Greenwich & Bexley
Community Hospice

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2017/18 Quality Account

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1. Introduction

1.1 Chief Executive's Comment

It is my pleasure to present our Quality Account for 2017/18 which provides an overview of our achievements this year, all thanks to the dedication, skill and hard work of all of the Hospice staff and volunteers and the significant support we receive from our partners and from local people and organisations across Royal Greenwich and Bexley boroughs.

In 2017/18 the Hospice cared for 2,212 people and their families. For each of these people we aimed to provide flexible, responsive and holistic care, focused on each individual's needs and priorities, as well as supporting their family throughout the illness and into bereavement. Although overall we saw a slightly reduced number of patients which is clearly explained as a result of specific service changes outlined later in the report, the changes allowed us to focus our resources on delivering expert care and support to people at end of life, which is our primary charitable objective.

The Hospice continues to support a significant number of people with terminal illness across the communities of Greenwich and Bexley; striving to ensure they are cared for in their preferred place of care for as long as is possible. In 2017/18 we increased the number of people who we were able to support to be discharged from the Queen Elizabeth Hospital by 7%, we also reduced the number of discharges to care homes and increased the number of discharges to home/ hospice.

Across all of our services we were able to achieve a 40% Home/ Care Home death rate and we achieved a 60% out of hospital death rate for people who died under our care. We continue to maintain momentum in reaching the 'older old' and those with non-malignant disease, and in particular we saw an increase in the proportion of people with a non-cancer diagnosis who accessed our inpatient beds and an increase in the proportion of people with a non-cancer diagnosis and those over 85 years in Day Hospice. Our inpatient unit continues to see an upward trend in the number of people who die during their admission, as opposed to returning home/ going to a care home at the end of their stay. In our specialist community service, we were able to provide varying levels of support by triaging some patients to a new Hospice telephone support service, which allowed the community specialist team to provide their support to a more targeted number of more complex patients.

We launched our new 3 year strategy at the beginning of the year and are now well in to delivering against our plans. We strengthened our internal assurance in 2017/18, introducing a new Trustee Assurance Programme. This programme has enabled Hospice Trustees to meet more members of Hospice staff, volunteers, service users and supporters and to improve the 'line of sight' for everyone involved in the charity. We also strove to ensure that more people in the community are aware of our services and have made headway in this area particularly with local Nepali and Black Caribbean/ African groups.

The Hospice is registered with the Care Quality Commission with an overall rating of 'good', and an 'outstanding' rating for our responsiveness. In recognition of our work to create a healthy workplace, we were awarded accreditation of the Healthy Workplace Charter Mark and we were awarded *Best Business or Social Enterprise* in the Bexley Business Awards 2017.

It costs almost £8 million per year to operate the Hospice, and we receive approximately one third of our funding from the NHS. The Hospice is extremely grateful for the support we receive from our community, without whom what we do would not be possible; whether this is by providing direct funding, in kind support or volunteering time and skills. All the support we receive is incredibly valuable and much appreciated.

The financial climate remains challenging for the Hospice, despite this we maintained control over our expenditure in all areas and were particularly pleased with the reduction in spending on agency staff in 2017/18. In line with our strategy, we are continuing to invest in key areas of contract management and income generation to build a more sustainable financial base for the future. In 2017/18 we began a comprehensive shop refurbishment programme which will help to achieve growth in retail in the coming years.

Our partnerships with other organisations were cemented in 2017/18 and in particular we were delighted to commence a more formal partnership with St Christopher's Hospice which has led to greater collaboration and sharing of resource, working together to improve patient care across south east London. We were also pleased to be collaborating with our partners through the integrated care partnership in Bexley, which we hope, in time will ensure that the needs of people with terminal illness are always considered at every step in health and social care planning, commissioning and delivery.

To the best of my knowledge, the information reported in this Quality Account is accurate and a fair representation of the quality of healthcare services provided by the Hospice.

Kate Heaps - Chief Executive

2. Quality Overview

2.1 Clinical Governance

The Hospice has a number of monitoring mechanisms to highlight priorities for clinical development, risks, incidents and necessary improvements:

Quality & Safety Committee (QSC)
This committee is a sub-committee of the Board and meets monthly to review progress against objectives, service performance, compliance to statutory regulation and risk. As part of the agenda, a number of items are regularly presented on a rolling programme, some of which are outlined below. The Chair of the committee presents a monthly report to the Hospice Board.

The Quality & Safety Committee continues to take a robust approach to monitoring the quality and safety of Hospice services. It is supported by a number of topic/project based advisory/ steering groups e.g. medicines, EPR, education, research and audit.

Quality Improvement Plan
This plan includes any actions for improvement that have been identified through our internal self-assessment mechanisms including Management Review, Trustee Assurance Programme, Staff Survey and Patient Feedback. Each item on the plan is categorised against the CQC's key lines of enquiry and has an identified lead and timescale against it. The plan is reviewed monthly by the Chief Executive, Registered Manager and the Quality and Contracts Team.

Operational Risk Register
This risk register supports the Senior Clinical Team and QSC to manage operational risks by helping to monitor challenges such as staffing risks, environmental risks etc., and outlines the mitigation/ resolution which is planned to manage/ eliminate the risk over time.

Service Activity
A regular report is presented to QSC and Board showing clinical activity and workforce over time. A new dashboard was developed in 2017/18 to demonstrate both quantitative and qualitative measures.

Patient Feedback

This regular report includes an overview of the various forms of feedback received including formal and informal complaints and compliments, Friends and Family Test and VOICES[1] responses. All complaints are fully investigated using root cause analysis and included in patient feedback and incident reporting.

Incidents and Accidents

This regular report includes accidents and any incidents across the whole Hospice including medicines incidents, falls, pressure ulcers and safeguarding. It provides an opportunity to review themes and look for improvements to be made including environmental improvements and staff training.

Mandatory Training Dashboard

This reports on compliance with our mandatory training programme for staff involved in regulated activity (clinical staff/volunteers) and non-regulated activity (all other staff/volunteers), against a target of 80% achievement. It also forecasts performance 1 month ahead so potential problems with compliance can be anticipated.

[1] VOICES is a validated questionnaire which is used to assess the views of bereaved informal carers about services received by their next of kin.

2.2 Service Activity

Although there has been a reduction in the total number of patients seen in 2017/18, this is due to several changes to our services:

- Previous years' data included patients under the care of the lymphoedema service: this has reduced in 2017/18. In 2016/17 we reviewed the service and observed that the patients requiring lymphoedema services have changed from when the service was initially established and that the service had become less consistent with our charitable objectives: i.e. a relatively small number of people were at the end of life or were living with a terminal condition. Following discussions with NHS commissioners, Greenwich CCG took the decision that all patients who were receiving care from the lymphoedema service who were under a Greenwich GP should be discharged. However, the lymphoedema service for Bexley GP registered patients was designated a 'commissioner-requested service', and in this borough we have been working with Bexley CCG to transfer the provision of care for people with lymphoedema to another provider. As part of this process new referral criteria were developed, leading to a number of discharges of people who had been referred to the service, with these people being redirected to primary care for appropriate treatment.

