring families, loved ones and GPs (as usual providers of a proposed Medical Certificate of Cause of Death) are as prepared as possible for dying, and to be information ready for necessary after death processes, towards making those processes smoother for the Medical Examiner/Registrar services and for the bereaved.

Aim

To co-create

1. a simple, informative leaflet for families and loved ones of people nearing the end of life who hope for urgent burial, to help them to be prepared for 'what next after death', and

2. a simple, information sheet for GPs as usual providers of the proposed Medical Certificate of Cause of Death, clarifying what clinical information they will need to be ready to provide for the Medical Examiner, so that they can prepare. This with hope that their preparedness will smooth after death processes and facilitate more rapid burial.

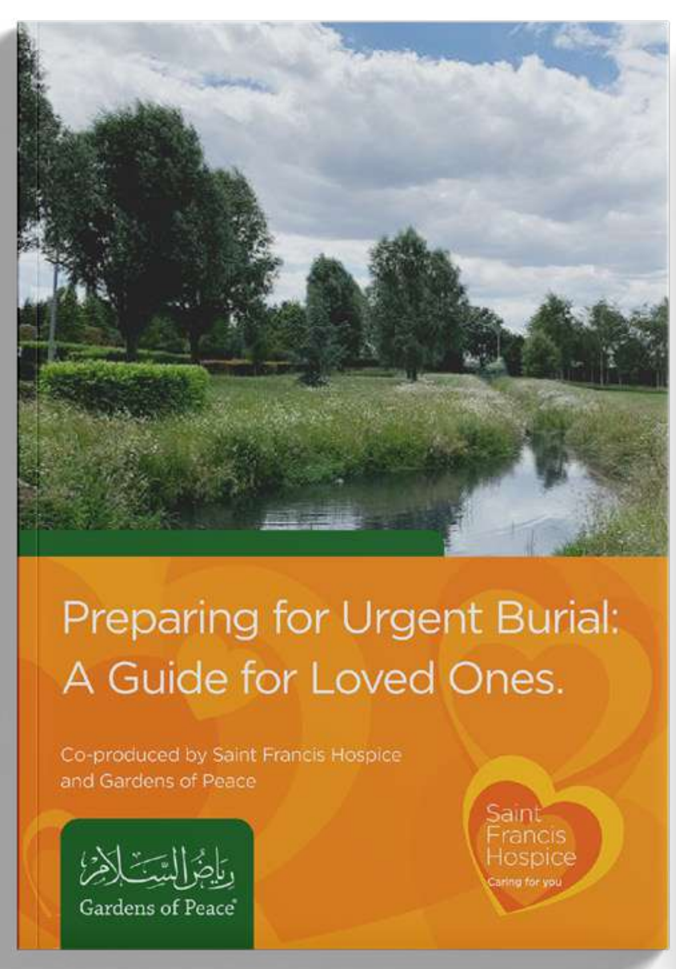
We wanted development of the family leaflet and GP information sheet to be collaborative, with the materials developed by the authors, then sense checked with faith leads from Muslim, Jewish and other communities, with families with experience of bereavement for whom urgent burial was important, and with local GPs.

Progress against the priority

Leaflets have been created, with helpful early feedback from our Individual Experience Management Group. We are currently awaiting final proof feedback from our co-author, then will share with named faith leaders, families and close GP colleagues, further adjusting as needed.

Going forward

We anticipate that the family leaflet and the GP information sheet will be ready for distribution and use very shortly. We will continue to gather feedback on their value, with ongoing adjustments as needed. It has been a real pleasure to work together on this project.



Urgent Burials: A Guide for GPs

Rapid burials are so important for people of faith. In all effort to help speed necessary processes, here are some top tips to help GPs to complete an MCCD proposal for Medical Examiner (ME) approval at speed:

Verification of death

- There is no need to see the person within 28 days of death as long as you have met them in life and feel in a position to propose the cause of death by your knowledge of them and through their clinical notes.
- Some of community nurses are trained in verification of death, but not all. If they don't have capacity, then this will be the duty of the GP.
- If you are called on to verify in hours, please do so. People will understand if you cannot do so immediately due to GP appointments, but in hours it is your duty to do this as soon as you are able to. Families will be so grateful.

Thinking ahead and planning

When death can be anticipated please do think in advance:

- What cause of death would you propose?
- What supporting information from the clinical notes would be helpful to the ME? Your practice staff can assemble the supporting information in advance of the death.
- If the death is anticipated, you can discuss the patient with the ME prior to death if guidance is needed.
- You can pre-populate the MCCD if you feel happier to do so. It is easier to do critical paperwork when not under pressure. The only thing outstanding would be the time and date of death, to be completed in the event of the death.

Co-produced by Saint Francis Hospice and Gardens of Peace

PART 3

PRIORITIES FOR IMPROVEMENT FOR 26-27

The priorities for improvement for the coming year were developed in line with our new 5-Year Strategy 2025-30

Priority 1: Patient Safety

1.1 Sentinel Event Management

Author: Mark Gilbey-Cross, Quality Improvement Lead

How was this identified as a priority?

This priority was identified following a review of how events (incidents) are reported, reviewed, investigated and how learning is shared across the organisation to improve patient safety.

What goals are we setting?

A review of the processes, use of Sentinel to manage events, an increase in the quality of reporting, earlier recognition of themes and trends, with improved and more robust sharing of learning lessons.

What will the impact be?

Simplified process and system that are more user friendly, with robust oversight and allocation of events to investigators, higher levels of governance oversight, improved recommendations, related actions and appropriate sharing of lessons learnt throughout the organisation.

How will the progress be monitored and reported?

Progress will be monitored via regular audit of events reported and associated analysis reported to the Quality Management Group and up to the Care & Quality Committee.

Priority 2: Clinical Effectiveness

2.1 Syringe Pump Training & Competency Assessment Support

Author: Jo Noguera, Head of Ward Services & Jane Crussell, Practice Education Facilitator

How was this identified as a priority?

It became clear through closer working relationships with the Enhanced Hospice at Home (EH@H) team and through requests for educational support from community colleagues that nursing home and community staff may lack confidence in their knowledge of syringe pumps and how to set them up. It was also recognised that, although theoretical training is available, there is a need for practical skill development and competency assessment. However, updating, assessing and maintaining knowledge and competencies can be challenging within a continually changing workforce and healthcare environment.

As the Ward team routinely use syringe pumps and completes mandatory annual updates, it was felt that, with support from the practice education team, they are well placed to support community colleagues by offering opportunities to attend the Ward to develop their skills and competence in setting up syringe pumps. The clinical setting and expert Ward team provides a valuable, practice-based environment for community staff to build their skills, competency, and confidence in a supported and assessed way.

Ward staff play an active role in delivering both the theoretical and practical elements of training, ensuring a consistent and structured approach. This initiative not only enhances the skills and confidence of community teams and strengthens collaboration across services but also offers Ward staff the opportunity to further develop their teaching, management and leadership capabilities.

What goals are we setting?

- Improve collaborative work across directorates to support syringe pump training & competency assessments for nursing home and community staff.
- Improve partnership working relationships between Ward, nursing homes and community teams.
- Provide regular, accessible training opportunities for nursing home and community staff and assess confidence outcomes.
- Enhance teaching, management and leadership skills in Ward staff.

What will the impact be?

- A more confident, competent and collaborative community workforce in their use of syringe pumps.
- Enable more individuals to be supported at home
- Enhanced communication and relationships with community colleagues
- A Ward team with increased teaching and leadership skills

How will the progress be monitored and reported?

- Record of the teaching sessions delivered, and evaluations provided to support changes based on the evaluations to adapt and alter the modules as needed.
- Audit community colleagues qualitative and quantitative feedback to demonstrate perceived value and impact
- Regular stakeholder events to offer opportunities to explore currency, efficacy, confidence and competence monitoring and to encourage a culture of learning and sharing.

Priority 2: Clinical Effectiveness

Frailty – identifying needs; building support

Author: Sharon Brahaj, Occupational Therapist & Klaire Craven, Complementary Therapist (Therapies Team)

How was this identified as a priority?

This piece of work was identified as a priority within the SFH Five Year Strategy 2025-30, which recognises frailty as an area of unmet need. There is a need to improve early identification and access to support, and to develop a more coordinated place-based approach that responds to the complex and evolving needs of people living with frailty and their carers. This will initially be delivered as an onsite pilot, allowing for evaluation and refinement before wider roll-out across the areas we serve.

