

# Healthier Communities Select Committee Agenda

Thursday, 20 July 2017

**7.00 pm,**  
Civic Suite  
Catford  
SE6 4RU

For more information contact: John Bardens (02083149976)

## Part 1

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# Healthier Communities Select Committee Members

Members of the committee, listed below, are summoned to attend the meeting to be held on Thursday, 20 July 2017.

Barry Quirk, Chief Executive  
Tuesday, 11 July 2017

Councillor John Muldoon (Chair)	
Councillor Susan Wise (Vice-Chair)	
Councillor Paul Bell	
Councillor Peter Bernards	
Councillor Colin Elliott	
Councillor Sue Hordijkenko	
Councillor Stella Jeffrey	
Councillor Olurotimi Ogunbadewa	
Councillor Jacq Paschoud	
Councillor Joan Reid	
Councillor Alan Hall (ex-Officio)	
Councillor Gareth Siddorn (ex-Officio)	

## **MINUTES OF THE HEALTHIER COMMUNITIES SELECT COMMITTEE**

**Tuesday 13 June 2017, 7.30pm**

Present: Councillors John Muldoon (Chair), Susan Wise (Vice Chair), Sue Hordijkenko, Stella Jeffrey, Olurotimi Ogunbadewa, and Jacq Paschoud.

Apologies: Councillors Paul Bell, Peter Bernards, Colin Elliot, Joan Reid, and Nigel Bowness (Healthwatch)

Also Present: Joan Hutton (Head of adult social care), Sarah Wainer (Programme Lead, Whole System Model of Care, Lewisham CCG), Amanda Pithouse (Deputy Director of Nursing, SLaM), Dr Daniel Harwood (Clinical Director, SLaM), Dr Alison Beck (Head of Psychology and Psychotherapy, SLaM), and Vanessa Smith (Service Director, mental health of older adults, SLaM), John Bardens (Scrutiny Manager).

### **1. Minutes of the meeting held on 18 April 2017**

Resolved: the minutes of the last meeting were agreed as a true record.

### **2. Declarations of interest**

The following non-prejudicial interests were declared:

- Councillor John Muldoon is a governor of the South London and Maudsley NHS Foundation Trust.
- Councillor Susan Wise is a governor of the King's College Hospital NHS Foundation Trust.

### **3. Responses from Mayor and Cabinet**

Resolved: the Committee noted the response from the Health and Wellbeing Board to their referral on the integration of health and social care.

### **4. SLaM Quality Account**

Amanda Pithouse (Deputy Director of Nursing, SLaM) and colleagues introduced the report. The following key points were noted:

4.1 The South London and Maudsley NHS Foundation Trust (SLaM) draft Quality Account for 2016/17 sets out the Trust's performance against the quality priorities and national priorities set last year, as well as setting out new priority areas for the coming year. It is part of SLaM's five-year 2014-19 Quality Strategy, which comprises more than 100 quality-improvement projects.

4.2 The quality priorities for 2016/17 covered patient safety, clinical effectiveness and patient experience. The Trust set nine priorities, achieved four and has seen improvement in all areas except staffing. Given the staffing pressures, SLaM is

currently working with local partners (Oxleas and St George's NHS Foundation Trusts) to consider new workforce models.

- 4.3 Overall, the number of restraints in the Trust has decreased by 20%. The number of prone restraints, however, has increased by 9% – the Trust had aimed for a reduction of 20%. This could be the result of better reporting by staff. The Trust is aiming for a 50% reduction in prone restraint in 2017/18.
- 4.4 Overall, 91% of patients received a full risk assessment – exceeding the target of 85%. This could be the result of an improved electronic system at the Trust. The Care Quality Commission (CQC) said in its recent report that it had also noticed improvements in this area.
- 4.5 The Trust achieved its target for people feeling involved in their care, with 90% of patients saying that they do. The Trust is however carrying out further work to speak to patients and understand what it means to them to be involved in their care.
- 4.6 The Trust partially achieved its target for physical healthcare screening of patients, with 93% of inpatient, 77% of early intervention services users and 68% of community service users assessed. The target for inpatient and early intervention was 90%, the target for community users was 50%.
- 4.7 43% of identified carers were offered a carers assessment and a carers care plan. The Trust did not achieve its target of 50%. In response to feedback from carers, the Trust has developed a new assessment tool which looks at more than just the financial aspects.
- 4.8 The Trust has set 12 priorities for 2017-18. This includes a new strand on staff experience, which includes priorities relating to staff wellbeing, stress and whether staff would recommend the Trust as a place to work.
- 4.9 The southeast London Sustainability and Transformation Plan (STP) should help the Trust improve further in some quality areas, for example, providing care closer to people's homes.
- 4.10 The impact of Brexit on nursing staff is unclear at the moment. The Trust has significant challenges in this area already. This is why it is collaborating with local partners (Oxleas and St Georges NHS Foundation Trusts) to try to reduce Trusts competing for staff.
- 4.11 Providing care close to home is about providing more person-centred care in the community. It involves community teams looking at what a person needs and whether they can be treated intensively at home. It's also about trying to shorten the length of stay when an admission to hospital has been necessary. It includes having crisis care plans in place and identifying triggers of poor health and intervening early on, at home or with a short stay in hospital.
- 4.12 One of the Trust's new quality priorities is to reduce work-related stress. The Trust is looking to achieve this by better job planning and improving appraisal

standards – making sure that people’s jobs are doable and that they feel valued. Support for line managers and staff will also be improved, enabling managers to better support staff and prevent stress-related illnesses developing.

- 4.13 The mortality rates among people with mental ill health are higher than average. People with mental ill health are more likely to be overweight, smoke and have poor access to services. Improved physical health screening can help with this. This is why the Trust is working with patients early on to make sure people register with a GP and get into the habit of having regular checks and seeking medical help.
- 4.14 SLAM’s IT systems were not affected by the recent NHS malware attacks.
- 4.15 SLAM, in partnership with Oxleas and South West London and St George’s, has developed new Assistant Practitioner roles to work in inpatient care areas. Assistant Practitioners will receive training at London Southbank University and work towards a Foundation degree via day release for 18 months. The new roles will be able to take some tasks away from registered nurses. It is anticipated that the delegation of appropriate tasks will release time for more therapeutic engagement time with patients.
- 4.16 The target to reduce the average length of stay from 45 days to 40 days and then to 30 days is not as drastic as it sounds. It is about focusing on those who tend to have very long stays (100s of days). It’s an ambitious but doable target. And by freeing up more beds the Trust can also relieve some pressure on community and primary care.

*Resolved: the Committee noted the report*

## **5. Neighbourhood care networks update**

Sarah Wainer (Programme Lead, Whole System Model of Care, Lewisham CCG) introduced the report. The following key points were noted:

- 5.1 Neighbourhood Care Networks (NCN) are a key part of the development of community-based care in Lewisham. There are currently four NCNs arranged around four neighbourhood area footprints.
- 5.2 Activity to improve the co-ordination and delivery of care and support includes holding further Multi-Disciplinary Meetings; Neighbourhood Coordinators supporting health and care staff in each neighbourhood; Lewisham’s Single Point of Access continuing to support residents with information and advice; and the introduction of online assessment forms for services users and carers. Officers are also looking at how those people who need support in making online self-referrals can receive support to do so, for example from their local community library/hub.
- 5.3 Staff who have been involved in Multi-Disciplinary Meetings have said how useful they have been, how they’ve helped professionals to take a more holistic approach

to people's health and wellbeing and to coordinate that care around the patient or service user.

5.4 With the right advice and support, many people can be supported to help themselves. People who present at GP surgeries, or elsewhere, who would benefit from local opportunities or activities which would help to maintain or improve their health and wellbeing can be referred to Community Connections (if over 18) or Lewisham SAIL (if over 65) and be connected to activities and opportunities available in their local neighbourhood. Anyone can make a SAIL or Community Connections referral.

*Resolved: the Committee noted the update*

## **6. Social prescribing in-depth review scope note**

John Bardens (Scrutiny Manager) introduced the report.

6.1. Members discussed the scoping paper and suggested a number of possible site visits as part of the review, including the Health Living Centre and St Mary's Therapeutic Garden in Lewisham and the Bromley-by-Bow centre in Tower Hamlets. Members also suggested making contact with the NHS's National Clinical Champion for social prescribing, Dr Michael Dixon.

*Resolved: the Committee agreed the key lines of enquiry for the review.*

## **7. Select Committee work programme**

John Bardens (Scrutiny Manager) introduced the report and updated members on a number of developments with the work programme, including:

7.1 An item on charging for some adult social care services is expected to be brought to committee in July. This follows on from the savings brought to the committee last year. It will set out the proposed charges and consultation process.

7.2 The report on the CQC inspection of Lewisham and Greenwich NHS Trust will not be published in time for the July meeting. This item will be postponed until there is a date for publication.

*Resolved: the Committee noted and agreed the work programme.*

## **8. Referrals**

*There were none.*

The meeting ended at 21.10pm

Chair:

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Date:

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Healthier Communities Select Committee		
Title	Declaration of interests	
Contributor	Chief Executive	Item 2
Class	Part 1 (open)	20 July 2017

## Declaration of interests

Members are asked to declare any personal interest they have in any item on the agenda.

### 1. Personal interests

There are three types of personal interest referred to in the Council's Member Code of Conduct:

- (1) Disclosable pecuniary interests
- (2) Other registerable interests
- (3) Non-registerable interests

### 2. Disclosable pecuniary interests are defined by regulation as:-

- (a) Employment, trade, profession or vocation of a relevant person\* for profit or gain
- (b) Sponsorship – payment or provision of any other financial benefit (other than by the Council) within the 12 months prior to giving notice for inclusion in the register in respect of expenses incurred by you in carrying out duties as a member or towards your election expenses (including payment or financial benefit from a Trade Union).
- (c) Undischarged contracts between a relevant person\* (or a firm in which they are a partner or a body corporate in which they are a director, or in the securities of which they have a beneficial interest) and the Council for goods, services or works.
- (d) Beneficial interests in land in the borough.
- (e) Licence to occupy land in the borough for one month or more.
- (f) Corporate tenancies – any tenancy, where to the member's knowledge, the Council is landlord and the tenant is a firm in which the relevant person\* is a partner, a body corporate in which they are a director, or in the securities of which they have a beneficial interest.
- (g) Beneficial interest in securities of a body where:
  - (a) that body to the member's knowledge has a place of business or land in the borough;

(b) and either

- (i) the total nominal value of the securities exceeds £25,000 or 1/100 of the total issued share capital of that body; or
- (ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the relevant person\* has a beneficial interest exceeds 1/100 of the total issued share capital of that class.

\*A relevant person is the member, their spouse or civil partner, or a person with whom they live as spouse or civil partner.

### 3. Other registerable interests

The Lewisham Member Code of Conduct requires members also to register the following interests:-

- (a) Membership or position of control or management in a body to which you were appointed or nominated by the Council
- (b) Any body exercising functions of a public nature or directed to charitable purposes, or whose principal purposes include the influence of public opinion or policy, including any political party
- (c) Any person from whom you have received a gift or hospitality with an estimated value of at least £25

### 4. Non registerable interests

Occasions may arise when a matter under consideration would or would be likely to affect the wellbeing of a member, their family, friend or close associate more than it would affect the wellbeing of those in the local area generally, but which is not required to be registered in the Register of Members' Interests (for example a matter concerning the closure of a school at which a Member's child attends).

### 5. Declaration and Impact of interest on members' participation

- (a) Where a member has any registerable interest in a matter and they are present at a meeting at which that matter is to be discussed, they must declare the nature of the interest at the earliest opportunity and in any event before the matter is considered. The declaration will be recorded in the minutes of the meeting. If the matter is a disclosable pecuniary interest the member must take no part in consideration of the matter and withdraw from the room before it is considered. They must not seek improperly to influence the decision in any way. **Failure to declare such an interest which has not already been entered in the Register of Members' Interests, or participation where such an interest exists, is liable to prosecution and on conviction carries a fine of up to £5000**
- (b) Where a member has a registerable interest which falls short of a disclosable pecuniary interest they must still declare the nature of the interest to the meeting at the earliest opportunity and in any event before the matter is considered, but they may stay in the room, participate in

consideration of the matter and vote on it unless paragraph (c) below applies.

- (c) Where a member has a registerable interest which falls short of a disclosable pecuniary interest, the member must consider whether a reasonable member of the public in possession of the facts would think that their interest is so significant that it would be likely to impair the member's judgement of the public interest. If so, the member must withdraw and take no part in consideration of the matter nor seek to influence the outcome improperly.
- (d) If a non-registerable interest arises which affects the wellbeing of a member, their, family, friend or close associate more than it would affect those in the local area generally, then the provisions relating to the declarations of interest and withdrawal apply as if it were a registerable interest.
- (e) Decisions relating to declarations of interests are for the member's personal judgement, though in cases of doubt they may wish to seek the advice of the Monitoring Officer.

## **6. Sensitive information**

There are special provisions relating to sensitive interests. These are interests the disclosure of which would be likely to expose the member to risk of violence or intimidation where the Monitoring Officer has agreed that such interest need not be registered. Members with such an interest are referred to the Code and advised to seek advice from the Monitoring Officer in advance.

## **7. Exempt categories**

There are exemptions to these provisions allowing members to participate in decisions notwithstanding interests that would otherwise prevent them doing so. These include:-

- (a) Housing – holding a tenancy or lease with the Council unless the matter relates to your particular tenancy or lease; (subject to arrears exception)
- (b) School meals, school transport and travelling expenses; if you are a parent or guardian of a child in full time education, or a school governor unless the matter relates particularly to the school your child attends or of which you are a governor;
- (c) Statutory sick pay; if you are in receipt
- (d) Allowances, payment or indemnity for members
- (e) Ceremonial honours for members
- (f) Setting Council Tax or precept (subject to arrears exception)

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# Agenda Item 3

Healthier Communities Select Committee		
Title	Response to referral from healthier communities select committee – in-depth review of health and adult social care integration in Lewisham	
Contributor	Scrutiny Manager	Item 3
Class	Part 1 (open)	20 July 2017

## 1. Purpose

The Mayor and Cabinet response to the recommendations of the Healthier Communities Select Committee's in-depth review of health and adult social care integration in Lewisham is attached.

## 3. Recommendations

The Committee is asked to note the response.

For further information, please contact John Bardens, Scrutiny Manager, on 02083149976.

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<b>Mayor and Cabinet</b>		
<b>Title</b>	Response To Referral From Healthier Communities Select Committee – In depth report into Integration of Health and Social Care in Lewisham	
<b>Contributor</b>	Executive Director for Community Services and Lewisham Health and Care Partners	Item
<b>Class</b>	Part 1 (open)	21 June 2017

## 1. Summary

- 1.1. This report sets out the proposed response to the recommendations made by the Healthier Communities Select Committee following the Committee's review of the integration of health and social care in Lewisham.

## 2. Recommendation

- 2.1. Mayor and Cabinet is recommended to:

- Approve the officer response to the recommendations made by the Healthier Communities Select Committee, and
- Agree that this report be forwarded to the Select Committee.

## 3. Background

- 3.1. The scrutiny process in Lewisham enables councillors to examine the performance of the Council and partners, to ask questions on how decisions have been made, and the performance of local services, investigate issues of local concern to consider whether service improvements can be put in place and make recommendations to this effect.
- 3.2. In July 2016 the Healthier Communities Select Committee agreed the scope of an in-depth review into the Integration of Health and Social Care in Lewisham and evidence sessions were held between September 2016 and January 2017.
- 3.3. In September 2016 the Committee heard from Lewisham Health Care Partners (LHCP) on the plans, successes and challenges of developing and delivering integrated care. In October 2016 the Committee heard from the Local Government Association, London Councils, Public World, and Age UK Lewisham and Southwark. In January 2017 the Committee heard from Health watch Lewisham, the Lewisham Pensioners' Forum, and the Lewisham Coalition.
- 3.4. The Committee agreed the report of its findings, and resultant recommendations, at its meeting on 1 March 2017.
- 3.5. On 22 March 2017, Cllr John Muldoon, Chair of the Healthier Communities Select Committee presented to Mayor and Cabinet and findings of the review. On receipt of the report and recommendations, the Mayor resolved that the Executive Director for Community Services be asked to provide a response for his consideration.

#### 4. Recommendations and responses

4.1. After consideration of the evidence taken within the review, the Healthier Communities Select Committee made 15 recommendations as a result of the review. The recommendations are listed below, along with the proposed responses for Mayoral consideration.

4.2. Recommendation 1: Lewisham Health and Care Partners (LHCP) should return to the Committee with an update on the progress of the “ward at home” scheme within six months of the conclusion of this review.

Response: The CCG has been working with providers in developing a Discharge to Assess model (D2A) of care “ward at home” for a cohort of patients in order to facilitate early discharge from LGT and ensure that assessments of on-going care take place in the community. The D2A commenced 20th March 2017 and is a pilot to inform the longer term modelling of discharge pathways in Lewisham. An update will be provided to the Committee in 6 months.

4.3. Recommendation 2: LHCP should monitor the figures for discharge delays caused by having to make arrangements for non-Lewisham residents to be discharged outside of the borough. They should also maintain regular contact with partners in other boroughs to tackle these delays as effectively as possible. LHCP should provide the Committee with an update within six months of the conclusion of this review.

Response: All Delayed Transfers of Care (DTC) are monitored and reported weekly to the NHS, and to the Association of Directors of Adult Social Care (ADASS) on the London Monitoring System. The Council and its partners meet twice a week to discuss people who are ready for discharge, this includes residents of other boroughs who are in acute beds. Senior Adult Social Care managers escalate delays to senior managers in other boroughs and work with them where possible to reduce the length of delays. Most delays are due to complex discharges, shortage of beds in residential and nursing homes and family choice. For the most difficult delays or where it is felt that further intervention is needed, delays are discussed with the Head of Adult Social Care, and if necessary the Executive Director for Community Services who in turn make contact with their counterparts in the relevant borough. Following NHS guidance, there are plans in place to work closely with our neighbouring boroughs to develop a trusted assessor model. This will allow staff based at hospitals to assess the needs of patients and make recommendations on care to the responsible borough. It is anticipated that this will help to speed up decision making and reduce the number of delays.

4.4. Recommendation 3: LHCP should return to the Committee within six months of the conclusion of this review with more detail about the model of community-based care being developed (influenced by the Buurtzorg model) in order to address the following questions:

Response: More detail on the development of community based care will be provided within six months of the review. This will include an update on development of new ways of working influenced by the Buurtzorg model. LHCP recognise the challenges of developing a ‘Buurtzorg’ model in Lewisham as highlighted by the Committee. It will not be possible to replicate the approach

exactly as it operates within a very different system and context. However LHCP are committed to exploring the key principles that underpin the model i.e. it is a person centred approach; one person delivers multiple aspects of care and support; workers are empowered to build relationships and networks to support people more effectively. Consideration of the Buurtzorg model is currently focussed on the opportunities to combine and flex the roles of those health and care professionals who visit and support people in their own homes. This activity is being developed within the devolution pilot. It will build on the achievements to date within the existing neighbourhood community teams and reflect the learning from local interpretations of the Buurtzorg model such as the GSTT initiative.

- 4.5. Recommendation 4: With the closer integration of community-based services, LHCP should consider an integrated complaints process, which is accessible to all who may need to use it.

Response: If a complaint covers more than one aspect of health and care, or relates to both the commissioning and provision of a service, complaints officers across the system work closely together to provide a coordinated response. In addition, in accordance with Care Act requirements, we are developing an approach to quality assurance that will give better oversight of the quality of provision within the market place so that we can prevent quality assurance issues becoming a safeguarding concern. This will be achieved by coordinating intelligence from a range of areas which includes complaints, quality assurance monitoring, CQC inspections and individual reviews. Once we have completed the integration of complaints within this process we will undertake a review, as suggested in recommendation 14, to assess how our approach to complaints can align further to the integrated practice that is being developed.

- 4.6. Recommendation 5: The neighbourhood-based care models currently being developed by LHCP should be carefully tailored to meet the needs profile of the areas they'll serve. The Committee should be provided with information about how LHCP plan to do this within six months of the conclusion of this review.

Response: In developing and delivering community based care, which is the care delivered outside a traditional hospital setting, both commissioners and providers will continue to use and monitor a range of information and data to ensure that the care is meeting the needs of local communities and improves health and care outcomes in the area.

Lewisham's commissioners will continue to produce detailed business cases before a service, or integrated service or provision is commissioned. Each business case will continue to set out the case for change, identifying any changes in local demographics or needs, and include an equalities assessment on how the new service or provision will impact on different communities and groups. It will also include feedback on public and patient views. There are no plans to alter this well-established approach to commissioning.

Similarly commissioners will continue to monitor and evaluate local provision and services to ensure the high quality and performance of local care. Providers will continue to be held to account through the contract monitoring process to ensure that they are meeting the specified outcomes and delivering the required

improvements. Where integrated services are being provided, these too will be subject to close monitoring and evaluation.

The establishment of neighbourhood hubs to facilitate the integration of primary and community health and care services and the provision of holistic care is currently at an early stage of development. Detailed analysis of current provision, pathways and any specific local needs will be required. This work will commence with two workshops with stakeholders to begin capturing the required data and information. A robust programme management approach is being established which will ensure full stakeholder engagement and consultation throughout the development of neighbourhood hubs.

