Greenwich & Bexley Community Hospice

2016–2017 Quality Account

Contents

Introduction

1.1 Chief Executive's Comment

It is my pleasure to present our Quality Account for 2016/17 which documents notable progress against our objectives, as well as some of the challenges we face.

In 2016/17 the Hospice cared for 2,518 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.

It costs almost £8 million per year to operate our Hospice, and we receive 32% 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 Hospice continues to support an increasing number of people with terminal illness across the communities of Greenwich and Bexley; of particular note is our increased reach in the Queen Elizabeth Hospital, where our small team saw a 21% increase in new patients and in our Inpatient Unit where we had 7% more admissions, resulting in a 3% increase in occupancy overall. Across all of our services we also saw a shift in the profile of our patient group, with us seeing a larger proportion of older people and people with non-malignant disease.

The Hospice is registered with the Care Quality Commission (CQC) and we received an overall 'Good' rating from the inspection which took place in 2016. Ellen Tumelty, Modern Matron for Inpatient Service, was approved as Registered Manager by the CQC in 2016.

The challenging financial climate remains a concern for the Hospice, however, we have been pleased with the progress made by the Hospice team following our 2015 restructure and have been able to report a minimal operating deficit at the end of 2016/17. Nevertheless, we have approached the forthcoming year with a deficit budget, funded through a surplus on legacies in 2016/17 and we are confident that the plans in our new strategy will help us achieve the necessary increase in income and control of expenditure in the foreseeable future. The level of uncertainty that surrounds our contracts and statutory funding remains a concern which we will continue to address in 2017/18. Our partnerships with other organisations and with the community will be vital if we are to continue to meet the increasing need and demand for Hospice care and support, expertise and education in the future.

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

1.2 About the Hospice service

For over 20 years Greenwich & Bexley Community Hospice has provided specialist palliative care, advice and clinical support for people with terminal illness, their carers and families. Our vision and mission is to give expert care, support and education to people with terminal illness, their families, friends and professional carers to maximise the quality of life for every dying person in the London boroughs of Greenwich and Bexley.

We are the only adult hospice in the London boroughs of Greenwich and Bexley, serving 2,500 terminally ill patients, their families and carers every year. We work from our woodland Hospice (founded in 1984 by two local people with cancer) providing care in our Inpatient Unit, Day Hospice and Outpatient Departments, in the homes of those who need our care though our community nurses and in hospitals, care homes and local prisons too. We aim to give quality care to people wherever and whoever they are.

Our clinical team is made up of specially trained staff including a Chaplain, Counsellors, Day Hospice Manager, Doctors, Nurses, an Occupational Therapist, Physiotherapists and a Social Worker as well as a team of Administrators and many volunteers working in all of our clinical services. In addition, our clinical teams are supported by our essential support and income generation departments.

The Hospice sits in the middle of two London Boroughs that are continually changing. Our catchment area contains some highly deprived areas and some internationally-known landmarks – presenting a unique and challenging mixture. The success of our Hospice in achieving its vision relies on us engaging with all parts of the community so that we can reach everyone with terminal illness in the London boroughs of Greenwich and Bexley as well as benefitting from any support our community is willing to give to help us achieve this aim.

1. Hospice Strategy 2017-2020

During 2016/17 the Hospice undertook a strategic review which is now complete. Our strategy seeks to support the Charity to achieve its vision to give expert care, support and education to people with terminal illness, their families, friends and professional carers, to maximise the quality of life for every dying person in the London boroughs of Greenwich and Bexley. If we are to achieve our vision we will need to address some of our biggest challenges of increasing need, reduced funding and changes in workforce, to which the key strategic objectives respond (see diagram 1).

Diagram 1: Themes and Objectives in the GBCH Strategy 2017- 2020

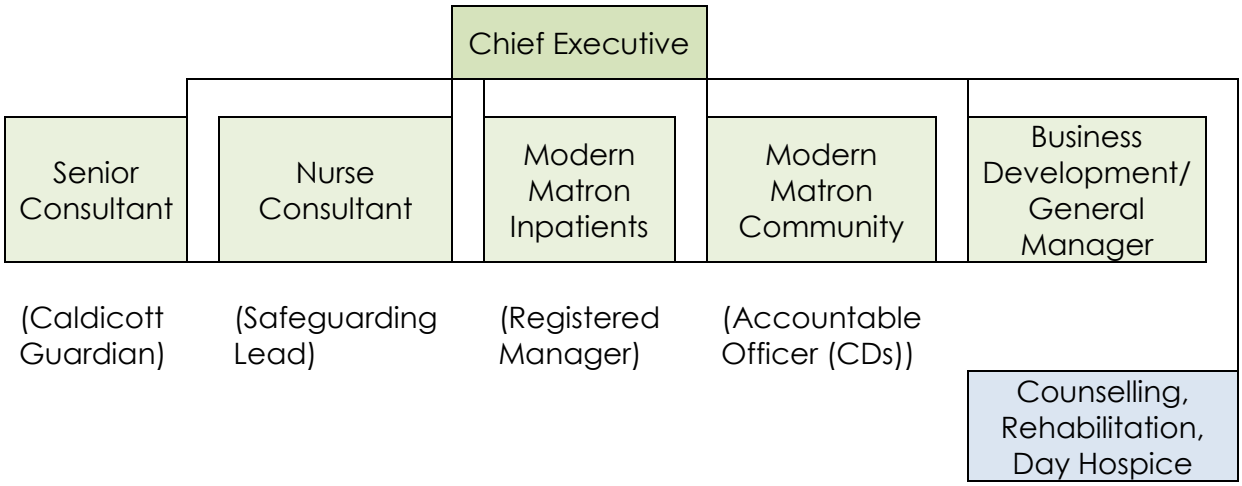
Our Priorities for Improvement for 2017/18 focus on the four core objectives outlined above and are detailed in our new Hospice strategy available on the Hospice website www.communityhospice.org.uk.

As we begin to implement our strategy, we will continue to focus on improving internal communication and our work to ensure a 'line of sight' for all staff and volunteers within the organisation by providing more opportunities for cross inter-departmental working and learning and by facilitating shadowing opportunities.

