

The image features a smiling elderly woman with grey hair and glasses, wearing a gold shawl, as the central focus. In the background, a community gathering is visible with people seated at tables and a red heart decoration hanging on the wall. The Community Hospice logo is positioned in the top left corner.

**COMMUNITY
HOSPICE**

For the people of
Greenwich & Bexley

COMMUNITY HOSPICE QUALITY ACCOUNT 2025-2026

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1. INTRODUCTION AND CONTEXT



1.1 About the Community Hospice

The Community Hospice is a local charity, commissioned by the South East London Integrated Care Board to provide specialist palliative and end of life care for adults across the Royal Borough of Greenwich and the London Borough of Bexley.

Every year we support more than 2,500 people, and we meet them wherever they are: on our inpatient unit, through our outpatient, rehabilitation and wellbeing services, out in the community, and in hospital. That support covers pain and symptom management, rehabilitation, and emotional, social and spiritual care, all shaped around the person in front of us.

1.2 Values

We exist to help people live as well as they can for as long as they can, because we believe dying is part of life, not apart from it. Our job is to take some of the weight off people's shoulders so they can focus on what matters most to them.

- **Mission:** To provide compassionate, expert care that empowers patients and families throughout their end of life journey
- **Vision:** A community where everyone approaches dying with dignity, supported by care that is personal, proactive and positive
- **Values:**
 - **Direct:** We are straight-talking and focused on what matters
 - **Uplifting:** We are warm, friendly and generous with our time
 - **Proactive:** We take responsibility and make things happen

These values show up in how we behave day to day: staying focused, speaking plainly, valuing one another, working together, thinking freshly, and rising to a challenge. They guide every interaction and every decision we make.

1.3 Overview of services

Our care spans three main areas:

- **Hospice-based care:**
 - Inpatient care for complex symptom control and end of life care
 - Outpatient and wellbeing services, including clinics, rehabilitation, complementary therapies, and support groups that help people live well
 - Emotional and spiritual support, including counselling for patients and for those who are bereaved
- **Community-based care:**
 - Multi-disciplinary specialist palliative care by phone, video or face to face, at home, in care homes and in our local prisons
 - Outpatient clinics offering in-person specialist palliative care for ambulant patients
 - Clinical training and support for care home and community-based staff
 - Greenwich Care Partnership, providing hands-on Hospice at Home packages for people eligible for Continuing Healthcare Fast Track support, alongside night sitting and rapid-response nursing out of hours

- A Virtual Ward for remote monitoring and timely intervention when people need more intensive support
- OneBexley for social work and carer assessments
- Compassionate Neighbours for community volunteer support
- **Hospital services:**
 - Specialist palliative care, advice and discharge coordination at Queen Elizabeth Hospital

New services for 2025/26:

In 2025/26 we expanded our outpatient clinics, giving people more choice about how they access care in a way that works for them.

We also ran a pilot in which an advanced nurse practitioner worked in the emergency department at Queen Elizabeth Hospital, Woolwich, identifying people with specialist palliative care needs and supporting them to receive care in a more appropriate setting, avoiding hospital admissions that weren't right for them.

1.4 Funding

Statutory funding from NHS South East London Integrated Care Board and local authorities makes up roughly 42% of our total income.

The rest comes from our charitable activities, in particular:

- **Retail**, which generated a net profit of £423,239 in 2025/26
- **Lottery fundraising**, contributing £128,297 in the same period
- **Donations, legacies**, income from trusts and community fundraising events, which make up the remainder

In 2025/26 we also received a £842,415 capital grant from the Department of Health and Social Care. Together, this funding sustains our services and the quality-improvement work behind them. We work hard to use every pound well: stopping what isn't working and trying new approaches. We are proactive and courageous but never cavalier.

1.5 Purpose and scope of the Quality Account

This Quality Account covers care provided between 1 April 2025 and 31 March 2026. It explains how we assure ourselves of the quality of our care and shows the progress we have made in raising standards.

Although we are not an NHS body, we are commissioned under the Health Act 2009 to deliver specialist palliative and end of life care. Quality Accounts are an NHS requirement for transparency and improvement, covering patient safety, clinical effectiveness and patient experience. We prepare and assess this report against the Care Quality Commission's (CQC) fundamental standards, including the statutory duty of candour under Regulation 20 of the Health and Social Care Act 2008.

1.6 How to use this report

Navigation: Each main section opens with clear, numbered headings.

Definitions and glossary: Key terms appear in bold on first use, with a full glossary in the Appendices.

Accessibility: We write in plain English and explain any acronyms; charts and tables are clearly labelled.

Feedback: Contact details appear at the end of each section if you have a query or want to know more.



2. LEADERSHIP AND GOVERNANCE



2.1 Chief Executive's statement

This account reflects a year of significant delivery for the hospice, alongside a period of leadership transition. As I step into the Interim Chief Executive role, following my time as Deputy Chief Executive, this report offers an opportunity to reflect on what has been achieved across the organisation.

This work builds on the strong foundations and clear direction already established across the organisation. While leadership has changed, our purpose has not: to help dying people across Greenwich and Bexley live as well as they can, for as long as they can.

Across our inpatient unit, our community teams, our clinics and our work in hospital, we supported more than 2,500 people this year. Behind that number is a remarkable depth of skill, compassion and determination from our staff and volunteers. I see this every day - the way our teams show up with professionalism, kindness and a deep sense of responsibility for the care they provide.

This has been a year of both delivery and increasing demand. We are supporting more people, with more complex needs, and we are doing so in a way that relies on strong partnership with colleagues across our local health and care system. Our work in hospital, in the community and through our partnerships is helping people receive care in the right place, at the right time.

At the same time, we are continuing to strengthen how we deliver care. We opened new outpatient clinics at Eltham Community Hospital and at the hospice, bringing specialist support closer to home. In hospital, our advanced nurse practitioner pilot in the emergency department at Queen Elizabeth Hospital has helped identify patients earlier and support care decisions that better reflect their needs and wishes. We have also strengthened how we use data, introducing live dashboards so that teams can learn and respond more quickly, and we have shared our learning nationally through eight presentations at the Hospice UK conference.

We are also committed to reaching people who have not always accessed hospice care. This includes improving how we understand our communities, and taking practical steps to make our services more accessible and inclusive.

I want to be open about the context we are operating in. Like hospices across the country, we are facing significant financial pressure, and we have agreed a planned deficit budget for the year ahead. We have approached this carefully and transparently, with the full support of our Board, making deliberate choices to protect frontline care and to continue reaching those who need us most.

Despite this, we are clear about our direction. The strategic priorities we set in 2022 remain relevant and continue to guide our work - improving access, strengthening quality, and making sure our care reaches everyone who needs it. This account shows how we are delivering that, through steady progress, partnership and a strong commitment to learning.

I want to thank our staff, volunteers and supporters. The care described in these pages is yours. Your commitment, resilience and generosity of spirit make this organisation what it is, and it is a privilege to work alongside you.



A handwritten signature in blue ink, which appears to read 'Aneta Saunders'.

Aneta Saunders
Interim Chief Executive

2.2 Trustee assurance statement

As Chair of the Quality and Safety Committee, it falls to me to offer the Board's assurance that the care described in this account is delivered safely, effectively and with the dignity every person deserves.

That assurance is not taken on trust. It is built through steady, structured scrutiny. Our committee meets every two months, drawing together trustees, senior leaders and clinical leads to test how the hospice manages risk, learns from what goes wrong, and listens to the people it serves. We are supported by the Clinical Quality Group and by focused forums covering medicines management, finance, information governance and our work on equity and inclusion. Together they give the Board clear lines of sight into clinical practice, patient experience and compliance with Care Quality Commission standards.

I have been struck this year by a culture that does not look away from difficulty. Complaints, incidents and feedback are examined openly, themes are drawn out, and lessons are acted on rather than filed away. The move to live dashboards has sharpened that work, putting better data in front of those who can use it. The introduction of weekly patient safety meetings has strengthened how quickly we identify risk and share learning across services.

I want to be candid. A year of leadership transition, alongside real financial pressure, tests any organisation. What I have seen is a hospice that meets those pressures honestly and keeps quality at the centre of its decisions.

On behalf of the Board, I thank the staff and volunteers whose care these pages describe, and I confirm that the trustees are assured of the quality of services set out in this account.



Alison Roberts,
Trustee and Chair,
Quality and Safety Committee

2.3 Overview of governance, risk and assurance processes

2.3.1 The role of our trustees

Our Board of Trustees holds ultimate responsibility for the hospice's direction, performance and good conduct as a charity. Trustees work closely with the Chief Executive and senior leadership team to make sure our resources go where they matter most: into patient care. They safeguard our financial sustainability, keep a close eye on clinical and operational performance, and hold us to the highest standards of stewardship and transparency.

2.3.2 Committees and groups

The Board can't oversee everything in detail on its own, so it delegates authority to a number of specialist forums.

The Quality and Safety Committee (QSC) is a formal sub-committee of the Board, chaired by a trustee. It meets every two months and brings together trustees, senior leaders and clinical leads. It provides assurance on how we manage clinical risk, reviews patient safety, patient experience and the effectiveness of our services, oversees this Quality Account, and monitors how well we meet Care Quality Commission standards.

The Clinical Quality Group (CQG) reports into the QSC and meets every other month. It draws together clinical leads from across our services to manage clinical risk, keep us compliant with standards, best practice and the law, and oversee clinical audit, service evaluation, policy, training and research governance. Its minutes and key actions are escalated to the QSC.

