People ask me "What are the carers like?" and my reply is "just little angels." I couldn’t have asked for more

Wife of GCP Patient
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1. Chief Executive’s Statement

Greenwich & Bexley Community Hospice continues to seek to improve and extend its services to meet the needs of dying people across the whole community and it is my pleasure to present our Quality Account for 2014/15 which documents some of the progress we have made as well as some of the challenges we face.

As a result of our involvement in the ‘whole systems’ work to improve resilience in the way we manage increased need in the winter months, we have reviewed our admissions processes for our inpatient unit, this reduced the length of time that people who needed a bed waited and improved access to our specialist beds at weekends. Our community services continue to respond to growing need, however recruitment difficulties reduced the number of people we were able to support. We continued to sustain the trend for an increasing proportion of people being supported in their own homes, achieving home or hospice as the place of death for 77% of people. As the general population ages, we continue to see an increase in the age profile of the patients receiving our care, particularly in Hospital, in 2014 we introduced the new role of a Nurse Consultant, who is focusing on improving care for the ‘older old’.

The Hospice is registered with the Care Quality Commission, no inspections took place in 2014/15.

The ongoing challenging financial climate is a concern for the Hospice and we are implementing efficiencies wherever this is possible to ensure we sustain levels of service where we can. Going forwards further expansion will be unachievable without additional investment from our commissioners and additional voluntary funding.

The planned development of the Hospice building began in January 2014, and we have developed plans for when the building is completed in June 2015. The development of Hospice- ACT (Assessment and Coordination Team) being the first of these developments, for implementation at the end of June 2015. We are extremely excited about the opportunities that our building expansion will provide to help us to reach more people who need our care and support as well as to provide training professionals and information to the public about Hospice care.

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.
2. Priorities for Improvement and Statements of Assurance from the Board

2.1 Priorities for Improvement 2015 – 2016

The following key Priorities for Improvement 2015/16 have been identified. These cover the three quality domains of Clinical Effectiveness, Patient Experience and Patient Safety:

**Improvement Priority 1: Access to Hospice Services**

**Why this was chosen as a Priority**
This was an Improvement Priority for 2013-14 but the Hospice strategy has identified this as a key area for development over the next 3-5 years and as such this is a long term strategic goal. (See page 10 for progress to date).

**What does the Access to Hospice Services Priority mean?**
The Hospice has developed its services over recent years to ensure that care is provided across the patient pathway in all settings. Opportunities to provide integrated care in hospital, at home or in a care home and in the Hospice building have already helped to improve access for people regardless of their diagnosis, age, ethnicity, preferred place of care etc. However the Hospice recognises that we still have a long way to go in providing access to Hospice services for all who need it.

GBCH has identified that as part of its response to the ever increasing need for Palliative and End of Life Care (EoLC) for people who may not have traditionally accessed Hospice care, it needs to redesign referral and assessment processes to ensure a smooth and responsive service is provided to meet the needs of each individual in the most appropriate way.

As part of this priority we will continue to expand our approach to ambulatory care and rehabilitation making use of the new “community hub”, released capacity in the day hospice facilities and our new rehabilitation gym. We will also continue to extend our links and partnerships with other organisations to ensure an appropriate response to people with specific needs e.g. dementia.

In 2015/16 we will work with others in the health and social care system including patients and the public, striving to lead the necessary changes to ensure that resources are used as effectively and efficiently as possible and that all local people with end of life care needs are identified, their care is planned and they are supported to ensure their preferences and needs are met.
What are the plans for this Priority?

- To continue to develop and implement our ambulatory care and rehabilitation strategy, making best use of the facilities provided in the new community hub, rehabilitation gym and additional capacity released within the day hospice. This will include expansion of outpatient clinics, development of rehabilitation and exercise groups and development of more opportunities to combat social isolation.

- To implement our plans for the introduction of a Hospice Assessment and Coordination Team (GBCH-ACT) which will reduce waiting times, ensure people are involved in development of their care plan and that resources are utilised appropriately to meet the needs of the local population. This will include introduction of a Triage Nurse and Initial Response Nurse to provide timely assessment and greater usage of the central register of people with an end of life care need (using the London-wide electronic palliative care coordination system Coordinate My Care).

- To work with our commissioners, partners and local people to develop our services; utilising our limited resources to meet the growing need for Hospice care in Greenwich and Bexley boroughs. Our emerging model of care will take account of local and national strategy and policy and make use of our expertise and specialist skills to provide good quality seamless care as well as leadership, training and support in end of life care.

- To continue to develop our workforce and services to meet increasingly diverse need, including providing dementia awareness training across the whole organisation and working with Oxleas NHS Foundation Trust to develop the care and support available for people with dementia and learning difficulties who have palliative/end of life care needs.

- To continue to improve and enhance the delivery of integrated end of life care across both boroughs and to ensure that people who are in hospital are enabled to die in their place of choice by improving and making more timely transitions between care settings.

Having developed new facilities on the Hospice site including a purpose built rehabilitation gym, a new education and training facility and a coordination centre, we will begin to exploit these improvements in 2015/16.

Progress against the plan to date:

- We published an evaluation of the Volunteer led Advance Care Planning Project in 2014/15 and embedded this into our care coordination service to ensure sustainability beyond the initial funding from Comic Relief and LB Bexley. Evaluation of the Hospice Neighbours service continues alongside service delivery, reporting to LB Bexley.

- A review of ambulatory care services was completed in 2014/15 and changes are in the process of implementation including a new outpatient clinic operational from December 2014. New volunteer role descriptions are currently in development and a new training programme for “patient facing” volunteers has been commenced.
• The Hospice has recently submitted a bid to develop rehabilitation by working with local partners to develop our use of volunteers in this area
• The Hospice’s “Capital Build Project” will be completed by June 2015 when we will begin occupation and implementation of planned changes to services. The staffing and structure of the Hospice’s new “Assessment and Coordination Team” has been agreed and the operational policy for the new service is being finalised, with recruitment underway, due for implementation in June - July 2015
• We have commenced Dementia awareness training at the Hospice and are working with the Health Innovation Network to deliver training using “Barbara’s Story” in care homes. We have recently submitted a bid for additional funding to jump start our joint work with Oxleas to improve end of life care for local people with dementia
• We continue to work with our commissioners to improve services and target resources, having secured additional resource through winter pressures funding in the winter of 2014/15 to increase inpatient beds from 13 to 17. We expect to have a new contract in place with NHS Greenwich from August 2015
• The Hospice continues to work with the Greenwich Prison’s Cluster to ensure that people in custody have appropriate access to end of life care. The strategy for end of life care in the prisons has been agreed and finalised

How progress against the plan will be measured
Progress against this plan will be measured by comparing previous activity with activity from 2015/16. This will include monitoring the diagnosis and demographics of the people accessing our services, an increase in the number of people on the electronic palliative care coordination system, improved response times, numbers of patient facing volunteers, access to training and by patient, family and referrer feedback.

How progress will be reported
Progress on this priority will be regularly reported to Clinical Leads meetings, the Quality & Safety Committee, relevant project boards and to the Board and Trustees.

In addition, formal written reports will be submitted to commissioners and grant funding bodies as appropriate.
Improvement Priority 2: MDT Working

What is Multi Disciplinary Team Working (MDT)?
MDT working aims to ensure that people accessing Hospice services receive the best possible care. The MDT approach enables the medical, nursing and allied health professionals involved in each person’s care to meet to discuss, plan and evaluate the person’s care. Each patient, and where appropriate, the family are also involved in the planning process in order to ensure that care is person centred and priorities are set according to the person’s wishes.