What goals are we setting?

The aim is to develop and pilot a hospice-led frailty workshop to address identified unmet need. We will establish a coordinated approach to frailty across the organisation supporting earlier identification and intervention for people living with frailty, empowering individuals and their carers to take a more proactive approach to their health and wellbeing, whilst enhancing knowledge, confidence and access to appropriate support.

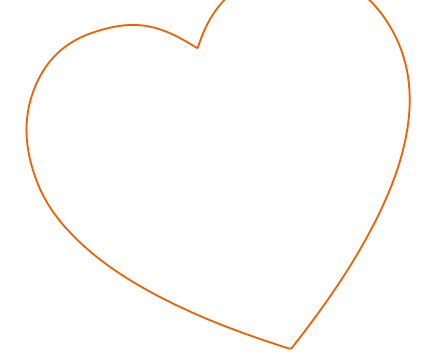
What will the impact be?

The impact would be improved patient-centred care and quality of life, increased coordination and integration across services, and a reduction in avoidable hospital admissions. It would support people to remain more independent for longer, reduce crisis-driven care, and create a more seamless experience for individuals living with frailty and their carers. The pilot will also support the development of a coordinated frailty approach within the organisation; to help to inform future service development and wider implementation across the areas that we serve.

How will the progress be monitored and reported?

The pilot will be monitored through participant and carer feedback, alongside simple outcome measures to capture changes in knowledge, confidence and perceived ability to manage health and wellbeing. Evaluation findings will be used to inform ongoing development of the workshop, with key learnings and outcomes shared through appropriate governance structures, including the Care and Quality Committee.

Priority 2: Clinical Effectiveness



2.3 The Careport Project for Remote Monitoring in the Community

Author: Dr Pippa Russell, Consultant in Palliative Care

How was this identified as a priority?

There is huge pressure on the community service to deliver to an increasingly complex cohort and to find innovative ways to meet demand.

This innovative pilot project introduces remote monitoring kits into the community palliative care setting - an approach originally designed for acute care but now being offered to support people in their own homes, including carers.

Individuals can input key data from home, with the idea of feeding directly into the IPOS (Integrated Palliative Outcome Scale) data we use, to in turn help our clinical teams to monitor symptoms remotely and respond quickly when needed.

This is a particularly exciting opportunity, as if benefits can be demonstrated, this may open the door to further innovation funding and future grant partnerships, to help us scale this approach across wider communities served.

What goals are we setting?

As the first hospice to tailor and trial this technology, our aim is to enhance early identification of clinical deterioration, improve symptom management, and enable more proactive, personalised care while reducing unnecessary hospital admissions. Key goals include increasing patient and family confidence in managing care at home and helping them to know when to call for advice/ support, enabling effective triaging of our response to changing clinical need, and strengthening multidisciplinary decision-making through real-time data.

What will the impact be?

The anticipated impact is improved patient experience, better symptom control, and more coordinated, efficient use of healthcare resources.

How will the progress be monitored and reported?

Progress will be monitored through a combination of quantitative metrics – we will look at response times, frequency of interventions and hospital admission use/avoidance, and gather qualitative feedback from patients, families, and staff. Findings will be reviewed regularly through governance structures and shared via quality reports, with iterative adjustments made to optimise the model and inform potential wider rollout.

Priority 3: Patient Experience

Keepsake Keyring in the Community

Author: Simone Sims, Enhanced Hospice at Home Team Leader

How was this identified as a priority?

In 2020/2021 the Ward developed a Keepsake keyring priority, whereby individuals and their loved ones were offered a keyring containing their loved one's fingerprint. With the majority of individuals being seen in the community, the Enhanced Hospice at Home (EH@H) team felt this could be offered to those who are cared for at home.

What goals are we setting?

Our aim is to offer people being cared for in the community a keepsake keyring in line with what the Ward team offer, also providing their loved ones with a simple leaflet outlining the concept including an option for a voluntary donation.

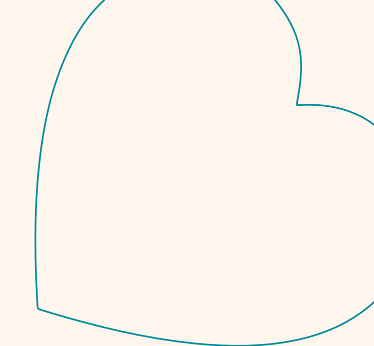
What will the impact be?

Offering a personal way to remember a loved one, a sense of comfort and connection, that is equitable with the offer made by the Ward team.

How will the progress be monitored and reported?

- Record the number of keyrings offered.
- How many decline the offer.
- How many accept the offer.
- How many keyrings have been provided.
- Value of donations received.

Priority 3: Patient Experience



3.2 Digital Legacy: embedding advice and support into our Advance Care Planning

Authors: Hannah Karet, Specialty Doctor and George Parish, Digital Marketing Manager

How was this identified as a priority?

Dr Karet presented a publication about digital legacy to the medical team journal club in December 2025.

The publication explored healthcare professionals' experiences of managing digital legacy as part of advance care planning (ACP).

Digital legacy is the information that is stored electronically or online about someone after they die e.g. photos, videos, social media accounts, email accounts, online banking. The publication suggested that we should be talking to individuals we care for and their loved ones about making plans for these digital belongings. The topic was well-received, the team recognising that this was highly relevant to people using our services. Further discussions with the community team highlighted a gap in our staff knowledge and familiarity with the topic. Our hospice currently has minimal resources on this topic.

What goals are we setting?

To develop SFH resources to support staff to talk about digital legacy as part of ACP conversations, with a page on the website and integration into our existing information leaflets, alongside training sessions for staff in our community, Ward and family & individual support teams.

What will the impact be?

To make talking about digital legacy part of ACP conversations, allowing those we care for opportunities to make plans for important digital belongings. Managing digital legacy can help people impact on preparation, grief and bereavement in a positive way.

How will the progress be monitored and reported?

Pre and post questionnaires to assess staff familiarity with and confidence to discuss digital legacy. Feedback from a group of our service users in co-designing additions concerning Digital Legacy to our website and leaflet resources.

Priority 3: Patient Experience

3.3 Enhancing Individuals and their loved one's experience on the Ward

Author: Joanne Noguera, Head of Ward Services and Victoria Miles-Gale, Head of Volunteering

How was this identified as a priority?

Through Ward team building days, feedback from people receiving care on our Ward and their loved ones, and feedback from existing volunteers. It was agreed by the team that we needed to focus on improving the overall experience on the Ward and create special memories for people receiving care and their significant others. Individualised care can be hampered by clinical tasks and the support of volunteers who could create positive experiences would be invaluable.

What goals are we setting?

To design, develop and recruit 5 people to a newly created Ward volunteer role – volunteer companion.

What will the impact be?

The role will support individuals in our care and their families with non-clinical and emotional needs. This will create a separation between clinical and non-clinical roles. There is anecdotal evidence that sometimes individuals will not share things that are on their minds or that they need, with clinical staff as they can see they are busy. This new role will provide a safe space for individuals to be themselves, speak openly and seek support and assistance when needed.

How will the progress be monitored and reported?

Initial pilot target of 5 volunteer companions to be monitored via volunteer activity report.

Impact on Ward to be monitored via feedback process.

Margaret
saint francis hospice

PART 4

PARTICIPATION IN CLINICAL AUDITS

Participation in Audits

Author: Mark Gilbey-Cross, Quality Improvement Lead

Saint Francis Hospice continues to recognise the value of audit in providing assurance around current practice and the identification or areas of improvement and links to development of quality improvement projects.

Oversight of all audit activity is maintained via:

- Bi-monthly Clinical Audit Group Annual Audit Programme
- Quarterly Management Meetings
- Quarterly Care & Quality Committee

Annual Audit Programme

Our annual audit cycle continues using both audit tools developed by Hospice UK (national charity for hospice care) and those identified internally; these audits allow us to measure our services against national standards of excellence and our own internal standards. Hospice UK audits are under regular review, ensuring audits are based around current evidence and best practice; the Clinical Audit Group is open to any member of staff.

Specific Tailored Audits

All members of the multidisciplinary team are encouraged and supported to consider areas of audit activity and quality improvement projects; this drives innovation as well as improving the care and treatment of those individuals receiving care and treatment from Saint Francis Hospice. Over the past 12 months there has been an increased focus on the links between audits and quality improvement projects as outlined below:

How individuals manage their medication post discharge from SFH

Aim: To improve the quality of discharges within the organisation and identify some of the difficulties faced by individuals with their medicines post discharge from the hospice.