- The Immediate Home Support Service for Bexley was not commissioned and ceased in March 2017. This was disappointing to us at the Hospice, as the service had prevented a number of unnecessary hospital admissions and had supported a large number of families in crisis. The CCG wanted the service to support residents by providing personal care so, whilst the service was successful in reducing admissions and saved money, miscommunication around the initial objectives meant that this model was not continued. To reduce the likelihood of this happening again and to improve understanding between organisations, the Hospice has implemented monthly informal meetings with their commissioner, to give more opportunity to build relationships and improve communication.

- Several staff left the Specialist Palliative Care Hospital Team based at Queen Elizabeth Hospital due to relocation and retirement. The team is a small team, so despite our best endeavours to recruit to these posts in time, this left the service depleted for some months whilst we recruited to these specialist and difficult to fill roles. There was an impact on the number of patients accessing the service due to the reduced capacity, however, we identified different ways of training and inducting new staff which will have a positive impact on the way the service operates in future.

- The Specialist Palliative Care Community Team saw fewer patients, despite a higher number of people being referred to the service. This was linked to an increase in the proportion of patients being referred for whom this specialist level of care was not appropriate, and these people were redirected instead to telephone support; it was also impacted by a greater number of urgent referrals requiring immediate, intensive support for a short period of time only.

- We note that some of our demographic data, particularly the ethnicity of people referred to our services, continues to be less complete than we would like. We aim to address this by improving our reporting, to allow us to identify and complete missing data; working on the quality of referrals, to ensure that this information is routinely provided by those referring to our services; by raising awareness and providing additional training to staff; and looking at our computer systems to enable us to access information from other places where this data is available.

	Patient Demographic Data:	2015/ 2016	2016/ 2017	2017/ 2018
	All Patients (counted once)	**2521**	**2723**	**2212**
Ethnicity	White British	79%	71%	70%
	White Other (White Irish/White Other)	3%	8%	3%
	Black or Black British (African, Caribbean, Other Black Background)	4%	4%	5%
	Asian or Asian British (Indian, Pakistani, Chinese, Bangladeshi, Other Asian background)	3%	4%	3%
	Mixed (White/Black Caribbean, White/Black African, White/Asian, Other)	0.5%	1%	1%
	Other	0.5%	1%	1%
	Unknown/Not Recorded	10%	11%	17%
	Percentage of patients where their ethnicity was not White British:	**12%**	**12%**	**12%**
Primary Diagnosis	Cancer	60%	57%	60%
	Cardiovascular	16%	11%	10%
	Respiratory	5%	5%	7%
	Neurological	3%	4%	5%
	Dementia	6%	10%	9%
	Renal Failure	1%	1%	1%
	Other	8%	7%	7%
	Unknown/Not Recorded	1%	5%	1%
	Percentage of patients where their primary diagnosis was not cancer	39%	38%	39%
Age	Under 25	0.3%	0.6%	0.4%
	25 to 74	48%	48%	47%
	75 to 84	28%	26%	26%
	85 Plus	23%	25%	26%
	Unknown/Not Recorded	0.7%	0.4%	0.6%
Deaths	Number of Patients who died whilst under the care of Hospice services (including Hospice hospital team)	**1305**	**1456**	**1278**
	Place of Death for these patients:			
	Home	28%	27%	31%
	Nursing/Care Home	10%	10%	9%
	Greenwich & Bexley Community Hospice	19%	17%	19%
	Other hospice	0.5%	0.3%	0.2%
	Hospital	42%	45%	40%
	Other/Unknown	0.5%	0.7%	0.8%
	Percentage of deaths not in hospital	58%	55%	60%
	Preferred place of death (PPD) achieved (of those patients who had PPD recorded)	**72%**	**76%**	**72%**

Hospital Specialist Palliative Care Team:	2015/ 2016	2016/ 2017	2017/ 2018
Total Number of Admissions to the team	981	960	921
Average wait from Referral to Admission (Note this is a five day a week service only)	1.6	1.6	1.7
Total Number of Deaths	397	443	380
Total Number of Discharges from SPC:	**597**	**520**	**556**
Home	53%	59%	60%
Nursing/Care Home	16%	17%	12%
Greenwich & Bexley Community Hospice	10%	10%	12%
Other hospice	0%	1%	0%
Continued as hospital patient	21%	13%	16%
Average length of stay (Median in days)	**5**	**5**	**4**

The hospital team provide an in-reach service at Queen Elizabeth Hospital in Woolwich across all inpatient wards and the emergency department.

During 2017/18 several staff in this team left due to relocation or retirement. Despite forward planning and best endeavours, this left the team short-staffed for several months whilst suitable new staff were recruited and developed and resulted in the team reaching fewer patients overall. However, the length of time patients were waiting to be seen did not alter significantly and the length of stay remained consistent. The team were able to increase the number of people who were discharged home and reduced the proportion who were discharged to a care home.

Due to the importance of this service in identifying new patients with a palliative care need, the reduction in activity in this team may also have influenced activity in other departments and in the inpatient unit in particular.

Inpatients:	2015/ 2016	2016/ 2017	2017/ 2018
Total Number of Referrals	614	577	509
Total Number of Admissions	368	353	346
Average waiting time in days (from referral to admission)	4.2	4.2	5.3
Cancer diagnosis	84%	81%	78%
Non-cancer diagnosis	16%	19%	22%
Aged 85 years and over	18%	22%	18%
Number of People whose stay ended in Discharges	153 (37%)	130 (34%)	117 (32%)
Number of People who Died in IPU	259 (63%)	248 (66%)	246 (68%)
Total number of completed episodes	412	378	363
Average length of stay (Mean)	10.7	10.7	12.4
Available capacity (number of bed days available)	6112	6141	6109
Bed occupancy	76%	81%	75%

Although the number of admissions is slightly lower than previous years, the average length of stay has increased. The median length of stay in 2017/18 was 9 days, compared to 8 in 2016/17. The majority of "older" patients generally come through the hospital referral route, hence the reduction in older patients being referred this year (see section above). 17 patients aged 85 and over were referred for inpatient care in 2016/17; this compares to only 8 in the same age bracket for 2017/18.

Specialist Palliative Care Community Services:	2015/ 2016	2016/ 2017	2017/ 2018
Total Number of Referrals	1316	1284	1358
Total Number triaged to telephone support service			245
Total Number triaged to specialist palliative care	967	954	873
Total number triaged as 'not appropriate'	349	330	240
New Patients under SPC Community Team:			
Cancer diagnosis	78%	69%	74%
Non-cancer diagnosis	22%	31%	26%
Aged 85 years and over	24%	27%	21%
Total number of contacts by specialist palliative care	25,181	23,464	24,032

There was an increase in the number of people referred to the community team in the year. Although there were some changes to staffing, the number of contacts in the specialist palliative care community service increased.

As part of the Hospice Community service, we introduced a Telephone Support Service which has meant that referrals are triaged more appropriately to differing levels of support. Patients under this service are supported by the Hospice via telephone contact and can be referred back to the specialist palliative care community team at any time. This service has taken more of the patients with non-malignant disease and those who are older, who are often living in care homes.