Why this was chosen as a Priority
At present the Hospice holds five multidisciplinary meetings (MDM) each week, these take place in silos and are dependent on the place of care of each person being discussed. These separate departmental MDMs do not fully facilitate integrated care or MDT working and it has been proposed that a new model should be developed to promote improved communication across teams; providing a more streamlined approach across geographical areas and supporting integrated working. These changes will ensure that the patient is in the centre of the decision making process and that all the teams who are involved in the patients care are able to input into this.

What are the plans for this Priority?
- To audit current MDM practice and identify the strengths and weaknesses of the current model
- To develop a new model for MDMs which better meets the needs of patients across the care pathway, the needs of Hospice and external staff, which promotes learning and developments and which meets the guidance outlined in National Standards (Peer Review)
- To develop clear guidance for the new model of MDM working so that it is consistently applied across the organisation

How progress against the plan will be measured
- Once introduced and the process in place, it will be evaluated after 3 months questionnaires will be given to the staff who attend, this feedback will be reviewed.
- An audit of the new format will be carried out in order to review the effectiveness of the process. The results will be compared with the audits carried out on the old format
- Any changes that are identified will be put in place

How progress will be reported
The progress of this plan will be brought to Clinical Leads to facilitate discussion of effectiveness; this will include the outcomes from feedback and audit results.

A report about the new model will be brought to the Quality and Safety Committee.

Updates will be shared within team meetings
**Improvement Priority 3: Using our limited resources to provide flexible models of care and support**

**Why this was chosen as a Priority**
As a result of increasing pressure on Hospice resources and involvement in a variety of initiatives including “winter pressures”, introduction of a Hospice Nurse Consultant, re-procurement of the Greenwich Contract, a joint bid to combat social isolation and a bid to provide day care services to older frail people; the Hospice senior management team and clinical leads have been engaged in a review of Hospice services so that we are able to utilise our limited resource to meet increasing demand in the future. A number of changes have already occurred as a result of this increased focus, however there is more work to do.

**What does Flexible Models of Care and Support Priority Mean?**
This priority relates to the way that we use our limited resources to respond to requests for support; whether this is through embedding and sustaining improvements already made; for example sustaining the increase in overall occupancy, reduction in waiting times and maintaining seven day a week admissions in the inpatient unit; or through driving forwards new improvements e.g. co-location of the night District Nursing Team for Bexley in the Hospice with the Greenwich Rapid Response Service.

By introduction of GBCH – ACT (see priority 1) we will tailor the level of support that is provided to people according to their level of need; we will start to use the categories of need highlighted in the evolving national work on data and outcomes for palliative care to inform the development of this model, including expansion of ambulatory care and outpatients clinics and by working even more closely with staff in primary care.

**What are the plans for this Priority?**
- To secure funding from NHS to maintain our inpatient unit at 17 beds and to sustain seven day admissions to the unit
- To collocate the Bexley Night District Nursing and Greenwich Rapid Response Service at the Hospice and to evaluate the impact of this on the quality of patient care, costs and responsiveness of service
- To develop an additional two outpatient clinics based within primary care, one in each borough
- To work with the Macmillan Facilitator in Greenwich to refine the model for non-specialist review of people registered as at the end of life, providing training and support to primary care and empowering generic staff to manage ‘stable’ patients at home with minimal specialist input
- As part of our involvement in the National Pilot Project for a new Specialist Palliative Care Dataset and to better understand our casemix and patient population, to introduce the following measures:
  - ‘Phase of Illness’ and Australian Karnofsky Performance Status
  - Integrated Palliative Outcomes Score and ‘Views on Care’
- To introduce the use of ACP volunteers in at least 2 GP practices
• To develop our rehabilitation programme and to recruit trained rehabilitation volunteers to support this development
• To finalise a new model of Day Hospice ensuring a robust assessment and care planning process as well as a formal review process

How progress against the plan will be measured
Progress against this plan will be monitored by collecting activity data, implementation of the specialist palliative care dataset and evaluation of new service models.

How progress will be reported
Progress on this priority will be regularly reported to Clinical Leads meetings, the Quality & Safety Committee, relevant project boards and to the Board and Trustees.

In addition, formal written reports will be submitted to commissioners and grant funding bodies as appropriate.
2.2 Priorities for Improvement 2014 – 2015

The key Improvement Priorities for 2014/15 were:

### Progress against Improvement Priority 1: Access to Hospice Services
(Ongoing priority, see improvement Priority 1 on page 4)

#### What does the Access to Hospice Services Priority mean?

The Hospice has developed its services over recent years to ensure that care is provided across patient pathways in a variety of settings. Opportunities to provide integrated care in hospital, at home or in a care home and in the Hospice building have already helped to improve accessibility for people regardless of their diagnosis, age, ethnicity, preferred place of care etc. However the Hospice recognises that we still have a long way to go in providing access to Hospice services for all who need it.

GBCH has identified that, as part of its response to the ever increasing need for Palliative and End of Life Care (EoLC) for people who may not have traditionally accessed these services, it wishes to redesign referral pathways, integrating existing elements of service further and developing new areas of provision.

As part of this, the concept of the Hospice as "a hub" will be developed. This enables the physical space to be used not only by patients, families and staff, but also to be a "hub" for the local community. For example, the Hospice may provide a space for socialising, rehabilitation, volunteering, receiving new kinds of care and support and training and education. By opening up the Hospice to other members of the community, we aim to challenge people’s perceptions of who and what hospices are there for, opening up the doors to support more people throughout their lives.

#### What was planned/achieved

- We published an evaluation of the Volunteer led Advance Care Planning Project in 2014/15 and embedded this into our care coordination service to ensure sustainability beyond the initial funding from Comic Relief and LB Bexley. Evaluation of the Hospice Neighbours service continues alongside service delivery, reporting to LB Bexley
- A review of ambulatory care services was completed in 2014/15 and changes are in the process of implementation including a new outpatient clinic operational from December 2014. New volunteer role descriptions are currently in development and a new training programme for “patient facing” volunteers has been commenced
- The Hospice’s “Capital Build Project” will be completed by June 2015 when we will begin occupation and implementation of planned changes to services. The staffing and structure of the Hospice’s new “Assessment and Coordination Team” has been agreed and the operational policy for the new service is being finalised, with recruitment underway, due for implementation in June - July 2015
- We have commenced Dementia awareness training at the Hospice and are working with the Health Innovation Network to deliver training using
“Barbara’s Story” in care homes. We are preparing to submit a bid for additional funding to jump start our joint work with Oxleas to improve end of life care for local people with dementia

- We continue to work with our commissioners to improve services and target resources, having secured additional resource through winter pressures funding in the winter of 2014/15 to increase our inpatient beds from 13 to 17. We expect to have a new contract in place with NHS Greenwich from August 2015.

- The Hospice continues to work with the Greenwich Prison’s Cluster to ensure that people in custody have appropriate access to end of life care. The strategy for end of life care in the prisons has been agreed and finalised.

Benefits/outcomes of this Priority

- By developing new approaches to care, particularly outpatient and ambulatory care services, our staff can reduce travelling time and reach more patients within their working day; this has already been achieved in the Hospice outpatient clinic, enabling an Associate Specialist to review more patients in the clinic setting.

- Initiatives such as our gentle exercise programme based in day hospice and a recent gentleman’s day have been extremely well evaluated.

- The changes we have made in the way we manage admission in the inpatient unit have resulted in avoided hospital admissions in the out of hours period as well as an increase in occupancy and reduction in waiting times.

