Weston Hospicecare

Our Strategy

2024 – 2026

Paul Winspear
Chief Executive

Dr Peter Smith
Chair of the Board of Trustees

Foreword

Founded in 1989, Weston Hospicecare provides palliative and end-of-life care to residents of North Somerset and Somerset, serving a catchment area of approx. 170,000 people

As a registered charity, all our services are provided completely free of charge, made possible by minority NHS contract funding and mostly via the generosity of the public who support the hospice in many ways.

The bulk of our care is delivered in community settings: patients' own homes, nursing and care homes. We have a team of highly trained nurse specialists who visit patients in the community, a 10-bed in-patient unit at our Uphill site, day services for outpatients, complementary therapies, a family support team, a comprehensive nursing and medical team, and allied health care practitioners.

Over the past forty years hospices and specialist palliative care services have demonstrated what can be done to provide physical, psychological, social and spiritual care for people and their families. From surveys of the general public we know that, given the opportunity and right support, most people would prefer to die at home. In practice, only a minority manage to do so. Many people die in a hospital, which is not their preferred place of care.

The palliative care needs of our local community are similar to many other areas of the United Kingdom but the demographics, distribution of health and social care services and availability of funding varies across the area Weston Hospicecare serves.

Our strategic plan for 2024 -2026 will guide our activities over the next three years and determine how we may best serve our North Somerset and Somerset communities. Appendix 3 gathers the available data and information relating to the particular features of our locality and will help to guide our decisions on how to meet the palliative care needs of our communities.

The palliative care landscape today

The majority of deaths at the start of the 21st Century followed a period of chronic illness such as heart disease, cancer, stroke, chronic respiratory disease, neurological disease, or dementia. Of these, around 18% occurred at home, 58% occurred in NHS hospitals, with 17% in care homes, 4% in hospices and 3% elsewhere.

> *Strategy is not the consequence of planning, but the opposite: its starting point.* Henry Mintzberg

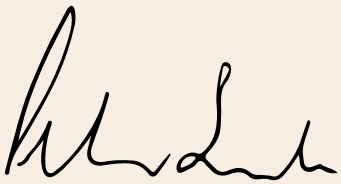
When the time comes, everyone will need care at the end of life. Good end-of-life care not only benefits the individual who receives it, but the people who care for them, and those bereaved. Palliative care refers to care provided when conditions cannot be cured, and aims to make the individual as comfortable as possible and relieve pain and other distressing symptoms, and provide psychological, social and spiritual care, as well as support for families, carers and those close to the person.

In 2021, there were 585,412 deaths registered in England and Wales, of which two-thirds were among people aged over 75. Since the pandemic started, COVID-19 has accounted for a significant proportion of deaths (13% between March 2020 and February 2022). However it remains the case that the large majority of deaths follow a period of chronic illness.

The population of the area we serve is growing. For details of demography and research into end-of-life preferences and care trends, please see Appendix 3.

Since the start of the pandemic, a third more deaths have occurred at home. Between March 2020 and February 2022, 29% of deaths in England and Wales occurred at home, 43% in hospital, 21% in care homes and 7% in hospices and elsewhere. Significantly increased demand for care in the community has been reported by services such as community nursing. Fewer people have died within hospices, but hospices have been providing more care in people's homes, and have adapted how they deliver services, with more care being provided remotely.

Studies show the number of people with palliative care needs is only going to increase, and therefore long-term, sustainable funding is essential. Existing funding models are insufficient, inequitable, a post code lottery, and unfair. A new funding model and improved models of care must be developed, to provide the basis for improving care at the end of life and to more frequently deliver services within communities rather than acute care settings.



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Chair of the Board of Trustees

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Chief Executive

“Weston Hospicecare is like a port in the storm.”

Background

In 2018, Weston Hospicecare implemented a 5-year strategic plan covering 2019-2023. Much of that plan and the strategic principles therein are just as relevant and applicable today and the Strategic Plan for 2019-23 remains available for our staff to access on our Hospice network.

Despite the disruption caused by the COVID-19 pandemic in 2020-21, our previous 5-year strategy enabled us to achieve a considerable number of improvements and growth of services and income – please refer to Appendix 1 for a reminder of our key achievements during the previous 5-year strategic cycle.

In 2023, having recovered from the pandemic and nearing the end of our 5-year strategic cycle, we have recognised the need to undertake a strategy refresh. This was launched in August 2023 with small teams of the hospice Executive team and Trustees working in partnerships; this document is a result of that collaboration. Our strategy is a journey on a defined heading towards our north star, rather than a fixed destination. Strategic ambitions and aiming points give us a purposeful direction of travel, against which our annual business cases and operational decision-making can be tested. The strategy is a flexible, living document that can and will be updated and adapted as events unfold and progress is made.

The cost-of-living crisis and associated pressure on our income sources, at the same time as two years of high inflation, mean that demonstrating affordability and implementing strategic initiatives only when we have the financial wherewithal, is more important than ever. Our ambition and passion to develop Hospice services still burns brightly, but ensuring affordability and thus financial sustainability is a necessary reality check at every decision gate.

Commissioning of Palliative Health Care

Commissioning is the process of assessing needs, planning and prioritising, purchasing and monitoring health services, to get the best health outcomes. Services are commissioned by integrated care boards and are overseen by NHS England on a regional basis. Commissioning develops in line with the aims set out in the NHS Long Term Plan.

Clinical commissioning groups (CCGs) were originally established as part of the Health and Social Care Act in 2012, and replaced Primary Care Trusts on 1 April 2013. On 1 July 2022, Integrated Care Systems (ICSs) became legally established through the Health and Care Act 2022, and CCGs transitioned across to the new ICS structure, of which 42 now cover the UK.

There is no single geography across which all services should be commissioned; some local services can be designed and secured for a population of a few thousand, while for rare disorders, services need to be considered and secured nationally.

Guidance has been developed by NHS England to support ICBs with their duty to commission palliative care services within integrated care systems (ICSs).

Continued

Regrettably, levels of hospice palliative and end-of-life care commissioning by Integrated Care Boards (ICBs) across the UK vary wildly. Recent data indicates the average percentage of total hospice income deriving from statutory sources (ICBs) is approx. 26% whereas for Weston Hospicecare this figure is approx. 20%, noting the relative percentage varies slightly from year-to-year depending on fluctuating income levels from all other fundraising and retail sources. Ongoing year-on-year reductions to statutory funding are resulting in further deterioration of this percentage, and this requires urgent attention to firstly stop the deterioration and secondly to restore statutory funding to at least national average levels.

The Ambitions for Palliative and End-of-life Care is a national framework for local action 2021-2026 which sets out a vision to improve end-of-life care through partnership and collaborative action between organisations at local level throughout England.
It is expected that ICBs will encourage the whole health and social care system to work together by activating partnerships between health, social care, public health and voluntary sector organisations, using resources already on the ground and collaborating more efficiently. This is entirely consistent with our hospice way of working.

Hospice care is free at point of delivery, paid for through a combination of minority NHS (statutory) funding and majority public support.

Ambitions for Palliative and End-of-life Care:

A national framework for local action 2021-2026

National Palliative and End-of-life Care Partnership May 2021

01 Each person is seen as an individual

02 Each person gets fair access to care

03 Maximising comfort and wellbeing

04 Care is coordinated

05 All staff are prepared to care

06 Each community is prepared to help

Contents

Our Vision

A society that cares deeply for its people at the end of their life and embraces dying as part of living.

Our Mission

To provide equitable access to outstanding palliative care for everyone in our community, helping people to live well, and giving them dignity, comfort and choice at the end of their life.

“Weston Hospicecare’s doctors, nurses and medical professionals care for patients as if they were family. My brothers and I were in a state of shock when mum was admitted, we had been told only days before that she was dying and did not have long but from the minute we entered the hospice we felt that mum mattered to them as much as she mattered to us. Everyone was so kind, caring and dedicated to do everything possible to make mum’s last days comfortable and peaceful.”