3. Quality Overview

3.1 Clinical Management Structure

Following the departure of the Director of Care Services in September 2016, the Hospice took the decision to review the Clinical Management Structure and we are currently trialling a new way of working. The new structure is outlined below and includes detail around where care related statutory responsibilities currently sit.



This structure will be reviewed by the QSC and Board in September and October 2017.

3.2 Review of Quality Performance

During the last year the Hospice was inspected by the Care Quality Commission (CQC) and we also began an internal GBCH Trustee Assurance Programme. We will use the feedback from the Inspection and Assurance visits as well as our internal self-assessment to improve our service provision overall for our Hospice.

The Inspection used the new CQC inspection model which asks other healthcare providers, staff, volunteers, patients and carers what they think of the service we deliver. This approach was supported by a strengthened inspection process with the Hospice having 3 CQC inspectors on site, including a Specialist Palliative Care Nurse and a pharmacist.

As this was a new inspection model, the Hospice team worked hard in preparation for the Inspection, to ensure that we had all the evidence available to demonstrate our performance on the five key lines of enquiry shown on page 6. Our effort was well recognised by the Inspection Team when they visited our site.

The Hospice was awarded an overall rating of 'Good' with an award of 'Outstanding' for the 'Responsive' domain. Through delivery of this strategy and our quality improvement plan we continue to aspire for an overall 'Outstanding' rating.

The Inspection continues to reassure our commissioners, our patients (and future patients), their carers, our staff, our volunteers and the general public that

Greenwich & Bexley Community Hospice delivers a strong specialist palliative care service in our hospice, in people's homes and in other settings across the local area. You can download a copy of the full CQC report at www.cqc.org.uk

3.3 What Inspectors said about our Services

The CQC inspection identified evidence to demonstrate our performance on the following aspects of our service, which they call 'key lines of enquiry'. The outcomes they found were as follows:

Ratings	
Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Outstanding ☆
Is the service well-led?	Good ●

Extracts from the report include:

'People were cared for by sufficient numbers of staff to meet their needs promptly. Staff were caring and understood people's and their relatives' concerns. People's privacy, dignity and confidentiality were protected. Staff were well supported and trained for their jobs and people benefitted from their care' Care Quality Commission 2017.

'A health and social care professional who worked with people who received care from community based staff from the Hospice told us, "Carers have demonstrated very good clinical knowledge especially with topics such as infection risks and pressure sore risks."'

'People told us they were well looked after by the staff and felt cared for. One person said, "Staff are so nice" and "They can't do enough for you." They added that staff gave them emotional support to deal with their situation, saying, "They are really good at helping you to adjust."'

'One healthcare professional told us they worked closely with the Hospice and they felt the staff had "a culture of excellent care." They also said the service was "quick to respond to referrals and I have always valued their input and advice."'

3.4 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, GCP, dementia, research.

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 at the QSC.

Operational Risk Register
This risk register supports the QSC and Senior Clinical Team to manage risk helping to monitor challenges such as staffing/ HR risks, environmental risk, Information Governance 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.

Patient Feedback report
This report includes an overview of the various forms of feedback received including complaints and compliments, Friends and Family Test and Voices Responses.

Incidents and Accidents
This report includes medicines incidents, falls, accidents and any other incidents across the whole Hospice. 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 and target of 80%. It also forecasts performance 1 month ahead so potential problems with compliance can be anticipated.

3.5 Service Activity & Comparison with National Minimum Data Set

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

The most recently published National Minimum Data Set for Palliative Care covers 2015/16. Data for the Hospice for 2016/17 has been collated but currently there is no comparative National MDS data available.

The Hospice has benchmarked data reports for 2016/17 under the following headings:

- Inpatients
- Day Care
- Home Care/Hospice at Home
- Hospital Support Team

3.5.1 Inpatients

MDS data for Inpatients is given in **Table 1.**

Based upon our 2015/16 return, the Hospice was included in the Medium category (between 11 and 17 beds).

Nationally, data was received from 43 Medium units. For London, data was received from nine out of thirteen units.

Table 1 Inpatient MDS data

	2016/2017 GBCH*	2015/2016 GBCH	2014/2015 GBCH	2013/2014 GBCH	2015/2016 National Median	2015/16 London Median
New Patients	**328**	344	295	281	**348**	**313**
% New Patients	**86%**	94%	95%	94%	**91%**	**93%**
% New Patients with Ethnicity Recorded	**92%**	92%	93%	91%	**93%**	**92%**
% New Patients with a Non-Cancer diagnosis	**18%**	16%	11%	14%	**13%**	**16%**
Average Length of stay, Cancer (days)	**14**	11	13	12	**15**	**15**
Average Length of stay, Non-Cancer (days)	**9**	9	8	13	**15**	**15**
% Occupancy	**81%**	76%	79%	73%	**80%**	**79%**
% of all patients aged 85 and over	**23%**	18%	18%	11%	**15%**	**16%**
% of people who died on the unit	**66%**	63%	67%	75%	**63%**	**63%**

* 2016/17 figures are unaudited, based on our submission.

Although the number of new patients is lower in the year, overall occupancy was increased due to an increase in admissions (393 admissions compared to 368 in 2015/16). In addition, there was an increase in the age profile and the number of people with a non-cancer diagnosis for whom we provided care.

My wife's best friend passed away in the Hospice 3½ years ago and it was that experience that my wife wanted to have, a dignified passing when she was diagnosed with cancer. My wife asked if she could be transferred to the hospice and it was all arranged by the staff at St Thomas and the hospice. I personally would like to say that my experience of the hospice is if you want to define heaven on earth go to the Hospice, it's not just the building that makes it; it's the staff – angels…. **Husband of an Inpatient**

3.5.2 Day Hospice

MDS data for Day Hospice is shown in **Table 2.**

Based upon our 2015/16 return, the Hospice (with a total number of 168 patients) was included in the Medium category (between 112 and 180 patients).

Nationally, data was received from 34 Medium units. For London, data was received from seven out of twelve units.