Recommendations:

- Implementation of a To Take Away (TTA) Medication Review Checklist
- Improved communication with community pharmacies
- Enhanced discharge handover
- Home visit medication reviews

Hyoscine Butylbromide as 1st line in managing secretions at end of life

Aim: To change current practice of 1st line anti-secretory from glycopyrronium to hyoscine butylbromide – starting at the level of the Ward.

Recommendations:

- Prescribe Hyoscine Butylbromide 20mg S/C 1 hourly PRN instead of Glycopyrronium at clerking onto the Ward.
- Clear instructions / indications on discharge for community in Emergency Departments / Medicines Authorisation and Administration Record (MAAR) charts
- Increase minimum stock of hyoscine butylbromide to 10 packs
- Information leaflet to be added to nurses' office for reference

Venous Thromboembolism (VTE) prophylaxis

Aim: To increase compliance with documenting VTE RA to 100%

Methodology: Process measures included compliance with completing VTE RA sections of the initial clerking and drug charts and doctors' subjective confidence rating.

Outcome measures were number of individuals prescribed VTE prophylaxis and their views on the impact on quality of life (QoL).4,5 The balancing measure was time taken to complete VTE RA. Fishbone/driver diagrams were used to understand underlying problems (low prescriber confidence and lack of robust decision-making framework) and identify solutions (education, updating the VTE RA section in the clerking document, adding a prompt to the handover document, twice weekly formal review and daily informal review).

Conclusion: This project demonstrates that improved clinical practice can be achieved using quality improvement methodology and the need for a standardised, evidence-based clinical decision tool for VTE risk assessment in specialist palliative care settings (SPC).

Urgent Ultrasound (USS) Audit

Aim: To train up members of the clinical team to enable them to perform focussed abdominal scans, with ongoing support and training from our volunteer sonographer.

Method: 3 senior doctors trained on Focussed Abdominal Ultrasound in Palliative Care (FASP) course. Review of documentation of scans performed in subsequent 6-month period to assess whether scanning had increased, and whether this was appropriate ie. followed standards of FASP course.

Conclusion: More scans are being performed due to greater availability of trained staff. Given that all performed scans had a valid indication, there is no reason to believe that extra scans are being performed unnecessarily. More trained staff offers the versatility to branch out and offer domiciliary scans for those less able to attend outpatient appointments and flexibility in timings for paracentesis procedures. Ongoing support from expert sonographer for newly trained staff to build on skills will help to future-proof this service.

IPOS QI project on the Ward

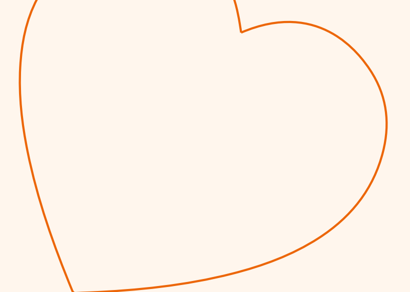
Aim: The Integrated Palliative Care Outcome Scale (IPOS) measures symptoms and concerns that people with advanced illness prioritise. At Saint Francis Hospice the IPOS questionnaire is printed, manually filled, and responses transferred onto an electronic smart form on iCare (software). The electronic form includes additional information about the individual's Phase of Illness (POI) and Australia-modified Karnofsky score (AKPS) which is completed for each form. IPOS forms are filled on admission, at discharge and for follow up assessments for the Multidisciplinary Team (MDT) weekly meetings where responses are read out to the team. Concerns were raised that the total electronic IPOS scores presented at the quarterly Outcome Assessment and Complexity Collaborative (OACC) meeting were lower than expected.

Conclusion: The hospice complete paper IPOS forms well and despite a few minor inaccuracies, transcribe information to electronic smart forms accurately. Results allow the hospice to consider using electronic devices to minimise paper-based exercises.

There is a need to consider alternative ways to electronically document MDT outcomes and for scores to be presented in a visual format during MDT to efficiently highlight patient concerns to the wider team.

PART 5

REVIEW OF QUALITY PERFORMANCE



Quality Performance Overview 2025-26

Author: Jan Scott, on behalf of Tes Smith, Director of Care and Community Services

During the last twelve months the number of people we cared for increased by 31% from 2,245 to 2,945 (this is an increase of 19% above our target for 2025-26). There has been an increase of non-cancer referrals rising from 39% to 44%. Often it is thought that we solely care for people with a cancer diagnosis, therefore we have encouraged health professionals to refer people with a non-cancer illnesses which has led to an increase in referrals of other life-limiting illnesses.

The Ward

During the last 12 months we cared for 285 people on our Ward, a reduction of 18%. This reduction is due to the refurbishment of our Ward environment between September 2025 and March 2026, which resulted in 50% of our beds being moved into the community via our newly formed Enhanced Hospice at Home service.

Many of the admissions required treatment for pain and other symptom control, enabling 21% of people to be discharged back home, or, if needed, into a care home. 79% of people cared for in our Ward sadly died and the average length of stay was 11.2 days compared to 12.7 in 2024-25.

Hospice Community Team (HCT) - formerly known as Specialist Community & Crisis Support (SCCS)

1,275 individuals were cared for by our HCT team in 2025-26, a 14.2% increase from 1,116 during the same period the year before. Complexities of illness have resulted in the number of face-to face visits and telephone consultations rising to 17,860 from 15,229 in the previous 12 months (a 17.3% increase), and consultations with health professionals rose from 20,864 to 23,260, a substantial increase of 11.5%. A temporary smaller Ward base during the Ward Development Project, plus growth in our referrals and reach, has contributed to this increase, alongside an ongoing rise in referrals for support for people with non malignant advanced disease.

Enhanced Hospice at Home (EH@H)

Our EH@H team cared for 807 people at home compared to 725 in 2024-25 (an increase of 82 people largely due to the reduction in Ward beds during the Ward Development Project) and made 6,264 home visits compared to 5,227 the previous year (an increase of 20%). 46% of people they cared for had a non-cancer diagnosis compared to 54% the year before. This trend indicates that healthcare professionals who refer are understanding that we care for people without a cancer diagnosis, and this has seen referrals steadily rising over recent 2 years. We are taking steps to ensure we remain flexible to crisis and need, on an hour-by-hour basis, by allocating shorter visits when possible, to ensure we can do more visits. This has increased the number of visits we achieve with shorter time frames allocated where appropriate.

People dying in their preferred place of death (PPD) rose from 85% to 92.8%.

Therapies

Pemberton Place, our day centre, has had an increase in complementary therapy sessions, rising from 1,395 in 24-25 to 1,479 in 25-26, an increase of 6%. During this period the therapies team experienced a fall in volunteer numbers, e.g. Complementary Therapy volunteers were difficult to recruit this year which resulted in an increased workload for the Complementary Therapists that are employed by SFH.

Occupational therapy support remained consistent at 549 compared to 531 the previous year.

Physiotherapy sessions experienced a decrease in numbers from 1,969 (2024-2025) to 1,007 (2025-2026), due to a recruitment gap thereby reducing activity.

Our Dementia group, held monthly at Pemberton Place, is becoming over-subscribed, so that we are hoping to run a second group if we can find the funding to do so.

Family and Individual Support

The number of adults receiving bereavement counselling remained consistent at 964 (2025-2026) from 974 (2024-2025). In addition, 107 children received bereavement counselling from our child and family therapists compared to 100 in 2024-25. In total these teams delivered 4,726 activities in 25-26.

This year we included data for our helpline 'OrangeLine' for the first time. In 2024-25 the team supported 1195 people with an increase to 1369 in 2025-26. This unique service is available to anyone in the community who has an advanced illness, or is caring for someone in that situation, or has been bereaved, and who requires emotional support, or is experiencing loneliness or isolation. Options for individuals include regular phone calls, face to face support or joining one of the many groups now available throughout our catchment areas.