- Our work in the hospital has ensured that we have had a regular presence at the Hospital ‘silver command’ meetings, helping to clarify the role of the Hospice and to smooth transition for people who are transferring to GBCH.

- We have continued to increase our education provision (see progress on priority 3 – page 15).

- Our work with the prison resulted in a successful anticipated death in custody with the staff being supported and the patient and his partner achieving their preferences.

Any outstanding areas to be addressed in 2015/16

This priority is an ongoing area for development and the ongoing plan is outlined on page 4.
**Progress against Improvement Priority 2: Embed Clinical Research and Audit**

**What is Clinical Research and Audit?**
Hospice engagement and understanding of research at different levels is necessary to ensure evidence based practice. Clinical audit provides assurance of compliance with best practice standards, with the aim of improving quality of care and patient outcomes.

**What was planned/ achieved?**

**Research**
The Hospice has made significant progress in becoming a “Research Active Hospice”.

Level 1: Research awareness of all professional staff. The Hospice has run a series of educational sessions on qualitative and quantitative research. There is also regular circulation of palliative care journals and the development of a multi-professional journal club.

Level 2: Engagement in research generated by others. This year the Hospice has established a Research Management and Governance Group. The Hospice Research Team has also been trained in Good Clinical Practice in order to be able to actively participate in research studies. This has enabled collaboration with the Cicely Saunders Institute to be developed and the Hospice has become a recruitment site for the multicentre iPOS validation study. Dr Branford also maintains her research collaboration with Royal Marsden Hospital, and has recently published a paper in the Journal of Pain and Symptom Management from this work.

**Audit**
Clinical audit activity at the Hospice has been reorganised in order to ensure appropriate prioritisation and quality of local audits.

Detail of Hospice local audits is outlined at 2.3.4 and involvement in research studies at 2.3.5

**Benefits/ outcomes of this priority**
By becoming a research active hospice we aim to create a culture of inquiry to promote evidence based treatment and care. We are working to build expertise in the critical appraisal of research in order to apply appropriate advancements in care to practice. Staff have attended study days and events at the Cicely Saunders Institute to develop understanding and skills.

By participating in research we hope to contribute to the evidence base e.g. by helping to recruit to the iPOS Validation study we have contributed to the development of outcome measures specific for the palliative care population.

**Outstanding areas for 2015/16**
To develop ongoing collaboration with palliative care research centres to further this work.
Progress against Improvement Priority 3: Workforce, Education and Training

What is the Workforce, Education and Training Priority?
Maintaining a diverse, competent and motivated workforce is vital to the future of Greenwich & Bexley Community Hospice. Our Staff and Volunteers are our most important asset and it is important that we plan strategically for future challenges that face us if we are to continue to support our local population.

The Hospice also has an important role in supporting and developing the skills of staff working for other organisations so that they can provide excellent end of life care.

What was planned/ achieved?

We have begun the implementation of a workforce strategy for the Hospice which provides opportunities for growth for existing staff and volunteers as well as developing strategies to improve recruitment and developing new creative roles to ensure care is delivered compassionately, creatively and efficiently.

With regard to formal education delivery, the Hospice benefitted from Continuing Professional Development Funding from Health Education South London for a second year and this was directed towards externally commissioned courses as well as internal staff development. We continue to have a particular focus on advancing the role of our senior nurses including developing advanced assessment skills. Several Nurses have joined the Community Specialist Palliative Care Team this year in development roles, and have progressed through to the full Clinical Nurse Specialist Role.

We continue to develop mechanisms for staff support and in 2014/15 we introduced Schwartz© Rounds. In addition we began to review our clinical supervision strategy, to be finalised in 2015/16.

In 2014/15 the Hospice continued to develop its mandatory training programme and reporting and now reports a ‘dashboard’ to the Quality and Safety Committee each month.

In 2015, the programme has been reviewed to take account of the changing needs and priorities of the Hospice and changes in best practice guidance. In particular, safeguarding training has been reviewed to include PREVENT training and is now provided across the entire organisation (clinical and non-clinical). In addition, all staff will receive dementia awareness training in 2015/16.
Example of Mandatory Training Monthly Dashboard

### Agenda Item 5.3

**Quality & Safety Committee – February 2015**

Q3 (November – January) Mandatory Training Dashboard

<table>
<thead>
<tr>
<th>Mandatory Training / Clinical</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb Forecast</th>
<th>Compliance</th>
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**New mandatory training sessions**

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<th>Dec</th>
<th>Jan</th>
<th>Feb Forecast</th>
<th>Compliance</th>
<th>Yearly Target</th>
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Compliance of 80% and above has been reached on the majority of training topics. The areas where numbers are lower are new to the mandatory training and are steadily increasing, with a plan to achieve the target of 80% by clear deadlines which have been discussed in the Quality and Safety Committee.

The Annual Report of the Education and Practice Development Team is published each year and demonstrates the reach and impact of their work, both internally and externally. This report is presented to the Hospice’s Clinical Leads and the Quality and Safety Committee.

In 2014/15 we had our first ‘return to practice’ nurse on placement; the placement was extremely well evaluated and we hope that there will be opportunity to have more. We are also exploring currently additional placements for paramedics. In 2015/16 we aim to continue to develop our workforce so that we are less reliant on bank and agency staff, we also intend to develop a VTS placement for Bexley GPs to mirror the one which we provide in Greenwich.

In addition, through our engagement in the South London Hospices Collaborative we were able to participate in the following joint projects:
1. Volunteers Project: a project focusing on streamlining the training and education we deliver to volunteers. Patient-facing volunteers are the main focus and a training package has been developed, piloted and will be rolled out to more volunteers next year¹.

2. QELCA: Quality End of Life Care for All course. This course is aimed at generic (non specialist palliative care) staff working in other settings. The Hospice has delivered this to health care professionals in local prisons (HMP Belmarsh & HMP Thameside) which have helped us to improve the understanding of Hospice care and support (thus improving access) as well as the quality of care for people in prison with end of life care needs. The course has been successfully evaluated and patients have now been enabled to be cared for in the prison until the very end of their lives.

3. Assistant Practitioner Project: The Hospice has taken an active lead on developing, implementing and delivering this project in collaboration with Croydon College. Learners on the programme will complete the City & Guilds accredited Level 5 Diploma for Assistant Practitioners in Health and Social Care. A robust curriculum has been devised to maximise learning and development of Health Care Assistants wanting to work at an Assistant Practitioner level. This course has learners from all settings, including from the Hospice and represents an important development in future for our workforce. We are currently planning where (AfC) band 4 roles can be introduced into the Hospice.

4. Care Certificate: The Hospice is currently piloting the Care Certificate, a new qualification introduced post the Cavendish Report. As of April 2015, all staff new to care are expected to complete the Care Certificate as part of their induction, the Care Certificate replaces the national Common Core Standards. Alongside the delivery of the Care Certificate we are also training a number of assessors so that we are better equipped for the future to assess, train and develop new staff.

We continue to develop training programmes and development opportunities for external staff in line with the End of Life Care (EoLC) education and training strategy for South London. Our 2014/15 prospectus included:

- Introduction to End of Life Care Course for Registered Nurses (3 days)
- Introduction to Dementia and Palliative Care (Study Day)
- Introduction to End of Life Care Course for Healthcare Assistants (2 days)
- Leading an Empowered Organisation (LEO course)
- Advance Care Planning Study Day
- Bexley Social Services Bespoke Study Day- Advanced Dementia and Palliative Care Study Day

Hospice clinical staff continue to be involved in delivering education in external organisations including King’s College London and the University of Greenwich as well as to care providers such as local care homes, Oxleas NHS Foundation Trust and Queen Elizabeth Hospital.