Table 2 Day Care MDS data

	2016/17* GBCH	2015/16 GBCH	2014/2015 GBCH	2013/2014 GBCH	2015/2016 National Median	2015/2016 London Median
New Patients	**56**	66	95	99	**90**	**144**
% New Patients	**46%**	46%	57%	58%	**61%**	**58%**
% New Patients with Ethnicity Recorded	**85%**	79%	95%	91%	**94%**	**94%**
% New Patients with a Non-Cancer diagnosis	**36%**	24%	23%	25%	**27%**	**23%**
% of all patients aged 85 and over	**12%**	15%	16%	15%	**13%**	**8%**
Day Care Attendances	**2159**	2487	2622	2686	**1545**	**1595**
% Places Used	**58%**	61%	70%	73%	**58%**	**60%**
Average Length of Attendances (days)	**524**	404	176	217	**177**	**176**

* 2016/17 figures are unaudited, based on our submission.

These figures show a reduction in the number of new patients being seen in the Day Hospice. There continues to be a shortage of volunteer drivers available to provide transport for people to attend Day Hospice and as a result we review transport options for each person to maximise attendance to the service. The length of attendance shown above is longer than in previous years; however this is skewed by several long-stay patients being discharged as a result of their need for the service being reviewed.

The increase in new patients with a non-cancer diagnosis is of note, and is thought to be as a result of the development of our Assessment and Coordination Team and the new approach to triage for Hospice referrals.

Mum attended your Thursday day club on just two occasions before she died but thoroughly enjoyed her visits, she was so impressed with the kindness of staff and volunteers. I hope you are able to continue and expand your excellent and much needed work.

Relative of Person who attended Day Hospice

3.5.3 Home Care/Hospice at Home

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

Based upon our 2015/16 return, the Hospice (with a total number of 1,276 patients) was included in the large category (more than 1,227 patients).

Nationally, data was received from ten large units. For London, data was received from three out of three units.

Table 3 Home Care/Hospice at Home MDS data

	2016/17 GBCH*	2015/16 GBCH	2014/2015 GBCH	2013/2014 GBCH	2015/2016 National Median	2015/2016 London Median
New Patients	**910**	966	822	945	**1162**	**1056**
% New Patients	**69%**	68%	65%	72%	**69%**	**68%**
% New Patients with Ethnicity Recorded	**86%**	88%	93%	93%	**88%**	**90%**
% New Patients with a Non-Cancer diagnosis	**26%**	24%	23%	26%	**28%**	**32%**
% of all patients aged 85 and over	**26%**	23%	19%	17%	**27%**	**24%**
% Home and Care Home Deaths	**60%**	56%	56%	53%	**56%**	**57%**
% Hospice Deaths	**23%**	22%	23%	27%	**n/a∑**	**n/a∑**
% Hospital Deaths	**21%**	22%	19%	23%	**n/a∑**	**n/a∑**

* 2016/17 figures are unaudited, based on our submission.
This data is no longer reported by NCPC.

These figures show a reduction in new patients seen by the team in the year, likely to have been affected by reduced capacity for part of the year, due to some long term staff sickness. The team consistently work hard to eliminate the waiting list for the service and we continue to be successful in recruitment to vacancies and development of staff into Clinical Nurse Specialists.

The support we had from the community team was wonderful. Although it was only for ten days, all the team were caring, helpful and supporting and myself and all our family were very happy our Mum never had to spend her final days in hospital.

Family member of a person cared for at home by the Hospice Specialist Community Team

3.5.4 Hospital Support Team

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

Based on the Hospice return for 2015/16, the Hospice was included in the medium category (437 to 749 patients).

Nationally data was received from 67 units. For London, data was received from 22 units out of a total of 28.

Table 4 Hospital Support Team MDS data

	2016/17 GBCH*	2015/16 GBCH	2014/2015 GBCH	2015/2016 National Median	2015/2016 London Median
New Patients	**960**	793	713	**898**	**730**
% New Patients	**97%**	92%	96%	**93%**	**92%**
% New Patients with Ethnicity Recorded	**91%**	94%	88%	**94%**	**94%**
% New Patients with a Non-Cancer diagnosis	**39%**	44%	35%	**34%**	**41%**
% New Patients over 85 years	**37%**	36%	35%	**24%**	**31%**
% Discharged to Home	**59%**	53%	52%	**46%**	**53%**
Average Length of Care	**7 days**	8 days	9 days	**8 days**	**8 days**

* 2016/17 figures are unaudited, based on our submission. 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.

Although the proportion of new patients with a non-cancer diagnosis was less in 2016/17 than in 2015/16, there was a significant increase in patients overall. In 2016/17 374 patients with a non-cancer diagnosis were seen compared to 349 in 2015/16. Despite the increase in the number of patients who we supported, the team were still unable to see approximately 10% of referrals in the year, largely due to a lack of capacity and the lack of 7 day service.

Thank you for all the care and kindness you showed to my mother. Myself and my Dad give our heartfelt thanks.

Daughter of a patient cared for by the Hospital Support Team

5.5 Additional Services

In addition to the Minimum Data Set that is submitted nationally; the Hospice also provided support in a number of other services. With the exception of lymphoedema, these services are provided to patients who are also under the care of other Greenwich & Bexley Community Hospice services.

Service		New patients/ clients seen	Total number of Contacts
Rehabilitation		364	1,342
Social Work		177	1,646
Counselling		97	1,282
Lymphoedema		37	480
Immediate Home Support		98	144
Greenwich Care Partnership	Rapid Response Service	331	1,563
	Multi Visit Personal Care	323	9,626
	Planned Night Care	119	907

Please pass on my thanks to the physiotherapist. She was quite amazing in her care to my Uncle and always cheered him up and made him smile, especially with talks about Italy and the love of food. It didn't get unnoticed and I am forever grateful. **Daughter of a patient cared for by the Rehab Team**

I'd like to say that everyone we met were as helpful as they could be in the situation. The nurses who visited regularly took the time to get to know my Husband and put him at ease. Resources are scare so it was wonderful to have the same nurses on a regular basis. **Wife of person cared for by Hospice at Home Team**

At a time when our family needed it the support we all received was exemplary. The care needed for our elderly relative at the end of her life was put into place swiftly and with good compassion. Fabulous people, fabulous care, nothing was too much trouble. Long may this service continue its work. Thank you all so much. **Relative of person cared for by *Bexley Immediate Home Support Service***

Counselling helped me so much to cope with caring for my brother who had MND and sadly passed away recently. My counsellor was wonderful and without her help I would not have been able to cope. A big thank you to her and all at the Hospice. **Counselling Team**