Greenwich Care Partnership - Number of Contacts:	2015/ 2016	2016/ 2017	2017/ 2018
Rapid Response Service:			
Number of Patients	274	230	252
Number of Contacts	1818	1619	1776
Multi-visit Personal Care:			
Number of Patients	181	181	184
Number of Visits	4691	4197	3853
Planned Night Care:			
Number of Patients	72	63	76
Number of Night sits	732	883	695

Greenwich Care Partnership is an integration of several services for which the Hospice is the prime contractor, with elements of the service being delivered by Oxleas NHS Foundation Trust and Marie Curie on the Hospice's behalf. The reduction of the number of contacts in 2017/18 is as a result of better management of patients who no longer meet 'fast track' criteria. For patients who no longer meet the requirements for the service, they are handed over to an alternative provider for ongoing support. This improvement has reduced the number of people who receive support for longer than their care is commissioned for, therefore reducing the overall number of contacts. It should be noted that there has been no increase in funding for this service since the service began: the Hospice continues to support a growing caseload despite a real terms decrease in funding from the NHS.

Outpatient Services - Day Hospice:	2015/ 2016	2016/ 2017	2017/ 2018
Total number of Referrals	160	143	117
Total Number of New Patients (including re-referrals)	68	58	58
Cancer diagnosis	72%	69%	55%
Non-cancer diagnosis	28%	31%	45%
Aged 85 years and over	16%	7%	24%
Total number of contacts with patients	2,223	2,163	1,685

A review of the Day Hospice service resulted in several long-stay patients being discharged in 2017/18. In addition, a Holistic Needs Assessment has been introduced to ensure patients are signposted to the most appropriate services. All new patients participate in a full assessment of physical, social, emotional, spiritual and financial needs on their second visit to Day Hospice, which is followed by development of a robust care and support plan and regular re-assessments. Transport for Day Hospice continued to present problems throughout the year and we are working hard to address this for 2018/19.

Outpatient Services - Rehabilitation:	2015/ 2016	2016/ 2017	2017/ 2018
Total number of Referrals	490	436	412
Total Number of New Patients Seen (including re-referrals)	365	363	326
Cancer diagnosis	85%	85%	84%
Non-cancer diagnosis	15%	15%	16%
Aged 85 years and over	14%	13%	9%
Total number of contacts with patients	2,518	2,214	1,940

Due to vacant posts within the rehabilitation team, the number of patient contacts is lower in 2017/18. The team are now fully staffed which will result in the number of patient contacts increasing in the coming reporting year.

Outpatient Services - Social Work:	2015/ 2016	2016/ 2017	2017/ 2018
Total number of Referrals	157	204	130
Total Number of New Patients Seen (including re-referrals)	141	177	102
Total number of contacts with patients	1,424	1,760	973

The Hospice has one Social Worker, who sees patients across all Hospice services. The post became vacant in 2017/18, during which time social and welfare issues were managed by other clinical staff. A new Social Worker has commenced and therefore activity will increase to previous levels in 2018/19.

Outpatient Services - Psychological Support:

We undertook a review of our Psychological Support Service in 2017/18 and are making service improvements to maximise impact. We are continuing to work on the design of our services by promoting and developing our group support options, which allows us to support a greater number of people with the same amount of resource. We are also working on ensuring that people seen by the Hospice's Psychological Support Team are people who can only be supported by the Hospice, rather than people who may be better served by other support provided by other agencies.

2.3 Patient Feedback/Case Studies

As part of our three year strategy, we started a review on how we gather and share patient and family feedback on our services.

Friends and Family Test

For community services we have historically given questionnaires to service users twice a year. Clinical staff are asked to give questionnaires to a random selection of users and although the Friends and Family Test results generally score highly, we found that the response rate of returned questionnaires was low.

In March 2018 we piloted a new method of distributing questionnaires in our specialist palliative care community team; we posted questionnaires to 30 patients who had received two or more visits. 30% of these questionnaires have been returned. This compares to 6% returned in the two previous mailshots in 2017/18.

FFT scores, based on number of questionnaires returned for the last two years are as follows:

	2016/17				2017/18			
	Sep-16		Mar-17		Sep-17		Mar-18	
	No of resp-onses	* FFT Score	No of resp-onses	* FFT Score	No of resp-onses	* FFT Score	No of resp-onses	* FFT Score
Day Hospice	23	100	30	77	30	77	29	90
Greenwich Care Partnership	6	67	1	100	3	100	6	83
Rehabilitation	2	100	0	NA	2	100	12	83
Social Work	7	100	6	100	2	100	0	NA
Specialist Community Service	0	NA	0	NA	2	100	9	100
Totals	38	**95**	37	81	39	**87**	56	**90**

NA = No questionnaires were returned

*The response rate is scored between +100 and -100, +100 being the best possible score and -100 being the worst. The score is worked out by taking the proportion of respondents who would be "extremely likely" to recommend the service minus the proportion of respondents who would not recommend ("neither likely nor unlikely", "unlikely" and "extremely unlikely"). Those who answer "likely" are not counted in the score.

Reflections from the Matron for the Hospice Inpatient Unit

The Hospice as a place for celebrations:

Last year on a particular nice day, the Inpatient Unit 'took over' the area normally used for Day Hospice. Nearly all the patients and staff were able to spend a lovely afternoon sitting outside on the veranda having lunch and listening to music; lots of chatter and laughter was heard.

For patients who are staying in our inpatient unit, we facilitated Stag parties, Hen parties and birthday parties throughout the year; these included parties for patients and family members or friends if the patient was too poorly to attend. Patients who have young children have, with support of the ward staff, decorated areas for their child's party and held social gatherings such as curry and pizza evenings with family and friends.

One young patient told me afterwards that he really never expected to be able to participate in his daughter's birthday party, knowing how unwell he felt and that 'there were not the words for him to express what it meant to him'.

In 2017/18 we have had weddings and civil ceremonies here at the Hospice, and have utilised our lovely gardens, the Day Hospice, patients' bedrooms, the prayer room and the family day room to make each occasion special. Sometimes we have had a bit of notice to organise; other times we have sorted everything out within an hour! This has involved lots of staff running around and raiding cupboards to get what we need. When we have had more notice, we have brought stuff in from home to help with the decorations; it really has always been a team effort.

These are just a few examples of how ward staff in this Hospice setting go the extra mile to enable patients to be themselves and enjoy special moments with their loved ones. These memories will stay with the families for ever.

"You have a very special place where the terminally ill and their families find so much solace, love and kindness. We cannot thank you enough for the care you showed our mother helping her to retain her dignity through her last days and enabling her to have a peaceful death. We will be forever grateful".

Relative of patient cared for on the Inpatient Unit

"Your Social Worker has worked with me over several episodes of my ill health and appears to have tailor-made her responses to my needs".

Patient who received support from Hospice Social Worker

"Thank you from the bottom of our hearts for everything you did for my Dad. You showed such kindness and care, your compassion made things better".