Other forums provide focused assurance in their own areas and report to the QSC, including the Medicines Management Group. The Finance, Information Governance and Information Technology Committee, and the Equity, People and Inclusion Committee (EPIC), are further Board sub-committees with their own areas of oversight.

2.3.3 How we manage risks

- Our **Corporate Risk Register** summarises the hospice's key strategic risks. Each entry sets out the risk, its likelihood and impact before and after mitigation, the controls and actions in place, who owns it, how we are assured, and when it was last reviewed
- Our **Operational Risk Register** is a fuller log of risks across our clinical and operational work, recording each risk's current rating, controls, planned actions, owner and review date
- Our **Quality Improvement Plan** is a prioritised programme of projects aligned to our strategic objectives and the CQC's Key Lines of Enquiry, each with a clear aim, lead, timeline, success measures, and current status

2.3.4 How we assure ourselves of quality

Information on quality and safety flows through every level of our governance via structured reports and dashboards.

Service activity: Clinical teams get monthly reports on how our services are being used and the outcomes we achieve, and our commissioning partners receive an aggregated summary at agreed points. A new Power BI dashboard now presents live clinical data, replacing the old manual spreadsheets.

Patient experience: We use a dedicated platform to gather ratings and comments from patients and carers in real time. Service leads review every compliment and complaint each month, and summary reports go to the QSC. Formal complaints follow our Complaints Policy, with themes and lessons reported to the Board's sub-committees.

Staff survey: We commission Picker to run our annual staff survey independently, giving us confidential, trustworthy data. EPIC reviews the findings and escalates them to the Board, so staff experience and wellbeing stay firmly in view. We benchmark results against the NHS and our own previous surveys to spot trends, such as any dip in how fairly people feel they are treated or how well resourced they feel, and we feed these into our Corporate Risk Register.

Incidents and accidents: Everything is recorded in our Vantage system. The relevant manager investigates each one, logs the findings and actions, and feeds back to whoever raised it. The CQG reviews quarterly summaries of trends and learning and shares them with the QSC.

Learning and improvement: Our weekly Patient Safety Incident Response Framework (PSIRF) meeting is where much of this comes together. It is a deliberately collaborative space that lets us manage risk promptly, draw out common themes, prioritise the actions and lessons that will make the biggest difference, and share that learning across services. The result is better outcomes for patients and stronger assurance for the Board.

Mandatory training: Our e-learning modules run through the Learning Nexus platform. Line managers receive monthly compliance reports, and overall rates are escalated through EPIC.

Safeguarding: Safeguarding concerns are flagged in our incident system so we can keep sight of how many we are identifying and of what kind. It is a standing item on every CQG and QSC agenda. Trustees are trained to a level appropriate to their role, as are all our staff, and the Safeguarding Lead Trustee reports to the Board on activity, training compliance and any emerging themes.



3. REVIEW OF LAST YEAR'S PRIORITIES AND PERFORMANCE



3.1 Overview of key priorities

- **Summary of 2025/26 priorities:**
 - Linking clinical data with other data sources to strengthen planning and equity insight
 - Delivering personalised care at scale through clearer access and referral pathways
 - Embedding quality and impact metrics and learning systems
 - Accelerating uptake of the Pan-London Universal Care Plan (UCP)

3.2 Detailed review of priorities

3.2.1 Develop and pilot a clinical data warehouse

- **Aim**

To develop the hospice's capacity to collect, manage and use clinical data systematically – improving the quality, consistency and accessibility of information to support clinical governance, commissioner accountability and service improvement.

- **Progress achieved**

While the development of a full technical data warehouse proved cost-prohibitive during this period, significant progress was made in building the practical infrastructure and capability that underpins the same strategic intent.

Reporting across key governance committees has transitioned to Power BI, with live dashboards now in use by the Quality and Safety Committee and the Clinical Quality Group. Commissioner reporting for the ICB contract is now delivered through Power BI, replacing more manual processes and improving consistency and timeliness.

Work has begun to automate reports that identify logically inconsistent combinations of values within SystmOne - flagging records for review and correction by the clinical team. This represents a meaningful step toward proactive data quality management rather than retrospective correction.

To sustain and build on this work, a new clinical data assistant post was recruited, with a job description designed specifically to support data correction, report production and the ongoing loading and maintenance of Power BI outputs.

Work to continue to improve further

Data infrastructure is only valuable if the data within it is trustworthy. In 2026/27, the hospice will continue to develop its Power BI capability, extending dashboards and reporting to team leaders and individual service teams - bringing data closer to the people who can act on it. This work directly supports our wider ambitions around equity of access. Understanding who we are and are not reaching, and responding meaningfully, depends entirely on data that is complete, consistent and fit for analysis. Strengthening that foundation remains a priority.

3.2.2 Launch two satellite outpatient clinics

- **Aim**

To launch outpatient clinics at satellite locations, increasing access to specialist palliative care and enabling more patients to be seen in the setting they most wanted.

- **Progress achieved**

Both clinics launched successfully during this period. Specialist palliative care outpatient clinics are now running at two sites - Eltham Community Hospital and the hospice itself - funded by a grant from The Balcombe Charitable Trust. This is a significant addition to how we deliver community specialist palliative care across Greenwich and Bexley, complementing rather than replacing our existing home visiting service.

The Eltham site places our clinicians within a primary and community care setting, supporting closer working with GPs, geriatricians and other non-specialist colleagues. Referrals are accepted from GPs, hospital teams (including Queen Elizabeth, Darent Valley, Guy's and St Thomas', and King's College Hospitals) and through self-referral, with all referrals triaged by an advanced nurse practitioner. Suitable patients already on the community caseload are being transitioned from home visits to clinic-based follow-up, reserving home visits for those who are housebound or have the most complex needs.

Patients can access a range of co-located services, including psychological support, during a single clinic visit. Clinic spaces are equipped with inclusive signage and accessible patient materials, and work is underway with our community development team to engage groups currently underrepresented in our caseload, particularly people from global majority communities.

As a prototype year, we have focused on establishing baselines and testing outcome measures rather than working to fixed targets. We are tracking patient uptake, referral source mix, phase of illness at point of referral, patient-reported outcomes via IPOS and iWantGreatCare, the demographic profile of clinic attenders, and qualitative feedback from patients, staff and referring partners. Early indicators will inform how the model develops in years two and three.

Work to continue to improve further

The clinics are embedded and running well. In 2026/27, the priority is growth - adding at least one further site, with locations informed by population health data and integrated neighbourhood team footprints. We are actively exploring additional space at Eltham and potential sites in GP practices and community venues. As the model matures, we expect to see earlier access to specialist palliative care, stronger equity of access including increased representation from global majority communities, growth in GP referrals, and efficiency gains across the wider community team as clinician travel time reduces and more patients can be seen overall.

3.2.3 Fast Track / Hospice at Home service and workforce review

- **Aim**

To carry out a full service and workforce review of an element of the Greenwich Care Partnership, namely the CHC (Continuing Healthcare) Fast Track coordination and delivery, examining both the service model and the workforce that delivers it, to ensure the service is configured to meet patient need safely and sustainably.

- **Progress achieved**

We have partially completed this review. Working with the Greenwich Continuing Healthcare team, we have reviewed the Standard Operating Procedure for the service, strengthening the clarity and consistency of how it operates. Alongside this, we completed a training needs assessment of the workforce, which gave us a clear picture of the capabilities the team holds and where development is needed.

The most significant finding to emerge was the case for enabling our own healthcare assistants to assist with medication administration, reducing the service's reliance on agency staff for this function. This has shaped a specific, costed commitment for the year ahead.

- **Work to continue to improve further**

The remaining elements of the service and workforce review will be completed in 2026/27. The clearest output of the work so far, training our healthcare assistants to assist with and prompt medication administration, is carried forward as a named quality priority for the year (Priority 3, Section 4.2), where it is set out in full alongside its safety rationale and measurable aim.



3.2.4 Emergency Department & Medical Assessment Unit identification work

- **Aim**

To test whether embedding a Specialist Palliative Care Advanced Nurse Practitioner (ANP) in the Emergency Department (ED) at Queen Elizabeth Hospital, Woolwich, could identify patients with palliative care needs more quickly, support care decisions that reflect their wishes, and prevent admissions that were not right for them. The model was conceived, designed and led by one of our hospital palliative care ANPs, who developed the clinical model and business case from a long-observed gap: patients arriving in ED with palliative needs were frequently not recognised, leading to avoidable admissions and care that did not match their preferences.

- **Progress achieved**

The pilot ran for 14 weeks, from 22 December 2025 to 31 March 2026, funded through Lewisham and Greenwich NHS Trust's Winter Community Shift Programme. Over 47 clinical days, the ANP reviewed 159 patients, completed 551 palliative care screens, newly identified 52 patients with palliative care needs, and initiated or updated 43 Universal Care Plans. She made 28 community and district nursing referrals and nine hospice referrals, frequently for patients who would otherwise have been admitted without community follow-up. Seven avoided admissions were formally recorded, though a review of the daily narrative logs showed consistent under-reporting against a deliberately conservative definition; the true figure was at least 13, alongside at least 12 same-day or rapid discharges facilitated.