The service I have received has been second to none. Nothing has ever been too much trouble and there is always someone on hand to answer any questions I may have. **Patient seen by Social Worker**

I was desperate to keep my relative at home and he was desperate to stay there but things were becoming extremely difficult and I began to doubt that I could manage. I experienced a huge feeling of relief when (nurse) arrived and proved so positive and capable. I realised at once that this would be a burden shared. The carers were incredibly wise and obviously experienced in working with people with dementia. And I learned a great deal from them. **Relative cared for by Community Dementia Nurse Specialist**

3.6 Complaints and Incidents

3.6.1 Complaints

Q1 April – June	2015/16	2016/17
Verbal Care Complaints	5	2
Verbal Non-Care Complaints	1	1
Written Care Complaints	6	4
Written Non-Care Complaints	1	1
Total	**13**	**8**

Q2 July – September	2015/16	2016/17
Verbal Care Complaints	4	4
Verbal Non-Care Complaints	-	1
Written Care Complaints	3	9
Written Non-Care Complaints	1	-
Total	**8**	**14**

Q3 October – December	2015/16	2016/17
Verbal Care Complaints	2	-
Verbal Non-Care Complaints	-	-
Written Care Complaints	4	4
Written Non-Care Complaints	3	-
Total	**8**	**4**

Q4 January – March	2015/16	2016/17
Verbal Care Complaints	5	2
Verbal Non-Care Complaints	-	1
Written Care Complaints	1	8
Written Non-Care Complaints	1	4
Total	**7**	**15**

The Care Quality Commission found that people were aware of how to make a complaint and that the procedure for managing complaints was effective.

'People said they were confident to speak with staff about concerns if they needed to. Records of complaints showed they were taken seriously by managers.'

'Where complaints were substantiated, people also received an apology and explanation. When improvements to the service were found necessary changes were implemented.'

'Staff understood whistleblowing procedures and how to raise concerns about colleagues' care and work practices, if they had any concerns'

3.6.2 Incidents

The Hospice aims to minimise falls, medication incidents and pressure ulcers through appropriate assessment, staff training, patient information and safe practices. These three areas are monitored closely and reported through the Hospice UK benchmarking study.

The Hospice is categorised based on the number of beds as category 'D' for comparison with other similar sized units.

3.6.2.1 Falls

2015/16				Actual Falls											
	AVAIL. BED NIGHTS	OCC. BED NIGHTS	BED OCCUP-ANCY	No Harm		Low		Moderate		Severe		Death		Total Falls	
				No.	%	No.	%	No.	%	No.	%	No.	%	No.	Per 1000 OBDs
GBCH	6,109	4,667	76%	54	73%	19	26%	1	1%	0	0	0	0	74	14
AVER-AGE CAT D	6,315	5,047	80%	33	61%	20	37%	1	1%	0.2	>1%	0	0	54	11

2016/17				Actual Falls											
	AVAIL. BED NIGHTS	OCC. BED NIGHTS	BED OCCUP-ANCY	No Harm		Low		Moderate		Severe		Death		Total Falls	
				No.	%	No.	%	No.	%	No.	%	No.	%	No.	Per 1000 OBDs
GBCH	6,141	4,969	81%	55	73%	18	24%	1	1%	1	1%	0	0	75	15
AVER-AGE CAT D	1,565	1,258	81%	8	61%	5	35%	0.4	3%	0	0	0	0	14	11

Despite the increase in occupancy, the number of falls remained stable compared to 2015/16, there was one fall which was classified as 'severe' as a result of the patient fracturing their femur. The team continue to learn from incidents as well as carrying out regular falls risk assessments for all inpatients and put controls in place to reduce the risk of falling and injury from any incidents.

It is not clear whether the Hospice reports more 'near misses' with regard to falls compared to other Hospices. We are, however, keen to learn more about what other Hospices have done to reduce falls and have therefore arranged a 'Preventing Falls in Hospices' workshop in 2017/18 in conjunction with the Health Innovation Network[1] to learn from others and share best practice.

[1] Health Innovation Network is the Academic Health Sciences Network for South London.

3.6.2.2 Medication Incidents

2015/16				Actual Medication Incidents											
	AVAIL. BED NIGHTS	OCC. BED NIGHTS	BED OCCUP-ANCY	Level 1 No adverse effects		Level 2 Patient monitoring no harm		Level 3 Some change, no harm		Level 4 Delayed discharge, additional treatment		Level 5&6 Permanent Harm/ Death		Total	
				No.	%	No.	%	No.	%	No.	%	No.	%	No.	Per 1000 OBDs
GBCH	6,109	4,667	76%	71	96%	3	4%	0	0	0	0	0	0	74	16
AVER-AGE CAT D	6,315	5,047	80%	29	83%	4	12%	2	5%	0.2	>1%	0	0	35	7

2016/17				Actual Medication Incidents											
	AVAIL. BED NIGHTS	OCC. BED NIGHTS	BED OCCUP-ANCY	Level 1 No adverse effects		Level 2 Patient monitoring no harm		Level 3 Some change, no harm		Level 4 Delayed discharge, additional treatment		Level 5&6 Permanent Harm/ Death		Total	
				No.	%	No.	%	No.	%	No.	%	No.	%	No.	Per 1000 OBDs
GBCH	6,141	4,969	81%	57	88%	8	12%	0	0	0	0	0	0	65	13
AVER-AGE CAT D	1,565	1,258	81%	5	35%	7	55%	1	7%	0.3	2%	0	0	13	10

Despite an increase in occupancy, the total number of medication Incidents reduced over the year compared to 2015/16 and the level of harm relating to the incidents remained minimal.