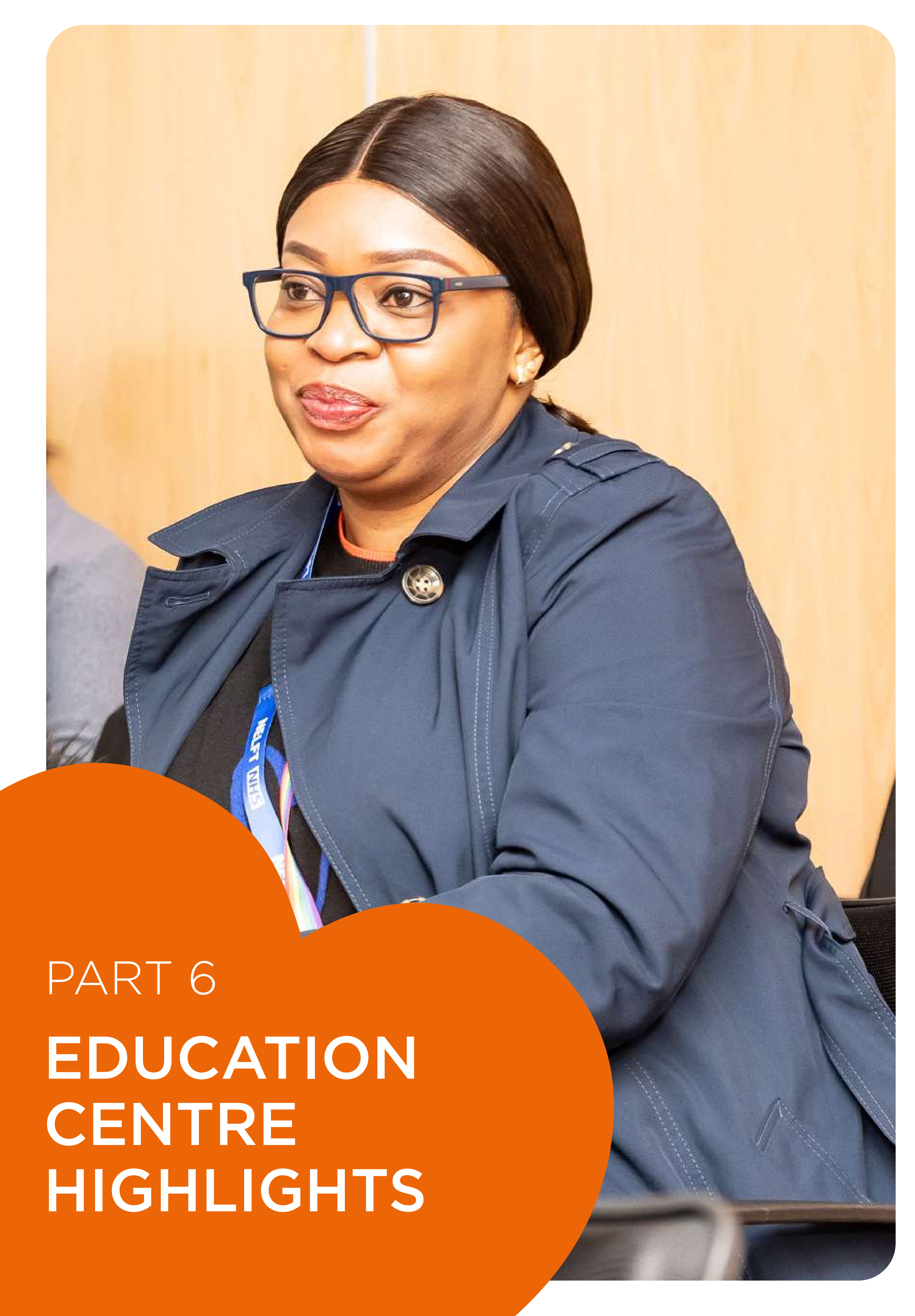
In Conclusion

Overall, this has been an outstanding year for providing services to our increasingly complex and diverse communities of people who need our care and support. With recruitment challenges and seeing changes to other services in primary and acute care - we remain immensely proud of all our services and teams and all they deliver. With the continuation of our Five Year Strategy: Growing Together, in 2025 the future of Saint Francis Hospice will continue being 'outstanding', supporting more people within areas of unmet need.

Review of Quality Performance

	Barking & Dagenham	Brentwood	Havering	Redbridge	West Essex	Out of Comissioned Area	Total 2025/26	Total 2024/25
OVERALL SERVICE								
Referrals Received	539	638	1231	262	33	66	**2,769**	2,684
People cared for by the Hospice	548	632	1383	227	23	132	**2,945**	2,245
% People cared for with non cancer primary diagnosis	52%	67%	62%	52%	70%	95%	**44.00%**	38.90%
% People cared for with cancer primary diagnosis	48%	33%	38%	48%	30%	5%	**56.00%**	61.10%
WARD SERVICES								
Total number of admissions	60	49	148	35	7	7	**306**	386
Total number of People cared for	59	46	134	35	6	7	**285**	348
% New People	85%	65%	75%	83%	83%	57%	**71.57%**	89.94%
% Occupancy	16%	16%	54%	9%	1%	4%	**79.00%**	76.66%
DIAGNOSIS								
% People cared for with non cancer primary diagnosis	22%	35%	18%	14%	57%	57%	**26.32%**	22.40%
% People cared for with cancer primary diagnosis	78%	65%	82%	86%	43%	43%	**73.68%**	77.59%
OUTCOME OF WARD STAYS ENDING								
% Died	85%	71%	72%	66%	60%	71%	**78.95%**	71.24%
% Discharged to home (including care home)	15%	29%	28%	34%	17%	14%	**20.70%**	27.72%
% Discharged to an acute hospital	0%	0%	0%	0%	17%	14%	**0.35%**	0.78%
% Discharged to another setting	0%	0%	0%	0%	0%	0%	**0.00%**	0.26%
Average length of stay (days)	10.17	13.41	15.13	9.91	57.83	22.71	**11.22**	12.73
HOSPICE COMMUNITY TEAM								
Number of Service users	291	366	595	18	3	2	**1275**	1116
% New People	88%	80%	76%	89%	67%	100%	**80.00%**	92.00%
% People with non cancer primary diagnosis	35%	55%	64%	72%	67%	100%	**40.80%**	39.61%
% People with cancer primary diagnosis	65%	45%	36%	28%	33%	0%	**59.22%**	60.39%
Number of face-to-face or telephone consultations with patient or relative /carer	3690	5165	8487	269	55	194	**17,860**	15,229
Number of face-to-face/ telephone consultations with a health professional	979	1267	2259	70	13	18	**4606**	4626
digital records checks with a health professional	3965	5131	9147	284	54	73	**18654**	20864
Average length of care (days)	57.19	28.7	39.64	36.67	76	73	**67**	26.7

	Barking & Dagenham	Brentwood	Havering	Redbridge	West Essex	Out of Comissioned Area	2025-26	2024-25
ENHANCED HOSPICE AT HOME								
Total number of People cared for	158	149	408	83	4	5	**807**	725
% New People	92%	79%	81%	90%	100%	80%	**84.14%**	86.48%
% People cared for with non cancer primary diagnosis	44%	50%	47%	36%	75%	80%	**45.70%**	58.34%
% People cared for with cancer primary diagnosis	56%	50%	53%	64%	25%	20%	**54.28%**	43.72%
Total number of visits	1241	1074	3379	504	50	16	**6264**	5227
% People who died at home (including care homes)	18%	15%	55%	12%	0%	0%	**95.91%**	85.26%
Average length of care (days)	10.77	9.26	11.76	7.65	15.33	4	**10.66**	8.15
BEREAVEMENT SERVICE								
Total number of clients								
Adult	163	156	444	83	11	107	**964**	974
Children	13	17	52	11	0	14	**107**	100
Total	176	173	496	94	11	121	**1071**	1074
Number of support/counselling telephone or face-to-face consultations (including health professionals)	683	856	2446	363	55	59	**4,462**	5,312
ORANGELINE								
Total number of clients								
Adults	244	278	704	103	11	29	**1369**	1195
Total Number of Face to Face Activities	222	307	475	68	16	30	**1118**	927
Total Number of Telephone Activities	351	742	1837	286	30	161	**3407**	2926
Number of Condolence Cards	287	292	746	129	9	12	**1475**	1,301
SPECIALIST MULTIDISCIPLINARY SUPPORT SERVICES								
Number of face-to-face consultations with patient or relative/carer by service:								
Pastoral care support	83	244	334	71	6	5	**743**	852
Complementary therapy	202	387	846	142	2	17	**1596**	1395
Family services (excluding bereavement)	266	310	758	102	23	91	**1550**	1492
Occupational therapy	508	629	1217	113	17	14	**2498**	1132
Occupational therapy equipment	107	116	277	25	5	1	**531**	549
Physiotherapy	137	232	536	69	9	36	**1019**	1969



PART 6

EDUCATION CENTRE HIGHLIGHTS

Education Highlights 25/26

Author: Bridget Moss, Director of Nursing, Quality & Research

The setting for this year has been the delivery of the first year of the 5 Year Strategy. Local data indicates an increasing need for palliative and end of life care, particularly as the population increases and we begin to increase our knowledge of the needs of underserved communities.