¹ Subject to further funding
Any outstanding areas to be addressed in 2015/16

Non-medical prescribing courses were not attended due to staffing issues and budgetary reasons; this will be a focus for the forthcoming year.

We will complete a review of and finalise the new clinical supervision arrangements in 2015/16.

We will review our recruitment strategies and review agency usage so as to reduce costs and maintain/improve quality.

We aim to work with GP colleagues to secure a Hospice based GP VTS rotation for Bexley GPs.
2.3 Outstanding Priorities from 2013/14

Progress against 2013/14 Improvement Priority 1: Development of a Quality and Governance Dashboard
Any outstanding areas addressed in 2014/15
The monthly commissioner reports to NHS Greenwich and NHS Bexley are now reviewed each quarter by the Quality & Safety Committee, as part of the annual reporting schedule.

Progress against Improvement Priority 2: Launch a Patient & Carer Survey Programme
Any outstanding areas to be addressed in 2014/15
The NHS Friends and Family Test (FFT) is an important opportunity for service users to provide feedback on the services that provide their care and treatment.

The survey, introduced in 2013 asks patients whether they would recommend services to their friends and family if they needed similar care or treatment. This quick feedback on the quality of the care patients receive, gives us a better understanding of the needs of patients, enabling improvements.

FFT has been rolled out to other Hospice services (Lymphoedema, Community, Social Work, GCP and Rehabilitation). Due to the nature of some of the services and also the settings for a number of these services, it is not practical to request FFT’s to be completed after each visit, session or contact. Twice a year, on nominated weeks approximately six months apart, services request FFT’s to be completed by all patients and clients seen or visited in those weeks. The following is a breakdown of FFT Responses carried out in October 2014.

<table>
<thead>
<tr>
<th>Area</th>
<th>Extremely Likely</th>
<th>Likely</th>
<th>Number of people eligible to respond</th>
<th>Number of responses for each area</th>
<th>Response rate for each area</th>
<th>FFT Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gentleman’s Day</td>
<td>13</td>
<td>0</td>
<td>24</td>
<td>13</td>
<td>54%</td>
<td>100.0</td>
</tr>
<tr>
<td>Stepping Stones</td>
<td>15</td>
<td>1</td>
<td>50</td>
<td>16</td>
<td>32%</td>
<td>93.8</td>
</tr>
<tr>
<td>Lymphoedema</td>
<td>12</td>
<td>2</td>
<td>21</td>
<td>14</td>
<td>67%</td>
<td>85.7</td>
</tr>
<tr>
<td>Social Work</td>
<td>19</td>
<td>0</td>
<td>19</td>
<td>19</td>
<td>100%</td>
<td>100</td>
</tr>
<tr>
<td>Greenwich Care Partnership</td>
<td>4</td>
<td>0</td>
<td>8</td>
<td>4</td>
<td>50%</td>
<td>100</td>
</tr>
</tbody>
</table>

Progress against Improvement Priority 3: Access to Hospice Service
(Ongoing priority, see Improvement Priority 1 on page 4)
2.4 Statement of Assurance from the Board

The following are a series of statements that all providers must include in their Quality Account. Many of these statements are not directly applicable to specialist palliative care providers.

2.4.1 Review of Services
During 1st April 2014 to 31st March 2015, The Hospice provided the following services:

- Inpatient Care
- Day Hospice Services
- Specialist Palliative Care Community Services in Greenwich and Bexley Boroughs
- Specialist Palliative Care Team at Queen Elizabeth Hospital
- “Greenwich Care Partnership”
- Rehabilitation Team
- Lymphoedema Treatment and Care Service
- Psychological Care Service (including the Telephone Bereavement Service)
- Chaplaincy
- Social Services
- Education and Training Team
- Care Homes Support Team
- Advance Care Planning Service
- Befriending Service

The Hospice currently shares its Senior Medical on call rota with Ellenor, a Specialist Palliative Care Service based in Kent.

The Hospice has reviewed all the data available to them on the quality of care in all its services.

2.4.2 Income Generated
The income generated by the NHS services reviewed in 2014/15 represents 100% of the total income generated from the provision of NHS services by GBCH for 2014/15. The income generated from the NHS represented 44% (unaudited) of the overall cost of running these services.

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

2.4.3 Participation in National Clinical Audits
During 2014/15, the Hospice was ineligible to participate in any national clinical audits or national confidential enquiries.
### 2.4.4 Participation in Local Audits

The following audits were carried out during 2014/15:

<table>
<thead>
<tr>
<th>Subject Matter</th>
<th>Outcomes of Audit</th>
<th>Follow-up Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountable Officer Audit</td>
<td>Annual audit of Controlled Drugs and non Controlled Drugs processes and policies. High level of compliance recorded.</td>
<td>Action plan drawn up for highlighted areas, progress reported at Quality &amp; Safety Committee meetings.</td>
</tr>
<tr>
<td>Trustees Inspections Programme</td>
<td>Schedule of unannounced inspections covering the CQC Essential standards of quality and safety outcomes.</td>
<td>Reports drafted and action list updated after each inspection and reviewed at Quality &amp; Safety Committee and Board.</td>
</tr>
<tr>
<td>Opioid prescription audit</td>
<td>Excellent overall compliance with local and national prescription guidelines.</td>
<td>Re-audit to be carried out in 2015/16.</td>
</tr>
<tr>
<td>Transfer of patients out of the hospice to acute care</td>
<td>This is a 3 year case series. Demonstrated senior led transfer decisions, multiple reasons due to unpredicted and predictable deterioration in condition unable to be addressed at hospice, isolated occasion of patient preference to be managed in hospital.</td>
<td>Continue to collate information for case series in 2015/16.</td>
</tr>
<tr>
<td>Audit of antibiotic prescribing</td>
<td>Microbiologist advice sought appropriately. Improvements however may be made in choice of antibiotic and length of course prescribed. New guidelines have been developed that are tailored to the hospice setting.</td>
<td>Implementation of locally devised antibiotic prescribing guidelines, and re-audit in 2015/16.</td>
</tr>
<tr>
<td>DNACPR documentation audit</td>
<td>Resuscitation Council DNACPR form introduced in Jan 2014. Audit of use showed very good documentation of decision making including discussions with patient and family.</td>
<td>Regular re-audit and review 2015/16.</td>
</tr>
<tr>
<td>Infection Control Annual Audit Programme</td>
<td>Agreed schedule defining Infection Control areas to be audited and frequency of audits.</td>
<td>Findings reported and reviewed quarterly at Quality &amp; Safety Committee meetings.</td>
</tr>
<tr>
<td>Unannounced Hygiene Inspection</td>
<td>Audits performed by Lead for Infection Control and a Trustee on a regular basis.</td>
<td>Action List updated after every audit and reviewed at Quality &amp; Safety Committee meetings.</td>
</tr>
<tr>
<td>Syringe pump audit</td>
<td>Quarterly audit introduced by ward sister. Results show good practice.</td>
<td>Quarterly re-audit planned.</td>
</tr>
</tbody>
</table>
### Subject Matter

<table>
<thead>
<tr>
<th>Outcomes of Audit</th>
<th>Follow-up Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care of the Dying Audit</td>
<td>EPR to be reviewed and re-audit selected items after an interval.</td>
</tr>
<tr>
<td>Used the same standards as the National Care of the Dying Audit. Results showed good overall documentation, however highlighted the need to document more clearly assessment of nutrition and hydration for these patients.</td>
<td></td>
</tr>
<tr>
<td>Nutritional Assessment Tool Audit</td>
<td>Tool is in the process of being developed.</td>
</tr>
<tr>
<td>Audit performed to assess uptake in use of the tool, and gauge staff opinion. Results showed that there was room for improvement in the regular use of the tool for assessments.</td>
<td></td>
</tr>
</tbody>
</table>

### 2.4.5 Research

The Hospice is currently participating in the following research projects:

**National Institute for Health Research (NIHR) Collaboration for Applied Health Research and Care (CLAHRC) South London – Palliative and End of Life Care**

The Hospice has registered interest in the South London CLAHRC.