3.6.2.3 Pressure Ulcers

2015/16					Pressure Ulcers					
	AVAIL. BED NIGHTS	OCC. BED NIGHTS	BED OCCUP-ANCY	Inherited	Avoidable		Unavoidable		Total Pressure Ulcers	
					No.	%	No.	%	No.	Per 1000 OBDs
GBCH	6,109	4,667	76%	Not recorded	0	0	16	100%	16	3
AVER-AGE CAT D	6314.8	5047	80%	Not recorded	3	15%	18	85%	21	4

2016/17					Pressure Ulcers					
	AVAIL. BED NIGHTS	OCC. BED NIGHTS	BED OCCUP-ANCY	Inherited	Avoidable		Unavoidable		Total Pressure Ulcers	
					No.	%	No.	%	No.	Per 1000 OBDs
GBCH	6,141	4,969	81	22	0	0	4	100%	4	1
AVER-AGE CAT D	1,565	1,258	81	14	1	12%	5	88%	6	5

Despite an increase in occupancy, the Hospice was able to report a much lower number of pressure ulcers in 2016/17 compared to 2015/16. We have invested in new pressure mattresses on the Inpatient Unit and are now using less agency staff. It is unclear whether these factors have contributed to the improvement but we will continue to monitor our progress in 2017/18.

4. Progress on Priorities for Improvement 2016/17

4.1 Access to Hospice Services

This Improvement Priority was initially identified in 2012/13 as a key area for development. The Hospice continued to promote and develop its services to ensure that care is provided to patients in all settings, maximising opportunities to provide integrated care in hospital, at home or in care homes, in local prisons and in the Hospice building.

In 2016/17 we led the development of an End of Life Charter for people in Bexley and Greenwich, and strengthened our clinical response within Day Hospice, providing a holistic needs assessment and individualised 12 week programme of care for everyone attending the service. This has resulted in a number of longer term patients being discharged and capacity being released in Day Hospice to reach more people. We also continued to develop our links and partnerships with other organisations to ensure an appropriate response to people with specific needs e.g. most notably our work in dementia has had a significant impact, improving quality and access to all Hospice services for this patient group.

Our work in Queen Elizabeth Hospital continues to be extremely important in raising awareness of Hospice services and we have reached more people than ever through this referral route. This has, however, placed significant additional demand on the team and we are working with the Hospital Trust to build a case for investment.

In 2016/17 we worked with NHS Bexley CCG to develop an Immediate Home Support Service to respond to urgent need in people's homes and whilst there was limited demand for the personal care element of the service, the registered nurse element has been invaluable in maintaining people at home, if this was their wish. Between August 2016 and March 2017, 99 patients received care from the service, of these only 3 were admitted to Hospital and a further 69 hospital admissions were avoided.

In the last year we have made significant in-roads in engaging with Black, Asian and Minority Ethnic groups who may have previously been unaware of the Hospice's services. Our Chaplain Rev Herbert Aparanga led this work supported by a grant from LB Greenwich and as a result we have made connections with Afro-Caribbean, Nepali, Vietnamese and Muslim Communities.

Our work to develop new roles for patient facing volunteers was delayed due to the departure of the Hospice's Volunteers Manager; however we have provided additional training to existing volunteers and are currently developing new roles to support ambulatory care.

The Hospice received an 'outstanding' rating in the CQC domain of responsiveness, which is testament to our progress against this priority.

4.2 Patient Experience

The people who we support tell us that the experience of the care they receive is as important to them as clinical effectiveness and safety. They want to feel informed, supported and listened to so they can make meaningful decisions and choices about their care. They want to be treated as an individual, not as a number, and they value efficient processes.

During 2016/17 we improved our reporting of patient experience and the quality of services including introduction of a regular report from QSC to Board and a new Trustee Assurance Programme which has robust reporting processes.

The Hospice appointed a new Business Development Manager in 2016 and he will work with our Quality Officer to improve mechanisms and increase opportunities to gather feedback from service users as well as ensuring our findings and actions are effectively shared and actioned as appropriate. We have installed a new 'you said, we did' notice board in our Inpatient Unit and plan to do the same in Day Hospice and in the Community Hub.

In 2016/17 we participated in the National Hospice Staff Survey and much of this feedback was used to shape questions for our Trustee Assurance Visits. We have identified some areas for development as a result of the survey including a programme of refurbishments in our shops and the development of a new well-

being programme for staff, which is in our strategy and is a priority for improvement in 2017/18.

We continued to develop our relationship with Healthwatch and plan to ask them to deliver training to staff to improve how we gather and respond to feedback in 2017/18.

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4.3 Flexible Models of Care and MDT Working

In the 2015/16 Quality Account (QA) we outlined our structure for multidisciplinary meetings (MDM), with five meetings occurring each week. In the QA we highlighted the risks that this may present, such as discussions taking place in silos, being over focused on care setting and not facilitating our aim for integrated care or MDT working.

The work on improving this situation was delayed due to a number of other priorities and the departure of the Director of Care Services. Our new strategy continues to highlight the importance of making changes to help ensure that each patient is at the centre of the decision-making process and to enable all team members involved in each person's care to input into this. The plan to develop this MDT model will also assist us with our sustainability objective, enabling us to improve how we use specialist expertise within the Hospice team.

Despite not achieving the objective of changing our MDM model, we have continued to improve other aspects to drive integration, particularly the appointment of a permanent post holder to the Triage Nurse role, which provides continuity and consistency in the decision making process around admissions.

Unfortunately, our pilot to co-locate the night District Nursing Team for Bexley with the Greenwich Rapid Response Service in the Hospice was unsuccessful, however we were successful in an application for a grant to purchase some tablet devices for clinical staff and have made progress in accessing NHS mail and Connect Care.

In 2016/17 we introduced two new nurse led clinics in the Hospice to release capacity by reducing the amount of time clinical staff spend travelling. Two of our nurses began the advanced practitioner training which will help to facilitate new ways of working in the future.

In 2016/ 17 we continued to implement and embed the use of outcome measures to inform our practice and service model. This development is beginning to enable us to better understand case mix, dependency and patient population as well as assessing the impact of our care on patient outcomes.

As part of our improvements in Day Hospice we introduced a new holistic needs assessment and care planning process, which is beginning to release capacity for new patients to benefit from the service. We also developed our rehabilitation programme in Day Hospice and are making steps to integrate rehabilitation into the Inpatient Unit. We were unable to recruit and train new rehabilitation volunteers due to staffing changes in the department.

4.4 Resilience and Sustainability

The past few years have been challenging for the Hospice, managing a deficit budget, a reduction in reserves and a need to restructure the organisation in order to meet current and future demands, whilst continuing to provide high quality palliative and end of life care services.