Relative of a patient cared for by the Hospice hospital team

"Thank you so much for the wonderful care you gave to my husband during his last few days. You were always not only professional and efficient but also cheerful, smiley, and happy; he always looked forward to your visits. You looked after him so very well and also cheered him up".

Relative of a patient cared for by Greenwich Care Partnership

"It gives me great pleasure to write to let you know how much I appreciate the great improvement in my well-being after a few short visits by your physio. He provided me with exercises to do and I am amazed how much stronger I have become, I now walk longer and my everyday movements are improving more than I ever thought possible, such things like getting into the car and using the stair. With his patience and practice gave me back the confidence I lacked".

Patient of Rehabilitation Service

"A few lines to say many, many thanks for the lovely time my husband had at Shornells. He looked so forward to each Thursday, he enjoyed it so much".

Wife of a patient who attended Day Hospice

"Thanks for the fine work you do. I am forever grateful to you that the Hospice provided me with bereavement counselling and support over a very difficult time. Your staff are wonderful".

Client who received support from Psychological Support Team

"Respect to one of our Plumstead Gurkha Veterans, the first Gurkha Veteran to receive the best possible care from the exceptional Hospice team.
A huge thank you".

Associate of patient who received care from our Specialist Community Palliative Care Team

2.4 Complaints

The Hospice has a robust complaints procedure. All complaints are fully investigated, both informal complaints such as comments received on patient and family feedback questionnaires and formal written complaints. A root cause analysis is carried out for all complaints.

Complaints Received:	2015/ 2016	2016/ 2017	2017/ 2018
Verbal Care Complaints	16	8	10
Written Care Complaints	14	25	12
Verbal Non-Care Complaints	1	3	5
Written Non-Care Complaints	6	5	9
Total	**37**	**41**	**36**

An example of learning from a complaint:

A complaint was received via a VOICES questionnaire (sent to all bereaved relatives) from the parents of a patient who had died. They felt it was unacceptable to wait 4 months to be asked if they needed counselling and 5 months to receive the VOICES questionnaire. Although they stated the carers were wonderful, they felt that members of the wider community team (from a partner organisation) had ruined the privacy of their son's death who appeared more concerned about watching them and wanting to retrieve their syringe driver and that they were reluctant to speak to the emergency services when it was required. The family had had to ring round countless chemists for medications for the syringe driver and the father had to pick them up at a time when he wanted to be by his son's bedside. A member of the Hospice team had said it would be difficult to know what drugs to prescribe (because of his underlying condition); however a hospital meeting they attended following his death revealed that the Hospice had already been informed what medication he should be prescribed when no longer able to swallow. The family found it very distressing to see their son, who was hallucinating badly and very distressed; it was a terrible experience, and although they did reflect that some staff had been very caring, they were still traumatised.

An initial letter was sent to the family apologising for the distress and giving details of contacts in the partner organisation. The Hospice's Chief Executive and Modern Matron for the Community investigated the complaint which included a 'phone conversation with the patient's father and a thorough internal investigation. A letter was then sent outlining the findings of the investigation which included:

- An apology for the distress caused;
- A summary of conversations between the Hospice and partner organisation requesting a visit;
- Issues identified with accessing specialist medicines in the community (Alfentanil), as it is not kept as a stock item and it has to be requested on an individual basis;
- That the drug had not been given on discharge from hospital as the patient had been managing oral medication;
- That unfortunately families are required to collect prescriptions to protect staff safety and the drugs are the property of the patient;
- That hospital discharge communication to the Hospice made no mention of injectable medications;
- An apology for having to wait 4 months for bereavement counselling. Explained the reason for delay;
- That the father's comments had been shared with the partner organisation with his permission.

Following receipt of the letter, the parents requested a meeting; the investigation team visited the parents at home and spent over an hour with them. It was a successful meeting and the parents thanked the team for the support the Hospice had given them. They also understood where their son's care and discharge had fallen down which they felt was not due to the Hospice.

Both parents talked about volunteering for the Hospice in the future.

2.5 HUK Benchmarking

We have continued to participate in the Hospice UK Benchmarking Project. The Hospice is categorised based on the number of beds as category "D" for comparison with other similar sized units. Pressure ulcers were not included in the benchmarking project this year.

Results from 2017/18 Benchmarking: Patient Falls

	Bed Occupancy				Actual Falls											
		AVAILABLE BED NIGHTS	OCCUPIED BED NIGHTS	% BED OCCUPANCY	No Harm		Low		Moderate		Severe		Death		Total Falls	
					No	%	No	%	No	%	No	%	No	%	No	Per 1000 OBDs
2015/16	GBCH	6,112	4,667	76%	54	73%	19	26%	1	1%	0	0	0	0	74	14
	AV. CAT D	6,315	5,047	80%	33	61%	20	37%	1	1%	0.2	>1%	0	0	54	11
2016/17	GBCH	6,141	4,969	81%	55	73%	18	24%	1	1%	1	1%	0	0	75	15
	AV. CAT D	1,565	1,258	81%	50	78%	12	19%	0	0%	2	3%	0	0	64	14
2017/18	GBCH	6,109	4,603	75%	50	78%	12	19%	0	0%	2	3%	0	0	64	14
	AV. CAT D	1,289	1,005	79%	6	60%	4	37%	0.3	3%	0.1	>1%	0	0	10	10

It is Hospice Policy to report all trips, slips or falls including near misses. Procedures are in place to prevent falls and minimise serious harm from falls, including regular Falls Risk Assessments, low-to-floor beds and regular checks, especially on those patients known to be prone to falls.

Most falls resulted in no injury or required first aid treatment only and we are happy to report a reduction in the total number of falls this year. Two falls resulted in transfer to hospital. In both these cases, the patients were diagnosed with a hip fracture and following appropriate treatment in hospital, returned back to the Hospice for ongoing care.

In order to improve our prevention and management of falls, the Hospice participated in a Falls Summit held in partnership with the Health Innovation Network. This resulted in the learning being incorporated in an internal Falls Audit, the final report for which is still awaited, however the audit will be repeated later this year and we hope to collaborate with other Hospices to allow further benchmarking.

Results from 2017/18 Benchmarking: Medication Incidents

	Bed Occupancy				Actual Medication Incidents													
					Level 0		Level 1		Level 2		Level 3		Level 4		Level 5&6		Total	
		AVAILABLE BED NIGHTS	OCCUPIED BED NIGHTS	BED OCCUPANCY	Error Prevented		No adverse effects		Patient monitoring no harm		Some change, no harm		Delayed discharge, additional treatment		Permanent Harm/ Death			
					No	%	No	%	No	%	No	%	No	%	No	%	No	Per 1000 OBDs
2015/16	GBCH	6,112	4,667	76%			71	96%	3	4%	0	0	0	0	0	0	74	16
	AV. CAT D	6,315	5,047	80%	N/A	N/A	29	83%	4	12%	2	5%	0.2	>1%	0	0	35	7
2016/17	GBCH	6,141	4,969	81%			57	88%	8	12%	0	0	0	0	0	0	65	13
	AV. CAT D	1,565	1,258	81%	N/A	N/A	5	35%	7	55%	1	7%	0.3	2%	0	0	13	10
2017/18	GBCH	6,109	4,603	75%	51	63 %	26	32%	4	5%	0	0%	0	0	0	0	81	18
	Av. CAT D	1,289	1,005	79%	4%	33 %	6	57%	0.8	8%	0.2	2%	0	>1%	0	0	11	10

In previous years, level 1 included those errors where errors were prevented by staff vigilance. This includes prescription writing errors such as missing signature, dosage or medication route. In 2017/18, these have been recorded under the separate category of "Level 0, error prevented". We are pleased to report 95% of incidents were level 0 or 1.