Learning and Development

Our mandatory training compliance continues to perform well. There has been a particular focus on ensuring our workforce is up to date with manual handling and Oliver McGowan training on learning disability and autism, to ensure all requirements of this knowledge and understanding are achieved and applied to care. This year we achieved 98% compliance across the organisation.

Our staff continue to access communication skills training at 3 levels, which includes Advanced Communication Skills training, to ensure this is central to high standard care delivery, as are skills in reflection to support learning from practice. The Digital Skills programme has delivered sessions to staff and volunteers to boost existing skills and has established the Digital Agents Programme which trains staff to champion, enable and navigate alongside others to ensure an increase in capability and confidence is sustained.

There is an increasing need to be able to show data that demonstrates strategic goals and clinical effectiveness, such as an increase in the numbers of people we care for, therefore there has been some training on data quality. There has also been training to support managers and leaders in communication within teams, and Quality Conversations training was provided for these roles.

A focus on clinical skills training has included developing newly appointed and existing registered nurses to attain the required qualification in the supervision and assessment of student nurses. This strengthens the effectiveness of student learning in practice and enables a growth in the numbers of students, which we hope to see next year. Reflecting on practice and applying any learning is a skill that needs to be maintained, especially for clinicians, and both reflective practice and revalidation workshops have been expanded and delivered throughout the year, as well as workshops around quality of care. There has also been specific development of a team of registered nurses to deliver skills-based training for

colleagues working in the community and in nursing homes.

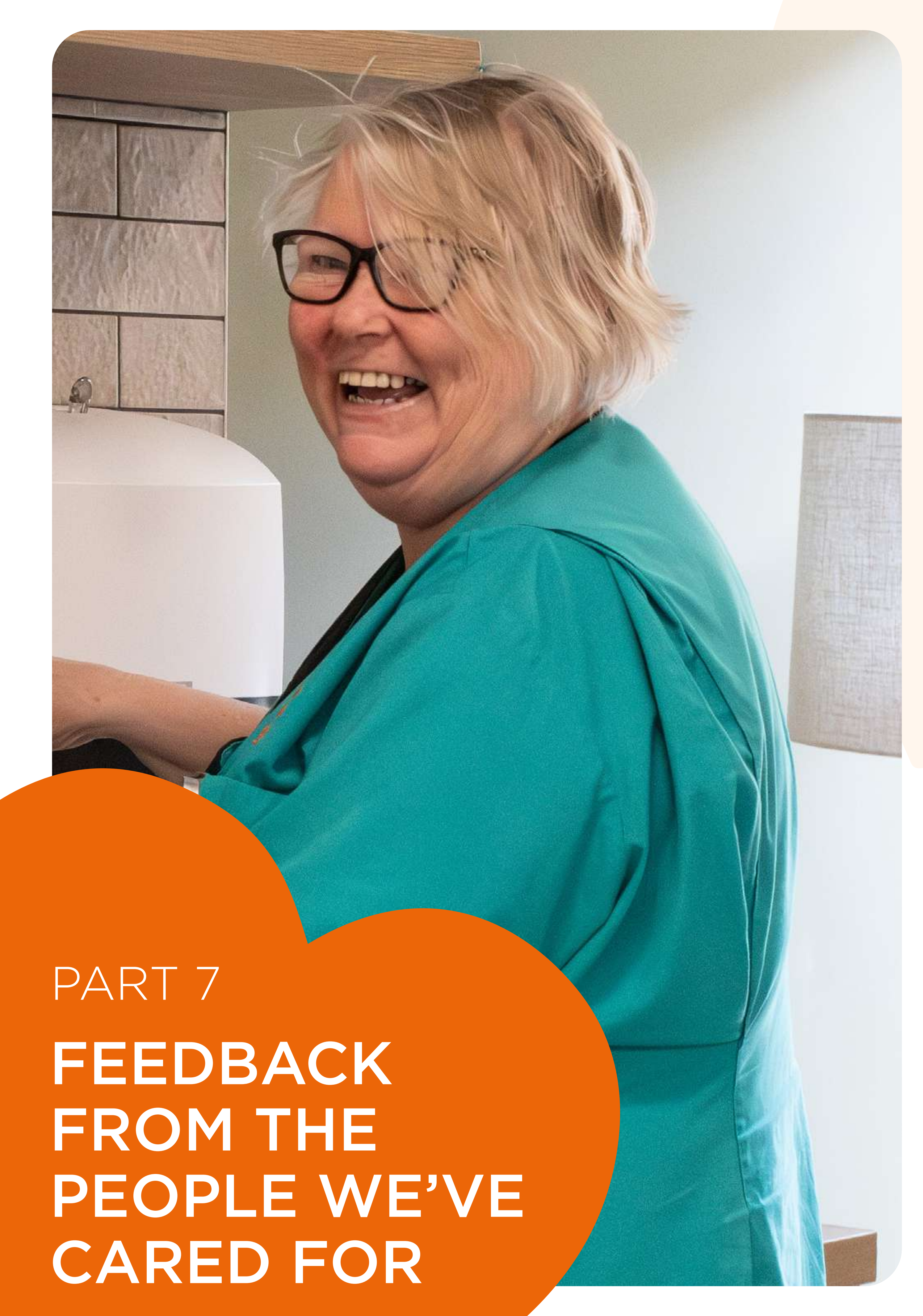
In line with the strategy, there is a focus on increasing our reach, especially to people who are underserved by palliative and end of life care. Training has therefore reflected a focus on dementia and has included experiential, immersive learning that reflects the experience of living with dementia. Additionally, there has been development of staff in the delivery of Namaste training; this focuses on the improvement of quality of life for people with advanced dementia using a range of physical, emotional and sensory approaches. This means we will be able to train staff to deliver this evidence-based, person-centred approach as part of care delivery.

Palliative care knowledge development was furthered through the submission of posters at the annual Hospice UK conference. This was a great opportunity to learn and to share the work of hospice at a national event. Colleagues were successful in submitting posters and the clinically relevant titles are listed below.

- Improving venous thromboembolism risk assessment in a hospice setting: implementing quality improvement methodology
- Evaluating the practice of completing and using the integrated palliative care outcome scale on the Ward: what can be improved?
- Future proofing a skill set: training up our medical workforce in ultrasound scanning

University partnerships

Saint Francis Hospice staff continue to benefit in their professional development from our partnership with London South Bank University (LSBU), with 10 module places going to staff this year. The three specialist modules form part of the master's degree in Palliative and End of Life Care. These modules are: Palliative Approaches to Pain and Symptom Management; Psychosocial, Spiritual and Ethical Aspects of Palliative Care, End of Life Care: Dementia and Other Non-Malignant Conditions. We have supported the learning of student nurse placements from LSBU, Anglia Ruskin University and University of East London.



PART 7

FEEDBACK FROM THE PEOPLE WE'VE CARED FOR

Compliments and Complaints

This report provides an overview of feedback (complaints, comments and compliments) received across the organisation, identifying themes, trends and importantly – learning. We encourage people to share their feedback with us, and we take all feedback seriously.

37 complaints were received in 2025/26, which is 10 complaints fewer than last year, marking a 21% decrease. There were no appeals received. Of the 34 complaints identified in a catchment area, the highest number of complaints were from the London Borough of Havering (16) 43%, this is followed by the Brentwood (6) 16%, Redbridge (6) 16%, Barking & Dagenham (5) 14% and West Essex (1) 2%. Of the 37 complaints received, 13 were care-related, and the remainder were from retail, fundraising and other areas.

The Executive Assistant to the CEO & Chair manages the day-to-day complaints records, acknowledgements, responses and process. In summary: The CEO continues to have overall responsibility for complaints and has access to all complaints and responses. The Complaints Co-ordinator will inform the CEO immediately if there are any specific complaint themes or if a complaint is deemed serious/ unusual. The Complaints Co-ordinator will request the CEO to review a complaint response if it is deemed complex or if additional guidance is required.