For the first time in several years, 2016/17 had a balanced budget and the out turn for the year was to be celebrated with only a very small operational deficit being reported, this was achieved as a result of strong leadership from the whole Hospice Management Team, the hard work and commitment of all Hospice staff and volunteers and the thorough preparation, planning and monitoring of the Finance Committee. Nevertheless, we have approached the forthcoming year with a deficit budget, funded through a surplus in legacies in 2016/17. The theme of resilience and sustainability remains a key objective in our new strategy and we are confident that, with the support of our commissioners, partners and the local community, our plans will help us achieve the necessary increase in income and control of expenditure to enable us to continue our vital work for years to come.

In 2016/17 we began to implement changes in our clinical staffing including the development of band 6 and band 2 roles in the community, secondment of staff to other areas of the organisation and the continuation of support for band 3 healthcare assistants to complete their NVQ level 5 qualification to support them in future band 4 opportunities. We also provided training to 66 patient facing volunteers and began to try new volunteer roles, for example providing support for patient discharge.

The Clinical Team continue to experience a growing workload due to an increase in referrals and complexity; this workload is being monitored closely to inform discussions with statutory and voluntary funders as well as our partners with a view to increasing capacity and ensuring that high quality standards of care are maintained.

In 2016/17 Revalidation for Registered Nurses was introduced and we supported a number of our staff to complete their revalidation, to ensure they maintained their professional registration.

An evaluation of the Advanced Dementia Service is also complete and will be shared with potential funders. We are currently exploring options to support the continuation of this service, as well as looking at other patient groups who may benefit from a similar targeted partnership approach.

The process used to support the development of the new Hospice Strategy has helped to refocus on our core values, develop understanding across the Hospice, improve motivation in some areas and provided an opportunity for those who were engaged to 'own' the objectives. As we launch the Strategy we will maximise further opportunities to increase line of sight and ownership of our shared objectives. Our values are shown on page 19:

Hospice Values

5. Workforce, Education and Training

Our new Hospice Strategy has 'Workforce' as a key objective and outlines the importance of providing opportunities for growth for existing staff and volunteers, as well as developing strategies to improve recruitment and develop new roles to ensure care is delivered compassionately, creatively and efficiently.

With regard to staff development and training, the Hospice has again benefitted from Continuing Professional Development funding from Health Education South London, which was directed towards externally commissioned courses in line with personal development plans.

There have also been opportunities for internal staff development, such as the rolling education, mandatory training programmes and the journal club. We continue to have a particular focus on advancing the role of more senior nurses including developing advanced assessment and prescribing skills.

We continue to develop mechanisms for staff support and to facilitate Schwartz© Rounds. Clinical supervision and/or coaching is provided for clinical members of staff.

In 2016/17 the Hospice continued to deliver its mandatory training programme and reports using a dashboard to the Quality and Safety Committee each month. The programme has been reviewed to take account of the evolving needs and priorities of the Hospice and changes in best practice guidance. All staff received Dementia Awareness training in 2016. We are aiming to introduce an e-learning system for mandatory training; however, there has not been the capacity to introduce this over the past year. Despite this, compliance of 80% and above has been reached in the majority of mandatory training topics and where this has not been attained (e.g. blood transfusions) clinical practice has been restricted until the relevant staff member has achieved compliance.

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 Quality and Safety Committee.

In 2016/17 we commenced a staff nurse rotation programme and have also recruited to our forthcoming GP fellowship programme, which will be delivered in partnership with a number of other organisations, for Bexley GPs.

Through our engagement in the South London Hospices Education 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 continue to be rolled out to more volunteers next year[2]. This project is now complete.
2. QELCA©: Quality End of Life Care for All. 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 e.g. HMP Belmarsh which has helped us improve access and understanding of Hospice care and support, as well as the quality of care for people in prison with end of life care needs.
3. Assistant Practitioner Project: The Hospice has taken an active lead on delivering this project in collaboration with Croydon College. Those participating in the programme completed the City & Guilds accredited Level 5 Diploma for Assistant Practitioners in Health and Social Care. This project is now complete and a second cohort has commenced.
4. In 2016/17 we were able to deliver several courses for Oxleas, Lewisham and Greenwich NHS Trust, Care Homes and Local Authority Staff. We have also contributed to GP vocational training programmes in both Greenwich and Bexley boroughs.
5. Hospice clinical staff continue to be involved in delivering education in external organisations, including King's College London and the University of Greenwich, and in order to further strengthen our links with the University of Greenwich, the Hospice's lead for Advancing Practice began a part time secondment to the University in 2016/17.

In 2016/17 we made significant progress in recruitment for our inpatient unit and reduced agency usage, enabling a reduction in costs.

[2] Subject to further funding

6. Statement of Assurance from the Board

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

6.1 Review of Services

During 1st April 2016 to 31st March 2017, The Hospice provided the following services:

- Inpatient Care
- Day Hospice
- Community Specialist Palliative Care in Greenwich and Bexley boroughs
- Specialist Palliative Care Team at Queen Elizabeth Hospital
- Greenwich Care Partnership (Greenwich)
- Immediate Home Support Service (Bexley)
- Rehabilitation Team
- Lymphoedema Treatment and Care (Bexley)
- Psychological Care Service, including the Telephone Bereavement Service
- Chaplaincy
- Social Work
- Advancing Practice Team, including Care Homes Support Team
- Advance Care Planning Support
- Befriending

The Hospice shared its Senior Medical on call rota with the Ellenor Hospice, a Specialist Palliative Care Service based in Kent until December 2016. Since March the GBCH Senior Medical On-Call has been supported by St Christopher's Hospice.

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

6.2 Income Generated

The income generated by the NHS services reviewed in 2016/17 represents 100% of the total income generated from the provision of NHS services by the Hospice for 2016/17. The income generated from the NHS represented 32% (unaudited) of the overall cost of running our specialist 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

6.3 Research and Audit

6.3.1 Participation in National Clinical Audits

During 2016/17, the Hospice was ineligible to participate in any national clinical audits or national confidential enquiries. However, the Hospice did participate in the Hospice UK benchmarking project.