- 4.7. Recommendation 6: Given that it is a key aim of integration, LHCP should set clear targets for reductions in unplanned hospital admissions and monitor performance against these. This would allow stakeholders to monitor progress.

Response: As part of the setting our new Better Care Fund Plan for 2017-19, partners will agree reductions in unplanned hospital admissions as part of the integration work. For 16/17, there was a 4.7% reduction in unplanned hospital admissions for Lewisham people.

- 4.8. Recommendation 7: LHCP should do all they can locally to make sure that the regulatory processes involved in health and care do not act as a disincentive to more integrated ways of working.

Response: Regulators have committed to taking a more aligned approach to regulation in London as part of the devolution agreement. Although legislation does not permit devolution of national regulatory functions for health services, NHS England and NHS Improvement have committed to streamlining regulation and oversight with joined up processes at regional level. National regulatory partners (NHSE, NHSI and CQC) have committed to closer working at London level, including alignment of regulatory actions and timelines for reporting wherever possible. CQC, NHS Improvement and NHS England will work with London to develop, support and resource a regulation and oversight model that meets the needs of the London system. Partners have committed to working to ensure that any joint arrangements developed minimise the administrative burden and provide robust governance and conflict of interest management.

- 4.9. Recommendation 8: LHCP should continue to explore ways of embedding integrated health and social care teams in each of the four neighbourhoods in order to achieve lasting cultural change.

Response: LHCP are committed to developing the four Neighbourhood Care Teams to achieve lasting cultural change. Building on the work to date, a range of activity is being undertaken to achieve this, including:

- Co-location of the NCTs – the N1 team will be the first to co-locate at the Waldron (summer 2017).
- Two 12 week pilots to test new approaches to multi-disciplinary working. Both projects will include mental health.

- A review of the Neighbourhood Co-ordinator role and several projects to test ways in which the role could develop further to support and embed integrated working.
- A Standard Operating Procedure for practice based multi-disciplinary meetings has been developed and is being considered as part of the PMS contract negotiations.
- Joint training across adult social care, the DN service and mental health.
- Joint approaches to communication across the NCTs.
- Regular interface meetings with home care providers and mental health services.

4.10. Recommendation 9: LHCP should review how the changes to health and social care are being communicated and how people, residents and staff are being engaged in the process. They should engage with relevant local stakeholders to help with this. Other areas have made use of case studies to help with explaining complex changes like this.

Response: LHCP have recognised the need to strengthen further communication and engagement on developments taking place across the system, both with staff and residents. It has established a communications and engagement group which includes communication and engagement representatives from the Council, the Clinical Commissioning Group, Lewisham and Greenwich NHS Trust, South London and Maudsley NHS Foundation Trust and One Health Lewisham. LHCP have asked the group to support them in developing effective system wide communication and engagement activity. To date this has included developing the vision, sharing key communications and updates across the partnership for onward communication to staff, and seeking opportunities for joint engagement on areas such as the Sustainability and Transformation Plan. Regular updates on key activity across the system are also being provided to Lewisham's Health and Wellbeing Board. LHCP will continue to engage with other key groups such as the Neighbourhood Community Development Partnerships and the primary care neighbourhood meetings. LHCP will also be sharing news on latest developments with staff, such as the Falls service and self-management education activities, via existing digital channels. However LHCP acknowledge that more could be done, including using case studies as suggested to demonstrate the changes that are taking place. LHCP will ask the communication and engagement group to review current practice and make recommendations on how it can be improved across the system.

4.11. Recommendation 10: There should be more co-production in the changes to health and social care and the development of the new models of care

Response: Lewisham Health and Care Partners fully support co-production and the involvement and input of service users and others in shaping and delivering local services. LHCP agree that all those involved in the development of new services, new provision or new models of care should ensure that service users, their families and communities are involved in the different stages of planning, design, delivery and review. LHCP will seek to ensure that this approach continues to be embedded throughout the system.

Adult Social care will use co-production with providers to shape the market so that it delivers more personalised care. This is in the early stages of development within

the neighbourhood teams as we work with the domiciliary care providers and involve them in the service delivery plans

- 4.12. Recommendation 11: While it may not be necessary to communicate to the wider public the organisational changes taking place behind the scenes, LHCP should effectively communicate these changes to relevant staff and health professionals in the borough, and in the voluntary and community sector.

Response: Please see response to recommendation 9.

- 4.13. Recommendation 12: The Committee appreciates that the Council and its partners will do all they can to make sure that the integration of services works for local people, but the Committee also notes that there is a risk to social care as a result of government-imposed cuts.

Response: In recognition that all LA's face pressure on the provision of ASC services, supplementary funding has been made available from central government. The draft conditions for the new money require that plans are agreed by the Health and Wellbeing Board and the CCG Commissioning board. They should contribute to ASC being maintained in line with inflation and should be invested in community services to manage transfers of care from hospital and avoid unnecessary admissions to hospital.

- 4.14. Recommendation 13: LHCP should ensure that all staff are able to provide a personalised and responsive service to people in their homes at all times.

Response: There is a commitment from all Lewisham Health and Care Partners to develop the workforce to ensure that they provide a personalised and responsive service to people in their own homes. A workforce development programme will be established to ensure that this approach is embedded from the initial point of contact a person has with the health and care staff involved in the person's assessment and care planning, through to those staff who work for the agencies responsible for providing the on-going support.

- 4.15. Recommendation 14: LHCP should review how the current complaints process for community-based services is working and how and when people are notified of it.

Response: Please see response to recommendation 4.

- 4.16. Recommendation 15: LHCP should draw up a plan on how they can work together to build capacity and avoid duplication in the area of activities for young adults with learning disabilities. People with learning disabilities represent a significant proportion of adult social care service users and developing more community-led services for this group could have a significant positive impact

Response: Adult Social Care and Children and Young People's services are working together to develop a transition team that will work with young people to prepare them for adulthood. The education, health and support plans will identify the services that are required to support these young people. We are working closely with commissioners and partners in Education and the Voluntary Sector to make sure we are responding to these needs and that more services are in place locally. Many of these young people present with a learning disability so, alongside our education and voluntary sector partners, we are focused on developing more

community based services to meet these needs.

## **5. Financial implications**

- 5.1. There are no financial implications arising out of this report per se; but there may be financial implications arising from carrying out the action proposed by the Committee.

## **6. Legal implications**

- 6.1. The Constitution provides for Select Committees to refer reports to the Mayor and Cabinet, who are obliged to consider the report and the proposed response from the relevant Executive Director; and report back to the Committee within two months (not including recess).

## **7. Further implications**

- 7.1. At this stage there are no specific environmental, equalities or crime and disorder implications to consider. However, there may be implications arising from the implementation of the Committee's recommendations.

## **8. Background papers**

[Healthier Communities Select Committee Review of integration of health and social care in Lewisham](#)

[Mayor and Cabinet 22 March 2017](#)

If you have any queries about this report, please contact Joan Hutton, Head of Adult Social Care, extension 48634

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# Agenda Item 4

Healthier Communities Select Committee		
Title	Adult Safeguarding Board introduction	
Contributor	Scrutiny Manager	Item 4
Class	Part 1 (open)	20 July 2017

## 1. Purpose

The slides of a presentation on adult safeguarding to be given to HCSC members by the new Chair of the Lewisham Safeguarding Adults Board, Professor Michael Preston-Shoot, are attached.

## 3. Recommendations

The Committee is asked to note this information ahead of a short presentation and Q&S session at committee.

For further information, please contact John Bardens, Scrutiny Manager, on 02083149976.

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# Adult Safeguarding Law

Presentation to Lewisham elected members  
20<sup>th</sup> July 2017

# Structure of the Legal Rules

- ▶ Primary legislation (Acts)
  - ▶ Secondary legislation (Regulations)
  - ▶ Policy Guidance
  - ▶ Practice Guidance
  - ▶ Case Law
- 
- ▶ Local Authority Procedures – audit for compliance with the legal rules
  - ▶ How well do local authorities and partner agencies comply? (look at judicial reviews and Ombudsman reports)

# Care Act 2014:

## Adult safeguarding provisions

- ▶ Duty of enquiry
- ▶ Duty to establish Safeguarding Adults Board
- ▶ Duty to carry out safeguarding adults reviews
- ▶ Duty to share information
  
- ▶ All within the overall unifying principles of the Act
  - The well-being of the individual is paramount
  - Local authorities must promote the individual's well-being in all decisions made with and about them
  - 'Well-being' is the outcomes that individuals seek for themselves

# Sections 42-47 – Safeguarding

- ▶ Duty to make enquiries if adult experiencing or at risk of abuse or neglect and is unable to protect themselves
- ▶ No new protection powers or power of entry
- ▶ Duty to have a Local Safeguarding Adults Board but what if agencies will not co-operate?
- ▶ Power to require individuals/agencies to provide information but what if agencies do not comply?
- ▶ LA obligation to protect property retained

# Duty of enquiry

- ▶ Where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)
    - has needs for care and support (whether or not the authority is meeting any of those needs)
    - is experiencing, or is at risk of, abuse or neglect, including financial abuse, and
    - as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of itthe local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what and by whom
- Eligibility criteria do not apply

# Duty to establish SAB

- ▶ Each local authority must establish a Safeguarding Adults Board for its area (two or more LAs may combine).
- ▶ The objective of a SAB is to help and protect adults in its area who have care needs and are at risk of abuse and neglect and are unable to protect themselves.
- ▶ The SAB must co-ordinate and ensure the effectiveness of what each of its members does, including provision of training.
- ▶ It must ensure the development of policies for protecting adults at risk in collaboration with relevant agencies, service users and their representatives.
- ▶ SAB membership must include the LA, the CCG and the Police; the LA, in consultation with the SAB, may decide further appropriate membership and must appoint a chair. All members and the chair must have relevant skills and experience, and members must attend meetings.
- ▶ SAB members may contribute financially and in kind.
- ▶ The SAB must produce a safeguarding plan, on which it must report progress annually; it should determine arrangements for peer review and self-audit

# Safeguarding Adults Reviews

- ▶ The SAB must carry out a safeguarding adult review
  - where they know or suspect that serious abuse or neglect has contributed to the death or serious harm of an individual, and
  - there is reasonable cause for concern about how SAB members or other persons with relevant care and support functions actedwith the aim of learning lessons, improving future practice and partnership, and minimising future recurrence
- ▶ Each member of the SAB must cooperate in and contribute to the carrying out of the review and applying the lessons learnt.
- ▶ SABs have the power to undertake reviews in other circumstances if they so choose

# Duty to share information

- ▶ Duty to comply with a SAB request for information if:
  - the request is made for the purpose of enabling or assisting the SAB to exercise its functions, and
  - the request is made to a person whose functions or activities are such that they are likely to have information relevant to the SAB's work, and
  - the information relates to the person to whom the request is made, a function or activity of that person, or a person in respect of they exercise a function or engage in an activityThus the duty could apply to a GP, family carer, volunteer, church minister, or people in similar roles, in relation to any aspect of the SAB's role (which is to help and protect adults who have care needs and are at risk of abuse and neglect and unable to protect themselves)
- ▶ The information may be used by the SAB only for the purpose of enabling or assisting the SAB to exercise its functions

# Section 1 – Principles

- ▶ Duty on LA to promote well-being of adults in need of care & support, and carers by having regard to wishes and feelings, avoiding delay and stereotypes, maximising participation, minimising restrictions on rights and freedoms
- ▶ Well-being includes dignity, physical & mental health, emotional well-being, protection from abuse & neglect, relationships, living accommodation, social & economic well-being
- ▶ Establish what being safe means for the individual – making it person-led and outcome-focused
- ▶ Target duty

# Sections 6 & 7 – Co-operation

- ▶ Section 6 – strategic duty on public bodies to co-operate
- ▶ Section 7 – new (because agency whose help is requested must comply) specific duty on public bodies to co-operate when LA requests this (mirrors section 27, Children Act 1989)
- ▶ Extends to SABs and partner involvement therein; and to modern slavery, self-neglect, organisational abuse, discriminatory abuse
- ▶ SAB must establish effective links with Health & Wellbeing Board, LSCB, and Safer Lewisham Partnership to share and co-ordinate work plans, to prevent abuse and neglect

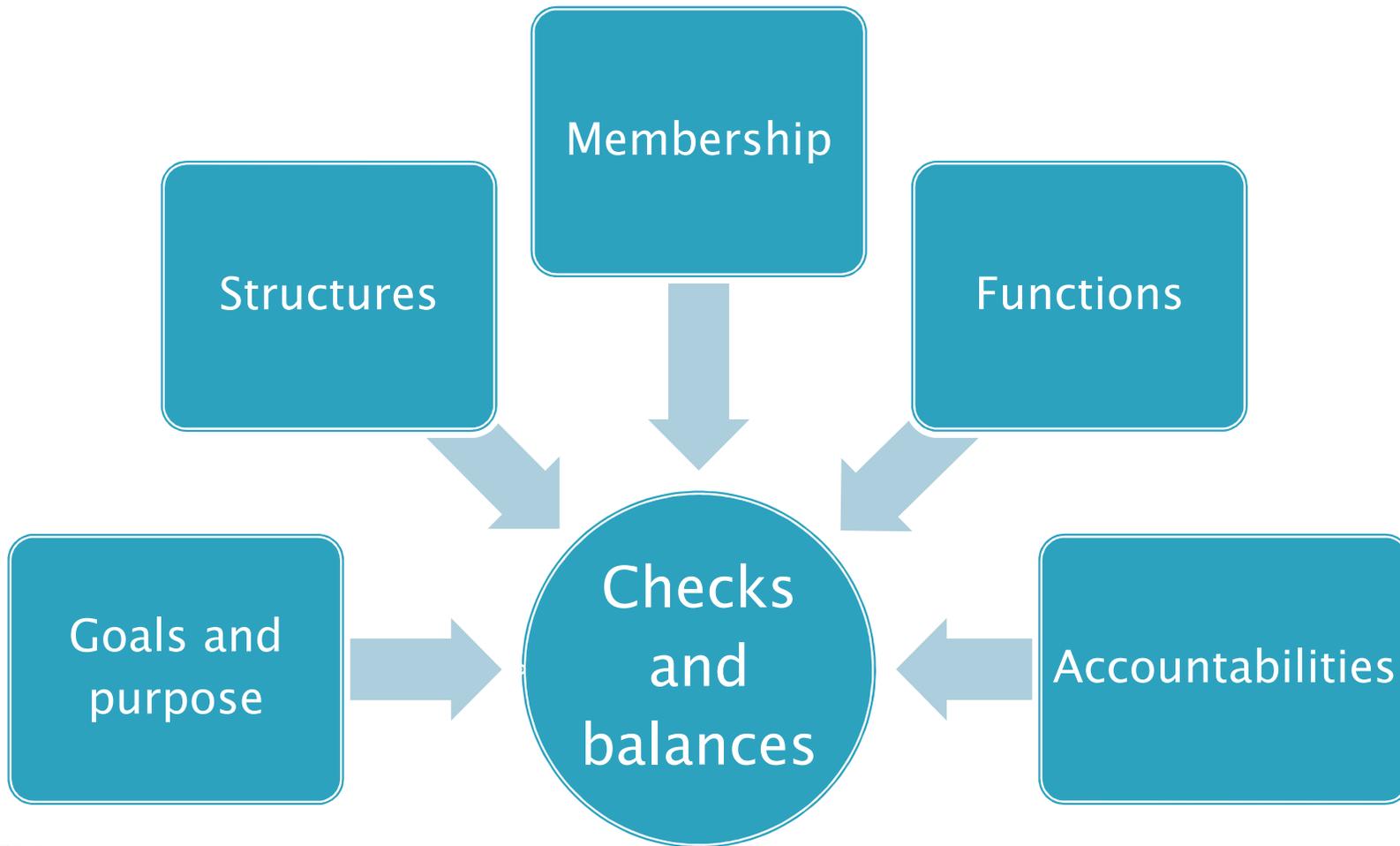
# Limitations of the legal rules

- ▶ Cannot command resources to guarantee capacity
- ▶ Cannot command multi-agency collaboration
- ▶ Partnership working still a challenge – how do you engage the disengaged?
- ▶ Complexity of legal rules for information-sharing
- ▶ How really independent can SABs be?
- ▶ Have we learned the lessons from LSCBs here?
- ▶ Importance of communication, relationships & partnership working at strategic & operational levels

# What does a good SAB look like?

- ▶ Senior executive commitment & involvement
- ▶ Independent scrutiny
- ▶ Internal & external challenge
- ▶ Appreciative inquiry & learning culture
- ▶ Commitment to intra and inter-agency audit
- ▶ Acceptance of shared responsibility
- ▶ Evidence of impact
- ▶ Good governance
  - Goals and purpose (clear principles, activity scope, strong leadership)
  - Structures (clear focus and linkages between activities)
  - Membership (resources, clear roles and responsibilities, engagement)
  - Functions (strategic planning, operational oversight, assurance through audit & performance monitoring, improvement agenda)
  - Accountabilities (clear links, clear remit & performance standards)

# So what does good practice in governance look like?



# In Lewisham

- ▶ An established SAB & Business Management team, with budget contributions from key partners;
- ▶ Newly established Executive
- ▶ Fully functioning case review group with two SARs underway
- ▶ Development day held, with strategic plan for 2017/2018
- ▶ Learning & service development seminars established
- ▶ Adult safeguarding conference planned

# In Lewisham (2)

- ▶ Annual report for 16/17 being prepared
- ▶ SAB membership being reviewed
- ▶ Task and Finish Groups being established to address key “hot topics”, including adults who self-neglect, prevention, transitions, performance reporting and analysis
- ▶ Co-operation established with Lewisham’s Safeguarding Children Board and Safer Partnership



# Learning from SCRs and SARs



# Agenda Item 5

Healthier Communities Select Committee		
Title	Grove Park Health Centre	
Contributor	Scrutiny Manager	Item 5
Class	Part 1 (open)	20 July 2017

## 1. Purpose

Attached is an update briefing from Lewisham CCG on the consolidation of the ICO Health Group primary care services in Grove Park and the intention to develop a new purpose built Health Centre.

## 3. Recommendations

The Committee is asked to note this information.

For further information, please contact John Bardens, Scrutiny Manager, on 02083149976.

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HEALTHIER COMMUNITIES SELECT COMMITTEE			
<b>BRIEFING:</b>	UPDATE: The consolidation of the ICO Health Group primary care services in Grove Park and the intention to develop a new purpose built Health Centre.		
<b>WARD:</b>	Grove Park	<b>ITEM:</b>	N/A
<b>CLASS:</b>	N/A	<b>DATE:</b>	6 <sup>th</sup> July 2017
<b>FROM:</b>	Lewisham Commissioning Clinical Group		

1. The purpose of this briefing is to provide the Chair of the Healthier Communities Select Committee with an update on the ICO Health Group proposals and some additional clarity with regard to the role of the CCG, under delegation made by NHS England to the CCG of certain functions relating to primary medical services under 13Z of the NHS Act.
2. The ICO Health Group has identified a numbers of sites over the years and with the majority of these intentions pre-dating NHS Lewisham CCG (and delegation) and therefore, was under the auspices of NHS England.
3. The ICO Health Group advised the CCG in September 2016 of its intentions for the site in question.
4. On the 25<sup>th</sup> April 2017 the CCG attended the Healthier Communities Select Committee, where members of the committee were recommended to note NHS Lewisham CCGs *support in principle* for proposed changes in core primary care services for the consolidation of the ICO Health Group primary care services in Grove Park and the intention to develop a new purpose built Health Centre.
5. As of the 6<sup>th</sup> July 2017 NHS Lewisham CCG still supports the proposed changes in principle in line with the local *CCG Primary Care Strategy – Developing GP Services*<sup>1</sup> shared with the committee on 12<sup>th</sup> January 2017 and national policies (GP Forward View<sup>2</sup>).
6. However, it is important to clarify that the proposals from the ICO Health Group are still in development and under review and no decision has been made by the CCG.
7. All proposals for premises relocation under delegated commissioning are submitted to the CCG Primary Care Commissioning Committee for approval.
8. At the Primary Care Commissioning Committee (a meeting held in public) on 20<sup>th</sup> June 2017, the committee received an update on the proposals and a request to convene an extraordinary committee meeting to review the proposals once finalised.
9. Cllr Suzannah Clarke, Grove Ward and Chair of the Planning Committee attended on 20<sup>th</sup> June 2017 to alert the committee to mounting local concerns and made a representation detailing concerns about the associated planning application. The committee welcomed Cllr Clarke's insights and advised that no decision had been made.
10. On reviewing requests for Premises Relocation the NHS England London Region Criteria is used to make an assessment this include; detail of the practice background, understanding of the local demography; an assessment of the strategic benefits of agreeing to a relocation; the revenue implications and capital requirements; that the relocation ensures that premises are fit for purpose in accordance with minimum

<sup>1</sup> <http://www.lewishamccg.nhs.uk/about-us/Who-we-are/Governing%20Body%20papers/Enc%2017.1%20-%20Lewisham%20PC%20Strategy%202016-21%20v0%206.pdf>

<sup>2</sup> <https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf>

standards set out in the 2013 GMS Premises Costs Directions; detail of service improvements that will arise as result of a relocation.