Our Values

Since inception in 1989, Weston Hospicecare has belonged to our local community and we are entrusted to look after it on their behalf. This is a responsibility we embrace with pride and passion, understanding we stand on the shoulders of those entrusted before us, knowing the history of the hospice and its development, and recognising the loyalty and dedication of our supporters, volunteers and staff. Our values lie at the core of all our services, our decision-making and how we run the charity.

Compassion

- Do all we can to help people maximise their quality of life.
- Stay person-centred and protect individual dignity.
- Provide people with information, understanding and choice.
- Support loved ones, family and friends, both during illness and after death.

Integrity

- Work ethically, responsibly and professionally, to safeguard our reputation.
- Give care according to clinical need regardless of personal circumstances.
- Cultivate a fearless culture of honesty, transparency and empathy.
- Stay humble, grounded, and open to learning from each other.

Excellence

- Provide best-in-class education and support to fellow healthcare professionals.
- Strive for excellence in all that we do, and go the extra mile.
- Display a mindset of continuous improvement.
- Stay at the cutting edge of developments in palliative and end-of-life care.

Respect

- Welcome everyone and adapt to other cultures, religions and personal beliefs.
- Cherish the invaluable support of our volunteers and supporters.
- Appreciate our staff, embrace our differences and support each other's growth.
- Value other health and social care providers, working in collaboration and partnership.

Our Strategic Goals

Goal 1

Extend the reach and impact of our care to every person in our area who would benefit from it

In short, this means doing more with less.

We believe that not everyone has equitable access to our care. We will be more proactive at identifying sections of our community to whom our outreach needs to be stronger.

Where gaps exist in our palliative and end-of-life care provision, we will look for ways to fill these gaps, either directly or in collaboration with H&SC partners.

We will strive to continually develop and improve our existing care and services, according to patient wishes and service user needs. We will do this through continual improvement of our facilities and investment in our staff.

Goal
2

Stay financially resilient and sustainable

Financial prudence is needed, not to limit the ambitions of our first goal but to enable us to choose wisely our priorities and the timing of implementation.

Balancing spending on our charitable objectives with our income potential is essential to ensure long-term sustainability.

At the end of 2023 we are fully immersed in a challenging new period of operating costs outstripping income, a predicted situation for which we budgeted and thus tolerable in the short-term, but which must be corrected in the medium-term. More rises to staffing and operating costs are expected in 2024, not least another national living wage increase, which will further exacerbate the current funding gap.

Goal
3

Build a purposeful culture by creating a high-performing and engaged organisation that attracts, develops and retains diverse and talented people

We recognise that our success or failure as a charitable institution depends entirely on the quality and engagement of our staff and volunteers.

As the hospice has grown and evolved, the small People Services team which manages our human resourcing has stayed mostly unchanged. We recognise a pressing need to invest in our People Services team, both via a suitable HR-information system and with additional human skills and experience, to better serve all our staff.

Central to our efforts will be a new staff Health and Wellbeing framework to ensure we are supporting and developing our employees to be as happy, fulfilled and healthy as they can possibly be.

Goal
4

Grow our community engagement

The only way we can aspire to our Vision and fulfil our Mission is to collaborate with others through influence, education, upskilling, inspiration and empowerment.

The hospice will always be resource-limited. Our impact can be geared by cooperation and partnerships with other health and social care providers and individuals.

Community engagement also serves to raise our profile and engender greater public support.

I am not sure as a family how we would have got through the last two months without the support of our hospice nurse visits at home and then the final week when we were lucky enough to secure a bed in the hospice. The care, patience and support all the hospice staff gave both ... and the family was invaluable, making what was a very hard time a little less stressful.

Our **Strategic Risk Register**

The Hospice has a strategic risk register (SRR) identifying twelve strategic risks of which one concerns Governance, six are Operational, two are Financial, and three concern Compliance.

The SRR is reviewed and updated six-monthly by the Executive team, and annually by the Board of Trustees; meanwhile changes resulting from evolving risks are applied throughout the year.

Risks are assessed both pre-mitigation and post-mitigation, assessing Likelihood and Impact, to determine if they are satisfactory (green), tolerable (amber) or unacceptable (red).

Likelihood Impact		Remote	Unlikely	Possible	Probable	Highly probable
		1	2	3	4	5
Extreme	5	5	10	15	20	25
Major	4	4	8	12	16	20
Moderate	3	3	6	9	12	15
Minor	2	2	4	6	8	10
Insignificant	1	1	2	3	4	5

"[The hospice community nurse] was outstanding in her approach, she was kind, caring, empathic, supportive. Made mum feel more reassured to move forward in the difficult journey she is on."

As of December 2023, there are five strategic risks which are unacceptably high pre-mitigation, but all five have been mitigated to a satisfactory or tolerable level. They are:

- Damage to our most important intangible asset: the reputation of Weston Hospicecare. Any incident or development that risks damage to our standing in the community would impact on our ability to raise funds and could even deter service users from trusting us.
- Ensuring the independent overall assessment of our care and services by CQC remains at least 'Good' thus protecting and enhancing our reputation. Meanwhile, we are aiming for 'Outstanding' at our next CQC inspection. Important: our CQC rating is not pursued as an end of itself but rather as an inevitable consequence of great care and diligent management.
- Our IT infrastructure and systems must be fit for purpose, robust and secure, providing appropriate connectivity for staff volunteers, patients and other service users.
- Keeping our Hospice premises compliant with all regulatory requirements of Health & Safety legislation and Fire Safety, with regular checks and maintenance in place.
- Assuring compliance with employment law, rules and regulations, and aiming for best practice in all HR-related matters, to provide a safe and happy workplace for our people, develop them to their full potential thus optimising our most valuable resource, while avoiding staff tribunals, costs of absence and replacement, and loss of business continuity.

Our strategic priorities will control and further mitigate our strategic risks, directly or indirectly.

Our Strategic Priorities

Sitting just behind this strategy summary document, our departmental strategies are owned by the assigned Director or Head of Department, and will be used to drive our business plans and strategic priorities in years 1, 2 & 3 for the follow areas:

- Clinical & Patient Care
- Fundraising
- People & HR
- Communications & Marketing
- Finance & IT
- Retail
- Estate & Facilities
- Alternative Income

The departmental strategies provide detailed strategic initiatives which always dovetail with our four Strategic Goals described above.

Our departmental priorities are summarised below. In all cases, our ability to invest in these priorities will depend upon the development of our combined income streams, and thus timing of implementation is inextricably linked to our financial position.

Clinical & Patient Care

Guided principally by strategic goal #1, we believe in providing our patients with knowledge, empowerment and choice. Therefore we will:

- Maintain and continually improve our existing 10-bed In-Patient Unit (IPU)
- Invest in our community care by growing our Day Services
- Plan for a 24/7 Hospice at Home service
- Continue to upskill our Community Nurse Specialist team
- Keep supporting patients and families through our Family Support Team, Complementary Therapies, Occupational Therapy and Physiotherapy.

Although we provide excellent care to patients in community settings (principally via our nurse specialist team, our day services and our family support team) we do not currently have the resources to care for such patients 7 days a week and 24 hours a day. We recognise that patients whose preferred place of care and perhaps death is home, are often unable to access the care they deserve and need. In Y1 we will finalise a comprehensive plan for a fully-fledged Hospice at Home service which will be presented to our ICB commissioners for consideration.