**iPOS Validation Study**

The Hospice in-patient unit was open as a recruitment site for phase II of The iPOS Validation Study in September 2014 – January 2015. This multicentre study lead by the Cicely Saunders Institute, Kings College involves both patients and staff to test the validity and reliability of this updated outcome measure. The results of this study are now being analysed and the King’s team will be presenting their findings at the hospice in the near future.

**Assessment of accuracy of prognosis prediction by the Palliative Prognostic Index (PPI): a prospective multi-centre study.** Could the accuracy of prognosis prediction by PPI be improved by two assessments and could the rate of change of PPI score be used to prognosticate better?

This study has been completed and the results presented at the European Association for Palliative Care Conference in Copenhagen, May 2015.

**Exploring patient perception of treatment success and benefit in self-management of breast cancer-related arm swelling (lymphoedema)**

This project has now been completed with the hospice acting as the primary recruitment site.

### 2.4.6 Quality Improvement and Innovation Goals Agreed with our Commissioners

Hospice NHS income in 2014/15 was partly conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation (CQUIN) payment framework.

The agreed Bexley additional payment related to completion of Friends and Family Test
2.4.7 What Others Say about Greenwich & Bexley Community Hospice

The Hospice is required to register with the Care Quality Commission and its current registration status is that we are registered to carry out the following legally regulated activities:

- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

The Care Quality Commission has not taken any enforcement action against the Hospice during 2014/15.

Recent feedback from partners is shown below:

‘Having the support and guidance available for the Care Homes Team has helped us hugely to ensure our dying residents are looked after well and the team have ensured that we (the staff) feel more comfortable with looking after our residents until the very end.’ Groveland Park Care Home, Bexley

‘The support from the Advancing Nurse Practitioner has enabled us to prepare for our residents’ end of life care much better. We feel much better equipped to deal with this very important event...... Due to the training and education provided we are now able to look after our residents but also their families better. We ensure that the care doesn’t stop at point of the resident dying. Care after death is now a very important part of the care we deliver to families’ Adelaide Care Home, Bexley.

‘When we discharge patients form the Royal Marsden Hospital our patients are always a little apprehensive. The minute they meet the team from the Greenwich and Bexley Community Hospice, their fears are allayed. The hospice and the home support are unmatched. Each patient is cared for as an individual, and together with their family and carers, they are supported night and day. At a time when patients are at their most vulnerable, the Greenwich and Bexley Community Hospice provides specialist pain and symptom control as well as high quality, compassionate care’ Dr Julia Riley, Royal Marsden Hospital

‘GBCH staff are fully engaged in delivering training both in-house and within other organisations. The visit team noted in addition to this that the new education centre facilities being built will enhance teaching opportunities for the hospice and will enhance this stream of income generation.

Learners highlighted that team work within GBCH is very good and they work with all members of the multi professional team which they found very beneficial. The learners felt empowered to discuss their training with the education team and highlight any areas for improvement.’ Susan Aitkenhead, Project Lead - on behalf of Health Education South London, Assuring Quality in Practice Placements Report.
2.4.8 Data Quality
During 2014/15, the Hospice did not submit records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

In accordance with our contract with Local Commissioners, the Hospice submits a National Minimum Dataset (MDS) annual return to the National Council for Palliative Care (see section 3).

2.4.9 Information Governance Toolkit Attainment Levels
The Hospice achieved level 2 of the NHS Information Governance Toolkit. The Hospice achieved an N3 connection in Quarter 3 of 2014/15.

2.4.10 Clinical Coding Error Rate
The Hospice was not subject to the Payment by Results clinical coding audit during 2013/14 by the Audit Commission.

3. Review of Quality Performance
The Hospice has chosen to present a number of key quality indicators to demonstrate the level of care that the Hospice services provide:

3.1 Comparison with National Minimum Data Set
Comparison with the National Minimum Data Set (MDS) for Palliative Care, provide a national and local context to Hospice performance over time.

The most recently published National Minimum Data Set for Palliative Care covers 2012/13. Data for the Hospice for 2013/14 has been collated but currently there is no comparative National MDS data available.

The Hospice has benchmarked data reports for 2014/15 under the following headings:
- Inpatients
- Day Care
- Home Care / Hospice at Home
- Hospital Support Team
- Bereavement Support
- Outpatients

The Hospice has been chosen to participate in a National Pilot project for a new Specialist Palliative Care Minimum Data Set (led by Public Health England) in 2015/16.
3.1.1 *Inpatients*

MDS data for Inpatients is given in Table 1.

Based upon our return, GBCH was included in the Medium category (between 11 and 17 beds).

Nationally, data was received from 45 Medium units. For London, data was received from 10 units.

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>New Patients</td>
<td>295</td>
<td>281</td>
<td>309</td>
<td>320</td>
<td>225</td>
<td>328</td>
</tr>
<tr>
<td>% New Patients</td>
<td>94.8</td>
<td>93.7</td>
<td>92.8</td>
<td>92.8</td>
<td>89.9</td>
<td>93.4</td>
</tr>
<tr>
<td>% New Patients with Ethnicity Recorded</td>
<td>92.8</td>
<td>91.0</td>
<td>93.9</td>
<td>88.8</td>
<td>95.8</td>
<td>96.8</td>
</tr>
<tr>
<td>% New Patients with a Non-Cancer diagnosis</td>
<td>11.1</td>
<td>14.3</td>
<td>13.9</td>
<td>12.5</td>
<td>12.4</td>
<td>16.5</td>
</tr>
<tr>
<td>Average Length of stay, Cancer (days)</td>
<td>13</td>
<td>11.5</td>
<td>15.3</td>
<td>10.6</td>
<td>13.2</td>
<td>13.9</td>
</tr>
<tr>
<td>Average Length of stay, Non-Cancer (days)</td>
<td>8.3</td>
<td>12.8</td>
<td>18.0</td>
<td>10.6</td>
<td>11.6</td>
<td>12.5</td>
</tr>
<tr>
<td>% Occupancy</td>
<td>78.5</td>
<td>73.0</td>
<td>86.4</td>
<td>75.5</td>
<td>77.5</td>
<td>77.6</td>
</tr>
<tr>
<td>percentage of people who died on the unit</td>
<td>66.7</td>
<td>75.4</td>
<td>64.9</td>
<td>58.5</td>
<td>57.7</td>
<td>63.7</td>
</tr>
</tbody>
</table>

* 2014/2015 figures are unaudited, based on our submission.

I wanted to express our gratitude to all the staff at the Hospice in making every possible effort to ensure my wife’s final days should be as peaceful and pain free as was possible. I have nothing but praise for the manner in which all the staff tended her care. Thank you so very much for making her final days ones of peace and tranquility: **Husband of person cared for in the Hospice Inpatient Unit, Bexley**

Thank you for encouraging Steve to eat, tempting him with your delicious meals and desserts! I’ve got a lot to live up to! **Wife of person cared for in hospice Inpatient Unit, Abbey Wood**
3.1.2 Day Care
MDS data for Day Care is given in Table 2.