11. The CCG is responsible for commissioning core personal medical services (PMS) provided by the ICO Health Group and not implementation.
12. On completion of this review recommendations are made to the Primary Care Commissioning Committee. Recommendations are subject and indeed caveated on the outcome of any associated permissions e.g. Planning Consent.

**CCG Contact:**

Diana Braithwaite, Director of Commissioning & Primary Care  
Email: [diana.braithwaite@nhs.net](mailto:diana.braithwaite@nhs.net)

<b>HEALTHIER COMMUNITIES SELECT COMMITTEE</b>			
Report:	Pre-Consultation: Urgent Care Review – New Cross Walk-in Centre		
Ward:	New Cross and Evelyn	Item No.	
From:	Dr Marc Rowland, Chair, Lewisham Clinical Commissioning Group Dr Jacky McLeod, Clinical Director, Primary Care Lead, Lewisham Clinical Commissioning Group		
Class:	Part 1 (open)	Date:	20 <sup>th</sup> July 2017

## 1. Purpose

1.1 The purpose of this briefing is to facilitate pre-consultation with the Healthier Communities Select Committee.

## 2. Recommendations

2.1 The members of the Healthier Communities Select Committee are asked to note (at the time of writing);

2.1.1 The Lewisham CCG Governing Body on 13<sup>th</sup> July 2017 will be recommended to commence formal consultation on the future of the New Cross Walk-in Centre;

2.1.2 This briefing facilitates pre-consultation with the Committee.

2.1.3 Formal public and stakeholder consultation (pending CCG Governing Body agreement) will commence on 31<sup>st</sup> July 2017 and as a part of this formal process with the Healthier Communities Select Committee on 7<sup>th</sup> September 2017.

## 3. Context

3.1 Both nationally and locally it is recognised that the urgent and emergency care system is under considerable pressure to meet current and growing demands. The Royal College of Emergency Medicine has reported a steady deterioration in urgent and emergency care with the NHS now facing the worst four hour A&E performance target in almost 15 years.<sup>1</sup>

3.2 In Lewisham, the number of patients using urgent and emergency care services for non-urgent or non-life threatening conditions is increasing and putting a strain on local A&E services.<sup>2</sup> In addition, demographics are changing across London, with the Office for National Statistics estimating that the population in Lewisham will grow by 14.4% by 2024.

3.3 As a result, primary and urgent care services across Lewisham need to change to provide the right care in the right place by the most appropriate professional and obtain better value for money – to meet future demands.

3.4 In the refreshed *Primary Care Strategy – Developing GP Services*<sup>3</sup> approved by the CCG Governing Body in October 2016 and shared with the Healthier Communities Select Committee on 12<sup>th</sup> January 2017, the CCG set out its vision and the changes required to improve access to primary care services.

3.5 Delivery of the Integrated Primary & Urgent Care Model commenced in October 2016 with commissioning of the Primary Care Assessment Pilot, currently provided by South East London Doctors Co-operative (SELDOC). The service supports with managing the flows of patients to the Urgent Care Centre (UCC) and Emergency Department by assessing and treating patients with

<sup>1</sup> [https://www.rcem.ac.uk/RCEMNews/News\\_2017/Emergency\\_Care\\_is\\_in\\_crisis.aspx](https://www.rcem.ac.uk/RCEMNews/News_2017/Emergency_Care_is_in_crisis.aspx)

<sup>2</sup> <http://www.lewishamccg.nhs.uk/about-us/our-plans/Commissioning%20intentions/Urgent%20care.pdf>

<sup>3</sup> <http://www.lewishamccg.nhs.uk/about-us/Who-we-are/Governing%20Body%20papers/Enc%202017.1%20-%20Lewisham%20PC%20Strategy%202016-21%20v0%206.pdf>

primary care needs at the front end of UCC or directing patients to an alternative care provider or self-care advice.

- 3.6 The CCG has also commissioned the local GP Federation (One Health Lewisham) to deliver its GP Extended Access Service, which provides bookable appointments 7 days a week, 08:00 – 20:00 through the patient’s registered practice, via Integrated Urgent Care (formerly NHS 111), through redirection from the Urgent Care Centre and in future via direct online patient booking. The service has access to patient’s medical records, which will support improved access and continuity of care. This service commenced in April 2017. Patients have access to a GP and Nurse for face to face appointments and can also access a GP via Video Consultation.
- 3.7 The CCG has conducted an initial review of access to primary and urgent care services in light of these new services and the need to provide clarity for our population on the most appropriate way to access primary and urgent care; cognisant of the multiple ‘front doors’ to services.
- 3.8 Currently, urgent care in Lewisham is accessed through a number of services;
- (i) the Urgent Care Centre located at the University Hospital Lewisham;
  - (ii) the Primary Care Assessment Service also located at the same site;
  - (iii) GP Extended Access also located at the same site;
  - (iv) through their GP practice;
  - (v) the New Cross Walk-in Centre;
  - (vi) Integrated Urgent Care (formerly NHS 111);
  - (vii) Pharmacies.
- 3.9 This provides confused messages and consequently patients are not always seen in the right care setting and not always seen at the right time.
- 3.10 The CCG adopted commissioning responsibilities for the New Cross Walk-in Centre from NHS England in 2015, when the GP register was disaggregated from the Walk in Centre. On the 1<sup>st</sup> January 2016 a new contract was issued to the Hurley Group (incumbent provider) of the New Cross Walk-in Centre, located in the Waldron Health Centre for a period of 24 months.
- 3.11 Based on the above position and the summary of headline findings from a review of the Walk-in Centre it is recommended that the contract for this service should not be automatically renewed when the contract expires on the 31<sup>st</sup> December 2017.
- 3.12 Instead it is recommended that a review and formal consultation be undertaken to inform the future commissioning intentions for this service in the context of the delivery of the CCG’s approved strategy for primary and urgent care services.
- 3.13 In February 2014, Monitor produced a report which reviewed the provision of Walk-in Centres across England. Monitor reported that out of the 238 Walk-in Centres estimated to have originally opened, commissioners have closed 51 of them between 2010 and 2013. Of these closures, about one-third were part of reconfigurations to replace the Walk-in Centres with Urgent Care Centres co-located with A&E departments at hospital sites, or with models that integrated primary care staff within an A&E department. Of the 51 Centres that closed, 20 were nurse-led centres, six were commuter Centres and 25 were GP-led health Centres.
- 3.14 Monitor found that where Walk-in Centres were closing, commissioners often had concerns that the Centres were generating extra demand for services; that they led to duplication because some patients used them in addition to other services for the same problems; and that they caused confusion among patients about where to go for care.
- 3.15 Commissioners also commonly reported they felt they were “paying twice” for patients who attended Walk-in Centres. This was because most patients attending a Walk-in Centre were registered with a GP practice elsewhere that was already being paid to provide GP services. Unequal access to the Walk-in Centres was also identified as a reason for closure as Centres

were mostly used by people who lived close by, rather than by groups from areas of high deprivation or those with significant health needs.<sup>4</sup>

#### 4. Commissioning Intentions

4.1 The CCGs commissioning intentions as set out in its approved Primary Care Strategy – Developing GP Services includes the development of an Integrated Primary & Urgent Care on the University Hospital Lewisham site. The GP Extended Access Service will provide our population with access to an additional **25,425** bookable appointments in 2017/18, increasing to **29,194** in 2018/19 – the CCG has invested £1.5m in this service in 2016/ and 2017/18 at a full year cost of £1.2m.

4.2 The Primary Care Assessment Pilot saw **7,881** patients from October 2016 to May 2017. The CCG has invested £0.6m per annum in this service and there are plans to maintain services post the pilot stage. An independent evaluation of the pilot identified the following key findings – between October 2016 and January 2017;

- A total of 3653 patients were seen during the period of 3<sup>rd</sup> October 2016 – 31<sup>st</sup> January 2017
- Pilot activity equates to approximately 9% (30-35 per day) of total Urgent Care Centre/Emergency Department activity.
- An average of 2.7 patients per hour were seen which was in line with the key assumptions of 2.5 to 3 per hour.
- 64% (up to 25 patients per day) of pilot activity did not go to the Urgent Care Centre or Emergency Department for further investigation or treatment. These patients received either immediate treatment, management at point of assessment, signposted to an alternative setting appropriate for their health care needs e.g. their own GP, Early Pregnancy Unit, Sexual Health etc. or provided with verbal and/or written clinical advice.

#### 5. The New Cross Walk-in Centre

5.1 The New Cross Walk-in Centre contract is due to expire on the 31<sup>st</sup> December 2017. A summary of headline findings from a review and interviews with users of the Walk-in Centre are provided below;

- In 2016/17 the Walk-in Centre saw **29,528** patients at cost of approximately **£748k** to Lewisham CCG.
- Of those attending the Walk-in Centre less than half (**43.5% or 12,726**) can be identified as Lewisham residents registered with a Lewisham GP.
- Of those Lewisham residents registered with a GP, **28.5% (3,638)** of the patients using the Walk-in Centre were already registered with one of the four GP Practices located in the Waldron Health Centre.
- **28.6% (8,367)** of patients who attended the Walk-in Centre cannot be attributed to any CCG, at a cost to the CCG of approximately **£296k** in 2016/17.
- **45.6%** of patients surveyed by NHS Lewisham CCG reported that they went directly to the Walk-in Centre without attempting to book a GP appointment, as they did not believe they would be able to get appointment at their GP practice.
- **82.2%** of patients surveyed by NHS Lewisham CCG reported they would consider using another service, which offered bookable appointments at another location, if their own GP practice did not have available appointments.
- Walk-in Centres by their very nature provide access to all. Lewisham is the only remaining CCG in South East London that commissions a Walk-in Centre and that provides access to patients from outside of the Borough. Neighbouring CCGs such as Southwark, Lambeth and Greenwich have all closed their Walk-in Centres and replaced them with GP Extended Access Hubs, which are predominantly used by patients registered within the respective boroughs.
- In 2016/17, **17.5%** of patients using Walk-in Centre were from neighbouring South East London Boroughs; Southwark 12.5%; Greenwich 2.7%; and Lambeth 1.3%.

<sup>4</sup> Monitor: Walk-In-Centre Review: Final Report and Recommendations

## 6. Duty Consult

- 6.1 The law requires NHS bodies to engage with members of the public before making decisions on changes to health services. Currently, separate sections of the NHS Act apply to CCGs and to other organisations.
- 6.2 CCGs are governed by section 14Z2 of the NHS Act 2006, which states;
- (1) *This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions (“commissioning arrangements”).*
  - (2) *The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways):*
    - a) *in the planning of the commissioning arrangements by the group,*
    - b) *in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and*
    - c) *in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.*
- 6.3 In summary, statutory requirements apply to any significant commissioning decision or reconfiguration. However, the statute does not insist on “consultation”, but seeks to make sure that service users are “involved”. In practice, for any significant proposed change to services, some form of consultation exercise will be required to comply with this duty.
- 6.4 A formal and comprehensive public, patient and stakeholder consultation programme will be developed to enable views and comments to be sought from 31<sup>st</sup> July 2017.
- 6.5 Formal consultation with the Healthier Communities Select Committee will be on 7<sup>th</sup> September 2017.
- 6.6 In 2010, the Secretary set out four key tests against which NHS service reconfigurations (significant changes to services) have to be assessed. These tests were set out in the Revision to the Operating Framework for the NHS in England 2010/12<sup>5</sup>. This requires reconfiguration proposals to demonstrate;
- a) support from GP commissioners;
  - b) strengthened public and patient engagement;
  - c) clarity on the clinical evidence base; and
  - d) consistency with current and prospective patient choice.
- 6.7 Consequently, a formal and comprehensive public, patient and stakeholder consultation programme will be developed to enable views and comments to be sought. It will consist of face to face and drop in sessions and on-line surveys. This will include (but is not limited to) consultation with the following constituent groups and a indicative timeline is provided;
- Patient Participation Groups (PPG) associated with the four local practices based in the Waldron Centre
  - Healthwatch
  - Local voluntary organisations
  - Local residents, patients, NHS staff and users of the New Cross Walk-in Centre
  - Elected Member/s (Vicky Foxcroft MP)
  - NHS Staff/other staff at the Waldron Centre
  - The four GP practices located in the Waldron Centre and neighbouring practices
  - Neighbouring CCGs (Southwark, Lambeth and Greenwich)
  - Lewisham & Greenwich Trust
  - Local Medical Committee

- Integrated Urgent Care Service (formerly NHS 111)

Date	Consultation
13 <sup>th</sup> July 2017	Governing Body: Recommendation
20 <sup>th</sup> July 2017	Lewisham Council Healthier Communities Select Committee: Pre-consultation
27 <sup>th</sup> July 2017	CCG Patient Reference Group
31 <sup>st</sup> July 2017	Formal Public and Stakeholder Consultation: Start
7 <sup>th</sup> September 2017	CCG Public Engagement & Equalities Forum
7 <sup>th</sup> September 2017	Lewisham Council Healthier Communities Select Committee
14 <sup>th</sup> September 2017	Interim Report to the Governing Body
TBC	New Cross Local Assembly
3 <sup>rd</sup> October 2017	Evelyn Local Assembly
23 <sup>rd</sup> October 2017	Formal Consultation: End
2 <sup>nd</sup> November 2017	Health & Wellbeing Board
9 <sup>th</sup> November 2017	Governing Body: Decision

## 7. Financial Implications

There are no financial implications for the council.

## 7. Legal implications

There are no legal implications for the council.

## 8. Crime and disorder implications

There are no crime and disorder implications.

## 9. Equalities implications

The CCG are in the process of conducting a full Equalities Impact Assessment, which will be completed prior to formal consultation.

## 10. Environmental implications

Not applicable.

## 11. Background Documents

### [Our Healthier South East London Sustainability & Transformation Plan](#)

Following publication of the NHS Five Year Forward view, all NHS regions in England are required to work together and with their local councils to produce a Sustainability and Transformation Plan (STP) for local services.

This work is being jointly carried out by south east London Clinical Commissioning Groups (CCGs), hospitals, community health services and mental health trusts, with the support of local councils and members of the public.

Link: <http://www.ourhealthiersel.nhs.uk/>

### *NHS GP Forward View*

The General Practice Forward View, published in April 2016, commits to an extra £2.4 billion a year to support general practice services by 2020/21. It will improve patient care and access, and invest in new ways of providing primary care.

Link: <https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf>

## 12. Contact/s

Diana Braithwaite, Director of Commissioning & Primary Care, Lewisham CCG  
Ashley O'Shaughnessy, Deputy Director of Primary Care, Lewisham CCG

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Healthier Communities Select Committee		
Title	Lewisham and Greenwich NHS Trust Quality Account 2016/17	
Contributor	Scrutiny Manager	Item 7
Class	Part 1 (open)	20 July 2017

## 1. Purpose

As part of Lewisham and Greenwich NHS Trust's plan to share and invite comments and contributions to its Quality Accounts, it has submitted the 2016-17 Account to the Committee (attached). The Quality Account highlights performance in key areas so that partners and staff know how the Trust is performing and how it is working to improve quality.

## 3. Recommendations

The Select Committee is asked to:

- Review the draft accounts and agree any comments it wishes to make.

For further information, please contact John Bardens, Scrutiny Manager, on 02083149976.

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## Summary of Quality Accounts 2016/17

Prepared for: Healthier Communities Select Committee

Date: 20<sup>th</sup> July 2017

Author: Aoife Cavanagh - Head of PALs, Complaints and Clinical Effectiveness

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## 1) Introduction

A Quality Account is an annual report to the public from a provider of NHS Healthcare about the quality of services they deliver. National guidance states that this report must be written in a way in which makes it easy for the reader to understand, is open and transparent.

This Quality Account is divided into three sections:

Part 1:

Statement on quality from the Chief Executive.

Part 2:

Our quality priorities for 2017/18, statement of assurances from the Board Directors and review of quality performance.

Part 3:

Our performance in 2016/17 against our quality priorities and what our stakeholders say about us.

This report is a summary of the Quality Account 2016/17 so will not include of all the detail that is included in the actual account but will cover the key elements.

## 2) How we chose our priorities

Throughout the year our progress towards achieving the 2016/17 priorities has been monitored, presented and reported at meetings held across the Trust, with key stakeholders being present at these meetings.

The progress of our performance with these priorities has been reviewed and although there have been significant achievements made throughout the year, there is still room for improvement within our priorities around safety practices and enhancing the patient experience. Therefore, to maintain focus, we have committed to continuing our work to improve patient safety by reducing avoidable harm, being open and exercising our Duty of Candour and also by signing up to the National Sign up to Safety programme reflected in our safety pledges. Implementing the seven day working standards and ensuring a safe and effective discharge for our patients are both National and local priorities, and therefore are included within the clinical effectiveness priorities for 2017/18. We will also continue to focus on using patient feedback to influence positive changes to practice in order to improve our patients' experiences and implement our strategies for patients receiving end of life care and patients with dementia.

These priorities have been developed with key Trust representative leads and are supported by our Trust Board, Trust Quality and Safety Committee and our Clinical Commissioning Quality Review Group (CQRG).

The following tables outline the 2017/18 quality priorities.

### 3) Our Quality Priorities 2017/18

<b>Patient Safety Quality Priorities</b>	
(i)	Early recognition and treatment of the deteriorating patient
(ii)	Improving the safety of Maternity Services
(iii)	Continue our focus on the aim to reduce the number of avoidable grade 3, 4 and unstageable Trust attributable pressure ulcers and ensure where pressure ulcers are acquired within our provision of community services, timely completion of root cause analysis is undertaken and learning is continually shared across all areas
(iv)	Reduction in the number of patient falls and harm incurred
(v)	Improving medication safety and learning from medication incidents
(vi)	Getting the basics right and keeping patients safe within the emergency department and those areas used for escalation
<b>Clinical Effectiveness Quality Priorities</b>	
(i)	Embedding processes for mortality reviews across the Trust
(ii)	Working towards delivering the seven day working standards – four clinical priorities
(iii)	Safe and effective discharge
(iv)	Improving patient outcomes through measures for Adult Community Services
<b>Patient Experience Quality Priorities</b>	
(i)	We will continue to work with our patients, carers, staff and partners to deliver consistently excellent standards of dementia care to improve the experience of our patients who have a diagnosis of dementia as well as that of their Carers
(ii)	We will continue to expand the ways in which we gain feedback from patients and service users and ensure that learning from feedback is used to support positive change
(iii)	Improving the quality of the End of Life Care pathways across the health care system
(iv)	Improving the Trust's Staff Recognition processes – Expanding the existing staff recognition processes within the Trust

#### 4) National Quality Indicators

For 2016/17, there are nine statutory quality indicators which apply to acute hospital trusts. All Trusts are required to report their performance against these indicators in the same format, with the aim of making it possible for a reader to compare performance across similar organisations. For each indicator our performance is reported with the national average and the performance of the best and worst performing Trusts, where this data is available

**i) Patient Safety Indicator 1 – The percentage of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism (VTE) during 2016/17**

Venous thromboembolism or blood clots, are a major cause of death in the UK. Some blood clots can be prevented by early assessment of the risk for an individual patient. Over 95 per cent of our patients are assessed for their risk of thrombosis (blood clots) and bleeding on admission to hospital.

VTE assessment rate	2015/16	2016/17
Lewisham and Greenwich NHS Trust	88.9%	95.4%
National Average	95.74%	95.6%
Best performing Trust	100%	100%
Worst performing Trust	82.29%	79.86%

Source: [www.england.nhs.uk](http://www.england.nhs.uk)

We have a number of processes in place to collect monthly data on the VTE assessments. A root cause analysis takes places for all cases of hospital acquired thrombosis. Teaching on stocking application is being provided and VTE champions have been appointed to our wards. VTE study days are also being provided to our staff.

**ii) Patient Safety Indicator 2 – The rate per 100,000 bed days of cases of Clostridium difficile infection (CDI) reported within the Trust amongst patients aged 2 or over during 2016/17**

CDI remains an unpleasant and potentially severe or fatal infection that occurs mainly in elderly and other vulnerable patient groups.

Whilst recognising the new reporting requirements for the purpose of Quality Account, unfortunately national data will not be available on the rate of *C. difficile* reported per 100,000 bed days until after the publishing date of the Quality Account on 30<sup>th</sup> June 2017.

The mandatory surveillance reporting is via Public Health England (PHE) who collect and publish the data on monthly 'counts' as opposed to rate per 100,000 bed days.

Once per year in July, the PHE publish the data as a rate per 100.000 bed days. This data will not be available for the publication of the Trust Quality Accounts. Therefore, the Trust has calculated its rate per 100,000 bed days using the bed availability and occupancy data as referenced below.

<b>C. difficile rate per 100,000 bed-days</b>	<b>2015/16</b>	<b>2016/17</b>
<b>Lewisham and Greenwich NHS Trust</b>		
<b>Trust apportioned</b>	37	25
<b>Rate per 100,000 bed days (Trust apportioned)</b>	11.0	6.5
National Average	14.9	TBC
Best performing Trust	5.4	TBC
Worst performing Trust	36.2	TBC

Data source for bed days – Trust information department

The table below demonstrates monthly counts of *C. difficile* infection by Acute Trust for patients aged 2 years and over - Trust Apportioned only\*.