- Develop our Day Services, making best use of our newly refurbished facilities, to provide a greater range of enrichment activities, offer tailored Outpatient Clinics, re-introduce specialist sessions, increase attendance levels, and gradually expand our care provision from 3 days a week currently to first 4 days and then 5 days a week. Eventually we would like to include some weekend provision too.
- In partnership with other H&SC providers, build an optimum business case for a Hospice at Home service, coordinated by Weston Hospicecare but using a range of resources, some of which are already on the ground, to submit to our ICBs.
- Take steps to better understand those sections of society who do not currently experience equitable access to our care, and build a proactive system of reaching out to them.
- Related to above, work to better understand the gap in PEOLC provision for young adults aged 18-30, collaborate with children's hospices, and consider the merits and viability of establishing a bespoke young persons' support group for this cohort of patients.
- Recruit a second Palliative Care Consultant on 6 sessions a week to boost our medical capability and provide peer support to our existing Consultant.
- Upgrade our IPU bathroom to a spa-style experience for patients.
- Gradually upgrade our IPU patient rooms to incorporate latest technology.
- Build on our preliminary successes in 2023 with IPU nurse-led admissions.
- Re-focus our Occupational Therapist and Physiotherapist to work across all hospice patient groups, implement a MDTA (multi-disciplinary team assistant) role working across Day Services and IPU, and seek more cross-area working of Band 2 and Band 5 nurses too.
- Use the Vantage system to organise and collate our evidence-based preparedness for a CQC inspection, and to better manage our responses to Safety and Quality incidents.
- Develop our external education offering to other health and social care professionals, so that they can better provide excellent end-of-life care in their own settings.

- Commission the making of a short film which highlights our clinical services and provides a good overview of the hospice.
- Build a Portal on our website for Patients and H&SC Partners including but not limited to: a short film highlighting our clinical services, signposting and links to other PEOLC resources including Somerset and BNSSG, our Day Services programme of events and booking system, and Hospice training materials including videos.
- Explore the advantages of new technology that may include monitoring tools, virtual wards and virtual reality, also allowing the hospice team to communicate better and enable people to access our care in new and innovative ways.

People Services & HR

Guided principally by strategic goal #3, first and foremost we want to cultivate a workplace setting and culture that promotes happiness, growth and excellence of our staff. Our staff retention rate is already good, but we aspire to make it even better and in doing so we will also have created an environment into which we can readily recruit when needed.

We recognise a need to train and upskill our line managers, at all levels of seniority, to be the daily conduit for our strategic initiatives and workplace culture improvements to reach our staff. Historically our line managers have been over-reliant on our HR department; by shifting more of the responsibility for people management through our line management, our People Services department will work more strategically to deliver the many improvement frameworks identified in the strategic priorities summarised below. This will require some investment in our People Services team, both via a suitable HR-information system and through additional human resources and investment in existing People Services staff.

We will continue to access support and insurance from an external specialist HR company.

- Purchase, construct and roll out the Ciphr HR-information system (including applicant tracking), with assignment of a dedicated project manager for this project.
- Recruit a HR and Payroll Officer to boost the People Services team, and upskill existing staff.
- Build a staff Health and Wellbeing framework which proactively protects and supports our staff, aiming for at least Bronze accreditation in the North Somerset Healthy Workplaces scheme.
- Compile a toolkit of resources and links to training materials for line managers to better undertake their responsibilities in the areas of recruitment, induction and onboarding of new staff.
- Start to build a training programme for Managers, to ensure that our line managers receive the training and support they need to develop into senior managers of the future.
- Update our staff compensation policies to ensure they reflect our intended approach and best practice as regards starting pay and pay progression.
- Introduce an Employee Relations framework which promotes safe mechanisms for employee feedback, and an effective way of dealing with concerns through initiatives such as restorative practice, mediation, civility & respect and culture/values-based leadership.
- Continue the roll out of Assemble (volunteer management system) to all teams. Embed, enhance and maximise the potential of the system for both staff and volunteers.
- Review & refresh our Volunteers recognition & thank you events, e.g. Awards/Cream Tea.
- Create new links and strengthen existing links with community organisations & businesses to increase volunteer numbers.

Finance & IT

Guided principally by strategic goal #2, the most critical factor of our financial strategy is to ensure the Hospice successfully navigates its way through an extraordinary period of spiralling costs at the same time as many of our fundraising income streams suffer downward pressure from the cost-of-living crisis, and thus remains sustainable at our current service levels, in the medium and longer term beyond 5 years.

We have made so many advancements during the last 5-yr strategy cycle and we do not want to be forced to unwind any of these, to cut costs. This will only be possible if we stay laser-focused on affordability, diligent budgeting and forecasting, and practicing restraint to maintain service levels until we can demonstrate that our income has recovered to re-balance our current level of operating costs.

- Lobby and apply for a fair and representative share of statutory funding for 2024/25 and beyond, seek one-off funding for Clinical staff pay awards to match their NHS colleagues, and apply for financial support for a Hospice @ Home pilot.
- Use our MTFS (medium term financial strategy) and associated 5-year financial forecast to test affordability of all Hospice spending plans, including strategic initiatives, which are not already included in current year budget, and ensure our standard Hospice business case template is used to present such spending proposals.
- Implement Vantage, our compliance management system, to ensure all compliance and risk information is captured within one place and is operational in Y1 of the strategy.
- Continue development of our IT infrastructure and systems in coordination with our IT Support provider to achieve Cyber Essentials accreditation during Y1.

> *"The entire Hospice team has been outstanding in their guidance, understanding and care. I can't thank you enough. I could never have done it without you."*

Estate & Facilities

A patient's initial impression of the Hospice is influenced by the appearance of our buildings and accessibility of our facilities. Research has demonstrated that patients do better in surroundings conducive to their sense of wellbeing, particularly enhanced by connection to the outdoors and nature. Therefore, it is imperative that services are delivered within well-designed environments, ensuring feelings of safety, security and comfort. Our buildings and facilities should be accessible to all, safe, environmentally efficient, meet privacy and dignity expectations, and minimise infection risks. To this end, our Estate & Facilities strategy is designed for:

- Alignment of premises development with service and capacity requirements
- Provision of safe, secure, and suitable buildings
- Delivery of high-quality environments, contributing to improved staff retention, boosted morale, and higher satisfaction levels
- Establishment of a framework which measures progress toward set goals
- Compliance with sustainable development and environmental requirements
- Improvements to mitigate risks associated with the built environment
- Disposal of under-performing assets, thereby releasing resources for reinvestment

Fundraising

In 2023 we conducted a comprehensive review of our Fundraising achievements over the past three years, alongside analysis of trends in UK charitable giving, to inform our Fundraising strategy. After a difficult year, our central drive is to rebuild our Fundraising team to be the best it can possibly be.

Our key Fundraising goals are to:

- Develop a professional and high-performing fundraising team; restructure the team to match strategic aims, build morale and introduce a programme of training and development.
- Diversify income and improve individual income streams' RoI (return on investment). We need to spread the income generation load by investing in and developing new income streams (e.g. Major Giving) and existing income streams (e.g. Individual Giving and Lottery) and bring current RoI more in line with sector norms.
- Grow Gifts in Wills (legacies) income – pivotal to the success of our fundraising portfolio, we must increase and invest in proactive, constant GiW marketing & stewardship with complete confidence that this will yield significant rewards over time.
- Turnaround the fortunes of our hospice Lottery.

Following the restructure of the team and with the benefit of additional investment, Fundraising will embark on a period of consistent year-on-year growth.

Communications & Marketing

Historically, our Communications team has been placed within the broader Fundraising & Communications department, as it was expedient to do so. The development of our Communications & Marketing team in terms of resource and skills is now one of our highest priorities, both for the importance of our internal communications and messaging to staff, and for our external communications to foster collaboration, engagement and support.

Our Comms & Marketing strategy needs further development, but ultimately our aim will be to establish a stand-alone Communications and Marketing department responsible for greatly enhanced internal and external activity. Initial focus areas include:

- Appointment of a Communications & Marketing Manager
- Expand the remit of the department's production and promotion of print and digital media to include marketing.
- Develop external messaging to align with our purpose and proposition, including PR and media relations, with monitoring and evaluation of brand awareness levels
- Better share details externally of our R&D initiatives and special projects, and engage in 'Thought Leadership'.
- Continue development and expand following of the Hospice social media platforms
- Further develop our website, in particular the Patient Portal

Retail

In 2022 & 2023, our Retail division achieved outstanding growth and development, both financially and as an organisation. Over the next three years we cannot reasonably expect the same level of growth, therefore our Retail strategy aims to consolidate those gains already realised, future-proof the division as much as possible against future economic shocks, and seek further gains in top line income and net income.