Alongside the complaints, comments and compliments policy we have the Volunteer Issue Solving Procedure. This has been put in place to help support and manage our Volunteers and any issues that may arise. This was developed by the Voluntary Services Projects Manager and is managed by the Voluntary Services team. As per the Complaints, compliments and comments policy we aim to acknowledge all complaints within 3 working days. After investigation, a response detailing the outcome of the investigation is issued to the complainant within 21 working days.

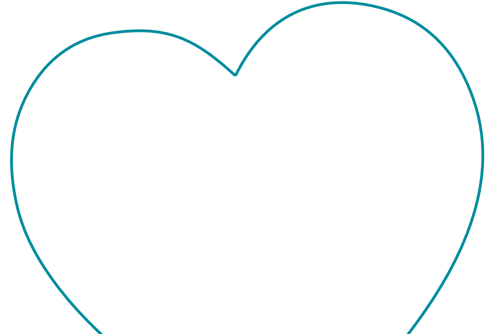
Here are the Complaints trends over the last 3 years:

PLACE	2023/24	2024/25	2025/26	3 Year Avg
Havering	29	21	16	22
Redbridge	8	3	6	6
West Essex	0	1	1	1
Barking & Dagenham	0	1	5	2
Brentwood	2	7	6	5
Unknown/Out of Area	15	14	3	11
Total by Year	**54**	**47**	**37**	**46**

Learning from complaints

As an organisation we work closely with each other and collaboratively with external colleagues, to continually review and update the way we communicate, the way we process information, and the way we respond to all people who use our services. Some examples of learning this year have been;

- Ensuring that iCare records are updated for all contact from people in our care, so we can ensure the correct signposting and advice is provided.
- The need for a more thorough handover from a referring team, so that we are certain of what is being asked and is expected from us.
- When we are advised of the death of a person in our care, we will attempt to contact the next of kin offering condolences and 'checking in' for any concerns, no matter what the time frame, as per our service standard.
- The need for appropriate communication courses as learning objectives for individuals. 2024/2025 Quality Account
- Ensuring that a telephone conversation takes place first wherever possible, before an email is sent, so that words are not misinterpreted



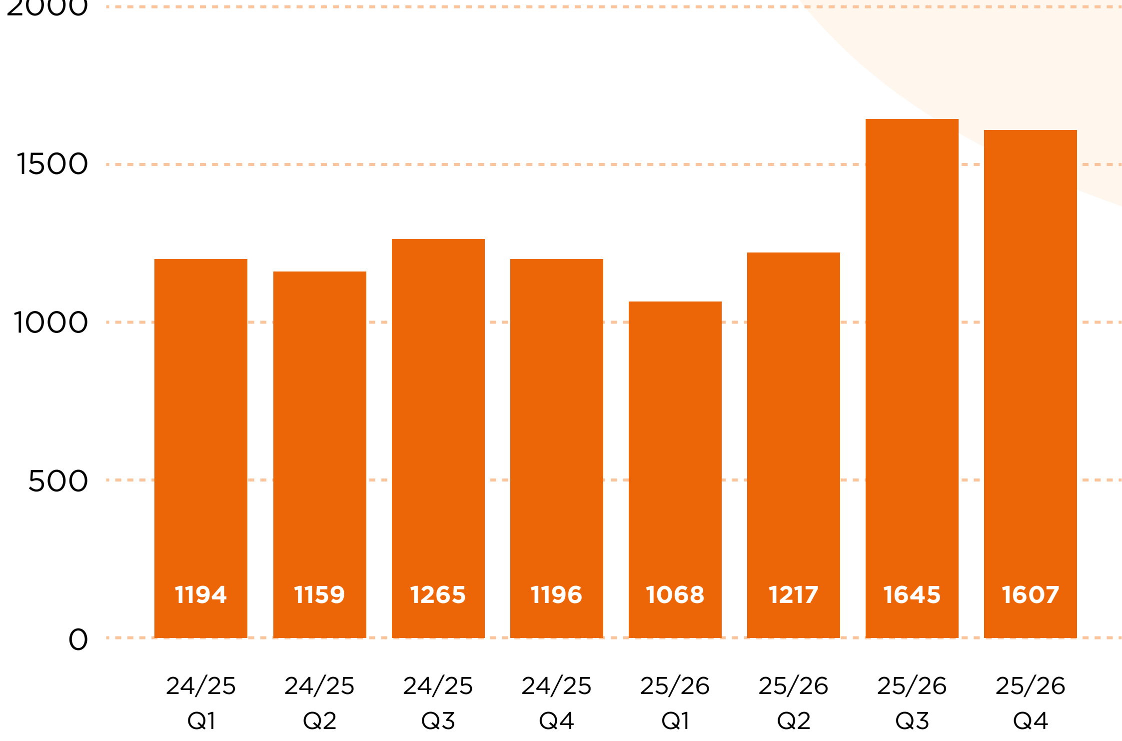
Compliments

A total of 1,393 (1,540 in 2024/2025) compliments were received in 2025/2026, 672 of which were from iWantGreatCare (41%). In addition, 3,472 from eBay, when added to the compliments total, which made a total of 4,865.

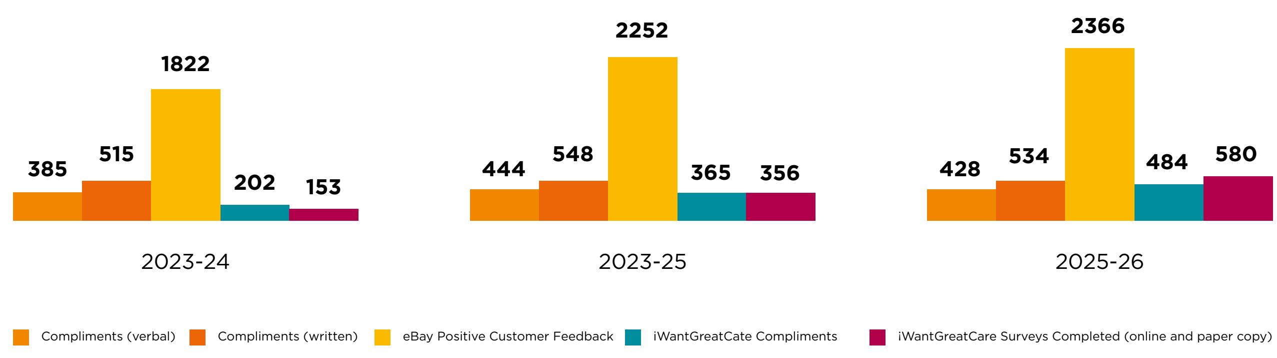
Of the 1,393 compliments, 129 (9%) were for the Hospice Community Team, 542 (39%) were for Enhanced Hospice at Home, followed by 182 for the Referrals Hub (13%). We are following a steady trajectory of increase in compliments year on year as our services grow.

Compliments Analysis

Compliments by Quarter

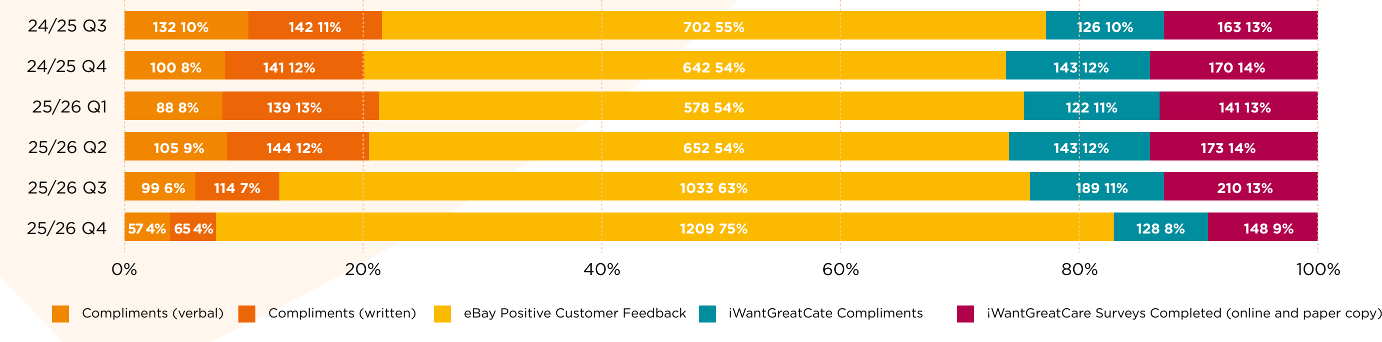


Average number of Compliments (per year, 3 year average 2022-25)



Total Number of Compliments for the last 3 years

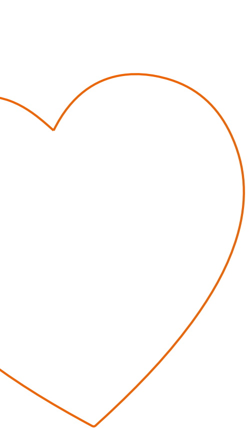
Compliments by Quarter and Category



iWantGreatCare (iWGC)

iWGC remains the one measured performance source/tool for gathering online feedback and surveys completed online.