Based upon our return, GBCH (total number of 172 patients) was included in the Medium category (between 112 and 180 patients).

Nationally, data was received from 56 Medium units. For London, data was received from 13 units.

Table 2 Day Care MDS data

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>New Patients</td>
<td>95</td>
<td>99</td>
<td>129</td>
<td>95</td>
<td>93</td>
<td>99</td>
</tr>
<tr>
<td>% New Patients</td>
<td>56.5</td>
<td>57.6</td>
<td>74.1</td>
<td>56.9</td>
<td>63</td>
<td>62.1</td>
</tr>
<tr>
<td>% New Patients with Ethnicity Recorded</td>
<td>92.6</td>
<td>90.7</td>
<td>98.4</td>
<td>91.6</td>
<td>93.8</td>
<td>94.2</td>
</tr>
<tr>
<td>% New Patients with a Non-Cancer diagnosis</td>
<td>17.9</td>
<td>25.0</td>
<td>18.6</td>
<td>22.1</td>
<td>25.0</td>
<td>21.1</td>
</tr>
<tr>
<td>Day Care Attendances</td>
<td>2487</td>
<td>2622</td>
<td>2686</td>
<td>2267</td>
<td>1616</td>
<td>2017</td>
</tr>
<tr>
<td>% Places Used</td>
<td>61.4</td>
<td>69.5</td>
<td>72.6</td>
<td>62.8</td>
<td>54.4</td>
<td>62.7</td>
</tr>
<tr>
<td>Average Length of Attendances (days)</td>
<td>176.3</td>
<td>216.6</td>
<td>158.4</td>
<td>162.8</td>
<td>154.8</td>
<td>151.0</td>
</tr>
</tbody>
</table>

* 2014-2015 figures are unaudited, based on our submission.

I want to convey how much I like Day Care. The staff always go the extra mile and the team are marvellous.

Person attending Day Hospice, Plumstead
### 3.1.3 Home Care/Hospice at Home

MDS data for Home Care/Hospice at Home is given in Table 3.

Based upon the Hospice return, GBCH (total number of 1316 patients) was included in the Large category (more than 1227 patients).

Nationally, data was received from 13 Large units. For London, data was received from 5 units.

#### Table 3 Home Care/Hospice at Home MDS data

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>New Patients</td>
<td>822</td>
<td>945</td>
<td>895</td>
<td>968</td>
<td>1096</td>
<td>945</td>
</tr>
<tr>
<td>% New Patients</td>
<td>64.4</td>
<td>71.8</td>
<td>71.7</td>
<td>69.7</td>
<td>70.5</td>
<td>69.3</td>
</tr>
<tr>
<td>% New Patients with Ethnicity Recorded</td>
<td>92.4</td>
<td>93.2</td>
<td>91.6</td>
<td>85.4</td>
<td>74.6</td>
<td>93.2</td>
</tr>
<tr>
<td>% New Patients with a Non-Cancer diagnosis</td>
<td>20.9</td>
<td>26.4</td>
<td>19.3</td>
<td>25.0</td>
<td>23.9</td>
<td>26.4</td>
</tr>
<tr>
<td>% Home and Care Home Deaths</td>
<td>55.8</td>
<td>52.9</td>
<td>48.9</td>
<td>50.6</td>
<td>52.0</td>
<td>61.4</td>
</tr>
<tr>
<td>% Hospice Deaths</td>
<td>21.5</td>
<td>23.0</td>
<td>27.2</td>
<td>24.8</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>% Hospital Deaths</td>
<td>22.2</td>
<td>19.2</td>
<td>23.1</td>
<td>24.0</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

* 2014-2015 figures are unaudited, based on our submission.

∑ this data is no longer reported by NCPC.

‘Thank you to everyone who had a great input into the care of my late husband and also for the support I myself received which I can assure you was very much appreciated by both of us. Just knowing that I could pick up the telephone and whenever possible someone would listen and help was a wonderful comfort and helped ease some of the stress.’

Wife of person cared for by Greenwich Care Partnership

‘May I say what a wonderful service you have given my brother in the last months of his life. It was a great relief to him that he could stay at home and he looked forward to the cheery visits of your carers. The seamless way the care operated was amazing. I am indebted to them all.’

Sister of Person cared for at home, Blackheath
### 3.1.4 Hospital Support Team

Historical MDS data for Hospital Support is given in Table 4.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>New Patients</td>
<td>713</td>
<td>n/a</td>
<td>730</td>
<td>654</td>
</tr>
<tr>
<td>% New Patients</td>
<td>95.6</td>
<td>n/a</td>
<td>92.4</td>
<td>89.3</td>
</tr>
<tr>
<td>% New Patients with Ethnicity Recorded</td>
<td>87.5</td>
<td>n/a</td>
<td>100.0</td>
<td>69.0</td>
</tr>
<tr>
<td>% New Patients with Non-Cancer diagnosis</td>
<td>34.9</td>
<td>n/a</td>
<td>26.7</td>
<td>33.3</td>
</tr>
<tr>
<td>% New Patients over 85 years</td>
<td>35.2</td>
<td>n/a</td>
<td>27.3</td>
<td>27.2</td>
</tr>
<tr>
<td>% Discharged to Home</td>
<td>52.3</td>
<td>n/a</td>
<td>57.8</td>
<td>51.4</td>
</tr>
<tr>
<td>Average Length of Care</td>
<td>9.4 days</td>
<td>n/a</td>
<td>8.0 days</td>
<td>7.8 days</td>
</tr>
</tbody>
</table>

The Hospice Hospital Support Team based at Queen Elizabeth Hospital, Woolwich, provide support, advice and education to staff in the hospital on end of life care and symptom control issues, as well as supporting patients and their families directly and helping to ensure their wishes for care are met.

+ Due to issues with admin support for the Hospital Team in 2013, there were difficulties with the collection and collation of the data which resulted in no 2013-2014 Hospital Support Team figures being submitted.

---

Your staff and volunteers do an amazing job. The care my granddad received in the hospice in his final weeks was amazing and it made a difficult and upsetting time more bearable knowing he was happy and being looked after properly. It's unfortunate that your work is often not fully appreciated until it is experienced first hand.'

Granddaughter of person cared for in the Hospice Inpatient Unit
3.1.5 Bereavement Support

MDS data for Bereavement Support is given in Table 5.

Based upon the Hospice’s return, GBCH, was included in the Medium category (between 114 and 262 service users).

Nationally, data was received from 38 Medium units. For London, data was received from 8 units.

Table 5 Bereavement Support MDS data

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>New Service Users</td>
<td>137</td>
<td>230</td>
<td>202</td>
<td>172</td>
<td>121</td>
<td>226</td>
</tr>
<tr>
<td>% New Service Users</td>
<td>71.7</td>
<td>99.6</td>
<td>92.7</td>
<td>68.0</td>
<td>70.8</td>
<td>84.1</td>
</tr>
<tr>
<td>% New Service Users with Ethnicity Recorded</td>
<td>65.7</td>
<td>60.0</td>
<td>38.6</td>
<td>70.3</td>
<td>74.3</td>
<td>91.4</td>
</tr>
<tr>
<td>Contacts per Service User</td>
<td>6.54</td>
<td>13.6</td>
<td>12.7</td>
<td>9.5</td>
<td>6.2</td>
<td>7.6</td>
</tr>
<tr>
<td>% Discharged</td>
<td>32.4</td>
<td>76.5</td>
<td>67.0</td>
<td>53.3</td>
<td>59.1</td>
<td>57.5</td>
</tr>
</tbody>
</table>

The significant reduction in activity is due to non-inclusion of the Telephone Bereavement Service activity this year (Level 2 support). We are currently liaising with MDS and awaiting the outcome of the wider discussions between ABSCO and MDS regarding inclusion/exclusion of bereavement support data going forward.