The principal aims and priorities of our Retail division are as follows:

Income Generation

- **Maximize Revenue Streams:** Implement strategies to optimise sales and donations, ensuring that all potential income sources are fully utilised.
- **House Clearance Department:** Establish a new department dedicated to house clearances, providing a comprehensive service to customers and patients, and generating additional income for the hospice.
- **Innovation and Technology Adoption:** Explore and implement innovative ideas and technology solutions to enhance income generation. This could include gift cards, digital marketing and influencer initiatives, and customer reward and recognition tools.

Estates/Sustainability

- **Increase Retail Estate:** Increase our portfolio to 20 leasehold stores over the next four years, ensuring coverage in all areas served by our Clinical teams.
- **Comprehensive Refit Schedule:** Implement renovations for efficiency, health & safety, customer appeal, and sustainability in line with our carbon net zero target.
- **Sustainability:** Incorporate sustainable and eco-friendly practices in our Retail operations, appealing to environmentally conscientious consumers.

Technology

- **New Till Systems:** Install upgraded systems to enhance in-store processes, increase gift aid capture, improve customer experience and cross-departmental working, i.e. advertising of fundraising activities, increased lottery sign ups, etc...
- **Logistics System:** Implement new logistics system to offer comprehensive services to customers and patients.

Retail

The Team

- **Upskilling and Empowerment:** Invest in continuous training and development to empower staff in maximising revenue generation for the hospice.
- **Real Living Wage Standard:** We have an aspiration and concerted wish to establish the real living wage as the benchmark for entry-level roles, to become an employer of choice, indeed not only for our Retail division but across the entire hospice. We recognise this aspiration will be constrained by affordability in the near term.
- **Succession Planning and Development:** Create a clear development plan for the team to establish a robust succession plan. This will minimize risks associated with key members leaving, ensuring continuity and stability.

Alternative Income

Presently, Hospice income is derived from four principal sources:

- **Statutory income from our Commissioners within the Integrated Care Systems of:**
  - Bristol, North Somerset & South Gloucestershire
  - Somerset
  - CHC (continuing health care) patient funding
- **Fundraising**
  - Donations – individual, community, corporate, etc...
  - Events
  - Lottery
  - Gifts in Wills (legacies)
- **Retail**
  - 16 Stores
  - Donated goods, including gift aid
  - New goods
  - E-Shopping
- **Hospice Reserves investment portfolio:**
  - Dividend income
  - Capital growth

While maintaining and optimising all four of our principal income sources, the Hospice will seek to develop alternative income streams to increase our overall income and strive for less income volatility. We will approach this by:

- Establishing a Think Tank for alternative income streams.
- Reviewing the Hospice UK Innovation Hub for good ideas, and liaising with sister Hospices.

Hospice-wide & longer term

- In 2024, the Hospice will undertake a Board review, as recommended by the Charity Commission every 3 years. We fully expect the review to highlight areas of governance and collaboration between Board and Executive where we can improve further, and therefore our strategy will be updated as a living document, once our Board review has been completed.

- In 2024, we will develop our EDI (equality, diversity & inclusivity) policy to ensure it fully encapsulates and reflects today's societal values.

- Use of artificial intelligence: whilst obvious concerns exist, there is no denying that AI can play a role for the Hospice in certain areas, such as: analysis and harvesting of our large databases to better understand aspects of our patients (EMIS) and supporters (Beacon), research into Trusts & Grants application-writing, etc... Use of AI to at least be discussed and considered during Y1, if not applied until later.

- We will build a roadmap to transform the Hospice to net carbon zero by 2045, five years earlier than the government's national target. This work has started during 2023 by mapping our carbon footprint and identifying those parts of our organisation and operations that contribute most to generation of CO2 equivalent.

Glossary

ACP	Advance Care Plan
ASP	Average Selling Price
AVT	Average Transaction Value
BCH	Bristol Community Health
BNSSG	Bristol, North Somerset and South Gloucestershire CCG
BoT	Board of Trustees
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CG	Clinical Governance
CHC	Continuing Health Care (Fast Track)
CQC	Care Quality Commission
CTC	Complementary Therapy Coordinator
DC	Donation Centre
DN	District Nurse
DPO	Data Protection Officer
DS&PT	Data Security and Protection Toolkit
E&F	Estates and Facilities
EMIS	The electronic patient records system formerly known as 'Egton Medical In formation Systems'
EOL	End-of-life
F&BP	Finance and Business Planning
FST	Family Support Team
GA	Gift Aid
GDPR	General Data Protection Regulations
H&SC	Health and Social Care
(H)CNS	(Hospice) Community Nurse Specialist
H@H	Hospice at Home
ICB	Integrated Care Board
ICS	Integrated Care System
IG	Information Governance
IncGen	Income Generation
IPU	In-Patient Unit
IPB	Items per basket
JBH	Jackson-Barstow House (Hospice HQ)
LSOA	Lower Layer Super Output Area (Populations of 1500 people or 650 households)
MDT	Multi-Disciplinary Team
MSE	Management Support Executive
MTFS	Medium Term Financial Strategy
NA	Nurse Auxiliary
NHSE&I	NHS England and Improvement
NMP	Non-Medical Prescriber
NSCP	(the former) North Somerset Community Partnership
OOH	Out of Hours
OT	Occupational Therapy/Therapist
PACR	The Physical Assessment and Clinical Reasoning course.
PCN	Primary Care Network
PEOLC	Palliative and End-of-Life Care
RN	Registered Nurse
R&M	Repairs & Maintenance
SMT	The hospice's Senior Management Team

Appendix 1
Achievements during the last strategy cycle

Achievements during the 5-year strategic cycle of 2018-2023:

Moved from the Crosscare to EMIS patient management system

Appointed a full-time Family Support Team manager (previously PT)

Appointed a full-time HCNS team manager (previously PT)

Introduce a third nurse at night on the IPU

Re-branded with a new logo and branding suite

Upgraded our website

Introduced a Children & Young Persons' Counsellor

Installed two bespoke garden counselling pods

Moved from the old Retail Hub in Oldmixon to the Superstore/Donation Centre in Searle Crescent

Opened a mega-store in North Worle

Replaced full repairing leases with internal repairing leases and renegotiated better lease terms

Built the basis of a Staff Intranet

Refurbished the IPU Carers' Lounge

Refurbished the Nurses & Housekeepers' changing room (Physio Corridor)

Refurbished the IPU Staff Lounge

Replaced the boilers and ancillary equipment in the IPU Plant Room to provide maximum backup/ redundancy and future-proofing for rooms 4-10

Recruited a Director of Finance, IT & Risk

Elevated our HR Manager to Head of People Services

Developed a Medium-Term Financial Strategy and a 5-yr Financial Forecast

Prepared for the roll-out of the Assemble volunteer management system

Prepared for the roll-out of the Vantage SAP management tool

Transformed our courtyard garden

Transformed our Day Hospice via the majority-funded £500K DHI project

Recruited a Head of Estate & Facilities to boost the prior E&F Manager role

Completed a major refurbishment of our Kitchen

Proposed a new Day Services operating and staffing model to replace traditional day hospice

Prepared for the refurbishment of our IPU bathroom to a spa facility for patients

Navigated through the pandemic without permanently closing a single clinical service line

Established 6 sessions per week of a Palliative Care Specialist doctor

Protected and enhanced our reputation

Appendix 2
Health & Social Care Partners

The Hospice works in collaboration with a number of other Health & Social Care providers, including but not limited to:

Hospice UK

Hospice UK is the national charity for hospice and end-of-life care. We work to ensure everyone affected by death, dying and bereavement gets the care and support they need, when they need it.

Homepage | Hospice UK

Sirona Care & Health

Formerly North Somerset Community Partnership, now a provider of adult and children's community health and care services in Bristol, North Somerset and South Gloucestershire (BNSSG) since 1 April 2020. Sirona have been piloting a version of Hospice@Home in conjunction with St Peter's Hospice, commissioned by the former Bristol, North Somerset & South Gloucester Commissioning Group.