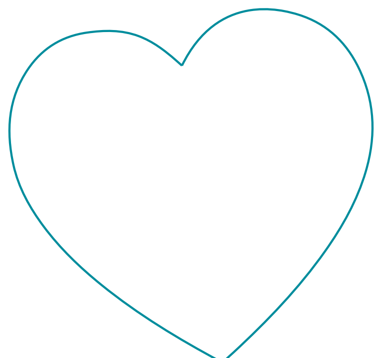
For the year 1st April 2025 to 31st March 2026, 672 reviews were received via iWGC, compared to 460 for previous year (only reviews where the author has agreed to share have been included). Our negative experience dropped from 3.3% to 1.36%. Our positive experience increased from 93.9% to 98.03% and our 5-Star Score increased from 4.77 to 4.89.



Feedback helps us continually improve how we communicate, coordinate care and respond to people who use our services and those close to them.

Some examples of learning this year have been;

- Compassionate communication – reinforcing compassion, empathy, approachability and an appropriate tone (including during telephone consultations), recognising that families may be experiencing an emotional and unfamiliar situation.
- Listening and partnership – emphasising the vital importance of listening to the person/family and working collaboratively with external partners (including care home staff who know residents well).
- Caseload management – discussing feedback directly with the individuals and services involved and reinforcing safe caseload management and escalation.
- Responding to 'red flags' – introducing a standard that triggers timely action when there are repeated calls in a short timeframe, to support a responsive face-to-face assessment where needed. This standard is now in operation to reduce the risk of people not being heard.
- Records and handovers – ensuring clinical records (e.g., iCare) are updated for all contacts and that referrals include a thorough handover so expectations, needs and responsibilities are clear.
- Bereavement follow-up – when we are advised of a death, making an attempt to contact next of kin with condolences and a 'check-in' for any concerns, regardless of the timeframe, in line with our service standard.
- Using the right channel – encouraging telephone conversation first where possible, before email, to reduce the risk of misinterpretation and to provide clearer guidance.
- Learning and development – setting individual learning objectives, including appropriate communication training where needed.



A selection of comments from across the organisation

"My mum and dad said what an amazing service it was. The renewal of their vows meant a lot to both of them."

Pastoral Care, November 2025

"Our family wanted to express our sincere thanks to all at Saint Francis for all the care, compassion and support you gave dad in his last few weeks at home"

Hospice at Home, February 2026

"The last five years OrangeLine team would phone me every two weeks to ask how my wife was, then on 12.12.2025 she passed away. Then the OrangeLine team would phone me, her husband, every week to see if I was ok. What I am trying to say, is that the team went beyond their normal line of duty to their clients. An excellent service by the OrangeLine team."

OrangeLine, March 2026

"To all staff. Thank you for such a rewarding placement. These seven weeks have flown by and I am so appreciative of the time you took to teach and support me. Thank you for everything you do for your patients. It has been a privilege to work alongside such a dedicated team."

Ward, March 2026

"I just wanted to reach out and share a heartfelt thank you to all the doctors, nurses and volunteers here at SFH. The cleaning team are always popping through the Wards ensuring areas are well kept and clear."

Housekeeping, July 2025

"Thank you for all the support the Ward has given me, especially the transport. I cannot believe the kindness I have been shown. The volunteer drivers from the Therapies Team that pick me up are so thoughtful and kind. I am so very grateful."

Ward and Therapies teams, November 2025

"To everyone who cared for my husband. Thank you from the bottom of our hearts for the compassion, dignity and love you showed him and our family. You stayed with us until the very end and never allowed us to feel alone in the most painful moments of our lives. Even though I may not remember every name, I will never forget your kindness and devotion."

Bereavement Service, March 2025

"Thank you for another lovely year of walks. May this year bring another year of memories with friends."

Family & Individual Support Services, January 2026

Saint
Francis
Hospice
STEVE
9024

You said, we did

Where we could attribute an improvement action to a comment, we ensured we did.

The Individual Experience Management Group met regularly throughout the year with members from across the hospice including guest members from external Healthwatch organisations.

You said: When in the community we are unable to see carers notes to find out about input and output for us to be able to assess appropriately..

We did: Created a basic chart to be left in people's homes for carers to complete.

You said: We need a vehicle with wheelchair access to bring individuals to the hospice.

We did: Appropriate vehicle procured via fundraising efforts with wheelchair access.

You said: Signage on the Ward is not clear and is confusing.

We did: Clear signage has been installed as part of the Ward Development project

You said: Insufficient documentation for families, loved ones and carers explaining what a syringe pump is for and how it is used.

We did: Working with the education team to develop a new leaflet for people.

You said: Lone working procedure was not sufficient or working correctly.

We did: Working with the IT team, we now have 'Peoplesafe' which is an app for lone workers.

You said: Changes within care services put extra pressure onto the co-ordinator role.

We did: Agreed with director to use bank admin to support.

You said: We would like to be able to access the outside from all bays and side rooms.

We did: As part of the Ward Development project, all areas can now access the outside.

You said: The nurse's on-call system on the Ward is loud and can disturb people receiving care.

We did: New aid-call system in place with individual staff pagers allowing noisy system to be disabled, creating a calmer environment.

You said: Ward bedside lighting is hard to reach.

We did: Lighting points were all adjusted for easy reach.

PART 8

STATEMENTS FROM OUR PARTNERS

Comments from our Partners

Pauline Leonard
Clinical Lead for Palliative Care
Barking, Havering & Redbridge University Hospitals NHS Trust

It is my honour to comment on the extraordinary services SFH provides to our shared patients & our on-going & deepening clinical collaborations.

As Clinical Lead for Palliative Care at BHRUT, I welcome the opportunity to comment on the excellent range of services Saint Francis Hospice provides to our shared patient population and the tangible benefit this partnership brings to people with advanced and life-limiting illness across our boroughs.

Over the past year, our two organisations have worked closely to co-design smoother pathways for some of the most distressing crisis presentations we see in patients with advanced disease particularly suspected malignant spinal cord compression and recurrent ascites. Anyone working in acute oncology knows how gruelling our Emergency Department environment can be for a frail patient in crisis and how much harder that experience becomes when compounded by long waits for investigation and treatment. The pathway we have built together allowing patients to be held safely at home or at the hospice, with interim treatment started immediately and planned next-day review by our Acute Oncology Team or hospice-led ultrasound has made a real, measurable difference this year. Patients have been spared unnecessary ED attendances while still receiving prompt, appropriate care and the feedback from those involved has been consistently positive.

This has been a year of genuine, demonstrable partnership benefit. Saint Francis Hospice's growth in capacity and clinical sophistication with consistently high scores in patient & family feedback makes our future together very exciting.

Matt Skinner
Chief Executive
Care City Innovation C.I.C

Thank you for the opportunity to comment on Saint Francis Hospice's 2025/26 Quality Account.

Care City has worked alongside Saint Francis Hospice over the past year, supporting the organisation to progress its digital strategy and ambitions. We are also working with the team to trial innovative care technology, including remote monitoring tools, as part of the CarePort programme across the Freeport geography. This work aligns closely with the Hospice's clinical effectiveness priorities, and in particular the ambition to strengthen the Hospice at Home offer. We were glad to see the strong progress reported against the Virtual Ward model and the move to support 12% more people at home this year.

The digital roadmap we developed together maps well onto Priority 3: Patient Experience, where we also looked at how new technology can improve communication with families and the people the Hospice cares for. We also recognise the active role Saint Francis Hospice is playing in neighbourhood health locally. That is a clear commitment to reaching communities where need is currently unmet, and it is an ambition we welcome and share.

On the Account itself, two things stood out to us. The first is its honesty. The audit of care for people with a learning disability is candid about where things fell short, not just where they went well. Reporting that openly takes confidence, and a self-critical audit culture of that kind is exactly what gives partners and commissioners assurance that the quality is real. We would encourage the Hospice to keep writing it up this way.