The Hospice policy is to record all incidents including near misses and prevented errors. Therefore our level 0 results are high, however incidents of level 2 and above are lower, reporting 5% compared to 10.3% for other hospices in the same category.

Pressure ulcers

In previous years the HUK benchmarking has also included pressure ulcers data; this was not included in the audit in 2017/18 but has been added back into the audit for 2018/19. Despite this, we continued to monitor, report and learn from pressure ulcers that were detected or acquired whilst under the care of the Hospice:

	Grade of Pressure Ulcer prior to Admission to Hospice Inpatient Unit		
	2015/16	2016/17	2017/18
Grade 2	2	5	0
Grade 2 to 3	1	0	1
Grade 3	10	9	7
Grade 4	2	5	3
Grade 4 to 5	0	1	1
Ungradable	0	0	1
Total	**15**	**20**	**13**

	Pressure Ulcer Acquired during Hospice Inpatient Admission		
	2015/16	2016/17	2017/18
Grade 2	3	4	1
Grade 2 to 3	1	0	0
Total	**4**	**4**	**1**

We are pleased to report an overall reduction in pressure sores, both on admission and acquired at the Hospice in 2017/18.

3. Hospice Strategy and Priorities for Improvement 2018/19

3.1 Introduction

The priorities for improvement in the Quality Account 2016/17 were as follows:

- Access to Hospice Services
- Patient Experience
- Flexible Models of Care and Multi-disciplinary Team (MDT) Working
- Resilience/Sustainability

In 2017 the Hospice finalised its Strategy for 2017 to 2020. The document outlines our strategic priorities. Four themes were identified and the priorities for improvement from last year have been linked to these four themes:

Priorities from Hospice Strategy 2017/2020	Priorities for Improvement from 2016/2017
3.1 Building Partnerships, Networking and Community	Access to Hospice Services
3.2 Sustainability, Efficiency and Innovation	Access to Hospice Services Patient Experience Flexible Models of Care/MDT Working Resilience and Sustainability
3.3 Developing and Retaining our Workforce	Resilience and Sustainability
3.4 Generating sufficient Income to Safely Meet Demand and Quality Requirements	(see below)

Our priorities for 2018/19 continue to focus on the four strategic priorities. Delivery against point four, "generating sufficient income to safely meet demand and quality requirements" is included in our Statutory Accounts and is therefore not specifically addressed in the Quality Account.

3.2 Building Partnerships, Networking and Community

- We made some changes to our Friday morning group, with Stepping Stones closing in June 2017 and the new Community Café taking its place from September 2017. The Community Café is a space for all people who benefit from Hospice services; their family and friends; the recently bereaved; and anyone wanting to learn about the Hospice. The service allows people in a similar situation to meet and support each other in a relaxed atmosphere, helping people to gain confidence and receive informal support and information.

- We are progressing with the launch of our community engagement project *Compassionate Neighbours* in both Bexley and Greenwich Boroughs and this will provide a specific focus on unreached communities.

- Building on and learning from our Dementia Project, we plan to increase our reach to other specific groups.

  - With funding from the St James' Place Foundation and additional support from the local community, we have recently recruited a Heart Failure nurse to increase our reach in this area and develop partnerships with other hospital and community heart failure services.
  - We have a small project to develop our skills and resources to better meet the needs of people accessing our services with a learning disability.

- We are exploring appropriate opportunities to secure funding to enable investment in volunteer development across all clinical services.

- With the support of Royal borough of Greenwich we have successfully reached out to local people from the Nepalese community and with some additional funding, we are now extending these links with others from 'want to reach' groups, especially those from the West African, Muslim and Afro Caribbean communities. We are using this opportunity to engage in dialogue, so all parties can learn about, and from, one another and to break down barriers that prevent access to quality care at the end of life.

- We have refreshed our website and simplified the information that people receive to help them access Hospice services, this piece of work will continue into 2018/19 with a review of our printed materials.

- We are partners in the Bexley Integrated Care System and are collaborating with our partners to make sure that care as people approach the end of life is commissioned and delivered to enable all services to appropriately meet the growing need in the borough.

3.3 Sustainability, Efficiency and Innovation

- We undertook reviews of the Psychological Support Service, the Assessment & Coordination Team and the Triage Service during 2017/18. The format of the reviews was to understand the model of the teams and to identify areas for further discussion. Action plans have been drawn up based on recommendations from the review papers and progress updates are given to the Hospice's Quality & Safety Committee, with the aim of improving quality of our services whilst ensuring that staff feel adequately supported and able to perform their duties.

- We developed stronger links with other organisations to ensure an appropriate level of specialist medical support is available across all teams. Through these developments we have supported Darent Valley Hospital and received support from St Christopher's Hospice. We are currently recruiting to a joint post between Darent Valley Hospital and the Hospice which will help to strengthen our partnership and improve care further, especially for Bexley residents.

- To allow patients to remain independent for as long as possible, we are developing an integrated rehabilitation approach across all Hospice services and plan to extend the use of outreach clinics on sites away from the main Hospice building.

- The Specialist Palliative Care Community Team started a clinic at the Hospice to reach ambulant patients more efficiently than visiting them at home. It provides an opportunity to be seen here at the Hospice, introducing patients to the building and allowing clinicians more patient facing time and less time travelling. During 2017 three different clinicians held varying amounts of clinics, an Associate Specialist Doctor, Modern Matron and a Clinical Nurse Specialist.

    - Over the year there were 56 clinics
    - 78 people attended clinic
    - 15 patients attended more than once
    - There were 18 clinic appointments that were not attended.

Clinician	Appoint-ments	Non attendances	Attend-ances	Repeat patients
Associate specialist	26	3	52	7
Matron	45	15	22	7
CNS	3	0	4	1

Findings:

- Some patients were very pleased to come to a clinic appointment, especially if it meant they had a medical review or could be seen sooner.
- It was sometimes patient choice to attend clinic; they did not want people visiting their home.
- Two patients have been supported in clinic only then admitted to die in the Hospice, which was their choice.
- The ability for patients to attend clinic appointments at the Hospice is sometimes restricted by the availability of transport
- Clinics present an opportunity for further efficiencies but require a cultural shift for some community staff and patients
- Clinics provide a very useful teaching forum for both visitors and staff on clinical examination courses.

Future Recommendations:

- To find more accessible sites to see patients in clinic.
- To promote clinics with referrers, Hospice staff and patients.
- To continue doctor and nurse led clinics at the Hospice especially for urgent reviews.