Home - Sirona care & health (sirona-cic.org.uk)

St Peter's Hospice

St Peter's Hospice is a local charity founded in 1978, that provides care and support to adults who are living with a progressive life-limiting illness in the Bristol, South Gloucestershire and North Somerset area. Operates from a purpose-built hospice at Brentry, with 15 separate rooms. Day services are delivered in the community at The Park Centre in Knowle. The catchment area are adjacent to that of Weston Hospicecare in the part of North Somerset close to Clevedon and Portishead. Nurses in the Hospice@Home service operated by St Peter's attend some patients within other parts of North Somerset.

St Peter's Hospice (stpetershospice.org)

St Margaret's Hospice

St Margaret's Hospice Care was founded in 1980. The charity started out with a Home Care Team of just three based at Flook House, in Taunton, and has since grown to just over 300 staff and 1,200 volunteers serving the whole of Somerset, caring for over 5,000 people each year. It operates two hospice sites; one in Yeovil and one in Taunton, as well as five community based teams caring for patients in their own homes. 12 inpatient beds in Taunton.

St Margaret's Hospice | Home Page (st-margarets-hospice.org.uk)

Dorothy House Hospice

Ten Bed, Inpatient Unit at Winsley Nr Bradford-on-Avon and ten Community Palliative Care Teams cover a 700 sq. mile area.

Home - Dorothy House

University Hospitals Bristol & Weston NHS Foundation Trust

UHBW delivers over 100 clinical services across ten different sites, serving people in Bristol, Weston and the South West. A multi-professional team offers support to patients and carers and specialist advice. Clinics are held in BHOC level 1.

University Hospitals Bristol and Weston NHS Foundation Trust (UHBW NHS)

Bristol, North Somerset and South Gloucester Integrated Care Board

The Integrated Care Board is the new organisation responsible for the day-to-day running of the NHS. The Integrated Care Partnership brings together a broad range of partners – including from the local voluntary sector and community groups – and sets the strategy to meet the population's health, care and wellbeing needs.

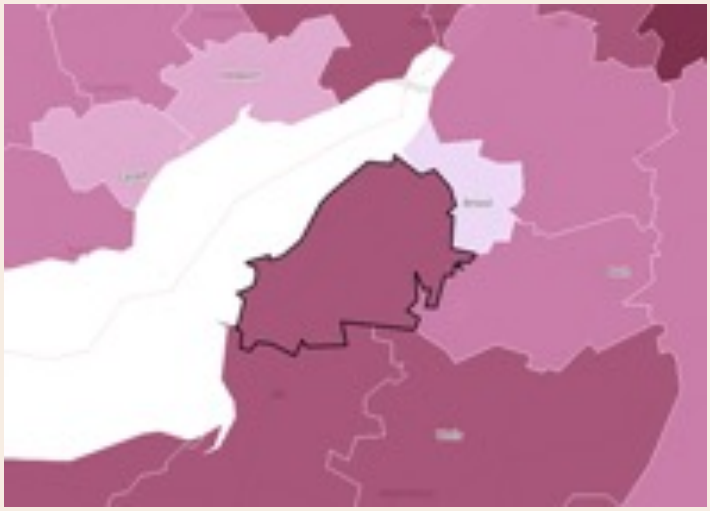
Homepage - NHS BNSSG ICB

Appendix 3
Demographics

Weston Hospicecare serves a geographical area loosely defined by boundaries between us and our neighbouring hospices of St. Peter's in Bristol, Dorothy House in Bath, and St. Margaret's in Taunton. The boundaries are acknowledged by historical agreements and some overlap exists, with the emphasis on patient coverage and choice. Our approximate catchment area, which comprises predominantly North Somerset but also some portions of Somerset, is depicted below inside the red line.

The South West region has a high percentage of its population over the age of 65 at 22.3%, compared to the average for England (18.4%) and London (11.9%). Our local area of North Somerset is even higher at 24%.

All persons	Under 15y	15 to 64y	65y & over
216,700	35,800 (16.5%)	129,000 (59.5%)	52,000 (24%)



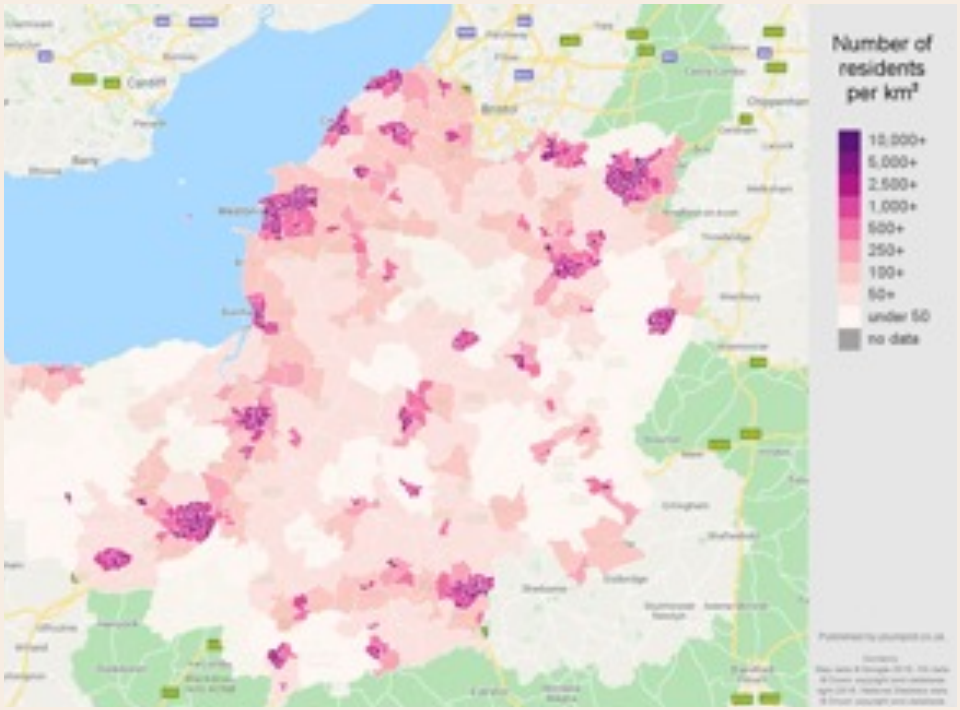
Age structure of the population, 2021, local authorities in England and Wales

Population over 65 years of age:

Bristol	**12.9%**
Bath	**19.3%**
North Somerset	**24.0%**
Mendip	**23.8%**
Sedgemoor	**23.8%**

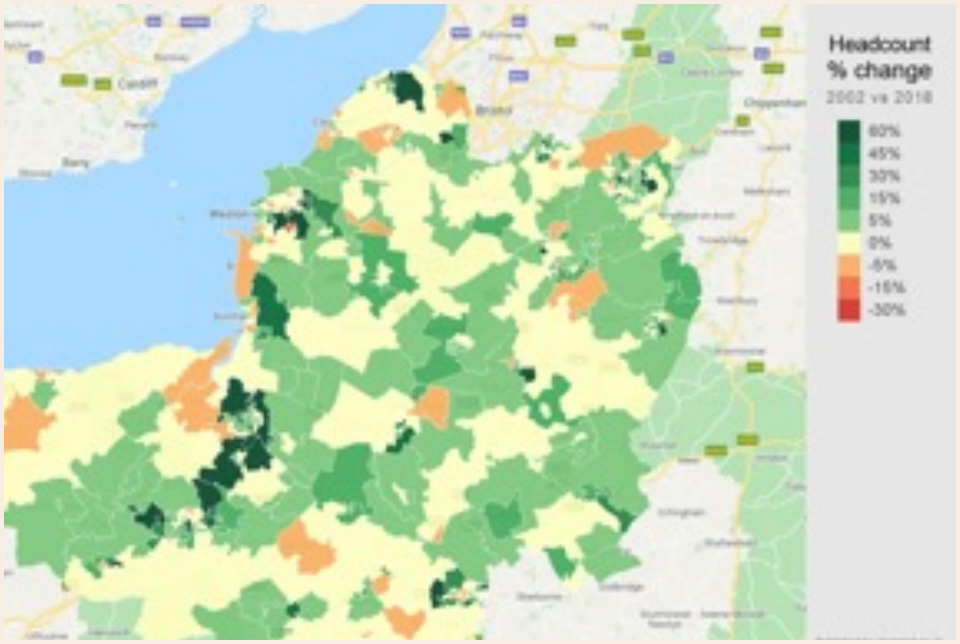
As well as having a significantly high proportion of elderly residents, the population density has increased in this area as well. In 2020 the population of the area of Somerset (including North Somerset) had a population density of 234 residents per square kilometre. This population grew by 13.1% since 2002 and the average age increased by 2.3 years over the same period.