<b>Monthly counts of <i>C. difficile</i> infection for patients aged 2 years and over by Acute Trust - Trust Apportioned only*</b>														
Reporting Period: April 2016 - March 2017														
<b>Trust Type</b>	<b>PHE Centre</b>	<b>Trust Name</b>	<b>April 2016</b>	<b>May 2016</b>	<b>June 2016</b>	<b>July 2016</b>	<b>August 2016</b>	<b>September 2016</b>	<b>October 2016</b>	<b>November 2016</b>	<b>December 2016</b>	<b>January 2017</b>	<b>February 2017</b>	<b>March 2017</b>
NHS Trust	London	Barking Havering and Redbridge University Hospitals	1	2	2	6	3	4	3	2	3	1	0	2
NHS Trust	London	Barts Health	7	4	3	6	7	7	3	8	0	11	4	10
NHS Trust	London	Croydon Health Services	0	2	2	1	1	0	1	0	2	3	0	1
FT	London	Guy's & St. Thomas's	9	2	2	4	3	1	1	3	4	2	1	4
FT	London	Homerton University Hospital	0	1	0	0	1	0	1	0	0	1	0	0
FT	London	King's College Hospital	5	5	5	7	6	9	4	10	9	4	3	3
NHS Trust	London	Lewisham & Greenwich	1	1	3	2	2	2	5	3	1	1	2	2
NHS Trust	London	North Middlesex University Hospital	2	4	3	2	2	1	2	3	5	6	0	3

The infection control team has taken the following actions to improve this number:

- Continue to undertake antimicrobial rounds with the Consultant microbiologists and clinical teams
- Ensure the continual and regular review of antimicrobial prescribing
- Monitor the performance of antimicrobial prescribing through monthly audits
- Work with our community partners to update antimicrobial prescribing guidelines for the community
- Maintain a strong and visible presence at ward level.

**iii) Patient Safety Indicator 3 – The number and rate of patient safety incidents reported within the Trust and the number and percentage of such patient safety incidents that resulted in severe harm or death for 2016/17**

Patient Safety Incidents	Apr 15- Sept 15	Apr 16- Sept 16*
<b>Lewisham and Greenwich NHS Trust</b>		
<b>Total reported incidents</b>	6,166	6,547
<b>Incidents causing severe harm or death</b>	5	5
<b>% of incidents causing severe harm or death</b>	0.1%	0.1%
<b>ACUTE NON-SPECILISED TRUSTS</b>		
Lowest incident reporting rate per 1,000 bed days	18.34	21.15
Highest incident reporting rate per 1,000 bed days	74.67	71.81
Lowest incidents causing severe harm or death	0.0%	0.0%
Highest incidents causing severe harm or death	3.6%	1.9%
Acute Trusts average % of incidents causing severe harm or death	0.4%	0.4%

The data for April 2016 to September 2016 is the latest published data available - we await the national publication of more recent data.

**All incidents reported onto the incident system:**

2016/17	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Number	1531	1548	1639	1657	1539	1535	1410	1561	1629	1807	1608	1967	19431

**Patient safety incidents reported within the Trust per month (excluding non-clinical incidents):**

2016/17	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Number	1171	1128	1282	1249	1138	1104	1082	1176	1233	1332	1151	1401	14,447

**Patient Safety Incidents where the impact was severe harm or death which was or may have been avoidable:**

2016 /17	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Severe harm	1	1	1	0	2	0	0	0	0	0	0	2	7
Death	0	0	0	0	0	0	1	0	0	1	3	0	5
Total	1	1	1	0	2	0	1	0	0	1	3	3	13

Note: At the time of writing this report, some investigations were still underway which when completed may change the level of harm recorded

For the period between April 2016 and March 2017 a total of 19,431 incidents (includes clinical, patient safety and non-clinical incidents) were reported on the incident reporting system within the Trust, which is an increase on the previous year, April 2015 – March 2016, where 17,382 incidents were reported.

Of the 19,431 incidents, 74.3% reported were considered to be patient safety incidents which are uploaded to the National Reporting and Learning System (NRLS) to help contribute towards national learning and improvements in patient safety.

## Duty of Candour

Duty of Candour is a statutory (legal) duty to be open and honest with patients (or ‘service users’), or their families, when something goes wrong that appears to have caused or could lead to harm. Duty of Candour specifically applies to “notifiable patient safety incidents” causing moderate or severe harm, psychological harm of more than 28 days or the incident resulted in death, to the patient.

Duty of Candour includes:

- Telling the relevant person, in person, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred
- Offering a sincere apology
- Providing support to them in relation to the incident, including when giving the notification
- Providing a full account of the incident, to the best of the provider’s knowledge
- Following up with a letter.

Within the Trust, the Medical Director is the named lead for Duty of Candour. Duty of Candour compliance is monitored on an on-going basis through the governance leads within the Clinical Divisions, Patient Safety Team, monthly Divisional Governance meetings and quarterly at the Trust's Quality and Safety Committee. Compliance is also included on the Trust scorecard which is presented on a monthly basis to the Trust Board.

## iv) Clinical Effectiveness Indicator 1 - Summary Hospital-level Mortality Indicator (SHMI)

The Summary Hospital-level Mortality Indicator (SHMI) is a mortality measure that takes account of a number of factors. It includes patients who have died while having treatment in hospital or within 30 days of being discharged from hospital. The SHMI score is measured against the NHS average which is 1.00. A score below 1.00 denotes a lower than average mortality rate and therefore indicates good, safe care.

To help understand the SHMI data, Trusts are categorised into one of three bands:

- Where Trust's SHMI is 'higher than expected' – Band 1
- Where the Trust's SHMI is 'as expected' – Band 2
- Where the Trust's SHMI is 'lower than expected' - Band 3.

### SHMI value and Banding

Summary Hospital-level Mortality Indicator	Oct 14 – Sep 15 (published March 2016)		Jan – Dec 15 (published June 2016)		Apr15 – Mar 16 (published September 2016)		Jul 15 – Jun 16 (published December 2016)	
	SHMI	Banding	SHMI	Banding	SHMI	Banding	SHMI	Banding
Lewisham and Greenwich NHS Trust	1.00	Band 2 'as expected'	1.01	Band 2 'as expected'	0.99	Band 2 'as expected'	1.00	Band 2 'as expected'
Best Performing Trust	0.652	Band 3	0.669	Band 3	0.678	Band 3	0.694	Band 3
Worst Performing Trust	1.177	Band 1	1.173	Band 1	1.178	Band 1	1.171	Band 1

The Medical Director chairs the monthly Mortality Review Committee. The organisation reviews its scores by looking at our patient's coded information. This coded information holds details of what diagnoses, co-morbidities and procedures the patient had whilst admitted to the Trust. If indicated, a case note review is carried out to ensure that the patient did receive the best quality of care possible. We continue to work closely with our coding team and junior doctors to ensure that the clinical documentation is as accurate as possible.

**v) Clinical Effectiveness Indicator 2 – Patient Reported Outcome Measures (PROMS)**

Patient Reported Outcome Measures (PROMS) measure quality from the patient perspective, and seek to calculate the health gain experiences by patients following one of four clinical procedures:

- Groin Hernia surgery
- Hip Replacement Surgery
- Knee Replacement Surgery
- Varicose Vein Surgery.

PROMs data is obtained through a pair of questionnaires completed by the patient, one before and one after surgery (at least three months after). Patients’ self-reported health status (sometimes referred to as health-related quality of life) is assessed through a mixture of generic and disease or condition-specific questions. For example, there are questions relating to mobility, self-care, e.g. washing and dressing, usual activities, e.g. work, study, house-work, family or leisure activities, pain/discomfort or anxiety /depression.

The types of questionnaires are specifically named and calculate a score based on the patient responses.

**Operations Lewisham and Greenwich NHS Trust have carried out from 1<sup>st</sup> April 2016 up to 30<sup>th</sup> September 2016 and the number of questionnaires returned for each procedure up to 30<sup>th</sup> September 2016.**

April 2016 – September 2016					
Procedure	Eligible Patients (Based on HES Data)	Number of Operations Performed (Based on Hospital Data)	No. of Q1 Questionnaires Received	No. of Q2 Questionnaires Issued	No. of Q2 Questionnaires Returned
<b>All Procedures</b>	<b>560</b>	<b>648</b>	<b>408</b>	<b>86</b>	<b>40</b>
Groin Hernia	144	240	91	40	18
Hip Replacement	106	126	117	11	5
Knee Replacement	167	155	177	19	10
Varicose Vein	143	127	23	16	7

We are working to ensure that all eligible patients are invited to complete the questionnaires and we will also continue to review the timeliness of questionnaire distribution in Q2 by our supplier. Where patients have reported a deterioration, we will continue to review these cases in order to understand and identify areas for improvement in each of the procedure processes.

**vi) Clinical Effectiveness Indicator 3 – Reduction in emergency readmissions within 28 days of discharge from hospital**

Emergency readmission to hospital shortly after a previous discharge can be an indicator of the quality of care provided by an organisation. Not all emergency readmissions are part of the original planned treatment and some may be potentially avoidable. Therefore reducing the number of avoidable readmissions improves the overall patient experience of care and releases hospital beds for new admissions.

However the reasons behind a readmission can be highly complex and a detailed analysis is required before it is clear whether a readmission was avoidable. For example, in some chronic conditions, the patient’s care plan may include awareness of when his or her condition has deteriorated and for which hospital care is likely to be necessary. In such a case, a readmission may itself represent better quality of care.

Lewisham and Greenwich NHS Trust monitors the readmission rate using the national data sources and also through CHKS, an independent leading provider of healthcare intelligence. Readmission data for the year 2016/17 is available through CHKS as shown in the tables 1, 2, and 3 below. The peer comparison has also been included to allow the organisation to benchmark its performance against peers (Acute Trusts Nationally). It is not possible to include peer data for individual hospital sites which form part of an NHS Trust, as CHKS peers are Trusts rather than sites.

**Lewisham and Greenwich readmission within 28 days**

Lewisham and Greenwich NHS Trust readmission within 28 days									
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Trust	8.29%	7.9%	7.9%	8.42%	8.6%	8.31%	8.28%	8.02%	8.62%
Peer	7.82%	7.84%	7.81%	7.8%	7.79%	7.75%	7.74%	7.67%	8.11%

The Trust continues to work with our commissioners and other partners to review the current patient discharge pathways across both sites with the aim of identifying ways of improving care following a patient’s discharge from hospital. Admission avoidance, management of our patients with long term conditions and working with our community services is part of the work underway to minimise the readmission rates.

**vii) Patient Experience Indicator 1 – The Trust’s responsiveness to the personal needs of the patient – national inpatient survey results**

Patient experience – responsiveness to personal needs of patients	2015	2016
Lewisham and Greenwich NHS Trust	62.8	65
Highest scoring Trust	86.1	86.2
Lowest scoring Trust	59.1	58.9

Source: <https://indicators.hscic.gov.uk>

Developments since July 2016 include:

- Introducing ‘quality rounds’ on our inpatient wards – with regular reviews of every patients so we can ensure their needs are being met
- A range of improvements to the emergency pathway, including:
  - Working with partners to improve the flow of patients through our hospitals – enabling earlier admission to a ward and earlier discharge from hospital
  - Improving processes for monitoring safety and being responsive to patients’ needs, including the introduction of detailed reviews of patients in the emergency departments several times a day
  - Introducing specialist services for older patients and specialist outpatient services (“ambulatory care”) to enable patients to see the right healthcare professional sooner
- Extended the meal time support available through our volunteer programme.

**viii) Patient Experience Indicator 2 - Patient Friend and Family Test – patient scores**

The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.

The following table shows the latest nationally published results for the Trust and England. The Maternity FFT is taken at four different points throughout the mother’s journey.

Patient recommendation to family and friends					
	January 2017	Lewisham and Greenwich NHS Trust	National Average	Highest Scoring Trust	Lowest Scoring Trust
<b>ED (Emergency Department)</b>	Response Rate	8.7%	12.3%	44.4%	0.5%
	Recommendation Rate	94%	87%	100%	45%
<b>Community</b>	Response Rate*	N/A	N/A	N/A	N/A
	Recommendation Rate	87%	95%	100%	83%
<b>Inpatient</b>	Response Rate	23.0%	23.6%	95.5%	3.8%
	Recommendation Rate	94%	96%	100%	80%
<b>Maternity – Antenatal</b>	Response Rate*	N/A	N/A	N/A	N/A
	Recommendation Rate	97%	96%	100%	75%
<b>Maternity - Birth</b>	Response Rate	45.9%	22.5%	103.3%	0.1%
	Recommendation Rate	93%	97%	100%	88%

<b>Maternity – Postnatal Ward</b>	Response Rate*	N/A	N/A	N/A	N/A
	Recommendation Rate	90%	94%	100%	77%
<b>Maternity – Postnatal Community</b>	Response Rate	N/A	N/A	N/A	N/A
	Recommendation Rate	100%	98%	100%	85%
<b>Outpatients</b>	Response Rate*	N/A	N/A	N/A	N/A
	Recommendation Rate	92%	93%	100%	72%

Source: <https://www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/>

The organisation is constantly looking at ways to increase the response rate to the Friends and Family test. We are currently investigating the use of technology such as SMS text message, in order to increase the rate.

**ix) Patient Experience Indicator 3 – The percentage of staff employed by the Trust who would recommend the Trust as a provider of care to their family and friends**

The annual staff survey is used to understand staff experience and perceptions on a wide range of subject areas. The survey is undertaken by all NHS organisations which enable comparisons to be made between similar Trusts and the national average for similar Trusts.

The table below shows the overall response to the Staff Friends and Family Test (SFFT) questions within the 2016 Staff Survey. It shows that:

- 62% of those who responded said they agreed or strongly agreed, they would recommend the Trust to friends and family as a place for treatment,
- 33% neither agreed nor disagreed that they would recommend the Trust to friends and family as a place for treatment.

This has improved from the 2015 survey where 60% of those who responded said they would recommend the Trust to friends and family as a place for treatment.

Lewisham and Greenwich NHS Trust 2016 Annual Staff Survey					
Q12. To what extent do these statements reflect your view of your organisation as a whole? d) if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation					
Strongly Disagree	Disagree	Neither agree	Agree	Strongly	Base respondents
4.85%	8.36%	24.65%	46.58%	15.57%	n 1,651

The following table shows how the Trust performed when compared to national results and those which demonstrated the highest and lowest scores for combined acute and community based Trusts.

Staff recommendation to family and friends	Composite scores for recommendation of the trust as a place to work or receive treatment	
	2015	2016
Lewisham and Greenwich NHS Trust	3.65*	3.68*
National Average	3.73**	3.71**
Highest scoring Trust	4.22**	4.20**
Lowest scoring Trust	3.23**	3.11**

\* denotes scores for Acute Trusts only

\*\* denotes score for combined acute and community Trusts Source: NHS Picker Institute

**The percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. The percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.**

Key Findings Question of NHS Staff Survey 2016 Percentage Base number of respondents	Percentage	Base number of respondents
<b>Key Finding 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</b>	%	n
All Combined and Acute Community Trusts	23	74,884
Lewisham and Greenwich NHS Trust	28	1,669
Best Performing Trust	19	-
Worst Performing Trust	32	-
<b>Key Finding 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</b>	%	n
All Combined and Acute Community Trusts	87	52,279
Lewisham and Greenwich NHS Trust	82	1,099
Best Performing Trust	94	-
Worst Performing Trust	66.6	-

The organisation is working to improve staff engagement and experience by:

- Actively recruiting to fill its vacancies
- Plan and run health and wellbeing events across both sites
- Ensure that the 100 day listening exercise for new recruits is maintained.

**5) Supporting the Hello my name is campaign (#hellomynameis)**

Lewisham and Greenwich NHS Trust is signed up to the #hellomynameis campaign which was started by Kate Granger, a terminally ill cancer patient. Kate observed that many staff did not introduce themselves before delivering care and thought that this should be a basic communication with patients. The Trust prides itself on delivering a warm welcome to our patients. Staff wear yellow badges with their names (usually just displaying their first name) to facilitate interaction with patients and to support the campaign.

**6) Participation in Clinical Audit**

The Trust uses Clinical Audit to assess and monitor its compliance against national and local standards, and to review the healthcare outcomes of its service users. It provides healthcare professionals the opportunity to reflect on their individual practice and the wider practices across the clinical directorates and the Trust. Lewisham and Greenwich NHS Trust actively encourages all clinical staff and those in training to be involved in Clinical Audit.

The Trust’s annual Clinical Audit Programme (CAP) is formulated each year to ensure that the Trust meets all mandatory, regulatory and legislative requirements as laid out by the NHS governing bodies. It is specifically designed to include all applicable National Clinical Audit and Confidential Enquiries the Trust is eligible to participate in, relevant published National Institute for Health and Care Excellence (NICE) guidance and NICE Quality Standards, and local governance and service level priority topics required to ensure compliance with statutory obligations.

**National Audit and Confidential Enquiries Programme**

During April 2016 to March 2017, 44 National Clinical Audits and 4 National Confidential Enquiries covered NHS services that Lewisham and Greenwich NHS Trust provides. During that period Lewisham and Greenwich NHS Trust participated in 100% (44/44) National Clinical Audits and 100% (4/4) National Confidential Enquiries of the National Clinical Audits and National Confidential Enquiries which it was identified as eligible to participate in.

**National Clinical Audit – Changes to practice**

Speciality	Change to Practice
Children’s Services	A local audit to assess the time to triage identified that patients were waiting longer than 30 minutes during busy periods to be seen, which was a cause for concern. As a result of the audit findings, clinicians in the Children’s Emergency Department introduced a Rapid Triage Tool to allow patients to be assessed more rapidly, identifying the most unwell patients early. Having the Rapid Triage Tool in place will help the department achieve the Royal College of Emergency Medicine Vital Signs standards.
Emergency Department	The Emergency Department will be piloting the use of nasal end tidal CO2 monitoring to support the Royal College of Emergency Medicine sedation in adults standards. A local clinical guideline has also been developed to ensure the Emergency Departments across the Trust are compliant with the recommendations made following the 2015 National Procedural Sedation Audit.

## Clinical Service area local audits and reports of local audit recommendations and changes to practice

The reports of 367 local audits were reviewed by the Trust from 1<sup>st</sup> April 2016 to 31<sup>st</sup> March 2017. The examples below taken from across the Trust demonstrate some of the actions taken to improve the quality of our services. A full list of the local audits reviewed is attached in Appendix 1.

Speciality	Changes to Practice
Emergency Department	Treatment of patients with Sepsis is audited quarterly in the Emergency Department (ED). An ED care set (implemented in January 2017) for Sepsis in FirstNet should drive improved and appropriate blood test ordering. A business case for a point-of-care (POCT) solution for Creatinine/Urea measurement has been written which if implemented will allow the department to answer the new requirement by NICE to assess patients for Acute Kidney Injury (AKI).
Children's Services	For patients with suspected sepsis where antibiotic administration within the first hour is critical, the Division is producing 'bundle packs' for cannulation to minimise delay to administration.
Children's Services	Following an audit against NICE guidance on epilepsy which identified that patients were waiting a long time for a first review, a 'first fit' clinic has been established.
Children's Services	Prolonged jaundice clinic has stopped performing routine urine cultures as a result of the recorded outcomes identified by a recent audit.
Children's Services	As a result of an audit looking at follow-up after first afebrile fits at University Hospital Lewisham, a monthly first fit clinic has been set up so these children can be seen in a dedicated clinic.
Children's Services	The multi-professional ROCAIP training is now delivered as part of induction for new staff. This was identified as an outcome of a documentation audit.
Orthopaedics	Following a patient feedback project and service evaluation, the Community Hip and Knee team are developing new exercise handouts for their patients. The service is also introducing a Hip and Knee Club with the aim of patients being invited to the club approximately 6 weeks before surgery to obtain information about their planned procedure and recovery.
Pharmacy	As an outcome of audit results, the development of the role of the pharmacy technician and an extension of the support that pharmacy technicians provide to wards has benefited patients a great deal. This has enabled pharmacy technicians to become more involved in medicines reconciliation, which in turn frees up the pharmacists' time to enable them to carry out more clinical duties e.g. ward rounds, patient counselling, etc. Wards with a medicines management pharmacy technician (MMPT) have much higher levels of completed pharmacy led medicines reconciliation within the patient's first 24 hours of admission.

Maternity	An Induction of Labour (IOL) audit has resulted in the review and update of Trust IOL guidelines to ensure women with uncomplicated IOL are still able to deliver in the Birth Centre.
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## 7) Participation in Research

Lewisham and Greenwich NHS Trust strongly encourages participation in research as part of its commitment to providing healthcare services that are evidence-based. In a wider context, greater collaboration between NHS trusts and the life-sciences industry is a high-level NHS objective so the Trust is further developing its commercial research.

Lewisham and Greenwich NHS Trust works collaboratively with the London South Comprehensive Research Network (CRN) whose remit includes the Trust's research in Rheumatology, Paediatrics, Age and Aging, Neurology, Critical Care, Dermatology, Respiratory Medicine and more recently Hepatology, Gastroenterology, Women's Health, Cardiology, Diabetes, Epilepsy and HIV. In addition, the Trust also hosts commercial research and supports a small number of other projects either forming part of a staff member's higher degree, or led by a local investigator in an area key to the Trust.

The Trust's research portfolio continues to expand, with an increase in the number of research studies opened and in the number of patients recruited into studies. The Trust's focus remains on studies that are of good quality and are relevant to the needs of the population it serves.