A key factor that made this possible was our integrated service model. Because the hospice provides hospital and community palliative care, Continuing Healthcare (CHC) Fast Track brokerage, and inpatient beds within a single organisation, the ANP could update a care plan, refer into the community and arrange a package of care within the same shift, without crossing organisational boundaries. Much of the admission avoidance documented here depended on that single-provider pathway spanning the hospital and community interface.

The pilot also delivered impact beyond activity. Patient and family feedback was consistently and deeply positive, with recurring themes of clear communication about prognosis, emotional support at a distressing moment, and reduced family anxiety when palliative care was present. The ANP supported 105 ED staff interactions, established a palliative care link nurse within the department, and delivered advance care planning teaching to ED nurses, contributing to a measurable shift in staff confidence. The logs also surfaced valuable system intelligence, including out-of-date Universal Care Plans, GP referral patterns that ran counter to recorded patient wishes, and gaps in community coordination, which we are feeding upstream to commissioners and community providers.

Financial analysis using published 2025/26 NHS Payment Scheme prices estimated gross savings of £61,000 to £92,000 against a programme cost of £28,853, a return on investment of 2.1 to 3.2 times over four months, with every key metric improving month on month as the service became established.

- **Work to continue to improve further**

The clearest measure of the pilot's success is that it will continue. On the strength of the emerging evidence, the South East London Integrated Care System End of Life Care group has agreed to fund the programme for a further 12 months beyond the LGT-funded pilot, giving the service the continuity it needs to mature and to build a robust case for recurrent commissioning. In 2026/27 we will strengthen data capture with clearer definitions and a simpler recording tool so that impact is fully evidenced, undertake targeted engagement with ED medical leadership to address pockets of clinical resistance, and continue to feed system intelligence to the ICB and community partners. We will also explore replicating the model at University Hospital Lewisham, as originally envisaged.



3.2.5 Achieve 70% UCP uptake across inpatient and community services

- **Aim**

Improving the uptake of the Pan-London Universal Care Plan (UCP) was a priority improvement area for us during 2025/26. The UCP is a digital, personalised care record that allows a person's wishes, preferences and key clinical information, such as resuscitation decisions and preferred place of care, to be recorded once and then shared securely across the London health and care system, including with GPs, hospitals, the London Ambulance Service, NHS 111 and out-of-hours providers. For people approaching the end of life, having a UCP in place increases the likelihood of being cared for and dying in their preferred place and reduces avoidable hospital attendances and admissions. Strengthening its use therefore sits at the heart of both our personalised care commitment and our wider work to help people remain at home.

- **Progress achieved**

During the year we undertook a structured audit of UCP use across our services, supported by a survey of clinical staff. The audit reviewed 60 cases, comprising 12 cases drawn from each of our inpatient unit, the Queen Elizabeth Hospital team, the Virtual Ward, our Community team and care homes, covering the period April to July 2025.

The audit found that a UCP was in place for 51 of the 60 cases reviewed (85%), which gives us encouraging assurance that the great majority of the people we care for now have a shared, personalised plan available to clinicians across the system. Recording within our own systems was less consistent: 38 of the 60 plans (63%) were marked on SystmOne, indicating that actual UCP presence is higher than our internal coding currently reflects. Completeness also varied across the different sections of the plan. Core information such as contacts and personal details was present in just over half of cases, while anticipatory medication and escalation planning were recorded less consistently. This points to a clear opportunity to improve documentation quality and consistency rather than UCP availability alone.

Our staff survey, completed by 24 respondents, showed strong foundations to build on. Almost all respondents (23 of 24) were aware of the UCP, three quarters (18 of 24) had accessed UCP training, and around 80% felt confident or very confident creating or contributing to a plan. Service-level monitoring and dashboard data indicate that access to, and creation of, UCPs has increased gradually over the past two years, with particular improvement in the availability of UCP information across our Community and Virtual Ward services.

- **Work to continue to improve further**

Building on this work, our priority for 2026/27 is to sustain UCP availability above 70% across our inpatient and community services while closing the gap between the plans that are in place and those reliably recorded in our clinical systems. To support this we will continue our targeted training offer for staff who are less confident, work with system partners to simplify and streamline the plan, embed UCP completion within our urgent care, fast-track discharge and admission-avoidance pathways, and strengthen the consistency of recording so that the improvements we are already seeing are fully and reliably evidenced.

3.3 Performance indicators and data review

3.3.1 Clinical audit

Over the past year, the hospice has undertaken a programme of clinical audit through its Quality Improvement Programme (QIP). This work has focused on the quality and completeness of clinical documentation, an area central to safe, person-centred care.

Audits completed during the period examined the completion of anticipatory medication administration charts and the adequacy of the information required to complete Medications Authorisation and Administration charts - which accompanies a prescription to give clear instructions to district nurses for injectable symptom control medicines at the end of life - ensuring that prescribing and administration records support safe medicines management. A further audit reviewed the completion of Do Not Attempt Cardiopulmonary Resuscitation forms, providing assurance around the documentation of resuscitation decisions. We also audited whether patients' preferred names are recorded in SystmOne (S1), recognising that getting these small but significant details right is an important part of treating people with dignity and respect.

We realise that clinical audit needs renewed focus and capacity in the year ahead, and we are committed to strengthening this programme so that audit findings are consistently used to drive improvements in care.

3.3.2 Hospice UK national benchmarking

We benchmark our inpatient unit against all participating hospices through Hospice UK's quarterly programme, reporting falls, medication incidents and pressure ulcers as rates per thousand occupied bed days. This section sets out what that data told us and, importantly, how we assured ourselves of safe care throughout.

A word on how to read these figures:

Our inpatient unit is small, so a single event can move a monthly rate sharply, and quiet months sat at zero. We therefore look at the shape of the year rather than reacting to any one point, while ensuring we investigate every individual incident in its own right. For every measure, our annual position sat at or below the all-hospice average.

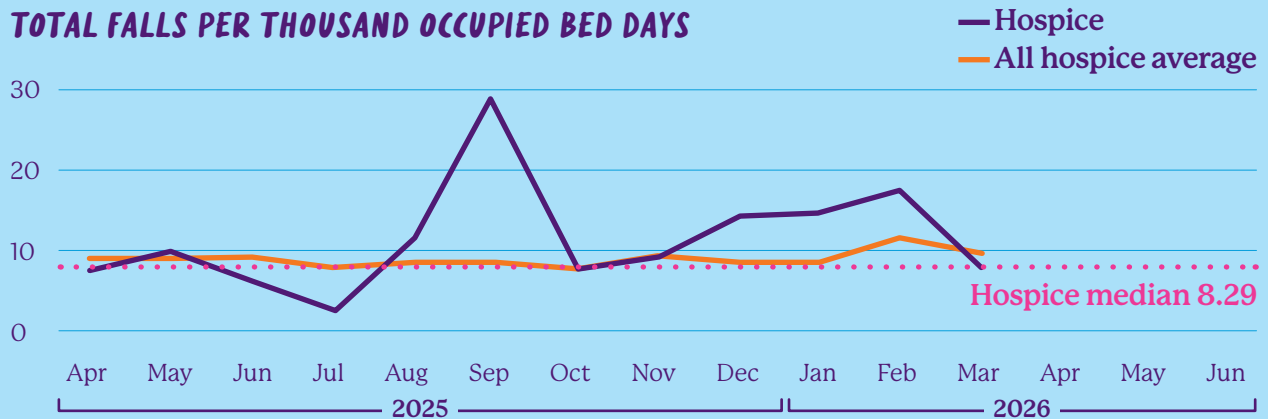


3. REVIEW OF LAST YEAR'S PRIORITIES AND PERFORMANCE

3.3.2.1 Falls

Our median rate (8.29 per thousand occupied bed days) was in line with the sector. We saw an isolated peak in September and a higher-than-average run across the winter months of December to February, before the rate returned to the benchmark by March. Each fall was reviewed individually, with themes considered through our quarterly incident analysis and overseen by the Clinical Quality Group. The winter pattern was examined in the context of patient acuity over that period and informed our continued focus on falls prevention.

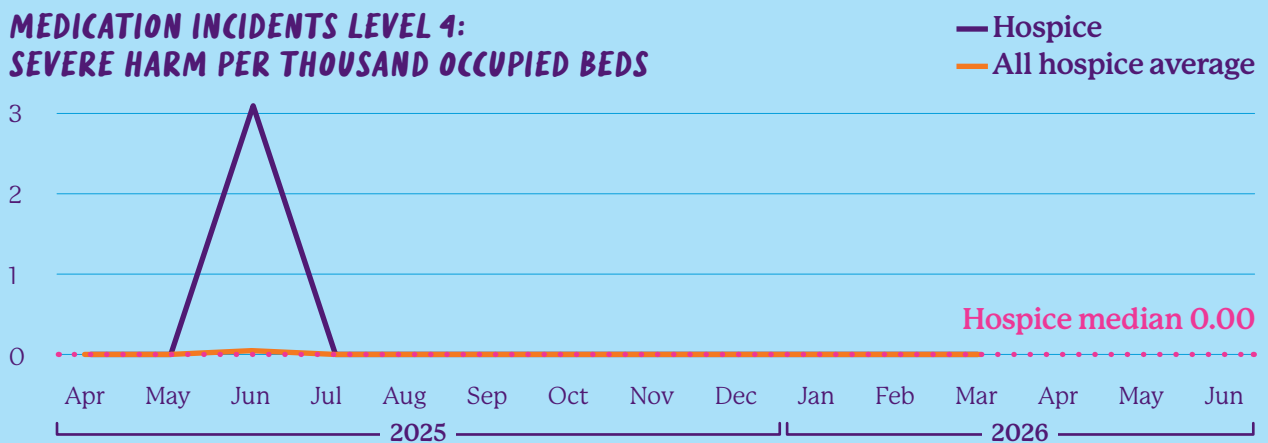
TOTAL FALLS PER THOUSAND OCCUPIED BED DAYS



3.3.2.2 Medication incidents (severe harm)

Our median was zero. There was a single severe-harm incident during the year, in June. It was fully investigated under our incident processes, with learning identified, actioned and shared. The unit otherwise recorded no severe-harm medication incidents across the year, consistent with the sector.