- We secured funding to pilot the use of ECHO[2] to act as training route and to enable MDT meetings across sites. We anticipate rolling this out in 2018/19.

- We are reviewing our current Electronic Patient Record system, to ensure the system we are using is as effective and interoperable as possible. Following a trial, the roll out of a new system will include using mobile computing devices for our community team to improve efficiency, communication and clinical decision making.

- We signed a contract with Greenwich CCG in July 2017 to cover 2017/18 and 2018/19. The contract saw the commissioners reduce the amount of funding provided to the Hospice, which clearly represents a challenge, especially in the context of an ageing and increasingly complex population. There have been challenges in terms of turnover of staff at the CCG but we are working hard to develop and maintain links and relationships with key personnel.

  We signed a variation to our existing contract with Bexley CCG which was active for 2017/18 which included a modest inflationary increase to the contract value.

[2] Project ECHO is a lifelong learning and guided practice model that revolutionizes medical education and exponentially increases workforce capacity to provide care using videoconferencing technology.

Neither contract allowed additional funding for service improvements, nor was substantive funding for demonstrably successful pilot services provided.

3.4 Developing and Retaining our Workforce

- In 2017/18 we achieved a high level of compliance with mandatory training across the Hospice, despite staff challenges in delivery and attendance of training. In order to maximise efficiency and improve delivery, we have agreed the funding for an e-learning system for all mandatory training to be introduced in 2018/19.

- We continued to increase our nursing staff bank which has enabled us to significantly reduce the number of agency staff used on our inpatient unit and in the last two months of 2017/18 no agency staff were required. Use of our own staff bank is not only more cost-effective, but improves continuity and quality of care for patients. We plan to further develop our bank and integrate this across all services in 2018/19.

- Our Day Hospice team delivered a tailored training programme for volunteers which included specific training for some volunteers in patient moving and handling, chair based exercise programmes, feeding and help with toileting.

- We trained a number of Healthcare Assistants on the Inpatient Unit to help them develop their skills and confidence in providing rehabilitation to patients helping us to promote greater independence for patients in the Inpatient Unit.

- We developed 2 new band 4 roles to support the Hospice registered nurse workforce, given the recruitment and productivity challenges experienced in nursing; and we supported both staff in their skill and competency development.

- In response to difficulties in recruiting senior experienced clinical nurse specialists in our hospital team, the Hospice clinical leadership team worked together to recruit and develop 2 new staff members through a robust development programme rotating through community and inpatients before commencing their roles in the hospital. Although the development of these staff took longer, they were more prepared for the challenging role they faced, and had good support and mentorship from senior colleagues. It was extremely positive to see the senior clinical team working so closely to solve a difficult problem using a lateral approach.

- A number of our clinical staff continued or completed formal post graduate courses at a range of academic institutions, supported by funding and study leave provided by the Hospice. Through this training, many have been able to develop their roles, which will provide a direct benefit to the individual, their team and to patients.

- We held our first ever Retail Conference in 2017 which elicited excellent feedback and we continue to support, develop and retain a diverse group of volunteers in our retail departments, with a plan to increase our volunteer workforce in this area.

- We developed a new Staff Wellbeing Group which has developed a Hospice wide wellbeing programme, and having already achieved commitment level, we hope that this group will help us to reach the Achievement level of the Healthy Workplace Charter in 2018/19.

4. Workforce, Education and Training

As well as the developments delivered under our strategic objectives outlined previously in this document, we continued to provide educational support and facilitation for many external organisations, and in 2017/18 we carried out the following training programmes:

- Introduction to End of Life Care (EoLC) Course for Registered Nurses and Allied Health Professionals delivered for staff in Oxleas NHS Foundation Trust and local care homes.
- Introduction to EoLC Course for Health Care Assistants and Social Care Assistants working in Oxleas NHS Foundation Trust, local care homes, domiciliary care and local authority
- QELCA© (Quality End of Life Care for All) delivered to staff in HMP Belmarsh
- Bespoke Bexley Social Services Difficult Conversations Training
- Leading an Empowered Organisation (LEO)course for staff working in the Hospice and partner organisations

Our involvement in the South London Hospice Education Collaborative (SLHEC) continued with the completion of our staff nurse rotation programme. After a successful evaluation, we have secured further funding from Health Education England to deliver an adapted version of this rotation programme again in 2018/19.

We continued to participate in the SLHEC assistant practitioner programme and began to build on the experience of this programme when participating in a collaborative project to pilot the nursing associate role in SE London.

We participated in a GP fellowship programme led by Bexley CCG/ Community Education provider Network, and have benefitted from a part-time GP fellow working closely with our community team.

South East London Nurse Rotation Graduation January 2018

5. Statement of Assurance from Board

5.1 Review of Services

During 1st April 2017 and 31st March 2018, the Hospice provided the following services:

- Inpatient Care
- Specialist Palliative Care Services in Queen Elizabeth Hospital
- Community Care, which includes:
  - Day Hospice
  - Community Specialist Palliative Care in Royal Greenwich and Bexley Boroughs
  - Greenwich Care Partnership in Greenwich
  - Rehabilitation
  - Lymphoedema Treatment and Care in Bexley
  - Psychological Care Service including Telephone Bereavement Service
  - Chaplaincy
  - Social Work
  - Advancing Practice Team including Care Homes Support Team in Bexley
  - Advance Care Planning Support
  - Befriending

5.2 Income Generated

All statutory income generated by the Hospice in 2017/18 was used to fund NHS commissioned care. The services also attracted a significant charitable subsidy as the NHS contribution is only approximately 1/3 of total costs of running the Hospice.

The above mandatory statement confirms that all of the NHS income received by the Hospice is used towards the cost of providing patient services.

5.3 Research and Audit

5.3.1 Participation in National Clinical Audit

- During 2017/18 the Hospice participated in the "National Comparative Audit of Red Blood Cell Transfusion in Hospices" This was a national audit and data was submitted to enable examination of transfusion practice. The audit results were used to bring our transfusion practice up to national standards through departmental teaching and policy review.

- The Hospice continues to participate in the Hospice UK Benchmarking Project

5.3.2 Participation in Local Audits

- During 2017/18 the Hospice Research and Audit Group met regularly to review the Hospice's activities against its Research and Audit agenda.

Audit Subject	Purpose of audit	Follow up actions
Accountable officer audit	Mandatory audit of controlled drugs and non-controlled audit. High level of compliance recorded.	Action plans drawn up for any areas of concern. Also discussed and actioned in the Medicines Management Committee.
Audit of referrals to hospital palliative care team	To examine referrals to the specialist palliative care team in QEH and improve process.	In progress.
Audit of use of oxycodone	To demonstrate best use of oxycodone as an alternative to morphine.	20 patient's notes audited. 65% of notes demonstrated an appropriate clinical indication. In 25% of notes the choice of opiate could be inferred. In 10% there was no documentation of why the opiate was changed. Results shared with the medical team to improve record keeping.
Audit of quality of hospital admission and assessment documentation	In detail examination of our documentation of assessment processes on admission.	Awaiting final report. Draft audit has been discussed at Medical Staff Meeting, with suggestions on how to analyse and present findings on the quality of referrals.
Nutritional Assessment Tool	To examine the implementation of a new nutritional assessment tool.	The piloted tool has been developed in partnership with local dietetic services to review current assessment and management of nutritional issues in the Hospice Inpatient Unit

Audit Subject	Purpose of audit	Follow up actions
Re-audit of discharge letters	To examine communication with external partners.	In progress.
Record keeping	Audit of missing data on the Electronic Patient Record System and to review how data collection can be improved.	Review of demographic data collection across all Hospice services is in progress, with plans to run an audit of 2017/18 data in June.