* These figures are unaudited, based on our submission.

I think the telephone bereavement service is a really wonderful service to offer. The telephone call comes at a time when some people could really do with support and then your service can kick in where needed. Losing someone to cancer can be a very traumatic experience, watching someone you love deteriorate daily. Your hospice service, all of it, is wonderful and really does make a huge difference to relatives/carers of the person who is terminally ill. I cannot thank you enough for all you have done.

Person supported by Telephone Bereavement Service, Sidcup
3.1.6 Outpatients

MDS data for Outpatients is given in Table 6.

Based upon the Hospice return, GBCH with a total number of 696 patients was included in the Large category (more than 316 patients).

Nationally, data was received from 48 Large units. For London, data was received from 14 units.

Table 6 Outpatients MDS data

<table>
<thead>
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</thead>
<tbody>
<tr>
<td>New Clients</td>
<td>149</td>
<td>192</td>
<td>255</td>
<td>158</td>
<td>292</td>
<td>129</td>
</tr>
<tr>
<td>% New Clients</td>
<td>25.7</td>
<td>27.6</td>
<td>39.8</td>
<td>24.3</td>
<td>40.7</td>
<td>64.9</td>
</tr>
<tr>
<td>% New Patients with Ethnicity Recorded</td>
<td>77.8</td>
<td>94.4</td>
<td>90.6</td>
<td>89.2</td>
<td>88.0</td>
<td>96.5</td>
</tr>
<tr>
<td>% New Patients with a Non-Cancer diagnosis</td>
<td>56.4</td>
<td>51.1</td>
<td>31.8</td>
<td>50.0</td>
<td>19.8</td>
<td>19.8</td>
</tr>
<tr>
<td>Total Outpatient Clinic Attendances</td>
<td>1087</td>
<td>2343</td>
<td>1202</td>
<td>1320</td>
<td>1542</td>
<td>220</td>
</tr>
<tr>
<td>Attendances per Patient</td>
<td>1.9</td>
<td>3.4</td>
<td>1.9</td>
<td>2.0</td>
<td>2.4</td>
<td>1.5</td>
</tr>
</tbody>
</table>

* 2014/2015 figures are unaudited, based on our submission.

I would like to sing the praises of your Clinical Nurse Specialist. Needless to say she knows her job very well, but, more than that, she was always available to come round, or give advice over the phone, and she has such a caring and compassionate nature. My mum really liked her, and my brother and I wouldn’t have known where to turn without her.

Daughter of person cared for at home, Belvedere
3.2 Clinical Governance

Having developed and enhanced the Quality & Safety Committee in 2013/14, it continues to take a robust approach to monitoring the quality and safety of Hospice services. It is still supported by a number of topic/project based advisory groups e.g. medicines, EPR, education, GCP.

The Quality & Safety Committee continues to receive regular reports, including the Clinical Dashboard and Operational Risk Register as well as responsibility for the review of existing policies and the development of new policies. It is also responsible for monitoring the clinical audit programme.

CQC is a standing item on the agenda and our response to the new care standards is reviewed monthly. Planning for a refreshed approach to Trustee Unannounced Inspections is underway.

3.3 Workforce

The Hospice has continued to invest in the planning, delivery and monitoring of mandatory training in 2014/15. It also benefitted from additional resource for Continuing Professional Development from Health Education South London which has enabled professional development of clinical staff in line with personal development plans.

Hospice clinical staff continue to be involved in delivering education in external organisations including King’s College London and the University of Greenwich as well as to care providers such as local care homes, Oxleas NHS Foundation Trust and Queen Elizabeth Hospital. We have also contributed to GP Vocational training programmes in both Greenwich and Bexley boroughs.

A new Nurse Consultant took up post in August 2015 and as a result of development roles in our community team, for the first time in a number of years, there are no Clinical Nurse Specialist vacancies.

To respond to winter pressures plans we had to rely on a locum Dr and additional agency nurses on the inpatient unit in 2014/15.

3.4 LCA Palliative Care Audit

In 2014/15 we participated in the Specialist Palliative Care Audit carried out across London, this provided us with a useful opportunity to benchmark our activity and workforce.

3.5 Building Work

The project to expand the Hospice building is now drawing to a close. The project has been well managed with minimal disruption to operations; we will now focus on our occupation of the extension.

3.6 Challenges

A number of challenges have been encountered in 2014/15, in particular:

- The Hospice continued to encounter difficulties in recruiting sufficient staff with the appropriate skills, expertise and attitude resulting in a high number of
vacancies in some services. This problem, which was also seen in other organisations, resulted in some difficulties in delivering care in as responsive a fashion as desired. This problem was particularly seen in recruiting staff nurses and clinical nurse specialists and resulted in us changing the way we respond to referrals to ensure a safe service continues to be delivered. As a result of this ongoing challenge, the Hospice continues to review service models and skill mixing to address the challenge in different ways.

- The increase in need for community services and the difficult economic climate has presented problems in meeting the need with existing capacity and finances. In 2014/15 we received some short term funding from NHS Bexley and NHS Greenwich to invest in inpatient care over the winter. We continue to work with commissioners to look at ways to reshape services to meet increased need as well as increasing our own contribution through additional voluntary income. Our discussions with NHS Bexley have not made as much progress as we would have hoped for something we hope to resolve in 2015/16. We were disappointed to report a financial deficit at year end.

- Following designation as a Commissioner Requested Service (CRS) by NHS Bexley, the Hospice registered with MONITOR in 2014/15. One of only 2 Hospices nationally to be designated CRS, this added additional regulatory and reporting requirements to be met. The Hospice maintained its MONITOR licence throughout and has resubmitted in 2015/16.

- Following a change to the non emergency patient transport contracts held by the local trust and a change to the London Ambulance Contract, transport for people accessing Hospice care was adversely affected. We have raised this locally and at a London level and continue to work with our commissioners and local transport providers to minimise the impact on patient care.

- The Hospice Director of Care Services post was vacant from September 2014 – March 2015. Inevitably such a key strategic senior role being vacant has an impact on the whole team and means that some key projects were not delivered as quickly as we would like. All of the Clinical Leads took on additional responsibility during that time to ensure that services remained safe and effective. The post was filled by Debbie Sevant in March 2015; Debbie brings with her 30 years’ experience working in a range of Nursing roles in Hospice care and the NHS.

- In 2015/15 the Hospice was much more closely involved in the local response to systems resilience (winter pressures). This brought many opportunities to develop relationships with providers and to improve our own pathways of care, however the involvement also brought significant challenges which we
continue to manage and we have begun to incorporate these into our
discussions around this years third strategic priority.

3.7 Publications

- Advance care planning in a UK hospice: the experiences of trained
  Journal of Palliative Care 22 (3) p.144-151
- Integrated end-of-life care services – the Greenwich Care Partnership:
  Heaps K, Marks-Moran D (2015): European Journal of Palliative Care 22 (2)
  p.84-89
- Poster: South London Hospices Education Collaborative – Working
  together to improve end of life care: Heaps K, Moback B (2014) LCA
  Palliative Care Conference
Appendix 1: Greenwich

NHS Greenwich
Marcos Menager – nominated person within NHS Greenwich

I must admit that the 2014-15 Quality Account has been a pleasant read as it contains a well presented description of the objectives set last year, the achievements and the future developments that the Hospice is planning to carry on doing. It is also with pleasure, to know that we, as a CCG, will be working together to achieve better co-ordinated services and deliver even more comprehensive care based on education, integration and training of the front line staff.