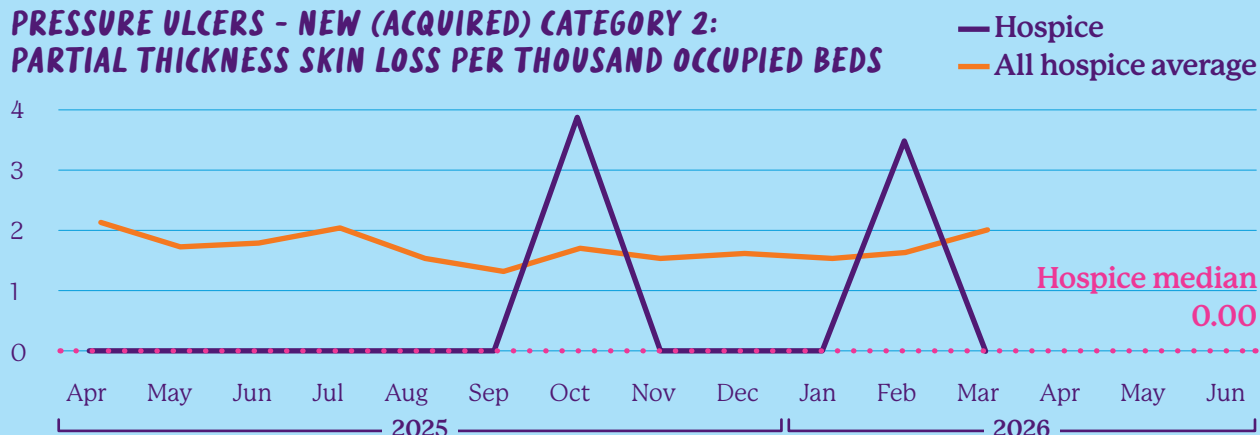
**MEDICATION INCIDENTS LEVEL 4:
SEVERE HARM PER THOUSAND OCCUPIED BEDS**



3.3.2.3 Pressure ulcers acquired in our care

Our median was zero, placing us below the all-hospice average for most of the year. Two months, October and February, recorded acquired Category 2 ulcers. Each was reviewed, with findings fed into our skin-integrity practice and reflected in tissue-viability oversight.

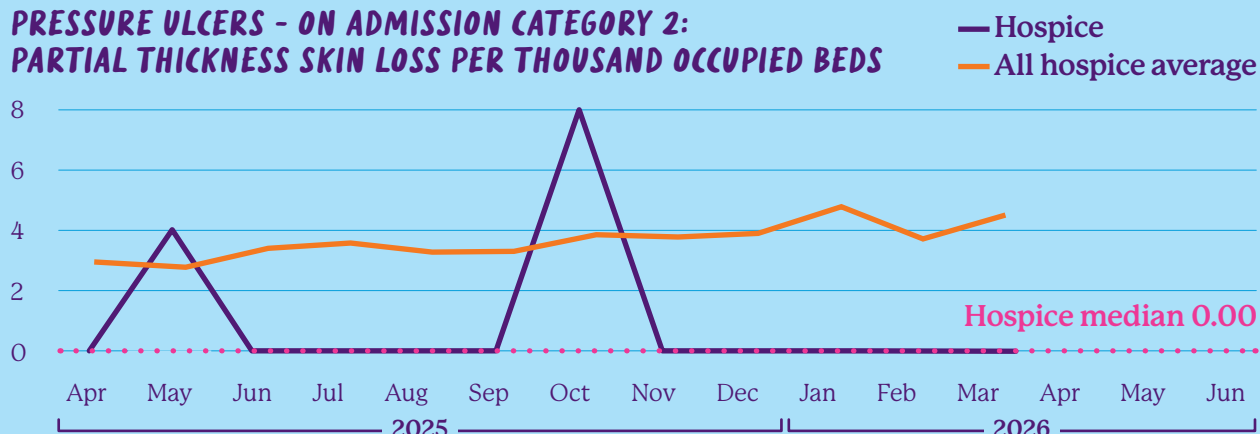
**PRESSURE ULCERS - NEW (ACQUIRED) CATEGORY 2:
PARTIAL THICKNESS SKIN LOSS PER THOUSAND OCCUPIED BEDS**



3.3.2.4 Pressure ulcers present on admission

These ulcers arrived with the patient and reflected the condition of those being admitted rather than the quality of our care. We consistently recorded them. The notable increase in October reflected the thorough assessment and documentation at the point of admission.

**PRESSURE ULCERS - ON ADMISSION CATEGORY 2:
PARTIAL THICKNESS SKIN LOSS PER THOUSAND OCCUPIED BEDS**



Taken together, the data gives the Board reasonable assurance that care on the inpatient unit was safe, that we benchmarked favourably against our peers, and that our governance routes reliably turned incidents into learning.

4. FUTURE QUALITY PRIORITIES AND IMPROVEMENT PLANS



4.1 Outline of future priorities by domain

For 2026/27 we have set four quality priorities, each owned by a named lead and mapped to the Care Quality Commission's domains. Together they span the safety of our clinical care, the effectiveness and responsiveness of our services, and our commitment to reaching everyone who needs us. They build directly on the work reviewed in Section 3 and turn it into commitments we can be held to.

Priority 1: Better ways of working on the inpatient unit (Safe, Effective)

Priority 2: 70% Universal Care Plan completion across community services (Effective, Responsive)

Priority 3: Closing the medication administration gap in community care (Safe)

Priority 4: Reaching communities we currently underserve (Responsive)

Each is set out in full, with its measurable aim and lead, in Section 4.2.

4.2 Planned initiatives and targets

4.2.1 Priority 1: Better ways of working on the inpatient unit

CQC domain: *Safe / Effective*

We will change how the inpatient unit works day to day, so that more of our staff's time goes into direct care. We will introduce structured board rounds and clearer clinical escalation, and relaunch BRIGID, our voice-activated notetaker on SystmOne, for healthcare assistants. We will also develop the HEAT escalation tool to strengthen operational oversight. Alongside this, a ward refurbishment will give every patient a single room.

Measurable aims: BRIGID relaunched and in active use, the HEAT tool implemented, and the new board round structure embedded by Q3 2026/27.

Lead: Inpatient unit team and Director of Nursing and Quality.

4.2.2 Priority 2: 70% Universal Care Plan completion across community services

CQC domain: *Effective / Responsive*

A person's Universal Care Plan (UCP) makes sure their wishes and treatment are visible to everyone caring for them. We will work towards a clear, public target of 70% completion across our community services. The dashboard that tracks this is already live, and UCP champions are in place across each service. This builds directly on last year's work and turns it into a concrete commitment we can be held to.

Measurable aim: 70% UCP completion across community services, tracked quarterly through the UCP dashboard and London Ambulance Service (LAS) audit.

Lead: Community team leads.

4.2.3 Priority 3: Closing the medication administration gap in community care

CQC domain: Safe

This is the most pressing patient safety issue in our community work. People being cared for at home currently rely on agency staff to support their medication, which creates risks around continuity, safety and cost. In 2026/27 we will put a sustainable alternative in place, training our own healthcare assistants (HCA) to assist with and prompt medication administration. The investment will be modest, around £10k, and will be clearly offset by reduced agency costs.

Measurable aim: HCA medication training programme completed, with a measurable fall in agency dependency, monitored through incident data and electronic patient record (EPR) audit.

Lead: Greenwich Care Partnership and Hospice at Home team lead.

4.2.4 Priority 4: Reaching communities we currently underserve

CQC domain: Responsive

Our referral data has shown recurring gaps around religion and ethnicity, and we are committed to a more systematic response. We will run outpatient clinics in more deprived and harder-to-reach areas, refresh our communications materials, and build equity monitoring of referral and access data into our routine reporting. This will be supported by community development work already underway with our Nigerian, Nepalese and Vietnamese communities.

Measurable aims: Ethnicity and religion recorded consistently across all services, equity analysis embedded in quarterly reporting, and outreach activity evidenced through referral data trends.

Lead: Director of Partnerships and community team leads.

5. RESEARCH, EDUCATION AND INNOVATION



5.1 Review of past year's research and educational activities

Investing in our people, contributing to the wider evidence base and continually improving how we work are central to delivering high-quality hospice care. This year has seen significant activity across research, education and innovation.