### Participation in Clinical Research

Lewisham and Greenwich NHS Trust continues to contribute to the achievement of the government's vision to embed research into every sector of healthcare. Now, more than ever, the Research and Development department of the Trust is committed to partnering with staff members and patients to promote research and ultimately, evidence-based healthcare. Therefore, participation in clinical research is a further demonstration of the Trust's commitment towards improving the quality of care we offer and the contribution and commitment that staff make to ensure successful patient outcomes.

Lewisham and Greenwich NHS Trust has been involved in conducting **142** clinical research studies in a number of different specialties.

The number of patients receiving NHS services provided or subcontracted by Lewisham and Greenwich NHS Trust in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was **2841**.

## 8) Goals agreed with Commissioners (CQUINs)

A proportion (2.5%) of Trust's income in 2016/17 was conditional on achieving quality improvement and innovation (CQUIN) goals agreed between Lewisham and Greenwich NHS Trust and Lewisham, Greenwich and Bexley Clinical Commissioning Groups and NHS England

The Trust achieved 80% of its CQUIN goals for April 2016 – March 2017.

## 9) What others say about the provider

### Care Quality Commission (CQC)

Lewisham and Greenwich NHS Trust is required to register with the Care Quality Commission and its current registration status is 'registered without conditions'.

The Care Quality Commission has taken enforcement action against Lewisham and Greenwich NHS Trust in 2016/17 following an unannounced inspection of our Urgent Emergency and Medical Care services at Queen Elizabeth Hospital Woolwich in June 2016. The CQC ratings resulting from this inspection are laid out below.

The ratings following that visit are given below.

### Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement					

Although the inspectors commented on progress made since the last inspection in 2014, including an improved pathway for all ED patients to UCC, opening of a clinical decision unit and Frailty Assessment Unit, the CQC requested a number of "must do" improvements, which included:

- Ensure patients are cared for in areas that are appropriate and have sufficient space to accommodate number of people using service at any one time
- Improve systems and processes for monitoring quality and safety in the emergency and medical services departments
- In medical care, all medicines must be stored safely, securely and in a temperature-controlled environment

In response, the Trust produced an improvement action plan, with input from local commissioners.

This included:

- Management of patient flow through daily meetings on each hospital site.
- Agreeing a frailty pathway and developing ambulatory care pathways
- Implementing a 'discharge to assess' pilot with Bexley Social Care

- Introducing weekly wards rounds as part of “business as usual”. This includes senior nursing staff monitoring the completion of observations, documentation of assessments and patient interviews, with immediate actions being put in-place to address sub-standard performance. Results to be fed back to staff within wards.
- Weekly medicines safety audits, results monitored through Divisional Governance Boards.

In March 2017, the CQC undertook a planned comprehensive inspection of all the Trust services, including our community services. The Trust has not received the CQC draft or final report at the time of writing this report.

In their initial feedback following the visit, the CQC commented on the professionalism of staff, and on the caring attitude staff showed in ensuring that patients were treated with dignity and respect. The CQC recognised a number of areas of good practice and improvements since the last Trustwide CQC visit in June 2016.

The CQC have also told us that we need to make changes more quickly, particularly with regard to the emergency care pathway. With our partners, we have developed and are progressing the implementation of our safety and improvement plan which aims to address the areas of feedback provided by CQC.

We are working with our partners to deliver improvements across the health and social care system, and delivering the plan is our main priority as an organisation.

Internally, we have four workstreams, each led by an executive director:

- Improving patient flow
- Clinical engagement, leadership and changing
- Upgrading your working environment
- Monitoring safety and quality of and quality of care

The programme as a whole is overseen by Programme Directors who will be working with operational and clinical teams to ensure the necessary changes result in improved performance across the Trust.

CQC inspection reports can be viewed via the following link:  
<http://www.cqc.org.uk/provider/RJ2>

## 10) Data Quality

### **Quality data is data that is:**

Confidential, accurate, valid (that adheres to an agreed list of codes/descriptions), consistently understood and used across an organisation, comprehensive in its coverage, delivered to a timescale that fits the purpose for which it is used and held both securely and confidentially.

The Trust measures many different aspects of Data Quality – from the presence of a General Practitioner and NHS Number recorded within a patient record, to the detail and depth within the clinical coding associated with an admission.

Data quality is taken very seriously by the Trust as it can impact on the quality of patient care provided to patients. The Trust's Data Quality scorecard shows performance against key targets and is used to identify areas for improvement. The scorecard, which contains over 90 measures, is updated on a monthly basis, and key Data Quality metrics are included on the Trust Board scorecard.

A training plan is in place to deliver training to coding staff around how to extract relevant information from source documentation as this was the cause of a large number of the coder errors that were evidenced in the audit reports in 2015/16. The coding Engagement Lead has requested additional time to work with junior doctors to ensure that they understand the rules that apply to how coders translate the information as written down in source documentation into the appropriate code – because coders cannot make assumptions, but must follow nationally mandated rules on how they translate what is written using the appropriate classification (ICD10 and OPCS 4). The junior doctors complete most of the source documentation (paper and electronic) hence it is important that they understand what they record in the patient's case notes is used for. It not only forms part of the patient's health record, it is also used to calculate how much the Trust should be paid for treating that specific patient via the Payment by Results process. Additionally, it is a national record of the Consultant's clinical practice.

## **11)Information Governance Toolkit**

Information Governance (IG) is the way by which the NHS handles all organisational information – in particular the personal and sensitive information of patients and employees. It requires organisations and individuals to ensure that personal information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care.

Every year the Trust is required to submit an annual Information Governance Toolkit submission. This is an online self-assessment which allows NHS and other related organisations to demonstrate whether they are compliant in basic information governance standards.

The Trust is required to upload evidence to support this assessment. Each control then scores each requirement from a Level 0 to 3. To achieve an overall 'Satisfactory' rating each control must be scored at a Level 2 or more.

For 2016/17, the Trust IGTK score was 77 per cent, achieving a satisfactory green pass rate in all IG controls. This provides the Trust Board with substantial assurance that appropriate controls are implemented and consistently applied to manage the information risks of the business.

## **12)Clinical Coding**

### **Payment by Results**

Payment by Results (PbR) is the method by which the Trust receives payment for admitted patients within the acute setting. Trained staff extract information about patient's stays – treatments they receive and what is wrong with them; this along with other information such as the patient's age and how long they were in hospital for is used to allocate each patient to a nationally agreed category. The categories, which are called Healthcare Resource Groups (HRGs), have a national tariff which is used to determine the amount that the Trust is reimbursed for patient care.

The HRGs are based on the Clinical Coding recorded against each episode of care, it is important that the coding is an accurate record of the patient's conditions and care received so that the Trust is not over or under paid. In addition to this, the coded data forms part of the patient's clinical record and is used to help identify where improvements in service can be made and to aid the planning of health service provision within the local healthcare economy. The data is also submitted nationally to the Secondary Use Service (SUS), who collect national data to allow them to look at trends and patterns across the NHS as a whole.

The Trust did not have its Admitted Patient Care Clinical Coding audited as part of any national audit programme in 2016/17; however qualified Coding auditors have completed clinical coding audits in year. The audit reports have been shared with the site based coding teams, with action and training plans developed around the audit recommendations.

**13)Review of Quality Performance in 2016/17**

<b>Patient Safety Priorities</b>	
(i) Improving our hand hygiene compliance	We partially achieved this
(ii) Early recognition and treatment of the deteriorating patient	We achieved this
(iii) Improving the Safety of Maternity Services	We partially achieved this
(iv) Continue our focus on the aim to reduce the number of grade 2, 3, and 4 hospital acquired pressure ulcers and ensure where pressure ulcers are acquired within our provision of community services, timely completion of root cause analysis is undertaken and learning is shared across our community areas.	We partially achieved this
(v) Reduction in the number of patient falls and harm incurred	We partially achieved this
(vi) Help people to understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress	We partially achieved this
<b>Clinical Effectiveness Priorities</b>	
(i) To continue to work on embedding the process for mortality reviews across the Trust and implement the new NHSE process	We fully achieved this
(ii) To improve the clinical pathways for Frailty and improve outcomes for these patients	We partially achieved this
(iii) Informed by the London Asthma Standards and building on the gap	We partially achieved this

analysis undertaken by OHSEL Asthma Working Group in 2015/16, the 2016/17 priority consolidates and expands the work undertaken locally on the Children's Asthma pathway redesign through 2015/16	
<b>Patient Experience Priorities</b>	
(i) We will continue to focus on providing individualised care for patients with dementia and their carers and continue to expand this work into intermediate and community care	We fully achieved this
(ii) Ensuring that learning from feedback is used to affect change (from complaints, FFT, NHS choices, national and local surveys etc.) and shared across the organisation	We fully achieved this
(iii) Continued expansion for gaining patient feedback from all services	We fully achieved this
(iv) Improving the patient experience and quality of End of Life pathways	We partially achieved this

#### **14)An explanation of who has been involved**

The Trust has consulted widely on the content of this Quality Account, namely with the Trust Board, senior nursing, medical staff, midwifery, clinical and managerial staff, patients and the public. The Patients' Welfare Forum and the local Healthwatch organisations have also been consulted.

We have also been able to consult and gain feedback from three local Clinical Commissioning Groups and the membership of the Clinical Quality Review Group.

#### **The Trust Board**

The Trust Board has been actively involved in setting the quality priorities for the Trust. Items on quality are discussed at every Board meeting and at frequent Board seminars. Quality Account indicators are part of the Trust scorecards, which have been presented and discussed through the Integrated Governance reports to the Trust Board.

The Trust Board is also presented with a performance scorecard which is examined at every Board meeting to assess trends in performance and highlight any issues of concern. In addition, Board members undertake quality walk rounds, visiting clinical departments to increase their understanding of services provided and hear first-hand of challenges that front-line staff face on a day-to-day basis.

## **Staff**

The Trust's Management Executive, which comprises the Chief Executive, the Medical Director, Director of Nursing & Clinical Quality, Director of Finance & Information, Director of Estates & Facilities, Director of Workforce & Education, Director of Service Delivery, the Chief Information Officer and the six Divisional Directors, have been involved in discussions around and provision of information for the Quality Account.

Key leads and stakeholders from within each of the six Clinical Divisions have contributed to the content, the setting of priorities, and agreement of the key outcome measures and have provided the commitment to lead on each of the key priorities for 2017/18.

The Trust Integrated Governance Committee, Quality and Safety Committee and Patient Experience Committee, which have Executive, Non-Executive, Clinical Team and lay members, Patient Welfare Forum members and members of our local Healthwatch, have the Quality Account as a standing agenda item and valuable input has been received from these committees.

The Divisional Governance and Risk meetings have also been used to consult widely on the Quality Account with Divisional Governance, Risk and Audit Leads participating in the review of the priorities.

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# Quality Account

## 2016 - 2017





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# Glossary

<b>AKI</b>	Acute Kidney Injury
<b>A&amp;E</b>	Accident and Emergency
<b>CAS</b>	Central Alerting System
<b>CAP</b>	Clinical Audit Programme
<b>CCG</b>	Clinical Commissioning Group
<b>CDI</b>	Clostridium difficile infection
<b>C. difficile</b>	Clostridium difficile
<b>CEFM</b>	Continuous Electronic Fetal Monitoring
<b>CEO</b>	Chief Executive Officer
<b>CHKS</b>	Independent provider of healthcare intelligence, benchmarking and quality improvement services
<b>CDs</b>	Controlled Drugs
<b>CRN</b>	Clinical Research Network
<b>CQC</b>	Care Quality Commission
<b>CQRG</b>	Clinical Quality Review Group
<b>CQUIN</b>	Commissioning for Quality and Innovation
<b>ED</b>	Emergency Department
<b>EDI</b>	Equality, Diversity and Inclusion
<b>ENT</b>	Ear, Nose and Throat
<b>EoT</b>	End of Treatment
<b>FFT</b>	Friends and Family Test
<b>FT</b>	Foundation Trust
<b>F/Y</b>	Financial Year
<b>GP</b>	General Practitioner
<b>HAT</b>	Hospital Acquired Thrombosis
<b>HES</b>	Hospital Episode Statistics
<b>HRG</b>	Healthcare Resource Group
<b>HSCIC</b>	Health and Social Care Information Centre
<b>HWBE</b>	Health and Well Being Events
<b>IA</b>	Intermittent Auscultation
<b>IG</b>	Information Governance
<b>IOL</b>	Induction of Labour
<b>LGT</b>	Lewisham and Greenwich NHS Trust
<b>LoS</b>	Length of Stay
<b>MEWS</b>	Modified Early Warning Score
<b>MMPT</b>	Medicines Management Pharmacy Technician
<b>MSK</b>	Musculoskeletal
<b>NEWS</b>	National Early Warning Score
<b>NCEPOD</b>	National Confidential Enquiry into Patient Outcome and Death
<b>NHFD</b>	National Hip Fracture Database
<b>NHS</b>	National Health Service

<b>NHS Digital</b>	Aims to improve health and care by providing national information, data and IT services (formally known as HSCIC)
<b>NHSE</b>	National Health Service England
<b>NHSI</b>	National Health Service Improvement
<b>NICE</b>	National Institute for Health and Care Excellence
<b>NICU</b>	Neonatal Intensive Care Unit
<b>NRLS</b>	National Reporting Learning System
<b>OHSEL</b>	Our Healthier South East London
<b>OSC</b>	Overview and Scrutiny Committee
<b>OWL</b>	Outcomes with Learning
<b>PALS</b>	Patient Advice and Liaison Service
<b>PDSA</b>	Plan, Do, Study, Act (part of an improvement methodology)
<b>PEACE</b>	Proactive Elderly Advance CarE
<b>PbR</b>	Payment by Results
<b>PHE</b>	Public Health England
<b>PROMS</b>	Patient Reported Outcome Measures
<b>PUG</b>	Patient User Group
<b>PSI</b>	Patient Safety Incidents
<b>PWF</b>	Patient Welfare Forum
<b>QEH</b>	Queen Elizabeth Hospital
<b>RAMI</b>	Risk Adjusted Mortality Index
<b>RCA</b>	Root Cause Analysis
<b>ROCAIP</b>	Reason, Observation, Comment, Assessment/Analysis, Intervention, Plan
<b>R&amp;D</b>	Research and Development
<b>SBAR</b>	Situation Background Assessment Recommendation
<b>SFFT</b>	Staff Friends and Family Test
<b>SHMI</b>	Summary Hospital Mortality Indicator
<b>SI</b>	Serious Incident
<b>SMR</b>	Standardised Mortality Ratio
<b>STP</b>	Sustainability and Transformation Plans
<b>SUS</b>	Secondary Uses Service
<b>UCC</b>	Urgent Care Centre
<b>UHL</b>	University Hospital Lewisham
<b>VTE</b>	Venous Thromboembolism
<b>Waterlow Score</b>	A score of the estimated risk for the development of a pressure ulcer by a patient
<b>WRES</b>	Workforce Race Equality Standard
<b>YSWD</b>	You Said We Did posters (a method of communicating improvements to practice)

# Introduction

A Quality Account is an annual report to the public from a provider of NHS Healthcare about the quality of services they deliver. National guidance states that this report must be written in a way in which makes it easy for the reader to understand, is open and transparent.

This Quality Account is divided into three sections:

## **Part 1:**

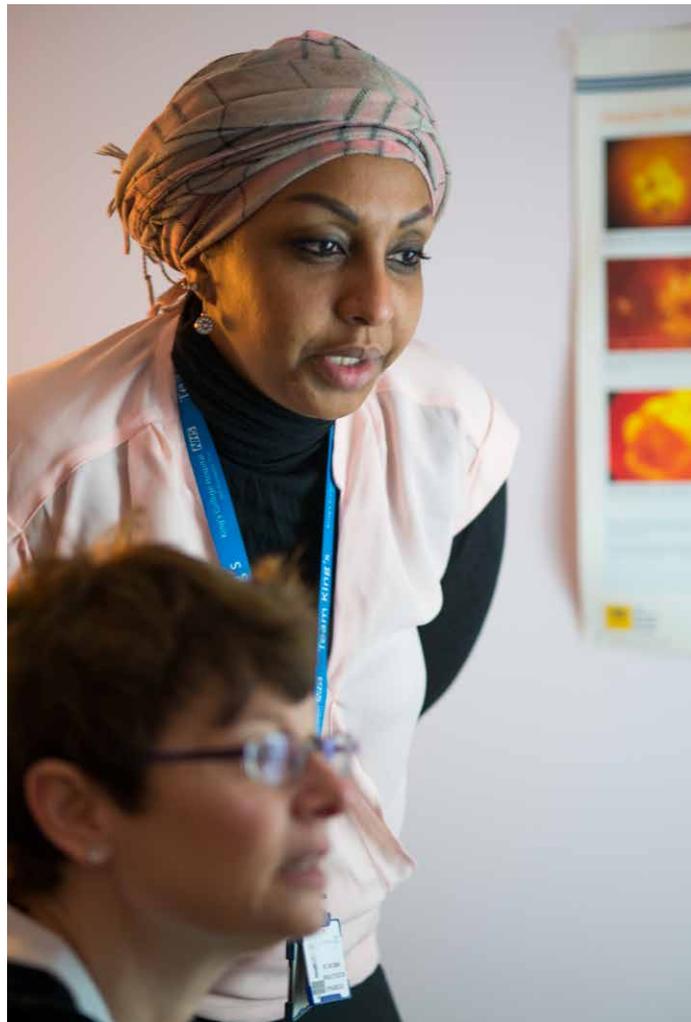
Statement on quality from the Chief Executive.

## **Part 2:**

Our quality priorities for 2017/18, statement of assurances from the Board Directors and review of quality performance.

## **Part 3:**

Our performance in 2016/17 against our quality priorities and what our stakeholders say about us.



# Part 1

## Statement on Quality from the Chief Executive

Welcome to the 2016/17 Quality Account for Lewisham and Greenwich NHS Trust.

I hope you find the account a useful guide to our performance and achievements in quality, safety and patient experience over the last year as we continue to work towards embedding what we have achieved, transforming our services, addressing the on-going challenges and working with local people and other local organisations to improve healthcare in Lewisham, Greenwich, Bexley and beyond.

Once again, I am proud of the way in which staff have worked tirelessly to serve our local communities. We can point to many areas of progress over 2016/17, which you can read about in the following pages. However, it is clear that we have more to do.

In March 2017, the Care Quality Commission (CQC) undertook a planned comprehensive inspection of all the Trust services, including our community services. The Trust has not received the CQC draft or final report at the time of writing this report.

In their initial feedback following the visit, the CQC commented on the professionalism of staff, and on the caring attitude staff showed in ensuring that patients were treated with dignity and respect. The CQC recognised a number of areas of good practice and improvements since the last CQC visit to the Queen Elizabeth Hospital in June 2016.

The CQC have also told us that we need to make changes more quickly, particularly with regard to the emergency care pathway. With our partners, we have developed and are progressing the implementation of our safety and quality improvement plan which aims to address the areas of feedback provided by the CQC.

Delivering the plan is our number one priority over the coming year, and our partners are working hard at the same time to deliver improvements across the whole health and social care system. The safety and quality improvement plan will be a fast moving project and we will issue regular updates on progress. At the time of writing, I am pleased to say that we are already seeing improvements resulting from the work which we and our partners are doing.

This account gives you an overview of recent developments and our priorities for the coming year.

Over 2016/17, the Trust has been developing “ambulatory care” services – providing early testing such as x-ray and ultrasound for local people in an outpatient setting, with results reviewed by specialist consultants. The new £1.2m Ambulatory Care Centre at UHL was officially opened in December 2016 by Terry Waite MBE. We are also working to expand the ambulatory care offered at QEH by summer 2017. Over 2016/17, we have been reviewing how we can improve the flow of patients through the hospitals. We continue to work with partners to improve the discharge process and free up hospital beds by enabling patients who do not need to be in hospital

to return home sooner. As part of this work, we have appointed care navigators to manage the discharge of patients who have a complex set of health and social care needs, so we can speed up the process for them.

Our midwives were named “Midwifery Team of the Year” for 2016 by the Royal College of Midwives (RCM), and received a visit from the RCM’s patron, HRH The Princess Royal, in February 2017 to mark their achievement. The RCM awarded the midwives this prize for their commitment to excellence and the innovative approaches they use to provide maternity services to local women and their families, as well as for improving team working, staff involvement and motivation. Some of the initiatives which the team have implemented include “Whose shoes?” which is an interactive workshop designed to improve the maternity experience through hearing the experiences and thoughts of both mothers and fathers. Our maternity service has also developed an electronic midwife called Edie the e-midwife. Women can ask questions via email or Twitter and a qualified midwife responds within 48 hours.

In simple terms, our goal is to get it right for every patient, every time. Clearly, we can only achieve this if our hospitals and community services have the right staff and the right facilities for the future, including both our Emergency Departments. We also need to deal with the financial challenges we face and work with our partners to support the development of community health and social care facilities for people who do not need to be treated at our hospitals. We have been developing exciting plans to do this and to secure the future of the Trust as a high performing organisation. We will continue to engage with partners, the public and staff during 2017/18 to finalise these plans.