6.3.2 Participation in Local Audits

The following audits were carried out during 2016/17:

Subject Matter	Purpose of Audit	Follow-up Actions
Accountable Officer Audit	Ongoing audit of controlled drugs and non-controlled drugs processes and policies. High level of compliance recorded	Action plan drawn up for highlighted areas and progress reported and reviewed quarterly by QSC
Infection Control Annual Audit Programme	Ongoing audit with agreed schedule defining Infection Control areas to be audited and frequency of audits	Findings reported and reviewed quarterly by QSC
Unannounced Hygiene Inspection	Audits performed by Lead for Infection Control and a Trustee on a regular basis	Action List updated after every audit and reviewed at QSC
FP10 Audit	To ensure FP10 prescribing in line with hospice policy	A total of 335 items were prescribed on FP10 during the audit period (97 in IPU and Community, 138 Lymphoedema). FP10s were used more in the community than in the inpatient unit, as expected. Use of FP10s was appropriate Order FP10 pads for Drs working across all services for use with Greenwich residents
Blood transfusion audit	To audit the completion of GBCH blood transfusion ICP in accordance with L&G Blood transfusion service criteria.	In most aspects of the audit, the target of 100% completion was reached. The importance of accurate documentation on the blood transfusion ICP should be emphasised at mandatory training, particularly consent. The timing of observations should be made clarified. Maximise efforts to ensure all required staff have had mandatory blood transfusion training. (Blood transfusion training is mandatory for clinical staff involved in transfusion.) Liaise with QEH Blood Transfusion Dept regarding updating ICP/policy in line with their practice. Re-audit to be planned once policy updated

In-patient admission and assessment audit	Using the Hospice UK Inpatient Admission Audit Tool – review at recording of processes surrounding admission	Consider review of relevant policies/procedures with respect to up to date guidance documents Review relevant EPR pages for initial assessments – including consent, ACP and alert pages. Review Woodlands welcoming procedures including information leaflets (ongoing) – and consider how to document. Highlight need to assess/document any financial concerns of patient/family. Ensure appropriate training regarding above.
CD prescribing re-audit	To compare CD prescriptions against local and national standards	The prescription of controlled drugs in Woodlands met the audit standards (100%) in the majority of domains. There were however three areas that could be improved: stating strength of liquid formulations, stating frequency of PRN medication and method of alterations to prescriptions. Training to be delivered to address issues identified Add requirements to alterations to medical induction Re-audit on an annual basis (or as required if clinically indicated).
MCA audit	To audit EPR documentation against Hospice Application of the Mental Capacity Act policy	This audit demonstrated the use of a formal mental capacity assessment tool by clinical staff at the hospice. It is being use both on the IPU and in the community setting. More in depth analysis of 30 assessments revealed that there was a large representation of patients with dementia (9 out of 30 forms, 30%) given 9% of new referrals had dementia as a main diagnosis, this is to be expected. Plan to re-evaluate the MCA training to raise awareness of mental capacity assessments, for the assessment to be driven by a specific decision, to define what common decision should trigger an assessment and define the level of detail to be documented.

6.3.3 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. As part of this, the Hospice will be collaborating in the NIHR Knowledge Mobilisation Research Fellowship Study in the implementation of the Outcomes and Complexity Collaborative (OACC) Tool.

6.4 Quality Improvement and Innovation Goals Agreed with Commissioners

There have been no CQUINS this year. However, we continued to work with both commissioners in relation to the Lymphoedema Service and with NHSB regarding the Immediate Home Support service.

6.5 Feedback from Partners

Recent feedback from partners is shown below:

Oxleas continues to work collaboratively with Greenwich and Bexley Hospice to ensure our local population receives timely, high quality care that works to the End of Life Care Charter, respect, compassion and dignity.

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

6.6 Data Quality

During 2016/17, 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.

6.7 Information Governance Toolkit Attainment Levels

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

6.8 Clinical Coding Error Rate

The Hospice was not subject to the Payment by Results clinical coding audit during 2016/17 by the Audit Commission.

7. Commissioner Requested Service

Following designation as a *Commissioner Requested Service (CRS)* by NHS Bexley, the Hospice registered with NHS Improvement (Monitor) in 2014/15. GBCH was one of only two Hospices nationally to be designated CRS in the first wave. The Hospice maintained its licence throughout 2016/17 and has resubmitted in 2017/18.

8. Challenges

A number of challenges have been encountered in 2016/17, in particular:

8.1 The Hospice continued to experience difficulties in recruiting sufficient staff with the appropriate skills, expertise, and attitude. This resulted in vacancies in some key positions. This problem, which was also seen in other organisations, resulted in the Hospice not always being able to deliver care in as a responsive manner as desired. Recently we have made some progress in an area of previous difficulty (staff nurse recruitment); however, our gaps in the very busy hospital service and in our rehabilitation team have had an impact on service delivery and development. We are exploring possibilities of partnering with another organisation to address the gap in the rehabilitation service and are working with the Hospital Trust to develop a contingency plan for the short term and a business case for development of the service longer term.

8.2 The increase in demand and need for all of our services, particularly in the hospital, together with the difficult economic climate has presented problems in meeting service need with existing capacity and finances. We continue to work with our staff, partners and commissioners to look at ways to reshape services to meet escalating need, as well as increasing our own contribution through additional voluntary income. Our discussions with NHS Greenwich CCG are ongoing and we hope to be able to secure a new contract with them with an appropriate statutory contribution in 2017. We also hope to come to an acceptable agreement with regard the lymphoedema service with NHS Bexley CCG. As a result of strict financial control, we were able to report a positive financial position at year end and are hopeful that we will be able to secure additional investment in 2017 to allow us to provide additional capacity in areas of high demand.

8.3 Despite having served notice on our Lymphoedema Service to both CCGs in 2015/16, we were unable to release ourselves from the obligation to deliver a service in Bexley due to our Commissioner Requested Service designation but we continue to work with the CCG to reduce the caseload through development of strict referral criteria and appropriate discharge. We hope that we will be able to support them to find a suitable alternative provider in 2017/18.