5.1.1 Hospice UK posters / research

Eight abstracts from the hospice were accepted and displayed at the Hospice UK National Conference, reflecting the breadth of clinical, organisational and community-focused work taking place across our teams:

- From heartbreak to hope: redefining hospice care through Music in Hospices
- Learning together: a whole-organisation approach to quality improvement
- Building an evidence-based approach to equitable community engagement in hospice care
- Building a team culture that powers fundraising success (without chasing the pounds!)
- A qualitative study to better understand the bereavement needs of the Pentecostal community in South-East London
- Nurse-led palliative care outpatient clinic
- Building the evidence: a system-wide data collection on out-of-hours palliative and end of life care
- Closing the gap – a service review of community palliative care referral, time of patient contact and assessment

5.1.2 Foundations

We continue to deliver our rolling 10-week training programme, Foundations in Palliative Medicine, designed to meet the learning objectives of our rotational medical team and new clinical staff. Topics covered include:

- Pain
- Respiratory symptoms
- Gastrointestinal symptoms
- Agitation and delirium
- Difficult conversations
- Emergencies
- Ethics
- Psychosocial spiritual and holistic care
- Frailty
- Palliative medicine in primary care

To date, more than 70 staff members have participated in these sessions

5.1.3 Nursing development

We have continued to run our education programme to support, develop and empower Band 6 nurses within our community team.

5.1.4 LEARN (Leaning into Education And Research Now)

We have continued our monthly 'Continuing Professional Development' sessions for clinical and non-clinical staff. Topics this year have included 'Deaf and Dying: Meeting Unmet Needs' and 'Improving Community Engagement: Experiences of Palliative Care Nurses Caring For Patients of Black African Pentecostal Backgrounds.' We have an exciting and varied programme planned for the coming year.

5.1.5 Placements

We continue to provide placements for resident GP Trainees, Foundation Year 2 Doctors and Student Nurses, and this year we have also welcomed local Elderly Care Resident Doctors working with us on a part-time basis. For the first time since the hospice opened, we have hosted medical students from City St George's, University of London, receiving excellent feedback and looking forward to continuing this partnership in the coming academic year. We have also hosted longer-term placement medical students from King's College London and the University of Birmingham.

5.1.6 External training for our staff

We remain committed to supporting the professional development of our staff. This year, members of the clinical team have undertaken Advanced Assessment Skills courses, worked towards the European Certificate of Essential Palliative Care, and completed a range of other courses that support both individual development and service improvement.

5.1.7 External presentations

Members of the hospice team have contributed to education and training across our local health and care system through Greenwich Protected Learning Time teaching, teaching for the Greenwich and Bexley GP training schemes, teaching for IMT residents and Foundation Year 2 residents at Queen Elizabeth Hospital, Healthcare Assistant (HCA) and Registered Nurse (RN) training at the hospital, monthly Care Homes ECHO teaching delivered to care home staff across Greenwich and Bexley, teaching for the Elderly Care Department Professional Development Meeting, and Grand Round presentations at Queen Elizabeth Hospital.

5.1.8 Mentorship

We have continued to learn from one another through mentoring relationships developing both within and across departments. These relationships have supported a number of staff to feel more confident, empowered and ready to pursue further development within their roles as well as future promotion opportunities. We believe that investing in our people is essential to delivering high-quality hospice care, and we are committed to creating a workplace where every member of staff is encouraged and supported to bring their whole self to work, contribute their unique skills and experience, and play an active role in our shared purpose of helping people to live as well as possible for whatever time they have.

5.1.9 Quality improvement

To encourage greater pan-hospice ownership of quality improvement and to harness the passion, initiative and creativity of our staff, we have introduced quarterly 'Quality Improvement Project Presentations'. All staff, clinical and non-clinical, are invited to contribute, and this has led to a wide range of presentations and shared learning opportunities, including:

- Community occupational therapy in terminally ill patients
- Improving collaboration between the palliative virtual ward and district nursing services
- Relational fundraising
- Signs of deterioration in health among adults with darker skin tones
- Palliative medicine in the emergency department
- Including children in hospice memorial events

We look forward to continuing and expanding this programme.

5.2 Future research and training priorities

Over the coming year, we plan to develop a Foundations programme specifically for healthcare assistants, extending the structured learning we offer to a wider part of our workforce. We also intend to strengthen educational collaboration across teams, recognising and sharing the breadth of expertise that exists within the organisation.

We look forward to welcoming a Practice Educator to the hospice team. Alongside this, we aim to build staff knowledge and confidence in research processes and protocols, with a view to participating in national research projects in the future in partnership with two local hospices, St Christopher's Hospice and Royal Trinity Hospice.

5.3 Partnerships and collaborative initiatives

Much of our research, education and innovation work is strengthened through partnership with others across our local system and the wider hospice sector.

We are developing a shared Practice Educator post with the University of Greenwich, bringing additional educational capacity and academic links to the hospice team. We are also establishing a shared research post with St Christopher's Hospice and Royal Trinity Hospice, which will support research training across the three organisations and, in time, the implementation of research-informed practice within our own services.

We also participate regularly in the Clinical Leads Collaboration Evenings held at the quarterly Greenwich Summit, providing a valuable forum for shared learning, joint problem-solving and closer working across the local palliative and end of life care community.

We are regular and active members of a number of governance forums in place, such as the Healthier Greenwich Partnership and the Health & Wellbeing Partnership in Bexley, as well as being members of the Home First Strategic and Operational Groups.

6. SERVICE USER AND WORKFORCE ENGAGEMENT



6.1 Service user feedback and involvement (iWGC, complaints, compliments)

6.1.1 Service user feedback

During 2025/26 the hospice gathered patient and family experience feedback through the iWantGreatCare (iWGC) platform across our community, inpatient, outpatient, and therapy services. Seven responses were received during the year. All rated their overall experience as excellent (5 out of 5), with consistently high scores for being kept informed (100%), being involved in decisions (100%) and being treated with dignity and respect (mean 4.7 out of 5). Free-text feedback highlighted the compassion, kindness and professionalism of our teams, and the difference our therapy services made to patients' mobility, confidence and independence.

Where feedback identified room for improvement, this centred on continuity of named clinicians during periods of staff leave, clearer communication of community visit timings, and the timeliness of onward fast-track referrals. These themes are being used to inform service learning. As set out earlier in this report, the low volume of responses reflects reduced capacity for feedback collection during a period of personnel change, and improving the consistency and volume of iWGC data is a named priority within team objectives for 2026/27.

6.1.2 Incidents

6.1.2.1 Reporting profile

During 2025/26 the hospice recorded 222 clinical incidents across its inpatient, community and therapy services. Clinical incidents accounted for 58% of all incidents reported organisation-wide, reflecting the clinical nature of our core work. Reporting volumes were stable across the four quarters with no upward trend, which we interpret as a settled and consistently applied reporting culture rather than a rise in events. A healthy level of incident reporting is itself a marker of an open and learning safety culture, and the hospice continues to encourage staff to report freely.

The profile of clinical incidents was broadly balanced across the recognised risk areas in specialist palliative care. Medication incidents, controlled and non-controlled combined, formed the largest group at 41% of clinical reports. The vast majority of these are minor errors, largely related to the use of our bespoke electronic drug chart. They are identified and corrected through routine good practice procedures and, as a result, do not lead to patient harm. Pressure ulcers, slips trips and falls, and medication each accounted for around a fifth of activity. Documentation and safeguarding incidents were comparatively few. This distribution is consistent with the clinical risks expected in a hospice caring for frail patients with complex symptom needs at the end of life and gives no indication of an outlier category requiring exceptional escalation.

6.1.2.2 Themes and patient experience

A defining feature of the year's clinical incidents is the visibility of families and carers within them: a family member or carer was referenced in 60% of clinical reports. This reflects the reality that hospice care is delivered in the presence of, and in partnership with, those closest to the patient, and it means the patient and family voice is captured directly within our incident records.

When we examined that voice thematically, the experience concerns raised by patients and families clustered not around the technical categories that dominate by count, but around how care was experienced. Three themes recurred:

- **Dignity and the manner of personal care**

A number of reports concerned the way personal care, repositioning and washing were delivered, with patients or families describing care as rushed or insufficiently gentle. These prompt important learning about consistency of compassionate, unhurried care, particularly for patients at the end of life, and about the supervision and support of care staff

- **Communication at the end of life and around death**

Several incidents related to how significant information was conveyed, including the breaking of bad news and the conduct of care during the dying phase, both by hospice teams and by external community providers working alongside us. These are the events with the greatest potential to affect family experience and bereavement

- **Responsiveness and continuity in the community**

Themes included delays in responding to family-reported deterioration and gaps in the availability of medication documentation in patients' homes

The clear learning is that the experiential dimension of an incident is at least as significant as its clinical classification. A medication error or a fall is recorded as such, but what patients and families tell us about is the distress, the communication and the human manner of the response. The hospice is using this insight to ensure incident review considers experience and dignity alongside clinical fact.

6.1.2.3 Governance, oversight and assurance

Clinical incidents are reported through the hospice's incident management system, reviewed by senior clinical staff, and closed at ward or service level. The Senior Leadership Team and clinical governance arrangements provide oversight of patterns and learning.

In reviewing this year's data we have identified two areas where our governance and assurance processes can be strengthened, and we are transparent about these:

- **Recording of outcome and harm**

A proportion of clinical incidents did not carry a completed status, closure or degree-of-harm grading. Strengthening the consistency of these fields will improve our ability to evidence timely investigation, demonstrate the level of actual harm to patients, and assure ourselves and our commissioners that learning is closed out

- **Thematic, cross-incident review**

Incidents have been reviewed and closed individually. Introducing a regular thematic review, looking across incidents to identify recurring patterns by theme, service and where appropriate by team or individual, will allow us to detect and act on clusters that individual closures can miss. This is particularly important for experience and dignity themes, which surface across multiple separate reports rather than in any single one

Focus for 2026/27

The hospice will embed routine thematic incident review within its clinical governance cycle, improve completeness of incident outcome and harm recording, and ensure that patient and family experience is explicitly weighed in incident learning, with a particular emphasis on dignity in personal care and on communication during the dying phase.