At the time of writing the last strategic plan for 2019-23, we had noted the North Somerset population to be around 212,800 and NS Council was estimating that population of North Somerset would increase by 24% over the next 35 years, predicting that in 2035 it will be home to 266,000 people.



Weston Hospicecare provides for five significant areas of high population density in Clevedon, Portishead, Nailsea, Weston-super-Mare and Highbridge & Burnham.

Other partner Hospices are located in similar areas of high population density but some are experiencing higher growth rates due to extensive housebuilding.



This map illustrates the percentage growth in headcount in the same area. Very high growth has occurred in the Weston-super-Mare area.

Inside the growth areas, the average age of the population is younger and the elderly are located in the older town centres, where there are higher numbers of care homes, and in the rural areas around the conurbations.

Our area has a mix of rural and urban dwellings and settlements and about two-thirds of people live in the five main settlements, with the remaining one-third living in rural areas and outlying towns and villages.

Across North Somerset 4,600 homes will be purpose built in the next 30 years specifically targeted at elderly living and to accommodate the growing numbers of people developing dementia.

The people of North Somerset

One in five North Somerset residents are aged over 65 years. This is higher than the national average (1 in 6) and also higher than the South West average. 1 in 3 of the over 65's in North Somerset will live alone. Additionally, 3.3% of North Somerset residents are currently aged 85+ years. This is a 33% increase since 2001 and higher than the national average by 1%, this figure is expected to rise to 7% by 2035.

The current population of North Somerset has a roughly even split of males (49%) and females (51%) living in the area. Average life expectancy at birth is 83.4 years for females and 80.1 years for males.

97% of all residents describe their ethnicity as White. The majority of the remaining 3% describe themselves as Asian or Mixed Race.

93.4% of the population describe their sexual orientation as heterosexual or straight. 2% identified their orientation as gay, lesbian or bisexual, 4% did not know or did not wish to answer the question, and 0.5% described their orientation as 'other'. Younger people were more likely to identify as LGBTQ+.

The proportion of those aged over 65 with a life-limiting illness, is set to increase at a rate of 3.4% per annum, predicted to reach 14,429 people by 2030. The rate of increase is particularly high in those aged over 85 years at 5.8% per annum.

Long term conditions

Long-term conditions are more prevalent in older people (58 per cent of people over 60, compared to 14 per cent under 40) and in more deprived groups (people in the poorest social class have a 60 per cent higher prevalence than those in the richest social class and 30 per cent more severity of disease).

The provision of palliative care for older people within the next decade will need to be substantially different to that provided today. In long-term care settings the achievement of quality palliative care will require attention to all levels of the health and social care system, in both its formal and informal manifestations.

Weston Hospicecare accepts patients with illness due to malignancy and other non-malignant, yet life-limiting conditions. These include people suffering from Chronic Obstructive Pulmonary Disease, Heart Failure, neurological and cerebrovascular disease, diabetes and other conditions.

The incidence rates for all cancers overall climb steadily as age increases, from fewer than 25 cases per 100,000 people in age groups under age 20, to about 350 per 100,000 people among those aged 45–49, to more than 1,000 per 100,000 people in age groups 60 years and older.

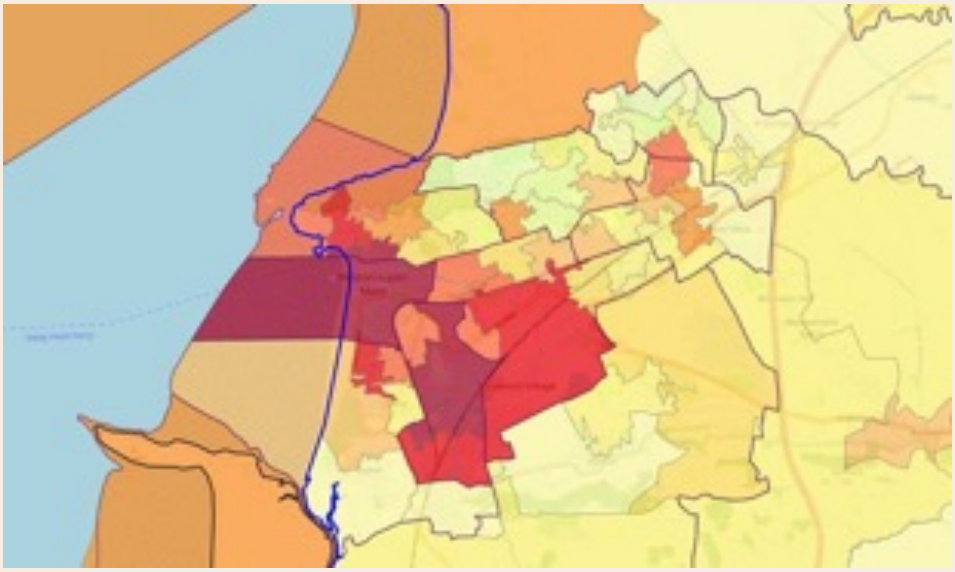
Deprivation also increases the likelihood of having more than one long-term condition at the same time.

Deprivation in North Somerset

Statistics have revealed that nine neighbourhoods in North Somerset are amongst the most deprived in England - and they are all in Weston-super-Mare.

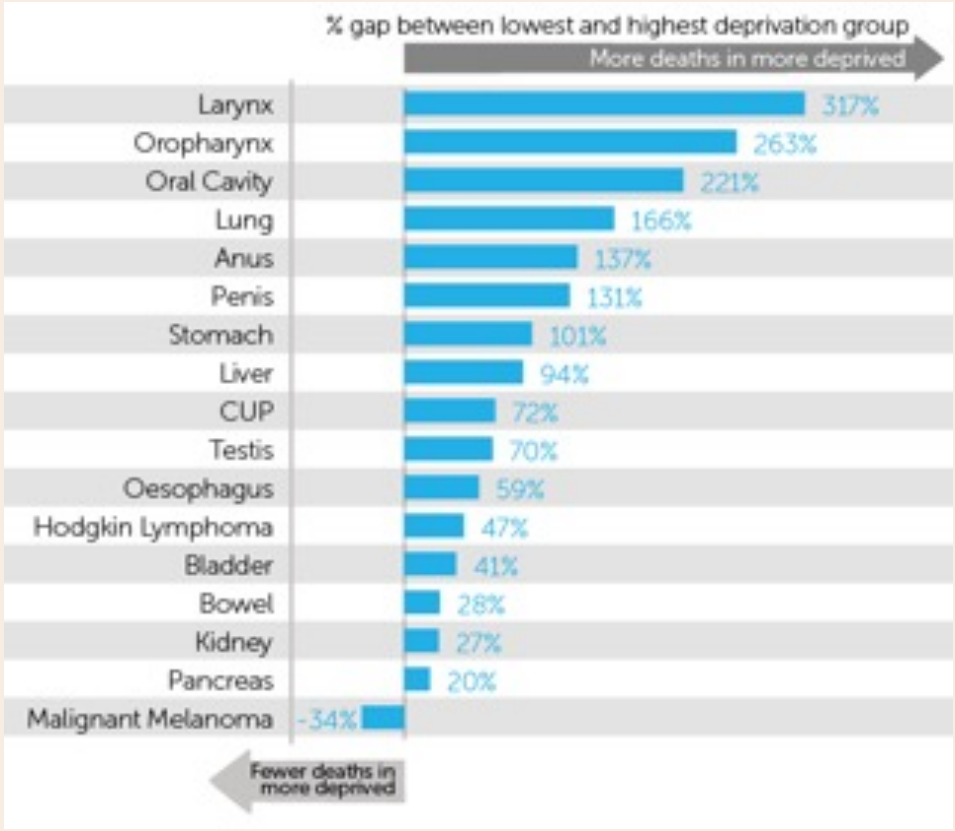
Analysis of government data has shown the locations most at risk, with the seaside town's South 021C ward leading the group. This area is ranked 120 out of 32,844 Lower Layer Super Output Areas (LSOAs) in the country, putting it in the top 10 per cent.