9. Publications and Presentations

The Hospice submitted the following for the Hospice UK Conference in November 2016:

- Heaps K, Lethem W, Dewar S. **Nurse Consultant Leadership in an Integrated Hospice Service: Evaluation of impact.** (2016) Poster - *selected for oral poster tour*

- Bryan L, Berg J, Reed L, King H, Vandeweghe M, Linehan G, Menezes T, Roots S, Hackett J, Moback B. **Qelca© (quality end of life care for all): an innovation in end of life care education – delivered by the South London Hospices Education Collaborative (SLHEC).** (2016) Poster

Appendices

Appendix 1: Greenwich

Royal Borough of Greenwich Healthier Communities and Adult Social Care Scrutiny Panel comments on Greenwich and Bexley Community Hospice 2016/17 Quality Account

Introduction

We recognise the value of the work of the Hospice, which provides specialist palliative care, and during 2016/17 care for 2,518 people and their families. We support the Hospice change in approach moving away from a service which focuses on care delivery in a building, to one which provides care in whatever setting it is required; this includes care in people's homes, care homes, hospital and at the Hospice in Abbey Wood.

The Panel also value the regular dialogue it has with the Hospice, especially in terms of Members visits and the Chief Executive and other officers attending our meetings and workshops.

We have been particularly interested in the Hospice Dementia Project and the work of the Clinical Nurse Specialist, which has included identifying people with dementia who may benefit from hospice care; education and training; and sharing best practice. The Council is a signatory to the Hospice's End of Life Charter, which "aims to make death and dying everyone's business – people, families, communities, health and social care networks and organisations – and to encourage all aspects of our community to help people at the end of life because this is something that affects us all".

We will continue to monitor the work of the Hospice and assess its impact on the health and wellbeing of local people.

1.1 Chief Executive's Statement
We recognise the importance of the Hospice's support of an increasing number of people with terminal illnesses across Greenwich and Bexley and are particularly pleased to note the increased reach in Queen Elizabeth Hospital (QEH). The team at QEH saw a 21% increase in new patients and in the Inpatient Unit where there were 7% more admissions, resulting in a 3% increase in occupancy overall. We were interested to note that across all of its services the Hospice saw a shift in the profile of their patient group, seeing a larger proportion of older people and people with non-malignant disease.

2. Hospice Strategy 2017-2020
We strongly support the Hospice's strategic aim of giving "expert care, support and education to people with terminal illness, their families, friends and professional carers, to maximise the quality of life for every dying person in the London boroughs of Greenwich and Bexley". We will monitor their progress against the four core objectives:

1. Building partnerships, networks and community.
2. Sustainability, efficiency and innovation.
3. Developing and retaining our workforce.
4. Generating sufficient income to safely meet demand and quality requirements.

We look forward to receiving further information on the progress on these objectives.

3.2 Review of Quality Performance.
We were very pleased to note that the Care Quality Commission (CQC) awarded the Hospice an overall rating of good, with an award of outstanding for the responsive domain.

The document has also been shared with **NHS Greenwich**

Appendix 2: Bexley

This document has been shared with:

NHS Bexley

Bexley Overview and Scrutiny Committee

Appendix 3: Healthwatch

Joint Response to Greenwich and Bexley Community Hospice 2016-2017 Quality Account

Healthwatch Greenwich and Healthwatch Bexley welcome the opportunity to comment on the quality of service provided by Greenwich and Bexley Community Hospice as compiled in the 2016-2017 Quality Account.

General Comments
Healthwatch would like to praise the layout of the 2016-2017 Quality Account which is clear and easy for a lay person to understand. The inclusion of quotes gives the cared for people and their relatives a voice and brings a human angle to the statutory requirements of the Quality Account.

Patient Safety
The number of falls (one of which one was severe) has not reduced and remains above the average figure for similar sized units nationally. Healthwatch is pleased that continued learning regarding how these are recorded is being carried out by the Hospice and the 'Preventing Falls in Hospices' workshop in 2017-2018 will hopefully increase knowledge and awareness.

A reduction in medication incidents, all of which remain minimal in their level of harm, is encouraging, and continued monitoring of these will hopefully lead to a further reduction year on year.

Healthwatch is pleased that the number of pressure ulcers is significantly lower than 2015-2016 and that improvements have been introduced which may have led to this decline.

Patient Engagement
The CQC found that complaints were handled effectively and people were confident to speak to staff if they were to have a concern. It would be useful to include the number of complaints in the same period from April 2015 – March 2016 as a comparison [3].

Healthwatch is pleased to hear that there has been significant in-roads engaging with Black, Asian and Minority Ethnic (BAME) groups. The numbers of individuals from BAME groups who access hospice services has traditionally been low and not representative of the population in the boroughs. This continued work will increase awareness of the service to these communities as well as increase understanding as to why this may be case. Healthwatch is keen to know what the numbers are arising from this engagement will be and what that has led to in terms of people accessing the service and welcoming this data in the 2017-2018 Quality Accounts.

[3] The report has been adapted to include 2015/16 complaints as a result of this feedback.

Healthwatch is pleased to see that the importance of people being involved in their care and treatment has been highlighted. Individuals need to be given as much information as possible for them to feel able and encouraged to make a meaningful decision about their care, and feel included and valued.

The installation of the new 'you said, we did' notice board is an effective way of communicating the learning taken from gathering feedback from service users. The future introduction of these in the Day Hospice and the Community Hub is a welcomed next step.

The areas of development that were identified by the survey used for the Trustee Assurance Visits will have a positive impact on not just staff but patients too. The priority of 'Developing and Retaining our Workforce' in the Hospice Strategy 2017-2020 will ensure that the importance of communication and knowledge sharing is key to an effective and supported workforce team.

Healthwatch is pleased with the growing relationship we have with Greenwich and Bexley Community Hospice. In particular, the training programme for staff to increase awareness of the importance of gathering patient and relatives' experiences, and how this can be used as an essential tool for improving services for all.

Challenges

Healthwatch Greenwich encourages the continuing discussions with NHS Greenwich CCG regarding a securing a new contract with an appropriate statutory contribution in 2017. Healthwatch Greenwich would also like to ensure that NHS Greenwich CCG has secured a suitable alternative provider of the Lymphedema Service in the borough which has not been in place since April 2016. This has been raised as an issue of concern to us by services users in Greenwich.

Healthwatch Bexley would like to encourage NHS Bexley CCG to find a suitable alternative provider for the Lymphedema Service in 2017-2018. Patients should remain a priority and their uninterrupted continued care is essential.