6.1.3 Complaints

Volume and status

We received a total of nine complaints. Eight of these were closed and one open at the time of writing (date extended due to multi-agency nature of complaint investigation, not overdue).

Quarterly distribution

- Q1: Four complaints
- Q2: Two complaints
- Q3: Two complaints
- Q4: One complaint

Themes

- Service quality: Five
- Staff communication/attitude: Two
- Staff performance: Two
- Service availability: Two

Services complained about

- Community Specialist Palliative Care: Three
- Inpatient unit: Three
- Greenwich Care Partnership: Two
- Other: One

Complainants

All nine were from relatives/carers. No patient-direct complaints recorded.

Format

- Email: Five
- Phone: Two
- Letter: One
- Incident Form: One

Timelines (closed cases)

Of the eight closed cases, six were closed within the 21 working day standard, with two requiring extensions due to availability of those involved in the investigation process (but closed within the agreed extension period).

Outcomes

Five complaints were not upheld on evidence.

Two complaints resulted in learning actions being identified and implemented – these complaints had an underlying theme of staff communication.

One complaint was delegated to a subcontracted partner organisation for investigation and resolution.

6.1.4 Compliments

Compliments are received formally and anecdotally and are recorded when we are made aware of them.

Volume

We recorded 19 compliments during the year. While these give us valuable insight into what people appreciate about our care, the data is not complete enough to provide a reliable month-by-month or quarterly breakdown. Several compliments received by our Community team (entries 7–17) were not recorded with a date, highlighting an area where we can strengthen our recording processes in the year ahead.

Service area

- Community specialist palliative care: 13
- Inpatient unit: Four
- Psychological support/HOLG: One
- General: One

Source

- Patients: Six
- Next of kin/relatives/carers: 10
- Colleague referral (staff passing on feedback): Three

Themes

The compliments cluster around a few consistent themes:

- Compassionate and dignified end of life care
- Practical impact of equipment and support
- Emotional support for families and carers
- Staff professionalism and calm under pressure
- Reversing feelings of abandonment by the system

A consistent thread runs through our feedback this year: across iWantGreatCare, complaints and incident records alike, the experience we capture is overwhelmingly relayed by families and carers rather than by patients directly. All nine of this year's complaints came from relatives or carers, and a family member was referenced in three in five clinical incidents. This reflects the reality of care at the end of life, where families are present and advocating, but it also sharpens a question we are taking seriously around how we hear the dying patient's own voice while we still can. Strengthening direct patient feedback sits within our 2026/27 priorities.

6.2 Workforce engagement and development

The hospice undertakes its Picker staff survey on an alternate-year cycle. Having surveyed in February 2025, no survey was undertaken in the 2025/26 reporting year. During 2025/26 our focus was therefore on engaging colleagues with the 2025 results and delivering the resulting action plan, which forms the basis of the workforce engagement and development activity reported here.

The 2025 survey affirmed a number of cultural strengths: strong team relationships, pride in work and a clear sense that colleagues' roles make a difference, alongside measurable improvement in work-life balance and wellbeing, line management support, and the appraisal experience. Colleagues also told us where they wanted to see improvement, including fairness and support following incidents, career development opportunities, IT resources, confidence in raising concerns, and resourcing and workload pressures in some teams.

We engaged staff directly in making sense of these findings. Results were taken out to colleagues through a series of meetings with all-staff, clinical, retail, the Wellbeing Champions and the Management Forum, so that action planning was informed by those affected rather than designed for them. The resulting plan was reviewed by the Senior Leadership Team and presented to the Board, providing governance oversight of our response.

On development, the action plan set in train a more structured approach to growing our people. This included introducing training needs analysis following appraisal, a quarterly appraisal follow-up process so that progress against objectives is actively reviewed, and use of the talent management functionality within our CIPHR system. Clinically, we progressed a practice development role in partnership with the University of Greenwich and took development planning to our Clinical Quality Group. Across the organisation we committed to mapping and publicising development opportunities, promoting shadowing, coaching and secondments, and establishing clearer governance for training through a training and education group with defined budgetary routes.

On engagement, wellbeing and culture, the plan prioritised: protected time for clinical supervision, supported by awareness sessions and monitored through attendance and pulse feedback; a refresh of our Freedom to Speak Up arrangements and the independent Work in Confidence service, promoted directly in team meetings; and a programme of bullying and harassment awareness and training for staff and managers, responding to colleagues' feedback on confidence in speaking up. We also undertook salary benchmarking against NHS and sector comparators, increased staffing in retail to reduce lone working, and encouraged cross-team collaboration through shared objectives and jointly led projects.

Progress against the plan is monitored through our people and wellbeing governance as part of our EPIC Committee, with the impact of these actions to be formally tested in the next Picker staff survey.

7. QUALITY ASSURANCE AND EXTERNAL ASSURANCE



7.1 Internal quality assurance processes

Community Hospice operates a clinical audit framework to ensure that care standards are consistently met and improved. Scheduled reviews of clinical practice, medicines management and environmental safety are carried out by teams. Findings are considered at bi-monthly Quality and Safety Committee meetings, where areas for action are identified, responsibilities allocated and progress against improvement plans monitored. All untoward events are recorded in the hospice's incident reporting system and analysed for themes. Lessons learned are shared in multidisciplinary briefings and incorporated into targeted training and reflective-practice workshops. Meanwhile, real-time time patient feedback system captures feedback from the people using our services and these insights inform staff development programmes and service reviews. Aggregate reports on audit results, incident trends and patient feedback are presented regularly to the Board of Trustees and senior stakeholders.

7.2 External assurance and stakeholder feedback

Community Hospice is registered with and regulated by the Care Quality Commission (CQC). At our most recent inspection, in September 2022, the hospice was rated as good overall, with ratings of good for each of the safe, effective, caring, responsive domains and outstanding for the well-led domain. We remain compliant with the CQC's fundamental standards, and the assurance processes set out in this account are designed to maintain and build on that position.

Community Hospice adheres fully to the NHS Quality Account requirements through regular audit cycles and clear performance monitoring against national standards. The following key metrics and external audit outcomes demonstrate the hospice's compliance:

- Data Security and Protection Toolkit – attainment levels reviewed and submitted in line with NHS Digital deadlines
- Clinical coding error rate – monitored quarterly to ensure accurate patient records
- Commissioning for Quality and Innovation (CQUIN) schemes – not applicable in this reporting period
- National Audit of Care at the End of Life (NACEL) – participation in the Lewisham and Greenwich NHS Trust submission for the national audit
- Infection prevention and control (IPC) audits – conducted by an external expert from Queen Elizabeth Hospital
- Hospice UK quarterly benchmarking – benchmarking of inpatient unit occupancy, throughput, falls, medication errors and the number of people admitted with pressure sores (and acquired on the unit)

7.2.1 Participation in networks

Recognising that the hospice plays a role in influencing end of life care provided by all partners in our health and social care system, members of the team participated in the following meetings and working groups throughout 2025/26:

- **Wider-system groups**
 - Healthier Greenwich Partnership
 - Bexley Wellbeing Partnership
 - Resplendent
 - Home First Strategic Boards in Greenwich and Bexley
 - Home First Operations Groups in Greenwich and Bexley
 - Community-Based Care Board in Bexley
 - Adult Social Care Personalisation Board (Bexley)
 - Controlled Drugs Local Intelligence Network
 - Greenwich Emergency Planning Liaison Group
- **Community and Voluntary Sector Networks**
 - METROGAVS Steering Group
 - Bexley Voluntary Forum
- **Hospice-sector groups**
 - Hospice UK National and Regional Clinical Leads Group
 - Hospice UK London CEO Group
 - Hospice UK Technology Leaders' Network
 - London PSIRF Group
- **End of life care networks**
 - South East London Palliative and End of Life Care Steering Group
 - Oxleas End of Life Care Steering Group
 - Lewisham and Greenwich NHS Trust End of Life Care Steering Group
 - College of Paramedics – Palliative and End of Life Care Special Interest Group
- **Community and Voluntary Sector Networks**
 - METROGAVS Steering Group
 - Bexley Voluntary Forum
- **Hospice-sector groups**
 - Hospice UK National and Regional Clinical Leads Group
 - Hospice UK London CEO Group
 - London PSIRF Group

8. FINANCIAL AND RESOURCE OVERVIEW



8.1 Funding and resource allocation

<i>INCOME</i>	<i>% OF TOTAL INCOME</i>
Charitable activities	46%
General donations	11%
Legacies	15%
Charity shop income	18%
Lottery income	3%
Other trading activities	8%

<i>EXPENDITURE</i>	<i>% OF TOTAL EXPENDITURE</i>
Operating a Hospice & Clinical expense	80%
Fundraising cost	5%
Charity shop expenditure	14%
Lottery expenditure	1%

8.2 Impact of financial performance on service quality

For 2026/27, the Community Hospice has planned for a deficit budget, a decision made carefully and with the full approval of our Board of Trustees. This approach reflects both the ongoing financial pressures facing the sector and our determination to continue providing high-quality care to everyone who needs us.