5.3.3 Research

- The Hospice participated in a qualitative study led by the Institute of Integrated Care, looking at Nurse Retention and Retirement. The final report is pending.

- Opel 'Hospice at Home' services for end of life care – phase 2 of this project is to visit Hospice at Home patients and compare their experiences against other Hospice models of care. The Hospice agreed to sign up to the next phase of this study. This is an externally led research project by Claire Butler from the University of Kent and the hospices participating are anonymous.

- We assisted Dr Sivakumar Subramaniam formerly of Ellenor; with data for a Research Project that was published in the British Medical Journal:

  "Prognosis prediction with two calculations of Palliative Prognostic Index: further prospective validation in Hospice cancer patients with multicentre study" Ref: http://dx.doi.org/10.1136/bmjspcare-2017-001418

- The Hospice took part in NIHR Knowledge Mobilisation Research Study in collaboration with Marsha Dawkins, Research Fellow from King's College London.

  The study, undertaken with the inpatient and community teams, explored how individual teams were implementing and using outcome measures in practice. The aim of the study was to explore whether Learning Circles could enable effective knowledge sharing across teams within the organisation. A multidisciplinary Learning Circle was successfully established and maintained through monthly meetings being held on site. The collective knowledge and experience of participants within the Learning Circle was effectively harnessed and utilised to progress implementation of the Outcome Assessment and

Complexity Collaborative (OACC) suite of measures. Publications from this work are in draft.

- We have been taking part in a project led by York Health Economics Consortium: LoTeCc [Long Term Conditions in the Community]. The project is funded by NHS Health Education England. The Hospice is contributing to an economic case study of our dementia Clinical Nurse Specialist post to understand the economic benefits of the post. The piece of work is ongoing and will be complete later in 2018.

- Kate Heaps, participated in the Project Advisory Group for the Guide Care Study, based at Cicely Saunders Institute, King's College London. The final report is still pending.

- We continue to participate in the Holistic Project, led by Hospice UK. This is a project which examines Hospice led interventions to reduce hospital admissions/ support discharge from hospital. The research is not yet complete.

5.4 Quality Improvement and Innovation Goals agreed with Commissioners

There were no CQUINs identified in either contract we hold with local CCGs. We have many ideas about how we could improve services and are developing the commissioners' understanding of Hospice services, with the aim of negotiating some appropriate goals in the next round of contract negotiations.

5.5 Trustee Assurance

2017/18 was the first full year of the Hospice's new trustee assurance programme. Planned, managed and co-ordinated by the Quality & Safety Committee, the programme has two main objectives; to raise the profile of the Hospice's trustees and more importantly, to reinforce and strengthen the Hospice's board assurance framework, with a particular focus on the quality and safety of the services provided to our patients and their families.

During the year trustees visited all clinical and non-clinical areas, support services and back office departments. They spoke to approximately 40% of Hospice staff along with a smaller proportion of volunteers, patients and their families, shop customers and fund-raisers. These conversations were used to try to understand concerns and worries, to assess the extent to which the Hospice supports its staff and volunteers in delivering high quality, safe and sustainable services, and to test the robustness of the Hospice's board assurance framework in relation to the identification and mitigation of risk.

After each visit individual departmental reports were presented to the Quality & Safety Committee and to the Board. These reports included the highlights of the visits along with the trustees' concerns and recommendations. Remedial actions agreed with the Senior Management Team (SMT), were added to the quality improvement plan, the delivery of which is in turn, monitored by the Quality & Safety Committee. Relevant trustees also conducted follow up sessions in each area to explain their findings and recommendations to staff and volunteers. The Chief Executive and appropriate members of the SMT have also attended these sessions to explain and discuss the management responses to these findings.

A year one review has recently been completed, and it was concluded that trustees could take a high level of assurance from the first year of this programme, that the Hospice has the appropriate committee structure in place to allow senior staff to report their concerns to trustees as part of routine business, and just as importantly, that those senior staff have the confidence and professional responsibility to describe these situations as they really are, no matter how difficult

the situation might be. It was also good to note that many of the remedial actions identified were already on the SMT's agenda prior to the trustees' visits, and that a significant number of them had already been completed or were well on the way to completion.

The review also concluded that the objectives of the programme remained relevant and that year two would focus on the Hospice's volunteer workforce and on the views and feedback of our patients and their families.
Ruth Russell, Trustee and Chair of the Quality and Safety Committee

5.6 Feedback from partners

"The CCG works closely with Greenwich & Bexley Community Hospice, who provide end-of-life care services to patients requiring palliative care and bereavement services to families and carers. "Beyond this, the Hospice is a key player in the development of an Integrated Care System (ICS) in the borough. In November, the Hospice signed a Memorandum of Understanding (MoU) for the ICS, which sets out high level principles such as the values and commitments necessary from participating partners. The MoU will also be used to develop the governance and regulations to underpin the new integrated care model in the borough. Representatives from Greenwich & Bexley Community Hospice also attend a number of committees, steering groups and working groups such as the CCG's primary care development working group and a GP-led end-of-life care educational roundtable. Involvement in these fora creates a platform for regular stakeholder engagement between the CCG and the Hospice."
Theresa Osborne, NHS Bexley Clinical Commissioning Group Managing Director

"Greenwich & Bexley Community Hospice not only provides a remarkable and unique palliative and end of life service for our residents, it also plays an important role in being a contributor to the development of our health and community partnership, helping to make sure that health, social care and community services work and plan together. Kate Heaps has been an exemplary member of the partnership, freely offering her insights and expertise as well as the odd (and very appropriate) challenge! So Greenwich & Bexley Community Hospice is more than just a local hospice service; it is integral to and plays a leadership role in our local health and care system."
Stuart Rowbotham, Head of Adult Social Care and Health, London Borough of Bexley Council

"Bexley CCG works collaboratively with the Greenwich & Bexley Community Hospice at the clinical, educational and commissioning levels. At grassroots level, the Hospice supports the primary care teams to deliver quality end of life care to patients and their families in the community. The quarterly Bexley Clinical Roundtable for Palliative Care & Cancer and the GP Cancer Education Events are held at the Hospice. There is regular input from the Hospice team at the Roundtable meetings to keep the GPs and other stakeholders abreast of the end of life care service development and on education topics. There is a dialogue at the commissioning level to develop a strategy to meet the increasing end of life care needs for the population of Bexley. A close working relationship with the Hospice is key to good communication amongst the service providers and seamless quality care for the patients and their families".