Of course, we do not work in isolation, so I would like to thank all our partners for their ongoing support. I would also like to take this opportunity to thank Elizabeth Butler, who is stepping down at the end of May 2017, for all her work as Chair. This has included overseeing the formation of Lewisham and Greenwich NHS Trust in 2013 and many important developments since. I am sure that all who read this report will join me in wishing her all the best for the future.

The full document will also be available on our website [www.lewishamandgreenwich.nhs.uk](http://www.lewishamandgreenwich.nhs.uk)

To the best of my knowledge, the information contained in this document is accurate.

Signed:



Tim Higginson, Chief Executive  
May 2017

# Part 2

## 2.1 Our Quality priorities for 2017/18

Our vision is to be a consistently high performing and financially sustainable organisation. This means ensuring that all our services provide the right quality of care, and have the right staff in place to do so. We aim to provide patients with an excellent experience of care. This ambition is reflected in the Trust's corporate objectives which include making improvements in quality and safety so we are one of the best performing Trusts in the country.

We have developed a set of priorities drawn from both the review of the work undertaken during 2016/17 and also from the areas which still require on-going focus and improvements. These priorities form the basis of the Divisional business plans, our CQUIN initiatives, the Sign Up to Safety Pledges and the Trust's Strategy and Operating plans.

The monitoring, review and reporting of progress for the priorities will be via the Trust's Quality and Safety and Integrated Governance Committees.

A single definition of quality for the NHS was first set out in the national publication "High Quality Care for All" (2008). The definition sets out three dimensions to quality, all three of which must be present in order to provide a high quality service.

### Patient Safety

Having the right systems and staff in place to minimise risk of harm to our patients and, if things go wrong, to be open and learn from our mistakes.

### Clinical Effectiveness

Providing the highest quality care, with high-performing outcomes whilst also being efficient and cost effective.

### Patient Experience

Treating patients with care, compassion and dignity. Meeting our patients' emotional as well as physical needs.

Source: High Quality Care for All, Department of Health, June 2008.

### How we chose our priorities

Throughout the year our progress towards achieving the 2016/17 priorities has been monitored, presented and reported at meetings held across the Trust, with key stakeholders being present at these meetings.

The progress of our performance with these priorities has been reviewed and although there have been significant achievements made throughout the year, there is still room for improvement within our priorities around safety practices and enhancing the patient experience. Therefore, to maintain focus, we have committed to continuing our work to improve patient safety by reducing avoidable harm, being open and exercising our Duty of Candour and also by signing up to the National Sign up to Safety programme reflected in our safety pledges. Implementing the seven day working standards and ensuring a safe and effective discharge for our patients are both National and local priorities, and therefore are included within the clinical effectiveness priorities for 2017/18. We will also continue to focus on using patient feedback to influence positive changes to practice in order to improve our patients' experiences and implement our strategies for patients receiving end of life care and patients with dementia.

These priorities have been developed with key Trust representative leads and are supported by our Trust Board, Trust Quality and Safety Committee and our Clinical Commissioning Quality Review Group (CQRG).

The following tables outline the 2017/18 quality priorities and why we have chosen them.

## 2.1.1 Patient Safety Priorities

During 2017/18 we will continue to progress work from the previous year. These priorities are linked to the pledges made by the Trust Board to the National Sign Up To Safety Campaign in late 2014. This is a 3 year programme, with 2017 being the final year.

Our quality priorities and why we chose them	What success will look like
<p><b>i) Early recognition and treatment of the deteriorating patient</b></p> <p>The early recognition and detection of deteriorating patients has been shown to improve the clinical outcomes for patients. Our review of incidents has shown that we need to improve the early detection of patients in whom their clinical condition has deteriorated by ensuring regular monitoring of observations is carried out, these are documented and that proactive intervention of observation results is taken.</p> <p>During 2016/17, a Sepsis Working Group was established which took the lead on improvement work on sepsis screening and treatment across the Trust. In 2017/18, the Trust will implement a new Sepsis screening tool, in line with recent NICE guidelines and seek to introduce an electronic early warning system.</p>	<ul style="list-style-type: none"> <li>■ 10% reduction in the number of out of Critical Care 'in hospital' cardiac arrests from 2016/17 figure.</li> <li>■ Eliminate all avoidable deaths from sepsis and septic shock by March 2018.</li> <li>■ Implement the adult community MEWs and Sepsis screening tool to assist in the early identification of deterioration of our patients within the community.</li> </ul>
<p><b>ii) Improving the Safety of Maternity Services</b></p> <p>Not only can babies be severely harmed by failures in assessment of the wellbeing of the foetus, the impact of harm has life changing effects for the child and all members of their family. The loss of a baby as a stillbirth also has significant impact for parents. Our priority is set around minimising the risk of these events.</p> <p>In 2017/18 we are looking to build upon the previous year's achievements of the Fetal Wellbeing team, which included development of a competency framework, new fetal monitoring guidelines and teaching of weekly fetal monitoring workshops.</p> <p>We will continue to implement the Trust's Maternity Strategy and national guidelines including NHSE's Saving Babies Lives.</p>	<ul style="list-style-type: none"> <li>■ Reduce stillbirths (to maintain under the Trust's current quarterly rate of &lt;5.3 per 1000 births).</li> <li>■ Increase detection of growth restricted babies in utero.</li> <li>■ Reduce poor neonatal outcomes associated with poor/inadequate fetal surveillance in labour, whether by intermittent auscultation (IA) or continuous electronic fetal monitoring (CEFM).</li> </ul>
<p><b>iii) Continue our focus on the aim to reduce the number of avoidable grade 3, 4 and unstageable Trust attributable pressure ulcers and ensure where pressure ulcers are acquired within our provision of community services, timely completion of root cause analysis is undertaken and learning is continually shared across all areas.</b></p> <p>All patients are potentially at risk of developing a pressure ulcer. However, they are more likely to occur in people who are seriously ill, have a neurological condition, impaired mobility, impaired nutrition, or poor posture or a deformity. Pressure ulcers can be serious and distressing and often result in extended lengths of hospital stay for patients. Mortality rates can increase particularly after infection.</p> <p>We will continue our focus and aim of reducing avoidable Trust attributable grades 3, 4 and unstageable pressure ulcers and pressure ulcers acquired within our provision of community services.</p> <p>We will build upon the work of our multi-agency Pressure Ulcer Panel which reviews reported pressure ulcer incidents and ensure necessary investigation and actions are taken.</p> <p>We will continue to offer and facilitate specialist 'Pressure Ulcer Prevention and Management' training in a variety of formats including e-learning packages.</p>	<ul style="list-style-type: none"> <li>■ Improve the accuracy of the Waterlow score for patients in hospital and achieve 95% compliance every month.</li> <li>■ Develop and implement with partners, a tool for formal carers to monitor skin and to alert concerns to adult community nurses.</li> <li>■ Amend the Trust Pressure Ulcer Policy to manage the risk to adult community patients in the absence of overnight care provision.</li> <li>■ Implement the pressure ulcer e-learning package in the adult community services. By the end of March 2018, 50% of eligible clinical adult community staff (from a training needs analysis - TNA) to have undertaken the new electronic learning package on pressure ulcer prevention and management. Relaunch the training package across the rest of the Trust in conjunction with this.</li> </ul>

Our quality priorities and why we chose them	What success will look like
<p><b>iv) Reduction in the number of patient falls and harm incurred</b></p> <p>Although the Trust has made significant progress through its Falls Steering Group, data highlights that there is still work to be done to minimise the number of falls in our hospitals. Within 2016/17, a Falls Strategy was developed, which focuses on three C's; Continence, Collapse and Confusion, and this will be taken forward in 2017/18.</p> <p>The Trust has signed up to an NHS Improvement programme in relation to falls and will be working towards pledges and the delivery of this through the Plan, Do, Study, Act (PDSA) methodology.</p>	<ul style="list-style-type: none"> <li>■ Reduction in the incidence of harm sustained from patient falls of 10% by the end of March 2018 (from March 2017 figure).</li> <li>■ Meet pledges stated within NHSI Falls Improvement collaboration.</li> <li>■ Implementation of first year of Falls Strategy.</li> </ul>
<p><b>v) Improving medication safety and learning from medication incidents</b></p> <p>Nationally, medication incidents account for around 10% of all reported incidents. The Trust has improved its level of medication incident reporting, however recognises that there is still work to do. We will continue to raise staff awareness of the importance of reporting medication related patient safety incidents.</p> <p>Medicine doses are often omitted or delayed in hospital for a variety of reasons. Whilst these events may not seem serious, for some critical medicines or conditions, such as patients with sepsis or those with pulmonary embolisms, delays or omissions can cause serious harm or death.</p> <p>We will continue to build upon 2016/17 achievements which included the implementation of Medication Safety Walkabouts and the development of a Medication Allergy Incident Panel in order to identify trends and respond to these.</p>	<ul style="list-style-type: none"> <li>■ Increase the number of reported medication related patient safety incidents from 2016/17 figure by 5%, by the end of March 2018.</li> <li>■ Maintain focus on low numbers of inappropriately omitted critical medicines (level at March 2017 - 0.7%).</li> <li>■ Continue to identify themes in prescribing and administration incidents, and share learning with staff at all levels.</li> <li>■ Reduce the number of patient safety incidents related to the prescribing and administration of penicillin based antibiotics to patients with a reported penicillin allergy from 2016/17 figure by 3%, by the end of March 2018.</li> </ul>
<p><b>vi) Getting the basics right and keeping patients safe within the emergency department and those areas used for escalation</b></p> <p>Following our planned CQC inspection in March 2017 concerns were raised with reference to the emergency care pathway at QEH and the use of escalation areas for patients awaiting ward beds. The Trust had already introduced Quality Rounds which are undertaken by Matrons every two weeks, but the CQC felt that the monitoring and tracking of patients within the ED and escalation areas should be improved. The Trust has planned a full programme of work on the emergency care pathway at both acute hospital sites and has already implemented daily checks on patients within the ED and escalation areas (when used) which we are tracking daily.</p> <p>Following the CQC visit, another area highlighted for improvement was within our medicines management practices. Although there had been much work undertaken throughout 2016/17, further work was required to continually improve.</p> <p>CQC provided feedback on observations made and recommended further work be undertaken in ensuring a robust process for the review and follow up of controlled drugs and safe and secure management of drugs audit results as part of the completion of the continuous cycle. The following areas will be our focus for the next year:</p> <ul style="list-style-type: none"> <li>■ Documentation improvement in management of Controlled Drugs</li> <li>■ Fridge Temperature monitoring and in particular documenting when action has been taken where temperatures are out of range</li> <li>■ Ensuring robust process for following up on all audit results and action plans agreed as part of the completion of the continuous audit cycle</li> </ul> <p>An overall theme from the learning of our preparation for and during the CQC inspection was the follow up on actions from quality reviews, audits and published reports. In response to this our quality improvement programme will include a focus on action planning and the follow-up cycle of tracking and monitoring actions associated with audit and report findings.</p>	<p><b>Emergency department and escalation areas:</b></p> <ul style="list-style-type: none"> <li>■ Quality and hourly senior nurse rounds supporting the implementation of quality of care will demonstrate improved patient experience.</li> <li>■ The quality care plan and checklist for all patients in ED will be embedded across the sites.</li> <li>■ Implementation of daily ED quality and safety metrics, NEWS monitoring and escalation process for safety and safety huddles and demonstration of improved trends.</li> </ul> <p><b>Medicines management</b></p> <ul style="list-style-type: none"> <li>■ Improved CD and safer storage audit results from the baseline of April 2017 demonstrated throughout the year.</li> <li>■ Demonstrable evidence of action plan and follow-up, post presentation of audit results.</li> </ul>

## 2.1.2 Clinical Effectiveness Priorities

Our quality priorities and why we chose them	What success will look like
<p><b>i) Embedding processes for mortality reviews across the Trust</b></p> <p>During 2016/17, the Trust's mortality rate has improved. However, with the new national mortality surveillance programme being introduced throughout 2017/18 and with the introduction of the national requirement for mortality reviews for those with learning disabilities, the Trust will carry out further work in relation to mortality reviews during 2017/18.</p>	<ul style="list-style-type: none"> <li>■ Continue to work towards reducing the Trust SHMI to under the current level (1.00).</li> <li>■ Implementation of the process for mortality reviews of patients with learning disabilities.</li> <li>■ Full implementation of the new mortality review form by ensuring that medical staff are trained on its usage.</li> <li>■ Increase the number of mortality reviewers by 10%.</li> <li>■ Increase comorbidity recording in patients' medical records to improve on the current quality and accuracy of coding.</li> </ul>
<p><b>ii) Working towards delivering the seven day working standards – four clinical priorities</b></p> <p>The Trust has signed up to be a part of the NHSE led Phase 2 delivery programme for the 4 priority clinical standards, requiring full compliance by March 2018. Participating in this phase will enable shared learning across the sector and will allow access to national learning through the NHSE 7 day team.</p> <p>Plans for 7 day working also form part of the STP as well as being included in commissioner contractual requirements.</p>	<p>By the end of March 2018, full compliance with the four clinical priority standards:</p> <ul style="list-style-type: none"> <li>■ Standard 2: Time to first Consultant review (Within 14 hours from patient's admission)</li> <li>■ Standard 5: Timely access to diagnostics</li> <li>■ Standard 6: Access to Consultant-delivered interventions</li> <li>■ Standard 8: On-going Consultant-directed review (every patient should be seen face to face by a Consultant every day or twice daily in high dependency areas).</li> </ul>
<p><b>iii) Safe and effective discharge</b></p> <p>There is considerable evidence for the harm caused by poor patient flow. Delays lead to poor outcomes for patients, create financial pressures and impact on key NHS performance measures. Delayed discharge has serious impact across health and care systems, reducing the ability of Emergency Departments to respond to people's needs, and increasing costs to local health economies.</p> <p>Inappropriate, early discharge carries risks to patients and therefore requires close monitoring of readmission rates. 2017/18 is the first year of a two year CQUIN programme.</p>	<ul style="list-style-type: none"> <li>■ Increase the proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 2.5% from identified 2017/18 Q1 baseline, in line with the CQUIN.</li> <li>■ Reduction in the number of inpatients medically fit and ready for discharge.</li> <li>■ Implement the discharge to assess model as part of the Enhanced Care and Support Programme.</li> </ul>
<p><b>iv) Improving patient outcomes through measures for Adult Community Services</b></p> <p>Capturing, monitoring and responding to data is a crucial part of continuous quality improvement. Although the Adult Community services have robust processes in place to monitor data it is recognised that improvements can be made to these current systems, which include all staff being able to readily access up-to-date information regarding performance and quality.</p>	<ul style="list-style-type: none"> <li>■ Development of an adult community services quality dashboard to support individual team ownership of quality objectives that support the delivery of our Trust objectives.</li> </ul>

## 2.1.3 Patient Experience Priorities

Our quality priorities and why we chose them	What success will look like
<p><b>i) We will continue to work with our patients, carers, staff and partners to deliver consistently excellent standards of dementia care to improve the experience of our patients who have a diagnosis of dementia as well as that of their Carers.</b></p> <p>During 2016/17 the Trust developed its 3 year Dementia Strategy setting out the priorities for improvement and action. Good progress has been made with the priorities for 2016/17 and we will continue to build on this work and implementation of the delivery plan during 2017/18.</p>	<ul style="list-style-type: none"> <li>■ Ensure the new Visiting Policy is fully embedded across the Trust.</li> <li>■ Implementation of the activities programme for dementia patients.</li> <li>■ Establish and implement use of a sensory room on both acute sites.</li> <li>■ Continue to implement our Staff Dementia training programme, this includes increasing the amount of training and tailoring training for different staff groups.</li> <li>■ Ensure that the Dementia Strategy fully incorporates improvements within our community services including increasing the specialist nursing workforce.</li> </ul>
<p><b>ii) We will continue to expand the ways in which we gain feedback from patients and service users and ensure that learning from feedback is used to support positive change.</b></p> <p>During 2016/17 the Trust developed its 3 year Patient Experience Strategy setting the priorities for improvement and action. Good progress has been made with the priorities for 2016/17 and we will continue to build on this work and implement the delivery plan during 2017/18.</p>	<ul style="list-style-type: none"> <li>■ Continue to spread and embed the “You Said We Did” approach across the Trust ensuring the concept is locally owned and used in all areas.</li> <li>■ Implement the use of patient stories as a learning tool across the Trust.</li> <li>■ Implement a patient experience micro site to raise the profile and provide extended opportunities for patients to provide feedback through social media.</li> </ul>
<p><b>iii) Improving the quality of the End of Life Care pathways across the health care system.</b></p> <p>Although the Trust has been making improvements in the care provided to patients identified as end of life, we recognise that there is much more that we need to do. During 2016/17 the Trust developed its 3 year End of Life Care strategy which outlines plans to meet the needs of end of life care patients, and those identified as important to them, as well as ensuring that we provide our staff with the education and training required.</p>	<ul style="list-style-type: none"> <li>■ Training on PEACE (Pro-active Elderly Advance Care) will be provided to increase the use of the tool.</li> <li>■ All areas to have a link nurse practitioner with established governance links into the End of Life Care Steering Group.</li> <li>■ Key clinical leads for End of Life Care to be identified.</li> <li>■ Bereavement survey undertaken and results evaluated.</li> <li>■ Use of End of Life Care volunteers to be established in the Trust. Adult Memorial Service to be held.</li> <li>■ Implement the “Say goodbye to your pets” initiative.</li> <li>■ Achievement of 95% training rate for qualified nursing staff in the T34 pump.</li> <li>■ Review of current end of life care training and develop additional training programmes.</li> <li>■ Implement the use of ‘Coordinate my Care’ within adult community services, as part of the 2017/18 CQUIN. This will also link into the acute sites through the Specialist Palliative Care Team at UHL.</li> <li>■ Implement the use of Principles of Care for the dying in Adult Community Services.</li> </ul>

## Our quality priorities and why we chose them

### iv) Improving the Trust's Staff Recognition processes – Expanding the existing staff recognition processes within the Trust.

The Trust has a well-established record of recognising the achievements of staff. Recognition is an important mechanism to positively influence organisational culture and ultimately the quality of care provided to patients using our services. Many research papers support this argument. A recognition event provides a spotlight on the attributes and behaviours which are strongly valued by the organisation and its patients' and encourages others to replicate these. Recognition events also publicly 'thank' individuals and teams, thereby raising morale and commitment to the organisation and the work being done. The existing processes do not cover the vast majority of Trust staff.

## What success will look like

To implement outlined recognition events during the year and therefore provide more opportunity for involvement/engagement and contribution by staff and service users.

### Implement events:

Academic prize giving: reinstate the UHL academic prize-giving ceremony.

External awards: advertise, encourage and support the entry into national and local recognition events and awards.

### Expansion proposals:

Annual staff recognition event, recognition scheme in maternity services, and the long service awards.



# Part 2

## 2.2 Statements of assurance from the Board of Directors

This section contains the statutory statements concerning the quality of services provided by Lewisham and Greenwich NHS Trust. These are common to all quality accounts and can be used to compare us with other organisations.

### A review of our services

During the 2016/17 reporting period Lewisham and Greenwich NHS Trust provided services in over 35 NHS specialties; this includes both hospital and community services. A detailed list of services provided is available on our website.

The Trust has reviewed all the data available on the quality of care in all of these services through its performance management framework and assurance processes.

The income generated by the NHS services reviewed in 2016/17 represents 100 per cent of the total income generated from the provision of NHS services by the Trust for 2016/17.

### National Quality Indicators

For 2016/17, there are 9 statutory quality indicators which apply to acute hospital trusts. All Trusts are required to report their performance against these indicators in the same format, with the aim of making it possible for a reader to compare performance across similar organisations. For each indicator our performance is reported with the national average and the performance of the best and worst performing Trusts, where this data is available.

### 2.2.1 Patient Safety

#### 2.2.1 (i) Patient Safety Indicator 1 – The percentage of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism (VTE) during 2016/17

Venous thromboembolism or blood clots, are a major cause of death in the UK. Some blood clots can be prevented by early assessment of the risk for an individual patient. Over 95 per cent of our patients are assessed for their risk of thrombosis (blood clots) and bleeding on admission to hospital.

We believe our performance reflects the following, that:

- The Trust has processes in place to collate monthly data on Venous thromboembolism assessments.
- Performance of a root cause analysis (RCA) takes place for all cases of Hospital Acquired Thrombosis (HAT - VTE occurring within 90 days of hospital episode).
- Teaching on stocking application is being provided and VTE champions have been appointed to wards.
- VTE study days are being provided to staff.

VTE assessment rate	2015/16	2016/17
Lewisham and Greenwich NHS Trust	88.9%	95.4%
Assessed (no. of patient episodes)	89,992	73,449
Admitted	101,121	76,920
Assessment Rate	88.9%	95.4%
<b>National Average</b>	<b>95.74%</b>	<b>95.6%</b>
<b>Best performing Trust</b>	<b>100%</b>	<b>100%</b>
<b>Worst performing Trust</b>	<b>82.29%</b>	<b>79.86%</b>

Source: [www.england.nhs.uk](http://www.england.nhs.uk)

**2.2.1 (ii) Patient Safety Indicator 2 – The rate per 100,000 bed days of cases of Clostridium difficile infection (CDI) reported within the Trust amongst patients aged 2 or over during 2016/17**

CDI remains an unpleasant and potentially severe or fatal infection that occurs mainly in elderly and other vulnerable patient groups, especially those who have been exposed to antibiotic treatment. The Trust assesses each CDI case to determine whether the case was linked with a lapse in patient care.