In setting this year's budget, we followed clear principles to guide how we use our resources. First and foremost, we have prioritised resourcing our teams to ensure we can deliver safe, effective care every day. Alongside this, we have protected investment in our income generating teams – our shops and fundraising work – so that we can continue to grow our voluntary income and strengthen our position for the future. We have also ring-fenced roles dedicated to tackling inequalities, ensuring our services remain accessible and inclusive across all the communities we serve.

8. FINANCIAL AND RESOURCE OVERVIEW

Every team at the hospice developed a detailed operational plan, which was fully costed and included in the overall budget. This has helped ensure that spending decisions are rooted in real service needs and reflect the priorities of each area of work. Although a deficit position presents challenges, we are taking a proactive and managed approach.

Our continued investment in key services and our long-term income strategy are supported by oversight from our Finance, Information Governance and Information Technology (FIGIT) Committee. This ensures strong financial governance as we work towards long-term sustainability, without compromising the quality or reach of our care.

That notwithstanding, we are actively contributing to pieces of work which we hope will address the structural challenge with statutory funding of the hospice sector: the Modern Service Framework for Palliative and End of Life Care and a South East London ICB-led review of the funding of palliative care. We are hopeful that these programmes will lead to a fairer flow of funding for hospices in the future.

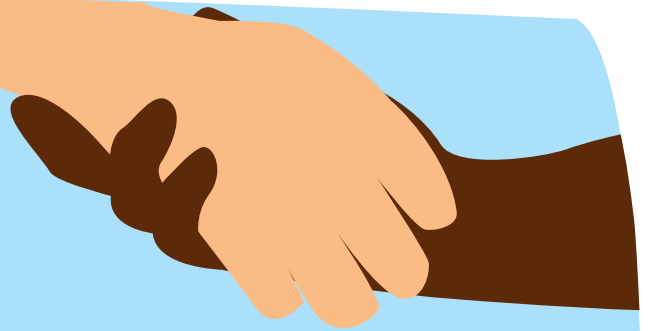


9. CASE STUDIES



Case study 1

When we asked Margaret* what palliative care meant to her, her answer was simple. It is care you can rely on. As she put it, if you contact the team, someone will turn up to see you or speak to you.



Recently the team has focused on Margaret's pain. We have reviewed her pain medication and kept an eye on things like her blood pressure, and the pain has started to ease.

Margaret is clear about what lies ahead. She knows the pain will not disappear completely, but what matters most to her now is being comfortable enough to get a good night's sleep, and she feels supported to do exactly that. "It's just the old body," she said. "Everything takes time, doesn't it?"

Our team visits Margaret around once a month, popping in to see how she is. These regular visits are one of the small things that make the biggest difference to her. When we asked whether there was anything we could be doing better, her answer was warm and to the point: no, everyone does their job well.

What stayed with us most was Margaret's thoughtfulness towards the people caring for her. She sees the team as people "just like me," who have their own pains and pressures, and she wanted to make sure they felt appreciated. "Thanks to everyone for coming and doing whatever they have to do," she said. "Everything helps. It's better than being left on your own and no one caring."

Margaret's experience reflects what we aim for in every relationship. We stay proactive, keeping in touch and managing symptoms before they escalate. We are honest about what we can and cannot change. And we want every person to feel more supported and less alone than when we arrived.

**Name changed to protect anonymity.*

Case study 2

For Arthur* and his wife, hospice care arrived completely out of the blue, and it was not what they expected. “I didn’t know it existed the way it does,” Arthur told us. He had been to hospital before and had sat with people as they died, but he had no idea that the hospice team came out to people in their own homes.

That reach surprised him most. He had not realised the team travelled across the borough, out from our Abbey Wood base to homes in Blackheath and Greenwich, to visit people where they live. The support, in his words, meant a lot.

When we asked whether there was anything we could improve, Arthur’s answer was straightforward: nothing he was aware of. What came through most clearly was his gratitude. “I can only say thank you to everybody for their support.”

Arthur’s experience speaks to something we work hard to get right. Good hospice care does not wait for people to find it. We come to them, in their own homes, wherever they are across Greenwich and Bexley, so that no one has to navigate the end of life alone or unsupported.

**Name changed to protect anonymity.*

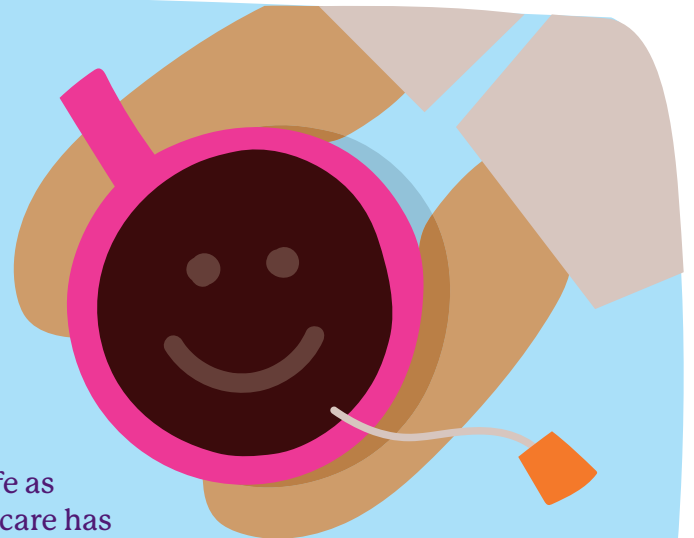


Case study 3

For Melanie*, an appointment at our nurse-led hospice outpatient clinic allowed her to access support for her symptoms and discuss future plans.

When her oncologist mentioned referring Melanie to palliative care she was frightened as she thought we only offered end of life care and she “wasn’t there yet”. Coming to clinic has helped Melanie in getting the support she needed when she needed it, in managing her pain and guidance in applying for a blue badge to help support her continue living her life as independently as possible. Melanie’s fear of hospice care has gone and she enjoys having a cup of tea and sandwich before or after her clinic appointment.

**Name changed to protect anonymity.*



10. GLOSSARY OF TERMS AND ACRONYMS



ANP Advanced Nurse Practitioner – A senior nurse trained to assess, diagnose and make clinical decisions, often working independently.

Board round – A structured, whole-team review of every patient on the ward, used to coordinate care and plan safely.

BRIGID – The hospice’s voice-activated note-taking tool, used within SystmOne to reduce time spent on documentation.

CHC (Continuing Healthcare) Fast Track – An NHS-funded care pathway that arranges urgent care packages quickly for people with a rapidly deteriorating condition who are nearing the end of life.

CIPHR – The hospice’s HR and people-management software system.

CQC Care Quality Commission – The independent regulator of health and social care services in England.

CQG Clinical Quality Group – A governance group within the hospice that oversees clinical quality, safety, audit and policy. Reports to the QSC.

CQUIN Commissioning for Quality and Innovation – An NHS scheme that links a portion of provider funding to quality-improvement goals.

Duty of candour – The legal duty (Regulation 20) to be open and honest with patients and families when something goes wrong with their care.

DSPT Data Security and Protection Toolkit – The NHS self-assessment that organisations complete annually to evidence safe handling of patient data and information.

ED Emergency Department – The hospital department treating urgent and emergency presentations; the setting for the ANP pilot at Queen Elizabeth Hospital.

EPIC Equity, People and Inclusion Committee – A Board sub-committee responsible for staff wellbeing, equality, diversity and inclusion.

EPR Electronic Patient Record – A digital record of a patient’s care; the hospice’s EPR system is SystmOne.

FIGIT – The Finance, Information Governance and Information Technology Committee, a Board sub-committee providing financial and information governance oversight.

Global majority – A collective term for people from Black, Asian, mixed-heritage and other ethnic groups who together make up the majority of the world’s population, used in preference to “ethnic minority.”

HEAT tool – An operational escalation tool used to strengthen day-to-day oversight on the inpatient unit.

HOLG Holding on, Letting Go – a psychological support group aimed at supporting the children of people who have died under hospice care.

Hospice UK – The national charity for the hospice sector, which runs the quarterly benchmarking programme and the annual national conference.

ICB Integrated Care Board – An NHS body that plans and funds health services in a local area; the hospice is commissioned by NHS South East London ICB.

ICS Integrated Care System – The wider partnership of NHS, local authority and other partners across an area; South East London ICS (SELICS) is the system the hospice works within.

IPC Infection Prevention and Control – Measures and practices used to prevent the spread of infection in care settings.

IPOS Integrated Palliative care Outcome Scale – A validated questionnaire that captures patients' symptoms and concerns to measure outcomes over time.

IPU Inpatient Unit – The hospice's specialist ward for people needing intensive symptom management or end of life care.

iWantGreatCare (iWGC) – The independent platform the hospice uses to gather real-time ratings and comments from patients and carers.

KLOE Key Lines of Enquiry – The structured questions the CQC uses to assess services under each of its domains.

LAS – London Ambulance Service.

LGT Lewisham and Greenwich NHS Trust – The local NHS acute trust, which runs Queen Elizabeth Hospital and funded the ANP pilot's initial phase.

MAU Medical Assessment Unit – A hospital unit for the short-term assessment of patients referred as medical emergencies.

METROGAVS METRO Greenwich Action for Voluntary Service – An infrastructure organisation that supports all voluntary and third sector organisations in the Royal Borough of Greenwich.

NACEL National Audit of Care at the End of Life – A national review of the quality of care provided to people in the last days of life.