The second is a friendly challenge. Several of the priorities describe activity and process clearly, how many people were reached, how many visits were made, what training was delivered, but are lighter on how impact itself will be measured. The co-design work is a good example: recruiting people and running workshops is the right start, and the "you said, we did" approach is a genuine strength, but it would be even stronger with a small number of outcome measures built in from the outset. Doing that across the 2025/26 priorities would help the Hospice evidence the difference it is making, as well as the work it is doing, and would strengthen its hand with the wider system.

We found those 2025/26 priorities well aligned with system needs, especially the continued shift of care closer to home. Throughout our work the team's energy around the new five-year strategy was obvious. There is real ambition here, including a sensible early start on how technology and AI might support both back-office operations and the experience for people and families, and the foundations are being laid well.

Throughout our partnership with Saint Francis Hospice, we have been impressed by your open innovation culture, which underpins your ability to meet and exceed the needs of those you care for. The willingness of staff to adopt new approaches and tools (like remote monitoring) will continue to be critical as we drive towards relational, neighbourhood models of care and overcome the funding challenges experienced throughout the Hospice sector.

Joanne McCollum
Director of Commissioning and Development
St. Luke's Hospice

Thank you for giving me the opportunity to comment on the Saint Francis Hospice Quality Accounts.

I wish to congratulate the Hospice leadership team on the In-Patient Ward Development. I have had the pleasure of seeing the new space and am amazed at the environment you have created - It is a beautiful space that looks like a five-star hotel and has catered sensitively for the needs of the individuals and the families that us it.

I was pleased to read of the successes and progress against the priorities set last year with a focus on patient safety, clinical effectiveness and patient experience. It is clear to see how the quality initiatives have benefitted the individuals who use Saint Francis services. I was particularly interested to read about the Dementia Framework that has been developed to provide a clear structure for service delivery working collaboratively with wider dementia services.

The priorities developed for the year ahead focus on the same themes of patient safety, clinical effectiveness and patient experience underpinned by the values of the Hospice – compassion, collaboration and creativity.

Saint Francis continues to deliver outstanding care to the palliative and end of life community, and we look forward to continuing to work collaboratively with Saint Francis over the next year. Well done to all the Saint Francis Hospice team (staff and volunteers), on your achievements in 2025/2026.

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 peoples 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.

- It is heart-warming to see Saint Francis Hospice have a focus on innovations with so many examples of what they have delivered throughout the year. It is great to see they have co-designed some of the innovative projects.
- It is great to see that Saint Francis Hospice have achieved Outstanding once again by the Care Quality Commission (CQC).
- We are pleased to see Saint Francis Hospice care for 2945 people this year, an increase of 31% from the previous year. Huge congratulations to the staff and volunteers for this incredible achievement.
- It is encouraging to see Saint Francis Hospice work closely with Healthwatch Redbridge to strengthen their approach to Accessible Information Standards.
- It is great to see Saint Francis Hospice investing in their staff by having 98% completing mandatory training compliance.
- It is really reassuring to see a 27% decrease in complaints, clearly demonstrating the hard work the team have put into their priority areas.

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.

Cathy Turland
Chief Executive Officer
Healthwatch Redbridge

Healthwatch Redbridge has been pleased to continue its work in partnership with Saint Francis Hospice to support the implementation of their Accessible Information Standard (AIS). This included delivering tailored AIS Champions training and supporting the hospice to develop their inclusive approach to service delivery. Through this collaboration, we have seen a strong commitment to improving how services identify and meet the communication needs of people with communication support needs.

This work represents an important step towards more inclusive, person-centred care and demonstrates the hospice's leadership in advancing accessible communication in end-of-life services.

Our Chair and Chief Executive have also had the pleasure of meeting with colleagues from Saint Francis Hospice to explore how we can continue to strengthen our partnership for the benefit of all patients and communities. These discussions have focused on ensuring that people are aware of, and able to access, the full range of support available, and on working together to reduce inequalities and improve experiences of care across our ethnically diverse communities.

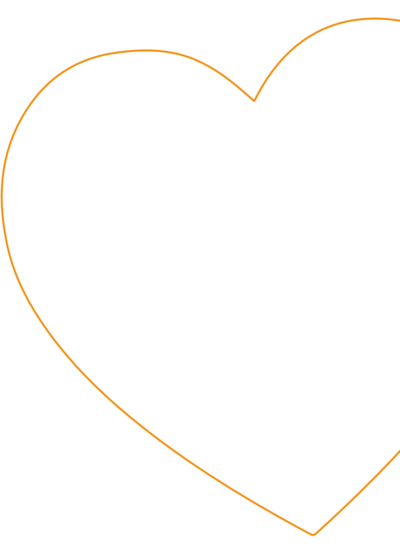
Mohamed Omer MBE
Board Member – External Affairs
Gardens of Peace Muslim Cemetery

Having read the SFH Quality Account 2025/26, it left me with admiration and sheer delight. To have been awarded outstanding by CQC is truly remarkable and fully deserved. The entire staff provide a professional and caring service to all its users, be it in the community or in house. The core values of Compassionate, Collaborative and Creative can be seen in the report. I can certainly see that they have achieved a lot in the last year and are on course with meetings their 5-year plan. The increase in government funding to the sector has helped them achieve some of their goals but there is a lot to be done. The management and the rest of the team, under the leadership of the dynamic Grazina Berry are determined to ensure that they are able to deliver what has been promised in the 5 year plan. I worked with them on the guidance from a faith perspective for Muslims on death and what really impressed me was that they were willing to learn and cater for faith requirements. All this to make sure that every patient and user of the services at SFH can be confident that they will receive the best care from a team that prides itself in being caring and professional.

With the change in demographics of the area they serve, it is pleasing to note that their staff and trustees truly reflect diversity and equality.

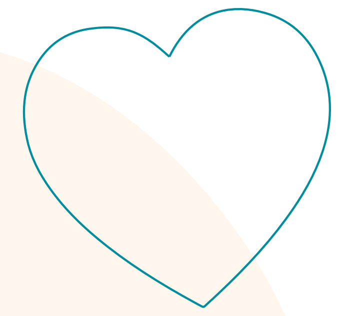
I will continue to support the work of SFH and lobby the government for more funding for this sector. It is a no brainer that if you wish to release bed occupancy in hospitals, fund the hospice sector. It will be cheaper or more effective.

A final message to the team, please continue your hard work and dedication. It is appreciated by the community as can be noted with all the compliments that you have received.



GLOSSARY

Glossary



A&E: Accident & Emergency

CEO: Chief Executive Officer

CNS: Clinical Nurse Specialist

CQC: Care Quality Commission

EA: Executive Assistant

GP: General Practitioner

H@H: Hospice at Home

HSE: Health & Safety Executive

IEMG: Individual Experience Management Group

IPC: Infection Prevention & Control

iPOS: Integrated Palliative Outcome Scale

IV: Intravenous

LSBU: London South Bank University

MDT: Multi-Disciplinary team

NELFT: North East London Foundation Trust

NMP: Non-Medical Prescriber

PEG: Percutaneous Endoscopic Gastrostomy

SCCS: Specialist Community and Crisis Support Service

SFH: Saint Francis Hospice

SOFIs: Short Observation Framework Inspection

Saint Francis Hospice Catchment Map

EPPING FOREST DISTRICT
CM5 ONGAR
CM16 THEYDON BOIS
IG10 LOUGHTON
IG9 BUCKHURST HILL
IG7 CHIGWELL
ABRIDGE
RM4
BRENTWOOD DISTRICT
CM4
SHENFIELD
CM15
CM14 BRENTWOOD
CM13
INGRAVE
IG8
RM5
HAVERING-
-ATTE-BOWER
RM3
RM6
WOODFORD GREEN
IG6
LONDON BOROUGH OF REDBRIDGE
RM7
RM1
RM2
ROMFORD
LONDON BOROUGH OF HAVERING
E11
IG4
IG5
IG2
IG3
IG1 ILFORD
RM8
RM11
RM12 HORNCHURCH
LONDON BOROUGH OF BARKING AND DAGENHAM
RM10
BARKING
IG11
RM9 DAGENHAM
UPMINSTER
RM14
RM15
RM13 RAINHAM
RM16
RM17
RM18
RM19
RM20

Postcodes in our catchment area | Postcodes not in our catchment area | Postcodes are borderline / shared areas | Shops | Saint Francis Hospice

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