Whilst recognising the new reporting requirements for the purpose of Quality Account, unfortunately national data will not be available on the rate of C. difficile reported per 100,000 bed days until after the publishing date of the Quality Account on 30th June 2017.

The mandatory surveillance reporting is via Public Health England (PHE) who collect and publish the data on monthly 'counts' as opposed to rate per 100,000 bed days.

Once per year in July, the PHE publish the data as a rate per 100,000 bed days. This data will not be available for the publication of the Trust Quality Accounts. Therefore, the Trust has calculated its rate per 100,000 bed days using the bed availability and occupancy data as referenced in the following table.

C. difficile rate per 100,000 bed-days	2015/16	2016/17
Lewisham and Greenwich NHS Trust		
Trust apportioned	37	25
Total bed days*	334,716	329,960
Rate per 100,000 bed days (Trust apportioned)	11.0	7.6
<b>National Average</b>	<b>14.9</b>	<b>TBC</b>
<b>Best performing Trust</b>	<b>5.4</b>	<b>TBC</b>
<b>Worst performing Trust</b>	<b>36.2</b>	<b>TBC</b>

Source: www.england.nhs.uk

The table below demonstrates monthly counts of C. difficile infection by Acute Trust for patients aged 2 years and over.

**Monthly counts of C. difficile infection for patients aged 2 years and over by Acute Trust - Trust Apportioned only\***

**Reporting Period: April 2016 - March 2017**

Trust Type	PHE Centre	Trust Name	April 2016	May 2016	June 2016	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017
NHS Trust	London	Barking Havering and Redbridge University Hospitals	1	2	2	6	3	4	3	2	3	1	0	2
NHS Trust	London	Barts Health	7	4	3	6	7	7	3	8	0	11	4	10
NHS Trust	London	Croydon Health Services	0	2	2	1	1	0	1	0	2	3	0	1
FT	London	Guy's & St. Thomas's	9	2	2	4	3	1	1	3	4	2	1	4
FT	London	Homerton University Hospital	0	1	0	0	1	0	1	0	0	1	0	0
FT	London	King's College Hospital	5	5	5	7	6	9	4	10	9	4	3	3
NHS Trust	London	Lewisham & Greenwich	1	1	3	2	2	2	5	3	1	1	2	2
NHS Trust	London	North Middlesex University Hospital	2	4	3	2	2	1	2	3	5	6	0	3

Source: www.gov.uk/government/statistics/clostridium-difficile-infection-monthly-data

**Lewisham and Greenwich NHS Trust has taken the following actions to improve this number, and so the quality of its services by:**

- Continuing to undertake antimicrobial and other ward rounds with the Consultant microbiologists and clinical teams.
- Ensuring continual and regular review of antimicrobial prescribing.
- Monitoring performance of antimicrobial prescribing through monthly antimicrobial care bundle audits undertaken by the antimicrobial pharmacists which are fed back to individual Divisional governance meetings and the Infection Control Committee.
- Working with our community partners to update antimicrobial prescribing guidelines for the community.
- Updating and standardising Trust antimicrobial prescribing.
- Linking with Greenwich CCG to participate in their review of community acquired C. difficile to identify any lapses in care or learning.
- Maintaining a strong and visible presence at ward level by the Infection Prevention and Control Team who monitor compliance with the Saving Lives C. difficile care bundle.
- Continuing the site based multidisciplinary weekly C. difficile review groups/ward rounds which allows for the review of care and progress of any patients with C. difficile.
- Undertaking root cause analysis on all Trust attributable C. difficile cases to allow any learning for practice to be understood and shared.
- Continuing to undertake joint audit work with the facilities staff to ensure that on-going standards of cleanliness are maintained.

**2.2.1 (iii) Patient Safety Indicator 3 – The number and rate of patient safety incidents reported within the Trust and the number and percentage of such patient safety incidents that resulted in severe harm or death for 2016/17**

**Number and Rate of Patient Safety Incidents Reported within the Trust**

The National Reporting and Learning System (NRLS) was established in 2003. The system enables patient safety incident reports to be submitted to a national database and is designed to promote learning. It is mandatory for NHS Trusts in England to report all serious patient safety incidents to the Care Quality Commission (CQC) and therefore, to avoid duplication, all incidents resulting in severe harm or death are reported to the NRLS, who then report them to the CQC.

There is no nationally established and regulated approach to the reporting and categorising of patient safety incidents, so different Trusts may choose to apply different approaches and guidance when reporting categorising and validating patient safety incidents. The approach taken to determine the classification of each incident, such as those 'resulting in severe harm or death', will often rely on clinical judgement. This judgement may differ between professions. For this reason, data reported by different Trusts may not be directly comparable. Within LGT, only the Medical Director and/or the Director of Nursing & Clinical Quality can declare a serious incident.

All serious incidents reports are offered to the patient or their family once concluded. The implementation of any learning arising from the investigations is reported to the governance groups within each clinical Division and the sustainability of learning reviewed and monitored via the Trust's Outcomes With Learning group (OWL).

During the year, the Patient Safety team have been working hard to increase staff awareness of incident reporting and the importance of it. This has been undertaken through a structured training programme including presenting at corporate inductions and at Trust wide meetings. Organisations with high reporting of incidents are seen as having a positive safety culture.

On 1st April 2016 the statutory patient safety functions previously delivered by NHS England transferred with the national patient safety team to NHS Improvement.

The previous reporting format has not continued and therefore, the reporting within the patient safety section is different from last year and the cycle of national validated data is delayed and therefore, some sections of the patient safety data comparison may not be available until after the mandatory deadline for the publication of this Quality Account.

**Lewisham and Greenwich NHS Trust considers that this data is as described for the following reasons:**

- The Trust has a process in place for collating the data on patient safety incidents.
- Data is collated internally and then submitted on a monthly basis to the NRLS.
- Data is compared to peers, highest and lowest performers, and our own previous performance as set out in the following table.

<b>Patient Safety Incidents</b>	<b>Apr 15-Sept 15</b>	<b>Apr 16-Sept 16*</b>
<b>Lewisham and Greenwich NHS Trust</b>		
Total reported incidents	6,166	6,547
Incident reporting rate per 1,000 bed days	35.78	41.21
Incidents causing severe harm or death	5	5
% of incidents causing severe harm or death	0.1%	0.1%

<b>Acute Non-Specialised Trusts</b>		
Lowest incident reporting rate per 1,000 bed days	18.34	21.15
Highest incident reporting rate per 1,000 bed days	74.67	71.81
Lowest incidents causing severe harm or death	0.0%	0.0%
Highest incidents causing severe harm or death	3.6%	1.9%
Acute Trusts average % of incidents causing severe harm or death	0.4%	0.4%

\*The data for April 2016 to September 2016 is the latest published data available - we await the national publication of more recent data.

The tables below show the current reporting of patient safety incidents (clinical and non-clinical) and the number where severe harm and death have occurred during the year of 2016/17 year to date.

<b>All incidents reported onto the incident system (Clinical (including non-PSI) and Non-Clinical) per month</b>													
<b>2016/17</b>	<b>Apr</b>	<b>May</b>	<b>Jun</b>	<b>Jul</b>	<b>Aug</b>	<b>Sept</b>	<b>Oct</b>	<b>Nov</b>	<b>Dec</b>	<b>Jan</b>	<b>Feb</b>	<b>Mar</b>	<b>Total</b>
Number	1531	1548	1639	1657	1539	1535	1410	1561	1629	1807	1608	1967	19431

<b>Patient safety incidents reported within the Trust per month (excluding non-clinical incidents)</b>													
<b>2016/17</b>	<b>Apr</b>	<b>May</b>	<b>Jun</b>	<b>Jul</b>	<b>Aug</b>	<b>Sept</b>	<b>Oct</b>	<b>Nov</b>	<b>Dec</b>	<b>Jan</b>	<b>Feb</b>	<b>Mar</b>	<b>Total</b>
Number	1171	1128	1282	1249	1138	1104	1082	1176	1233	1332	1151	1401	14,447

<b>Patient Safety Incidents where the impact was severe harm or death which was or may have been avoidable</b>													
<b>2016/17</b>	<b>Apr</b>	<b>May</b>	<b>Jun</b>	<b>Jul</b>	<b>Aug</b>	<b>Sept</b>	<b>Oct</b>	<b>Nov</b>	<b>Dec</b>	<b>Jan</b>	<b>Feb</b>	<b>Mar</b>	<b>Total</b>
Severe harm	0	1	1	1	1	0	0	0	0	0	0	0	<b>4</b>
Death	0	0	0	0	0	0	1	0	1	1	1	0	<b>4</b>
<b>Total</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>8</b>

Note: At the time of writing this report, some investigations were still underway which when completed may change the level of harm recorded

For the period between April 2016 and March 2017 a total of 19,431 incidents (includes clinical, patient safety and non-clinical incidents) were reported on the incident reporting system within the Trust, which is an increase on the previous year, April 2015 – March 2016, where 17,382 incidents were reported.

Of the 19,431 incidents, 74.3% reported were considered to be patient safety incidents which are uploaded to the National Reporting and Learning System (NRLS) to help contribute towards national learning and improvements in patient safety.

The month in which the incident report was made will sometimes be different to the date that the patient safety incident was uploaded to the NRLS (validation of the actual impact after investigation of the incident may affect the upload date) therefore the figures in the tables above will not tally exactly with the published NRLS report.

## Duty of Candour

Duty of Candour is a statutory (legal) duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused or could lead to harm. Duty of Candour specifically applies to "notifiable patient safety incidents" causing moderate or severe harm, psychological harm of more than 28 days or the incident resulted in death, to the patient.

### Duty of Candour includes:

- Telling the relevant person, in person, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred
- Offering a sincere apology
- Providing support to them in relation to the incident, including when giving the notification
- Providing a full account of the incident, to the best of the provider's knowledge
- Following up with a letter.

Within the Trust, the Medical Director is the named lead for Duty of Candour. Duty of Candour compliance is monitored on an on-going basis through the governance leads within the Clinical Divisions, Patient Safety Team, monthly Divisional Governance meetings and quarterly at the Trust's Quality and Safety Committee. Compliance is also included on the Trust scorecard which is presented on a monthly basis to the Trust Board.

## 2.2.2 Clinical Effectiveness

### 2.2.2 (i) Clinical Effectiveness Indicator 1 - Summary Hospital-level Mortality Indicator (SHMI)

#### Mortality

The Summary Hospital-level Mortality Indicator (SHMI) is a mortality measure that takes account of a number of factors. It includes patients who have died while having treatment in hospital or within 30 days of being discharged from hospital. The SHMI score is measured against the NHS average which is 1.00. A score below 1.00 denotes a lower than average mortality rate and therefore indicates good, safe care.

To help understand the SHMI data, Trusts are categorised into one of three bands:

- Where Trust's SHMI is 'higher than expected' – Band 1
- Where the Trust's SHMI is 'as expected' – Band 2
- Where the Trust's SHMI is 'lower than expected' - Band 3.

#### The Lewisham and Greenwich NHS Trust consider that this data is as described for the following reasons:

- The Trust has a process in place for collating data on hospital admissions from which the SHMI is derived
- Data is collated internally and then submitted on a monthly basis to NHS Digital via the Secondary User Service (SUS). The SHMI is then calculated by NHS Digital
- Data is compared to peers, highest and lowest performers, as set out in the following table:

Summary Hospital-level Mortality Indicator	Oct 14 – Sep 15 (published March 2016)		Jan – Dec 15 (published June 2016)		Apr15 – Mar 16 (published September 2016)		Jul 15 – Jun 16 (published December 2016)	
	SHMI	Banding	SHMI	Banding	SHMI	Banding	SHMI	Banding
Lewisham and Greenwich NHS Trust	1.00	Band 2 'as expected'	1.01	Band 2 'as expected'	0.99	Band 2 'as expected'	1.00	Band 2 'as expected'
Best Performing Trust	0.652	Band 3	0.669	Band 3	0.678	Band 3	0.694	Band 3
Worst Performing Trust	1.177	Band 1	1.173	Band 1	1.178	Band 1	1.171	Band 1

**The Lewisham and Greenwich NHS Trust has taken the following actions to improve this rate and so the quality of its services by:**

Making sure that the ‘as expected’ SHMI banding achieved by the Trust is sustained and through ensuring that any SHMI scores that are higher than expected are reviewed by looking at each patient’s coded information. This coded information holds details of what diagnoses, co-morbidities and procedures the patient had whilst admitted to the Trust. If necessary, a case note review is carried out to ensure that the patient did receive the best quality of care possible.

When NHS Digital publishes the National SHMI scorings on a quarterly basis, they also publish a number of contextual indicators, including the percentage of patients who have died at each Trust and those who are receiving palliative care. The method used to calculate Trust SHMI scores currently makes no adjustments for palliative care

patients. This means that any Trust with a higher number of palliative care patients may appear to have a higher number of deaths than expected using the SHMI scoring system. For example, a Trust which has an onsite hospice or palliative care unit would have a higher number of deaths than other Trusts.

Therefore, this higher number of deaths may not be an indicator of poor care being provided but rather a reflection of the type of patients that are being treated within that Trust.

The percentage of the Trust’s patients with palliative care coded at either diagnoses or speciality level for the Trust is shown in table below. The table also highlights the highest and lowest percentages nationally of palliative care patients treated within each reporting period.

<b>Percentage of deaths with palliative care coding</b>	<b>Oct 14 – Sep 15</b> (published March 2016)	<b>Jan – Dec 15</b> (published June 2016)	<b>Apr15 – Mar 16</b> (published September 2016)	<b>Jul 15 – Jun 16</b> (published December 2016)
<b>Lewisham and Greenwich NHS Trust</b>	26.6	24.9	24.4	25.0
<b>Lowest percentage Trust</b>	<b>0.2</b>	<b>0.2</b>	<b>0.6</b>	<b>0.6</b>
<b>Highest percentage Trust</b>	<b>53.5</b>	<b>54.7</b>	<b>54.6</b>	<b>54.8</b>

Source: NHS Digital Indicator Portal

**The Lewisham and Greenwich NHS Trust consider that this data is as described for the following reasons:**

Lewisham and Greenwich NHS Trust treats a number of patients who require palliative care and has a specialist palliative care team, and through the continuous work of our End of Life care pathways, we have seen a slight increase of patients being coded as palliative care patients. We are continuously working on improving our data quality for clinical coding and have developed, through reviews of mortality, a new approach to ensure that the relevant clinician confirms whether the patient should be coded as palliative care.

For the purpose of the quality account we are required to publish data from the national reports. It is difficult to compare these rates, as the configuration for cancer services and cancer pathways across all NHS organisations is very different.

**The Lewisham and Greenwich NHS Trust has taken the following actions to improve this rate and so the quality of its service by:**

Ensuring that the Trust clinical coding team receive a regular report of those patients who have been treated by the palliative care team so that the care being provided is accurately reflected in the Trust’s coding which is used as the basis for the palliative care indicator and therefore providing context for the SHMI score and the Trust’s overall mortality rating.

**2.2.2 (ii) Clinical Effectiveness Indicator 2 – Patient Reported Outcome Measures (PROMS)**

Patient Reported Outcome Measures (PROMS) measure quality from the patient perspective, and seek to calculate the health gain experiences by patients following one of four clinical procedures:

- Groin Hernia surgery
- Hip Replacement Surgery
- Knee Replacement Surgery
- Varicose Vein Surgery.

PROMs data is obtained through a pair of questionnaires completed by the patient, one before and one after surgery (at least three months after). Patients’ self-reported health status (sometimes referred to as health-related quality of life) is assessed through a mixture of generic and disease or condition-specific questions. For example, there are questions relating to mobility, self-care, e.g. washing and dressing, usual activities, e.g. work, study, house-work, family or leisure activities, pain/discomfort or anxiety/depression.

The types of questionnaires are specifically named and calculate a score based on the patient responses.

The questionnaires are named as the following:

- EQ-5D
- EQ-VAS
- Oxford Hip Score
- Aberdeen Varicose Vein Score.

The questionnaire completed before surgery (Q1) is provided to patients prior to their operation in the pre-assessment clinic. The questionnaire provided to patients to complete after their surgery (Q2) is sent directly to the patient by a PROMS supplier company, which for Lewisham and Greenwich NHS Trust is Capita.

The Q2 questionnaires are sent to patients who underwent Hip and Knee operations up to 6 months after the operation. For groin hernia and varicose vein operations these are sent out up to 3 months after. The operation dates are provided to the PROMS suppliers by NHS Digital after they have matched the operation date with the dates recorded in the Hospital Episode Statistics (HES) data. If NHS Digital is unable to match the PROMS Q1 questionnaires to a HES record, the PROMS suppliers are instructed to allow an additional three months

after the Q1 completion date, to ensure the three months minimum required time has passed before patients are invited to report on their post-operative health status. There are instances where patients do not receive a Q2 questionnaire until 9 months after their surgery, which results in a time delay in reporting and recording patient outcomes following their procedure.

The figure below provides details of the number of operations Lewisham and Greenwich NHS Trust have carried out in 2016 for the four procedures covered by PROMS, the number of patients eligible to participate in PROMS based on HES data, and the number of questionnaires returned for each procedure up to September 2016.

**i) Operations Lewisham and Greenwich NHS Trust have carried out from 1st April 2016 up to 30th September 2016 and the number of questionnaires returned for each procedure up to 30th September 2016.**

<b>April 2016 – September 2016</b>					
<b>Procedure</b>	<b>Eligible Patients (Based on HES Data)</b>	<b>Number of Operations Performed (Based on Hospital Data)</b>	<b>No. of Q1 Questionnaires Received</b>	<b>No. of Q2 Questionnaires Issued</b>	<b>No. of Q2 Questionnaires Returned</b>
<b>All Procedures</b>	<b>560</b>	<b>648</b>	<b>408</b>	<b>86</b>	<b>40</b>
Groin Hernia	144	240	91	40	18
Hip Replacement	106	126	117	11	5
Knee Replacement	167	155	177	19	10
Varicose Vein	143	127	23	16	7

The figure below shows the published NHS Digital PROMS health gain data for the reporting period 1st April 2015 up to and including 30th September 2016.

<b>PROMS</b>	<b>Measure</b>	<b>Lewisham &amp; Greenwich Adjusted Health Gain April 2016 – September 2016</b>	<b>Lewisham &amp; Greenwich Adjusted Health Gain April 2015 – March 2016</b>	<b>National Adjusted Health Gain April 2015 – March 2016</b>	<b>Best Performer - Adjusted Health Gain April 2015 – March 2016</b>	<b>Worst Performer - Adjusted Health Gain April 2015 – March 2016</b>
Groin Hernia	EQ-5D	< 30 records	0.110	0.087	0.157	0.021
	EQ-VAS	< 30 records	-0.710	-0.804	4.970	-4.746
Hip	EQ-5D	< 30 records	0.389	0.438	0.510	0.320
	EQ-VAS	< 30 records	9.643	12.404	18.715	4.956
	Oxford Hip Score	< 30 records	19.251	21.616	16.892	24.972
Knee	EQ-5D	< 30 records	0.311	0.320	0.397	0.198
	EQ-VAS	< 30 records	5.152	6.225	12.629	1.505
	Oxford Hip Score	< 30 records	15.701	16.367	19.919	11.960
Varicose Veins	EQ-5D	< 30 records	< 30 records	0.095	0.148	0.018
	EQ-VAS	< 30 records	0.559	-0.451	4.859	-0.871
	Aberdeen Varicose Vein Score	< 30 records	< 30 records	-8.596	3.059	-18.019

**The Lewisham and Greenwich NHS Trust consider that this data is as described for the following reasons:**

- The published data from NHS Digital covers the reporting period April 2015 – September 2016
- The Trust has identified that the number of Q2 questionnaires returned for period April 2016 – September 2016 for all procedures is fewer than that which is statistically significant for the recording of data for the PROMS
- The Trust performance for its PROMS is comparable to the national average for groin hernia surgery.

**The Lewisham and Greenwich NHS Trust intend to take the following actions to improve this rate, and so the quality of its services by:**

- Ensuring all eligible patients are invited to complete the PROMS questionnaires
- Continuing to review the timeliness of Q2 questionnaire distribution by the nominated PROMS supplier
- Continuing to review cases where patients have reported a deterioration to understand why and identify any areas for improvement in each of the procedure processes.

**2.2.2 (iii) Clinical Effectiveness Indicator 3 – Reduction in emergency readmissions within 28 days of discharge from hospital**

Emergency readmission to hospital shortly after a previous discharge can be an indicator of the quality of care provided by an organisation. Not all emergency readmissions are part of the original planned treatment and some may be potentially avoidable. Therefore reducing the number of avoidable readmissions improves the overall patient experience of care and releases hospital beds for new admissions.

However the reasons behind a readmission can be highly complex and a detailed analysis is required before it is clear whether a readmission was avoidable. For example, in some chronic conditions, the patient’s care plan may include awareness of when his or her condition has deteriorated and for which hospital care is likely to be necessary. In such a case, a readmission may itself represent better quality of care.