Adjacent neighbourhood 021D, also in the South ward, is the second most deprived, ranked number 266. Within South or Central wards of Weston-super-Mare are 5 LSOAs within the most deprived 5% in England.



The Central and South Wards are shaded purple on this map.

Percentage Deprivation Gap in European Age-Standardised Mortality Rates, Statistically Significant Cancers, Males, England, 2007-2011.



The relationship between deprivation and cancer varies by cancer type. Some lifestyle factors that are closely associated with an increased risk of cancer, such as smoking and obesity, are highest in deprived populations. Most cancer types show an increasing incidence and mortality in areas of higher socio-economic deprivation.

End-of-life

Numerous surveys have been conducted in the last two decades, regarding the wishes of people who are suffering from life-limiting illnesses.

End-of-life care covers any support and treatment for those nearing death and includes palliative care. The 'end-of-life' stage is generally defined as the period where people are dying with advanced, progressive, incurable conditions. It includes those who may die within 12 months and those with life-threatening acute conditions (the latter group are rarely encountered in community palliative care settings).

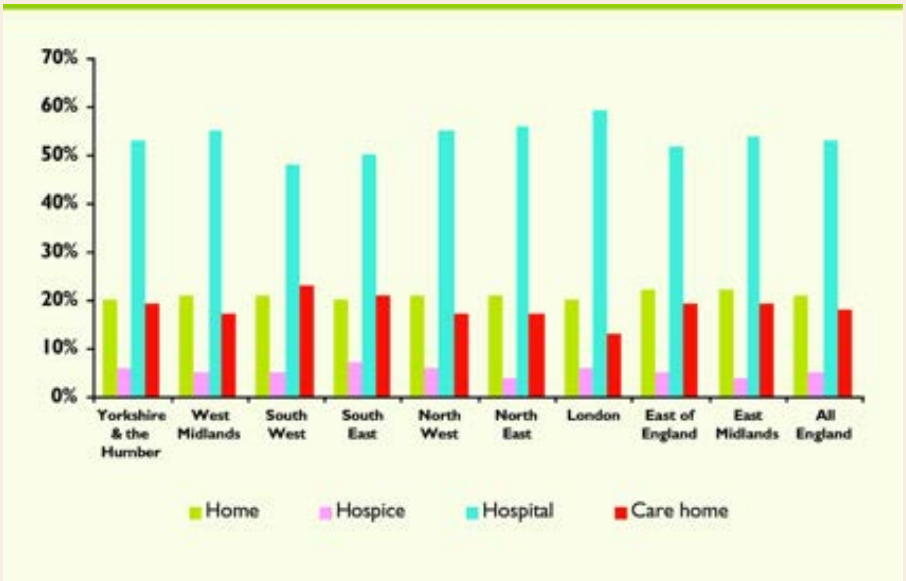
While some people experience excellent end-of-life care in hospitals, hospices, care homes and in their own homes, many others do not. Research shows that many people experience unnecessary pain and other symptoms, being treated with a lack dignity and respect, and many people do not die where they would choose to.

Research suggests that people want the following things at the end-of-life:

- Pain and symptoms controlled
- Spiritual/existentialist peace/acceptance
- Preservation of identity
- Dignity (wishes, cultural and religious traditions) respected
- Compassionate medical staff
- Die in place of choice – may be influenced by culture
- Not alone (with family present)
- Not to be a burden on family
- Some want to make their own decisions, others to delegate
- Some want to die – accepting life's natural course, loss of identity and independence

Place of death

Actual places of death in the nine English Government Office Regions (GORs)



The majority of participants in all regions said that they would prefer to die at home if circumstances allowed.

ONS mortality statistics showed that only 21% of all 461,016 deaths in England in 2010 took place at home. This had risen to 29% by 2022.

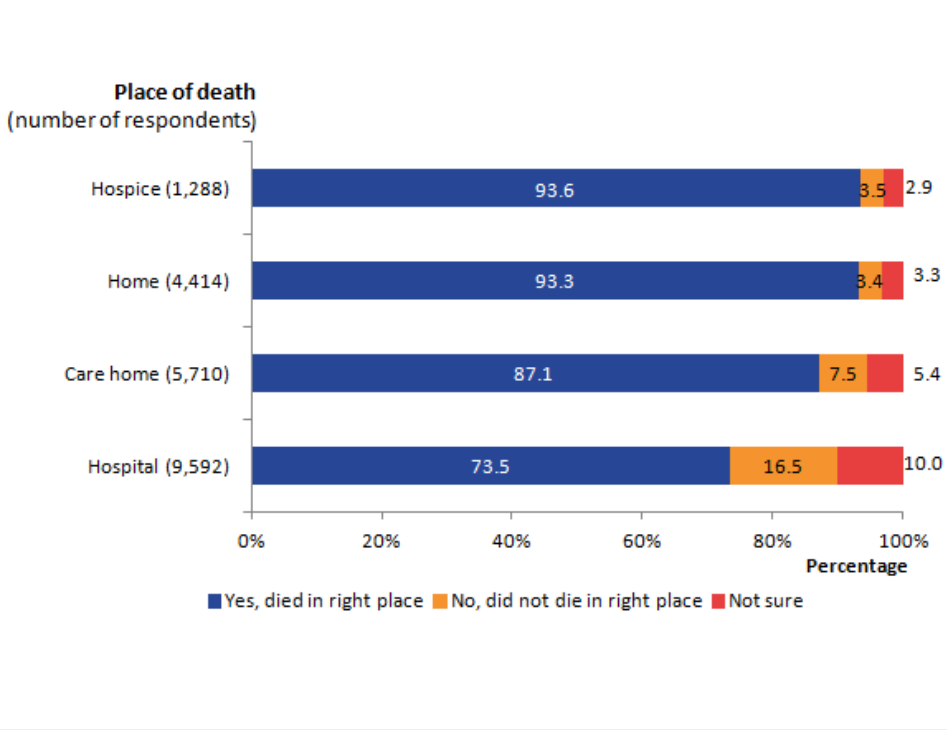
Preferred place of death

Preferences to die at home and in hospices seem to have increased in recent years. In order to narrow the gap between preferences and reality for place of death, at both national and local levels, maximum impact is derived from focusing future investment and service developments in extending and improving care at home and in hospices.

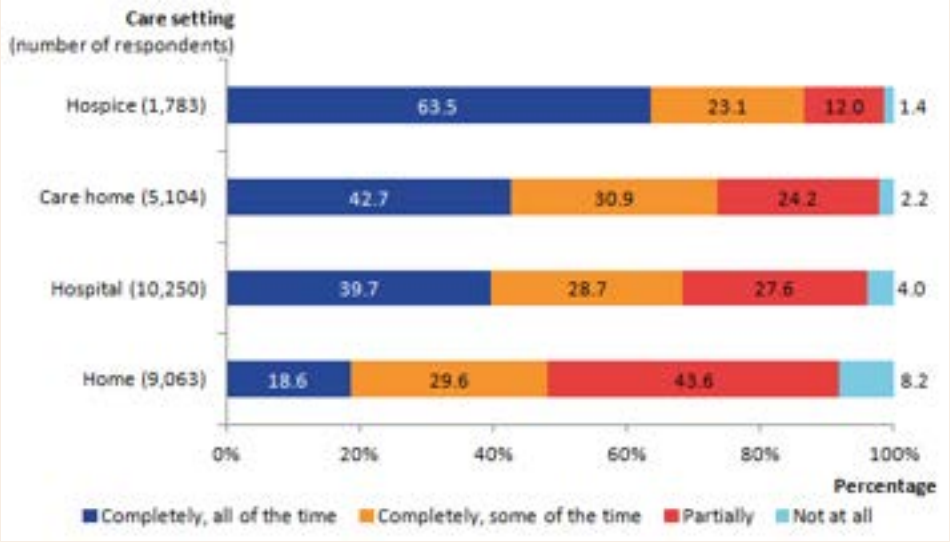
Preferred versus actual place of death by age group.