Dr Winnie Kwan, Clinical Lead for EOLC & Cancer Bexley CCG, Macmillan GP, Senior Partner Crook Log Surgery

"Lewisham and Greenwich NHS Trust and the Hospice continue to work collaboratively on the Queen Elizabeth Hospital site to improve End of Life Care. The Specialist Palliative Care team are highly valued by the clinical teams and have a high profile within the Trust. They have been actively involved in the Trust's strategic aim to raise awareness of the 'Principles of Care for Dying patients'."

Jo Peck, Associate Director of Nursing, Lewisham and Greenwich NHS Trust and Julie Baker, Macmillan Lead Cancer Nurse, Lewisham and Greenwich NHS Trust

Greenwich & Bexley Community Hospice continues to work with Oxleas to provide excellent care to terminal patients across the boroughs. The Hospice supports Oxleas staff with regular training and support. Hospice staff are keen members of the end of life working group in Oxleas continuing to offer guidance and support on all matters

Maggie Grainger, Head of Nursing (Education and Development), Oxleas NHS Trust

Feedback was requested, but not received from Greenwich CCG/ LA.

5.7 Data Quality

During 2017/18 the Hospice was not required to submit records to the Secondary Uses Service for inclusion in the Hospital Episodes Statistics, which are included in the latest published data.

The National Minimum Dataset (MDS) is no longer collected by Hospice UK.

The Hospice has established a GDPR Project Group and is developing a GDPR action plan to ensure compliance with the General Data Protection Regulation (2016). As part of this project, we have begun implementing a new HR system to enable robust monitoring, deliver efficiencies and support compliance with GDPR.

5.8 Information Governance Toolkit Attainment Levels

The Hospice achieved level 2 of the NHS information Governance Toolkit.

5.9 Clinical Coding Error Rate

The Hospice was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission.

6. Challenges

The Hospice continued to face a number of challenges in 2017/18, many of which are ongoing and mostly not unique to this Hospice, and which we are seeking to address through our 3 year strategy/ quality improvement plan and ongoing dialogue with commissioning partners.

The biggest challenge relates to the increasing demand for specialist Hospice care with increasingly complexity of the people we serve, against a reducing financial envelope and challenges in recruiting staff.

This report outlines some of the ways that we are trying to address these issues, by working more efficiently, providing more tailored care according to level of complexity and need and trying new roles to deliver care and support. This alone will not be adequate to deal with this challenge and so we also continue to work with our commissioners, partners and other (charitable) funders to develop a case for investment, trying and evaluating new approaches to care to reach our growing beneficiary group.

We were particularly disappointed not to be able to secure an increase in our contract funding to support our successful advanced dementia project or the equally successful Immediate Home Support Service that we trialled in Bexley in 2016/17. Unfortunately, despite best endeavours, we have also experienced extreme delays in handing over of the lymphoedema service for Bexley, and are anxious to make sure this gets handed over to a more appropriate provider in 2018/19.

We continue to work in partnership with Lewisham and Greenwich NHS Trust to improve end of life care in the Queen Elizabeth Hospital, and will continue our work to develop a business case for a 7 day specialist palliative care service on this site.

We also continue to collaborate with St Christopher's Hospice to share resource, improve care and try to influence the SE London Sustainability and Transformation Partnership to support improvement and investment in palliative and end of life care services.

Although not specifically referenced in this report, our 3 year strategy is also seeking to address issues in reducing voluntary income, particularly in our retail division. This area is expanded in the Hospice strategy and 3 year plan.

7. Publications and Presentations

The Hospice submitted the following for the Hospice UK Conference in November 2017:

- **Supporting people and families at end of life to ensure they are in their preferred place of care.**
  McCarthy A, Heaps K, Devlin J

- **Improving the experience of people with advanced dementia at the end of life in Greenwich and Bexley Boroughs**
  McCarthy A, Heaps K, Devlin J, Morris L, Dewar S

- **Delivering an integrated end of life care service – is it sustainable six years on?**
  McCarthy A, Heaps K, Devlin J

8. Appendices

8.1 Joint Response: Greenwich and Bexley Healthwatch

Joint Healthwatch Response to Greenwich & Bexley Community Hospice 2017/18 Quality Account

Healthwatch welcome the opportunity to comment on the Hospice quality account and we are pleased to see how the Hospice is continuously improving and developing to meet the needs of the local population and extend its reach to a wider cohort.

We welcome the Hospice efforts to develop and retain its workforce and are pleased to see a reduction in the number of agency staff used, as this is a key aspect of continuity of care, thus improving quality of care.

We are also pleased to see the Hospice commitment and involvement with research and audits, as this will help to deliver evidence based practice and ensure high standards of care.

Healthwatch would like to take the opportunity to congratulate the Hospice as recipients of the Healthy Workplace Charter Mark and Best Business or Social Enterprise awards.

<u>Areas of success</u>
Healthwatch are pleased to see the proportion of people dying in their home who were previously under the Hospice's hospital team has increased from 27% to 31% and that the percentage of people dying in hospital continuing to decrease.

- We welcome the introduction of a Telephone Support Service to ensure patients are referred to the right service and level of support.

- Healthwatch are pleased to see the introduction of Holistic Needs Assessment for patients and encourage links with the voluntary sector and in particular with Community Connect in Bexley.

- We welcome the increased efforts to obtain feedback from service users and are pleased to see an increase in the number of respondents. However, we felt the table was somewhat unclear and propose that some comments may be added to provide clarity and the Hospice reflection on the feedback.

- Healthwatch were pleased to read through the report's examples as the Hospice being a place for celebrations and how this contributes to a positive experience for patients and their families.

- We were pleased to read the case studies from a complaint and how the Hospice managed the complaint and supported the family throughout this process.

- Healthwatch welcome the Compassionate Neighbours initiative to extend its reach to harder to reach groups.

<u>Areas for improvement</u>
The Hospice reflects on the lack of completion of demographic data and we note that the percentage of non-completion for ethnicity recording has increased to 17% from previous year. We encourage the Hospice to continue to ensure that demographic data is captured to accurately reflect the patient population.

- We note that the Hospice was left short-staffed in several areas during a period of time, which resulted in fewer patients being reached and being offered the care available to them. We encourage the Hospice to ensure contingency plans are in place to cover staff shortages and retirement in particular.

- We note that the Immediate Home Support Service in Bexley and the Lymphoedema service for Greenwich residents is no longer commissioned and express our regret regards to this. We have in the past received calls from residents expressing concerns in not being able to access the Lymphoedema service.

- We note that transport for the Day Hospice continues to be a challenge and welcome any improvements to this services so ensure patients can access the care they need.

8.2 Hospice response to Healthwatch feedback

As a result of the feedback received from Healthwatch, the Hospice has added some commentary to the table at 2.3 as well as clarifying points raised at 2.2. This includes clarification of the rationale behind the closure/ transfer of the lymphoedema service from the Hospice.

We will continue to ensure that people with lymphoedema are signposted to appropriate support via primary care and we will work with commissioners to ensure that there is sufficient capacity and responsiveness to ensure that people at the end of life get the community care which adequately meets their needs.