Royal Borough of Greenwich Healthier Communities and Adult Social Care Scrutiny Panel
Alain Lodge - Scrutiny Officer for our Healthier Communities and Adult Social Care Scrutiny Panel

Introduction
We recognise the value of the work of the Hospice which provides a range of palliative and end of life services including the Greenwich Care Partnership. This partnership between the Hospice, Marie Curie Cancer Care and Greenwich Community Health Services, provides personal care, a rapid response service, a co-ordination centre and planned night visiting.

The Panel value the regular dialogue it has with the Hospice, especially in terms of Members visits and the Chief Executive attending our meetings, and will continue to monitor the work of the Hospice and assess its impact on the health and wellbeing of local people.

Part 2 – Priorities for Improvement and Statements of Assurance from the Board

2.1 Priorities for Improvement 2015-16
Improvement Priority 1: Access to Hospice Services
This is a priority that the Chief Executive discussed with the Panel when she attended our meeting on 5 February 2015. We support the work the Hospice has undertaken to develop its services to ensure that the care is provided across the patient pathway in all settings. We also recognise the improvements in access that have resulted from the opportunities to provide integrated care in hospital, at home or in a care home and in the hospice buildings.

The Panel will closely monitor the Hospice’s responses to the ever increasing need for Palliative and End of Life Care (EoLC) for people who may not have traditionally accessed Hospice care. This includes:

- A redesigned referral and assessment process
- Continuing to expand the approach to ambulatory care and rehabilitation making use of the new ‘community hub’, released capacity in the day hospice facilities, and the new rehabilitation gym.
Continuing to extend the Hospice’s links and partnerships with other organisations to ensure an appropriate response is provided to people with specific needs.

The Panel are particularly interested in the Hospice’s plans to continue to develop its workforce to meet the increasingly diverse need including providing dementia awareness training and working with Oxleas to develop the care and support available for people with dementia.

**Improvement Priority 2: Multi-Disciplinary Team Working (MDT)**
The Panel recognise the importance and benefits of MDT working, which involves health and allied health professionals meeting regularly to discuss, plan and evaluate a person’s care.

However multi-disciplinary meetings currently take place in ‘departmental silos’ and we recognise the further benefits of a new model of multi-disciplinary meetings that promotes improved communication across teams, provides a more streamlined approach across geographical areas and supports more integrated working.

**Improvement Priority 3: Using our limited resources to provide flexible models of care and support**
The Panel understands the challenges the Hospice faces in terms of using its limited resources to respond to requests for support and the need to continue to develop flexible models of care and support. This is an area of particular interest for Panel Members and one that it will focus on in the coming year.

2.2 Priorities for Improvement 2014-15

**Progress against Improvement Priority 1: Access to Hospice Services**
We continue to support the developing of the Hospice as a hub for the community which will provide a space for socialising, rehabilitation and volunteering. We share the Hospice’s aim that by opening it up to other members of the community they can challenge people’s perceptions of who and what hospices are for, opening up the doors to support more people throughout their lives.

We were pleased to note, from the Chief Executive on 5 February 2015, that the Hospice’s Lead Chaplain is positively engaging with local faith groups in terms of discussing issues such as long term illness and death. The Panel realised that different communities addressed the issue of end of life differently and that in some cases an outreach approach rather than hospice care may be more ‘socially and culturally acceptable’.

We look forward to visiting the ‘new building’ and further discussing the planned changes to services.

2.4.7 What others say about Greenwich and Bexley Community Hospice

**Care Quality Commission (CQC)**
We noted that the CQC has not taken any enforcement action against the Hospice during 2014/15.
Part 3 – Review of Quality Performance

3.3 Workforce
We support the priority that the Hospice accords to training both for its own staff and staff within other organisations. We welcome the appointment of a new Nurse Consultant and that there are no Clinical Nurse Specialist vacancies.

3.6 Challenges
The panel are familiar with the ongoing challenges the Hospice faces in terms of recruitment; meeting the increased need for community services with existing capacity and finances; and system resilience (winter pressures). The Panel discussed these issues at length with the Chief Executive at our meeting on 5 February 2015.

Appendix 2: Bexley
NHS Bexley
This document has been shared with Zoe Hicks-John, Assistant Director for Quality, NHS Bexley.

Bexley Overview and Scrutiny Committee
This document has been shared with the Chair of the Health OSC.

Appendix 3: Healthwatch
Jade Landers - nominated person within Healthwatch Greenwich
Anne Hines-Murray – nominated person within Healthwatch Bexley

Healthwatch Bexley and Greenwich welcome the opportunity to comment on the Quality Account for 2014-2015. We have submitted a joint report as the Hospice provides a service for residents of both boroughs.

Comment on priorities for improvement 2015-2016

Priority 1 – Access to Hospice Services
We understand this is a long term strategic goal for the Hospice and will be a priority for the next few years. We are pleased to see the Hospice is continuing to improve access to end of life care for residents of Bexley and Greenwich. We welcome the introduction of the Assessment and Coordination Team to reduce waiting times and ensure people are involved in developing their care plan. We are also glad the Hospice is committed to ensuring more people are enabled to die in their place of choice.

Priority 2 – MDT Working
Healthwatch hopes this proposed new model of working will improve patient experience by putting the person at the centre of the decision making process around their care. We look forward to the evaluation of the new model and the impact on patients and staff.
Priority 3 – Using our limited resources to provide flexible models of care and support
Healthwatch appreciate there is increasing pressure and demand on the Hospice and are glad to see consideration being given to how best to use limited resources. It is great there is a focus on care planning throughout the priorities and ensuring the patient is able to make informed decisions about their care. Healthwatch Greenwich hopes the Hospice’s work with the Greenwich Macmillan Facilitator to improve training and support in primary care will lead to patients being referred to services in a more timely manner and improve access to care.

Comment on priorities for improvement 2014-2015

Priority 1 – Access to Hospice Services
Although this is a longer term plan, there have been many achievements in this area during the year. Healthwatch look forward to the completion of the ‘Capital Build Project’ and the benefits this will bring for patients and their families. We are pleased the Volunteer led Advance Care Planning project was a success and has now been embedded into the care coordination service. We are glad the Hospice now has a regular presence at meetings with the local NHS Trust, which will mean patients experience more joined up care and are less likely to ‘fall through the gaps’.

Priority 2 – Embed Clinical Research and Audit
It is clear the Hospice has used their participation in local and national audits and research to improve their services and provide care which is based in evidence.

Priority 3 – Workforce, Education and Training
The Hospice has continued to develop its staff and volunteers, and Healthwatch are satisfied the Hospice will meet its targets for staff training across all topics by the end of the year. The training the Hospice provides for care homes across the two boroughs is an important way to ensure staff are well equipped to provide the best possible care and support to residents and their families.

Other comments
We would like to see the Hospice improve their response rates to the FFT test, as it is an important way for service users to provide feedback. Although the figures included in the report provide a good overview of the Hospice’s work, Healthwatch would be interested to know how many patients are able to die in their preferred place, in addition to the percentage of deaths in different locations. We would like to thank the Hospice for including quotes from partners and services users within the report, as it gives us the opportunity to see some of the feedback from local people.

Appendix 4: LCA
This document has been shared with Maureen McGinn, Project Manager, Palliative Care Group, London Cancer Alliance