Place of death by age bands:	45-64 years		65-74 years		75+ years	
	Preferred	Actual deaths	Preferred	Actual deaths	Preferred	Actual deaths
Home	63%	32%	56%	28%	45%	17%
Hospice	32%	11%	37%	9%	41%	3%
Hospital	1%	50%	4%	54%	6%	54%
Care home	1%	3%	2%	7%	5%	25%

Hospitals are still the most common place of death, despite low preference in all age groups. In certain circumstances it is inevitable and appropriate. However, for many people the last hospital admission before death may have been preventable.

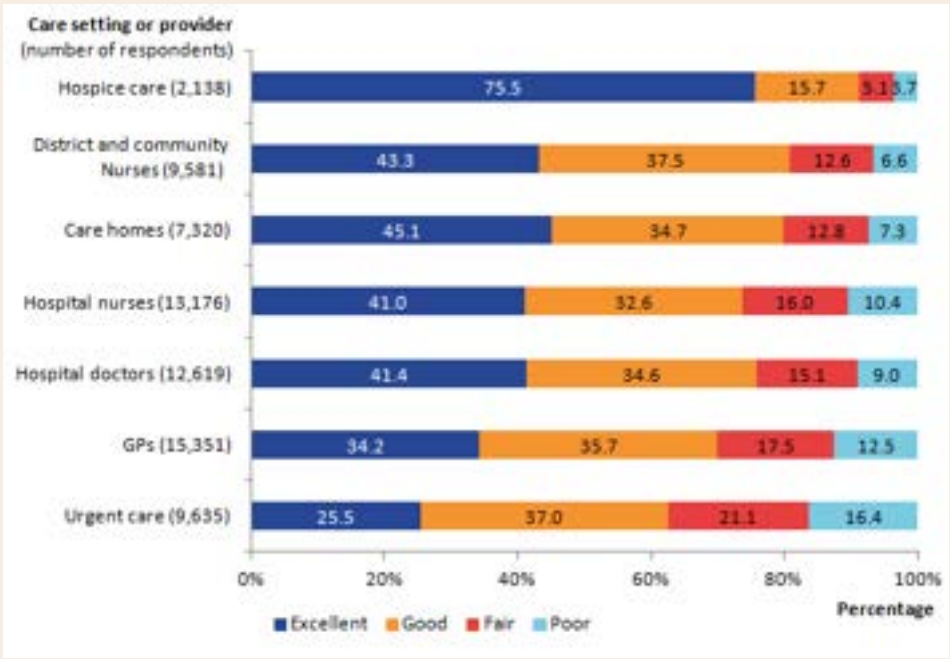


Interestingly, almost three-quarters (74%) of respondents whose relative died in hospital believed that their relative died in the right place, despite only 3% of all respondents stating that patients wanted to die in hospital.



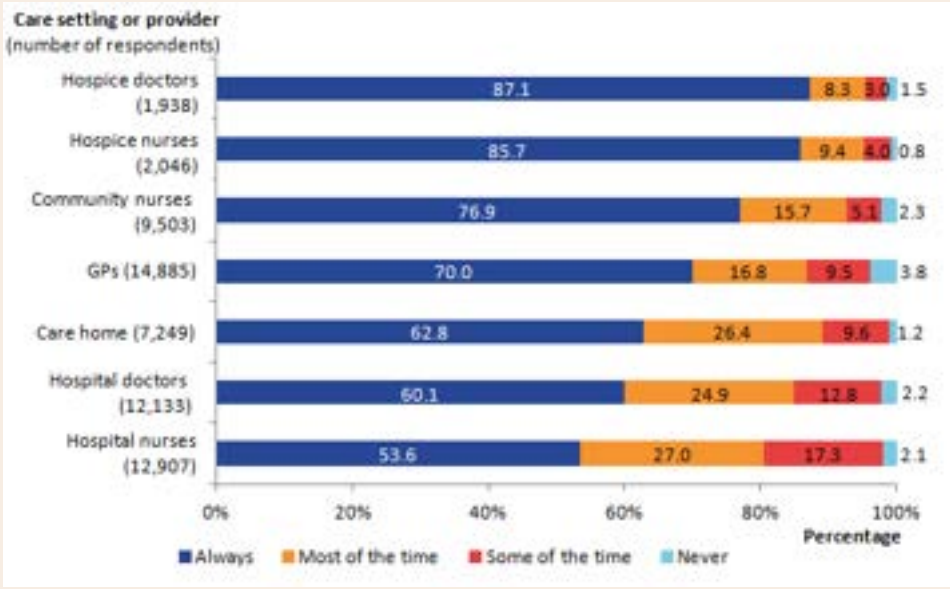
Relief of pain in the last 3 months of life

Skilled management of pain relief has always been a high priority for patients, their relatives and the staff who care for the dying. Regrettably, when surveyed in 2015, almost 1 in 13 (8%) people cared for at home did not have their pain relieved at all. In this respect, care in hospices has always managed the symptoms very effectively.



Overall quality of care by setting or service provider

Quality of care rated as excellent was highest where care was provided by hospices (76%) and lowest where care was provided by urgent care services (26%). Only 11% of NHS trusts offered out of hours face to face access to palliative care services.



Dignity and respect by care setting or provider in the last 3 months of life

Staff in hospices were most likely to be rated as always showing dignity and respect to the patient in the last 3 months of life (87% for hospice doctors and 86% for hospice nurses) which was significantly higher than any other setting.

Alternative forms of care at home

Family, especially spouses, have to cope with many issues which grow and intensify over time including 'pre-death grief', increasingly physical aspects of care, and increasing levels of decision-making which may be compounded by lack of knowledge and experience, and poor communication with professionals. They often fear discussing end-of-life issues prematurely, leading to a tendency for active interventions such as hospital admission, antibiotics and other treatments which have little use, or may be against the patient's wishes.

Any national strategy to achieve new forms of care at home, requires increased investment but also close cooperation of NHS and non-NHS institutions such as independent, voluntary and social care organisations. Hospital at Home services, for example, extend the reach of palliative care into home settings and are found to significantly increase patients' chances of dying at home.

Many different initiatives are evolving around the country in the form of enhanced community services, rapid response arrangements and what are loosely described as Hospice-at- Home. Weston Hospicecare already provides community nurses with palliative care support and plans for a more comprehensive in-home support for the dying are being actively explored.

Bibliography

Palliative-and-End-of-Life-Care-Statutory-Guidance-for-Integrated-Care-Boards-ICBs-September-2022.pdf (england.nhs.uk)

ambitions-for-palliative-and-end-of-life-care-2nd-edition.pdf (england.nhs.uk)

ONS Census 2021 Phase one - Census 2021 first results - Census 2021

Somerset population growth rates. (plumplot.co.uk)

The North Somerset Housing plan (2016-2021)

Long-term conditions and multi-morbidity. The Kings Fund Long-term conditions and multi-morbidity | The King's Fund (kingsfund.org.uk)

Office for National Statistics 2018 - 2020

Cancer research UK Deprivation gradient for cancer mortality | Cancer Research UK

Age UK – End-of-life Evidence review.

Ethical challenges in end-of-life care in a pluralist society. Presentation by Professor Julia Verne, National End-of-life Care Intelligence Network. 2013

Local preferences and place of death in regions within England 2010 https://www.palliativecarescotland.org.uk/content/publications/Local-preferences-and-place-of-death-in-regions-within-England-2010.pdf

National Survey of Bereaved People (VOICES) - Office for National Statistics (ons.gov.uk)


Weston Hospicecare

Weston Hospicecare

Our Strategy

2024 – 2026

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