NHS National Health Service – The publicly funded healthcare system of the United Kingdom.

NHSE NHS England – The national body overseeing the budget, planning and operation of the NHS in England.

NHSPS NHS Payment Scheme – The national rules and prices that set how NHS providers are paid for care; used in the ANP pilot's financial analysis.

Occupied bed days – A measure of inpatient activity (one occupied bed for one day); benchmarking rates are expressed per thousand occupied bed days to allow fair comparison between hospices.

OneBexley – The adult social care alliance, led by the hospice, providing social work and carer assessments.

Power BI – A Microsoft data tool used to build the hospice's live reporting dashboards.

PPD Preferred Place of Death – Where a person has said they would most like to die; compared against where death actually occurred to assess whether wishes were met.

PSIRF Patient Safety Incident Response Framework – The NHS approach to responding to and learning from patient safety incidents; the hospice holds a weekly PSIRF meeting.

QIP Quality Improvement Plan – A prioritised, structured programme of projects to improve service quality and safety.

QSC Quality and Safety Committee – A formal sub-committee of the Board providing oversight of clinical quality and safety.

SystemOne – The hospice’s electronic patient record system.

UCP Universal Care Plan – A shared digital record (used London-wide, “Pan-London”) that makes a person’s treatment wishes and preferences visible to everyone involved in their care.

Vantage – The hospice’s incident-reporting system.

VOICES – A survey gathering the views of bereaved relatives and carers about the quality of end of life care (from “Views of Informal Carers, Evaluation of Services”).

VW Virtual Ward – A service providing short-term, intensive clinical support and remote monitoring so people can be cared for at home rather than in hospital.

II. APPENDICES



11.1 Activity and outcomes data

11.1.1 Referrals and discharges (overview)

MEASURE	2024-25	2025-26	CHANGE
Total referrals	4,634	5,131	+10.7%
Accepted referrals	4,413	4,927	+11.6%
Not accepted	221	204	-7.7%
Unique patients (by NHS no.)	2,224	2,388	+7.4%
Accepted unique patients	2,122	2,308	+8.8%
Total discharges	4,583	5,041	+10.0%
Unique discharges (by NHS no.)	2,274	2,293	+0.8%

11.1.2 Referrals by service

SERVICE	ALL REF 2024-25	ALL REF 2025-26	% CHANGE
IPU	375	468	+24.8%
Rehab	378	301	-20.4%
Hospital	1,326	1,449	+9.3%
Community	1,592	1,745	+9.6%
Psychosocial	294	433	+47.3%
GCP	284	315	+10.9%
Virtual Ward	177	260	+46.9%
Outpatient Clinic	0	151	new

11.1.3 Community referrals by locality (all referrals)

LOCALITY	2024-25	2025-26	% CHANGE
Bexley	625	677	+8.3%
Care Home	428	474	+10.7%
Greenwich	539	549	+1.9%

11.1.4 Hospital team discharge location (all referrals)

LOCATION	2024-25	2025-26
Home	215	298
Hospice	71	82
Hospital	878	806
Nursing Home	86	117
Other (prison, relative's home, rehab unit)	2	2
Unknown / Not Recorded	114	137

Analysis

Total referral activity grew 10.7% to 5,131, with acceptance holding at 96.0% (up from 95.2%), while the unique patient population rose more modestly at 7.4% to 2,388, indicating more referrals per patient and rising service intensity.

On an all-referral basis volume grew across almost every service, led by Psychosocial (+47.3%) and Virtual Ward (+46.9%), with a newly recorded Outpatient Clinic stream; Rehab was the only fall (-20.4%), which is largely explained by the decommissioning of one area of service (in 24/25 the Community Hospice hosted an occupational therapist who was working alongside the generalist community occupational therapy service in Greenwich) and periods where the team was holding vacancies, reducing capacity.

Measured by all referrals, every community locality grew (Care Home +10.7%, Bexley +8.3%, Greenwich +1.9%).

On hospital discharge location, the movement from hospital (878 to 806) toward home (215 to 298) is the notable shift.

11.2 Equity data

11.2.1 Age and gender (unique referrals)

GENDER	2024-25	%	2025-26	%
Female	1,282	54.5%	1,238	52.6%
Male	1,065	45.3%	1,115	47.4%
Indeterminate	4	0.2%	0	0%
Total	2,351		2,353	

11.2.2 Ethnicity (recorded patients only, sums to 100%)

AGE BAND	2024-25	%	2025-26	%
0-17	1	0.0	11	0.5
18-24	6	0.3	5	0.2
25-64	290	13.7	350	15.1
65-74	316	14.9	348	15.0
75-84	587	27.7	646	27.8
85+	920	43.4	960	41.4

11.2.3 Ethnicity (recorded patients only, sums to 100%)

ETHNIC GROUP	2024-25	%	2025-26	%
White British	1,222	73.4%	1,343	76.3%
Other White	143	8.6%	78	4.4%
Mixed / Multiple	66	4.0%	58	3.3%
Asian / Asian British	85	5.1%	99	5.6%
Black / Black British	115	6.9%	112	6.4%
Other	34	2.0%	70	4.0%
Recorded base	1,665	100%	1,760	100%
<i>Ethnicity not recorded</i>	<i>377 of 2,042</i>	<i>18.5%</i>	<i>675 of 2,435</i>	<i>27.7%</i>

11.2.4 Primary diagnosis (recorded patients only, sums to 100%)

CATEGORY	2024-25	%	2025-26	%
Cancer	730	40.3%	620	40.9%
Dementia	243	13.4%	280	18.5%
Respiratory	228	12.6%	155	10.2%
Frailty / Old Age	128	7.1%	172	11.3%
Cardiovascular	138	7.6%	104	6.9%
Neurological	119	6.6%	35	2.3%
Renal	63	3.5%	39	2.6%
Sepsis	47	2.6%	37	2.4%
Liver	42	2.3%	10	0.7%
Coronavirus	2	0.1%	2	0.1%
Other	71	3.9%	62	4.1%
Recorded base	1,811	100%	1,516	100%
<i>Diagnosis not recorded</i>	<i>558 of 2,369</i>	<i>23.6%</i>	<i>668 of 2,184</i>	<i>30.6%</i>

11.2.5 Sexual orientation (unique referrals)

	24-25	%	25-26	%
Heterosexual	1,005	87.8%	1,245	52.9%
Gay or Lesbian	8	0.7%	12	0.5%
Bisexual	0	0%	0	0%
Prefer not to say	112	9.8%	216	9.2%
Other, not listed	20	1.7%	6	0.3%
Not Recorded	0	0%	874	37.1%
Total	1,145		2,353	

11.2.6 Preferred place of death (PPD) vs actual death location, 25-26

DEATH LOCATION	PPD COUNT	MET (YES)	NOT MET (NO)	NOT RECORDED	% MET
Home	605	377	194	34	62.3%
Hospice	236	105	111	20	44.5%
Hospital	84	81	3	0	96.4%
Residential / Nursing Home	128	75	48	5	58.6%
Care Home	94	0	92	2	0%

Analysis

The referred population remains old and slightly female-majority: 62.4% are aged 78+ and 23% are 90+, with women at 52.6%, broadly stable year on year. Among patients whose ethnicity was captured, White British rose to 76.3% (from 73.4%), with recorded non-White-British representation slipping to 23.7%; given the diversity of Greenwich and Bexley, under-recording as well as under-reach is the likely explanation, reinforced by completeness rising from 18.5% to 27.7% not recorded. On diagnosis, cancer holds steady at around 41% of recorded patients while dementia (13.4% to 18.5%) and frailty (7.1% to 11.3%) grow markedly, consistent with the shift toward non-malignant and multi-morbid need. Where a place of death preference was expressed and an outcome captured, around 64% of wishes were met, strongest for hospital deaths (96.4%) and weakest for hospice deaths (44.5%).

11.3 Service user feedback (iWGC summary)

During 2025/26 the hospice gathered patient and family experience feedback through the iWantGreatCare (iWGC) platform across our community, inpatient, outpatient and therapy services. Seven responses were received during the year. All rated their overall experience as excellent (5 out of 5), with consistently high scores for being kept informed (100%), being involved in decisions (100%) and being treated with dignity and respect (mean 4.7 out of 5). Free-text feedback highlighted the compassion, kindness and professionalism of our teams, and the difference our therapy services made to patients' mobility, confidence and independence.

Where feedback identified room for improvement, this centred on continuity of named clinicians during periods of staff leave, clearer communication of community visit timings, and the timeliness of onward fast-track referrals. These themes are being used to inform service learning. As set out earlier in this report, the low volume of responses reflects reduced capacity for feedback collection during a period of personnel change, and improving the consistency and volume of iWGC data is a named priority within team objectives for 2026/27.

11.4 Methodology and data sources

We have written this account with reference to our strategy and sub-strategy documents, our scheme of delegation, the terms of reference of our groups and sub-committees, and the minutes and reports from those groups.

The data is drawn from several of our own systems:

- **SystmOne**, our electronic patient record system
- **Vantage**, our incident reporting system
- **iWantGreatCare**, our patient feedback system
- **CIPHR**, our HR system

Where information does not yet fit neatly into these systems, we have also drawn on supporting spreadsheets. In addition, we have relied on data from two external sources: Picker, who deliver our annual staff survey, and Hospice UK, who supply the benchmarking data behind several of our quality measures.

COMMUNITY
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