Lewisham and Greenwich NHS Trust monitors the readmission rate using the national data sources and also through CHKS, an independent leading provider of healthcare intelligence. Readmission data for the year 2016/17 is available through CHKS as shown in the tables 1, 2, and 3 below. The peer comparison has also been included to allow the organisation to benchmark its performance against peers (Acute Trusts Nationally). It is not possible to include peer data for individual hospital sites which form part of an NHS Trust, as CHKS peers are Trusts rather than sites.

The CHKS readmission rates are calculated by dividing the total number of patients readmitted within 28 days of discharge by the total number of hospital discharges.

The tables below shows that the readmission rate for the Trust is consistently higher than our peers. At a Trust level, the Divisional and Speciality level breakdowns reveal higher than peer rates for the following Divisions and Specialities:

- Neonatology
- Trauma and Orthopaedics.

The Trust continues to work in collaboration with the local Clinical Commissioning Groups (CCGs) and other key partners to review the current patient discharge pathways across both sites with the aim of identifying ways of improving patient care following a patient’s discharge from hospital. As part of collaborative working with key partners, admission avoidance, management of patients with long term conditions and working with our community services is part of the Trust’s on-going strategy to minimising its readmission rates.

<b>Lewisham and Greenwich readmission within 28 days</b>									
	<b>Apr-16</b>	<b>May-16</b>	<b>Jun-16</b>	<b>Jul-16</b>	<b>Aug-16</b>	<b>Sep-16</b>	<b>Oct-16</b>	<b>Nov-16</b>	<b>Dec-16</b>
Trust	8.29%	7.9%	7.9%	8.42%	8.6%	8.31%	8.28%	8.02%	8.62%
Peer	7.82%	7.84%	7.81%	7.8%	7.79%	7.75%	7.74%	7.67%	8.11%

<b>University Hospital Lewisham readmission within 28 days</b>									
	<b>Apr-16</b>	<b>May-16</b>	<b>Jun-16</b>	<b>Jul-16</b>	<b>Aug-16</b>	<b>Sep-16</b>	<b>Oct-16</b>	<b>Nov-16</b>	<b>Dec-16</b>
Trust	6.74%	5.87%	6.02%	5.44%	5.31%	5.76%	5.59%	5.32%	6.14%

<b>Queen Elizabeth Hospital readmission within 28 days</b>									
	<b>Apr-16</b>	<b>May-16</b>	<b>Jun-16</b>	<b>Jul-16</b>	<b>Aug-16</b>	<b>Sep-16</b>	<b>Oct-16</b>	<b>Nov-16</b>	<b>Dec-16</b>
Trust	9.92%	9.77%	9.72%	11.08%	11.48%	10.43%	10.41%	9.83%	10.63%

<b>Lewisham and Greenwich NHS Trust readmission within 28 days by age</b>									
	<b>Apr-16</b>	<b>May-16</b>	<b>Jun-16</b>	<b>Jul-16</b>	<b>Aug-16</b>	<b>Sep-16</b>	<b>Oct-16</b>	<b>Nov-16</b>	<b>Dec-16</b>
15 & under	14.49%	15.38%	13.47%	15.41%	14.06%	16.17%	17.57%	15.13%	15.8%
16 & over	7.07%	6.31%	6.77%	7.01%	7.71%	6.84%	6.3%	6.48%	7.12%

## CHKS Peer Group

- Barts Health NHS Trust
- Croydon Health Services NHS Trust
- Guy's and St Thomas' NHS Foundation Trust
- Homerton University Hospital NHS Foundation Trust
- King's College Hospital NHS Foundation Trust
- West Middlesex University Hospital NHS Trust

### 2.2.3 (i) Patient Experience Indicator 1 – The Trust's responsiveness to the personal needs of the patient

Patient experience – responsiveness to personal needs of patients	2015	2016
Lewisham and Greenwich NHS Trust	62.8	65
Highest scoring Trust	86.1	86.2
Lowest scoring Trust	59.1	58.9

Source: <https://indicators.hscic.gov.uk>

The results of the Care Quality Commission's (CQC) national adult inpatient survey 2016 provides analysis of patient feedback across the NHS from July 2016. This will be the third inpatient survey to be carried out since Lewisham and Greenwich NHS Trust was established in 2013. The results were based on a small (337) number of responses from patients with 71% coming through the emergency pathway. Overall, the results are worse when compared to 2015.

However, since the survey was issued a number of improvements to patient care have been implemented which address some of the issues raised. We will continue to work with staff and patients to make improvements in any areas which have not already been addressed.

Developments since July 2016 include:

- Introducing 'quality rounds' on our inpatient wards – with regular reviews of every patient so we can ensure their needs are being met
- A range of improvements to the emergency pathway, including:
  - Working with partners to improve the flow of patients through our hospitals – enabling earlier admission to a ward and earlier discharge from hospital
  - Improving processes for monitoring safety and being responsive to patients' needs, including the introduction of detailed reviews of patients in the emergency departments several times a day
  - Introducing specialist services for older patients and specialist outpatient services ("ambulatory care") to enable patients to see the right healthcare professional sooner
- Extended the meal time support available through our volunteer programme.

Our goal is to improve so we are consistently one of the best performing Trusts. Going forward, we will continue to focus on improving patient experience, and will maintain the recruitment and retention drive which has increased staff numbers since the Trust was established in October 2013.

Data from the 2016 survey is shown in the following table:

CQC Inpatient Survey Composite Scores for question sections	2015	2016	Increase or Decrease
Emergency Department	8.6	8.3	-0.3
Waiting lists and planned admission	8.2	8.2	0
Waiting to get to a bed on a ward	7.1	6.2	-0.9
Hospital and ward	8.0	7.6	-0.4
Doctors	8.4	8.2	-0.2
Nurses	8.1	7.4	-0.7
Care and treatment	7.7	7.3	-0.4
Operations and procedures	8.4	8.3	-0.1
Leaving hospital	6.8	6.4	-0.4
Overall view of care and services	5.5	5.2	-0.3
Overall experience (0-10 scale)	7.8	7.7	-0.1

The results of the Care Quality Commission's (CQC) national Maternity Survey was last undertaken in 2015.

CQC Maternity Survey 2015 composite scores for question categories	2015
Labour and birth	8.5
Staff during labour and birth	8.5
Care in hospital after the birth	7.6

A large amount of work has been done to ensure the service offered to women is respectful of their wishes and we support the whole family during pregnancy, birth and postnatally. The Maternity services have run 3 "Whose Shoes" events in the last 12 months with one being dedicated to Fathers to be able to understand what patients and their families want from the service. "Whose Shoes" is an interactive workshop based on building conversations to generate ideas from service users to improve the service.

The most recent NHS England national Cancer Survey was undertaken in 2015.

For the majority of the questions the Trust fell within the expected range. Areas where the Trust fell below the expected range related to:

- hospital care as an inpatient
- support for cancer patients; specifically information about the impact of cancer on day to day living and support groups and home care
- support relating to collaborative working and support from health and social care services.

The Trust did not score above the expected range for any question. However, when asked to score their overall care on a scale of zero (very poor) to 10 (very good), respondents gave the Trust an average rating of 8.6.

### 2.2.3 (ii) Patient Experience Indicator 2 - Patient Friend and Family Test – patient scores

The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.

The following table shows the latest nationally published results for the Trust and England. The Maternity FFT is taken at four different points throughout the mother's journey.

Patient recommendation to family and friends					
	January 2017	Lewisham and Greenwich NHS Trust	National Average	Highest Scoring Trust	Lowest Scoring Trust
ED (Emergency Department)	Response Rate	8.7%	12.3%	44.4%	0.5%
	Recommendation Rate	94%	87%	100%	45%
Community	Response Rate*	N/A	N/A	N/A	N/A
	Recommendation Rate	87%	95%	100%	83%
Inpatient	Response Rate	23.0%	23.6%	95.5%	3.8%
	Recommendation Rate	94%	96%	100%	80%
Maternity – Antenatal	Response Rate*	N/A	N/A	N/A	N/A
	Recommendation Rate	97%	96%	100%	75%
Maternity - Birth	Response Rate	45.9%	22.5%	103.3%	0.1%
	Recommendation Rate	93%	97%	100%	88%
Maternity – Postnatal Ward	Response Rate*	N/A	N/A	N/A	N/A
	Recommendation Rate	90%	94%	100%	77%
Maternity – Postnatal Community	Response Rate	N/A	N/A	N/A	N/A
	Recommendation Rate	100%	98%	100%	85%
Outpatients	Response Rate*	N/A	N/A	N/A	N/A
	Recommendation Rate	92%	93%	100%	72%

Source: [www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/](http://www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/)

\*Denominator information not available nationally to calculate percentage response rate

The Trust has been working with all of its service leads and with staff to promote the Friends and Family Test. We have worked hard to promote the survey at staff training and handover sessions and identifying Friends and Family Test champions on the wards and in the EDs. Results of the Friends and Family Test are given to staff so they can see how well they are doing and to include the feedback in any decisions they make about service changes.

The average national FFT response rate for the ED has declined with a decrease also being seen by the highest scoring Trust. In 2016 the highest scoring Trust demonstrated a 47.2% response rate compared to the rate of 44.4% for January 2017. It is thought that this could be related to the pressures facing EDs across the country.

The Inpatient FFT scores have however remained comparable. The average national FFT response rate for inpatients was 24.1% in 2016 and 23.6% in January 2017. In 2016, the highest scoring Trust response rate was 100.0% with the lowest being 1.7%.

For 2017/18 the Trust will focus on introducing new ways in which to collect the FFT data using mobile and tablet devices.

### 2.2.3 (iii) Patient Experience Indicator 3 – The percentage of staff employed by the Trust who would recommend the Trust as a provider of care to their family and friends

The annual staff survey is used to understand staff experience and perceptions on a wide range of subject areas. The survey is undertaken by all NHS organisations which enable comparisons to be made between similar Trusts and the national average for similar Trusts.

The table below shows the overall response to the Staff Friends and Family Test (SFFT) questions within the 2016 Staff Survey. It shows that:

- 62% of those who responded said they agreed or strongly agreed, they would recommend the Trust to friends and family as a place for treatment,
- 33% neither agreed nor disagreed that they would recommend the Trust to friends and family as a place for treatment.

This has improved from the 2015 survey where 60% of those who responded said they would recommend the Trust to friends and family as a place for treatment.

Lewisham and Greenwich NHS Trust 2016 Annual Staff Survey					
Q12. To what extent do these statements reflect your view of your organisation as a whole?					
d) if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation					
Strongly Disagree	Disagree	Neither agree	Agree	Strongly	Base respondents
4.85%	8.36%	24.65%	46.58%	15.57%	n 1,651

The following table shows how the Trust performed when compared to national results and those which demonstrated the highest and lowest scores for combined acute and community based Trusts.

Staff recommendation to family and friends	Composite scores for recommendation of the trust as a place to work or receive treatment	
	2015	2016
Lewisham and Greenwich NHS Trust	3.65*	3.68*
National Average	3.73**	3.71**
Highest scoring Trust	4.22**	4.20**
Lowest scoring Trust	3.23**	3.11**

\* denotes scores for Acute Trusts only

\*\* denotes score for combined acute and community

Trusts Source: NHS Picker Institute

### The percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. The percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.

Key Findings Question of NHS Staff Survey 2016 Percentage Base number of respondents	Percentage	Base number of respondents
<b>Key Finding 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</b>	%	n
All Combined and Acute Community Trusts	23	74,884
Lewisham and Greenwich NHS Trust	28	1,669
Best Performing Trust	19	2,953
Worst Performing Trust	32	9,520
<b>Key Finding 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</b>	%	n
All Combined and Acute Community Trusts	87	52,279
Lewisham and Greenwich NHS Trust	82	1,099
Best Performing Trust	94	470
Worst Performing Trust	72	6,284

**The Lewisham and Greenwich NHS Trust consider that this data is as described for the following reasons:**

During 2016 all staff have been extremely busy working towards achieving priorities set out in the previous year. Whilst much progress has been made, which are reflected in the improvements in the 2016 survey results, we still have much work to do in our aim to be the organisation and employer of choice for staff.

Examples of work undertaken within the Trust to improve staff engagement and experience include:

- Actively recruiting to fill its vacancies
- Development and implementation of an online appraisal system
- Delivery of health and wellbeing events across both sites, to promote and complement wider health and wellbeing provision
- Progress on achieving Equality, Diversity and Inclusion (EDI) objectives
- Continuous implementation of 100 day listening exercise for new recruits
- Implementation of bespoke 'One Organisation - Well Led' management development programme, inclusive of LGT management statement and principles.

Further analysis of the 2016 staff survey will be undertaken and shared across the organisation. This analysis will include:

- Reviewing the data by division, site, staff group, and demographic group where possible including the WRES Element
- Further interrogation to department/ward level where useful, using web based portal provided by Quality Health, supporting development of local action plans
- Run focus groups made up of staff to share the results and identify specific areas for action.

In addition to the above, each of the divisional Human Resources Business Partners with their senior management teams, will identify areas of focus and will develop and implement local plans.

**Lewisham and Greenwich NHS Trust intends to take the following actions to improve the rates to these two indicators and so the quality of its services by focussing on the following two key Trust wide areas in 2017/18:**

- Health and Wellbeing with specific focus on improved physical activity; increased take up of flu vaccinations amongst front line staff; and
- Improved staff experience and retention, with specific focus on reduction of Harassment and Bullying and improved equality, diversity and inclusion outcomes.

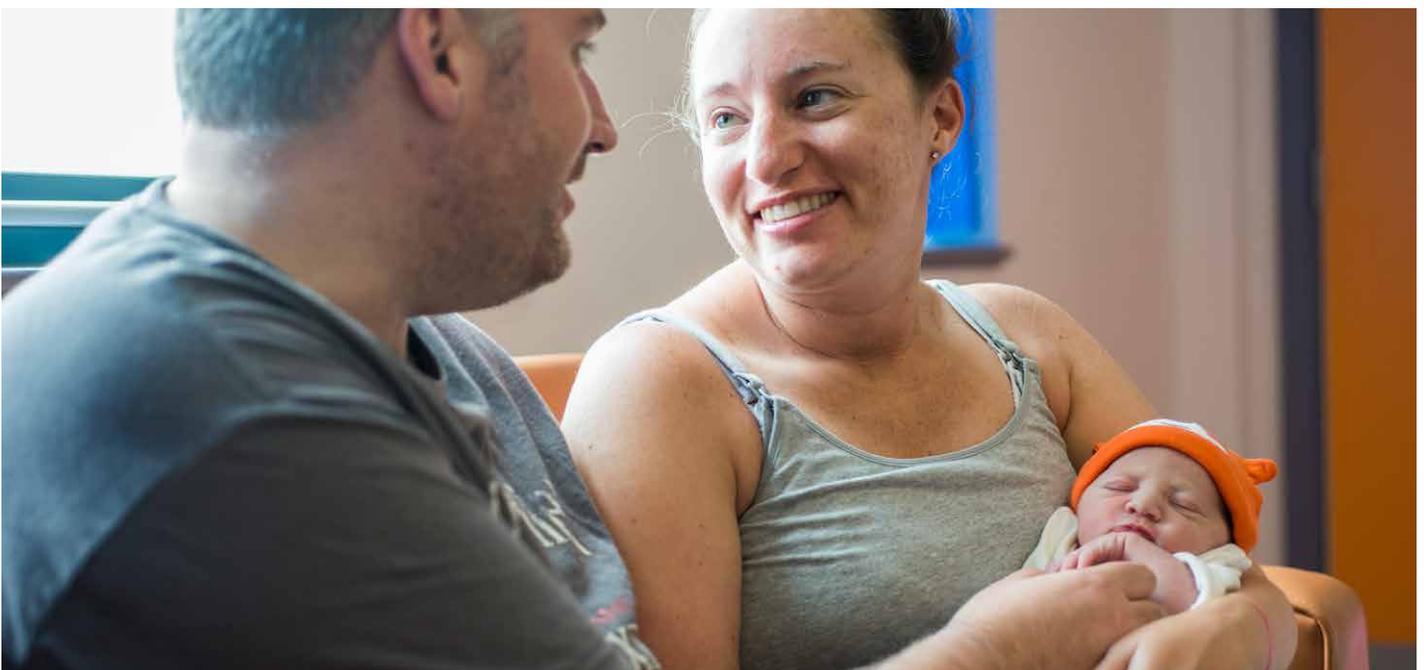
In addition to the above the Trust will:

- Continue to promote staff engagement with all Trust activities, including quality, patient and staff priorities, creating a working environment where staff are supported to develop and where development opportunities are supported
- Continue Staff Briefing sessions with the Chief Executive (CEO) and participation from senior staff in Executive Walkabouts
- Continuation of the production of a Weekly Bulletin advocating and celebrating success of the Trust.

**Supporting the Hello my name is campaign (#hellomynameis)**

Lewisham and Greenwich NHS Trust is signed up to the #hellomynameis campaign which was started by Dr Kate Granger, a terminally ill cancer patient. Kate observed that many staff did not introduce themselves before delivering care and thought that this should be a basic communication with patients.

The Trust prides itself on delivering a warm welcome to our patients. Staff wear yellow badges with their names (usually just displaying their first name) to facilitate interaction with patients and to support the campaign.



# Part 2

## 2.3 Participation in Clinical Audit

### Overview

#### Participation in Clinical Audits

The Lewisham and Greenwich NHS Trust is committed to continually improving the healthcare we provide to service users. Clinical Audit is a crucial part of the Trust's strategy to improve the healthcare we provide.

The Trust uses Clinical Audit to assess and monitor its compliance against national and local standards, and to review the healthcare outcomes of its service users. It provides healthcare professionals the opportunity to reflect on their individual practice and the wider practices across the clinical directorates and the Trust. Lewisham and Greenwich NHS Trust actively encourages all clinical staff and those in training to be involved in Clinical Audit.

The Trust's annual Clinical Audit Programme (CAP) is formulated each year to ensure that the Trust meets all mandatory, regulatory and legislative requirements as laid out by the NHS governing bodies. It is specifically designed to include all applicable National Clinical Audit and Confidential Enquiries the Trust is eligible to participate in, relevant published National Institute for Health and Care Excellence (NICE) guidance and NICE Quality Standards, and local governance and service level priority topics required to ensure compliance with statutory obligations.

### National Audit and Confidential Enquiries Programme

During April 2016 to March 2017, 44 National Clinical Audits and 4 National Confidential Enquiries covered NHS services that Lewisham and Greenwich NHS Trust provides. During that period Lewisham and Greenwich NHS Trust participated in 100% (44/44) National Clinical Audits and 100% (4/4) National Confidential Enquiries of the National Clinical Audits and National Confidential Enquiries which it was identified as eligible to participate in.

The following tables show:

- The National Clinical Audits and National Confidential Enquiries that Lewisham and Greenwich NHS Trust was eligible to participate in during April 2016 to March 2017
- The National Clinical Audits and National Confidential Enquiries that Lewisham and Greenwich NHS Trust participated in, and for which data collection was completed during April 2016 to March 2017, are listed alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.



**Table 1 - National Clinical Audits on the Healthcare Quality Improvement Partnership (HQIP) List for Inclusion in Quality Accounts**

Audit Title	Eligible UHL	Eligible QEH	Participated UHL	Participated QEH	Reporting Period	% Submission Rate - UHL	% Submission Rate - QEH
1 Acute Myocardial Infarction & Other ACS (MINAP)	Yes	Yes	Yes	Yes	1st April 2014 – 31st March 2015	113 cases	127 cases
2 Asthma – Adult	Yes	Yes	Yes	Yes	1st September 2016 – 31st October 2016	100%	100%
3 Asthma – Care in the Emergency Department - Adults	Yes	Yes	Yes	Yes	1st January 2016 – 31st January 2017	100%	100%
4 Asthma – Care in the Emergency Department - Paediatrics	Yes	Yes	Yes	Yes	1st January 2016 – 31st January 2017	100%	100%
5 Adult Critical Care (ICNARC CMPD)	Yes	Yes	Yes	Yes	1st April 2016 – 31st March 2017	100%	100%
6 Bowel Cancer (National Bowel Cancer Audit)	Yes	Yes	Yes	Yes	1st April 2014 – 31st March 2015	95%	
7 Cardiac Arrhythmia (Cardiac Rhythm Management Audit)	Yes	Yes	Yes	Yes	1st April 2014 – 31st March 2015	40 cases	262 cases
8 Chronic Obstructive Pulmonary Disease (COPD) – Pulmonary Rehabilitation	Yes	No	Yes	N/A	12th January 2015 – 10th April 2015	100%	N/A
9 Coronary Angioplasty (PCI)	No	Yes	N/A	Yes	1st January 2015 – 31st December 2015	N/A	100%
10 Cystic Fibrosis Registry	Yes	No	Yes	N/A	1st January 2015 – 31st December 2015	100%	N/A
11 Diabetes – National Adult Diabetes Inpatient Audit (NaDIA) – Patient Experience Questionnaires	Yes	Yes	Yes	Yes	21st September 2016 – 25th September 2016	69 questionnaires	57 questionnaires
Diabetes – National Adult Diabetes Inpatient Audit (NaDIA) – Bedside Audit Questionnaires	Yes	Yes	Yes	Yes	26th September 2016 – 30th September 2016	69 questionnaires	62 questionnaires
12 Diabetes (National Adult Diabetes Audit)	Yes	Yes	Yes	Yes	1st January 2015 – 31st March 2016	100%	1173 cases
13 Diabetes - Pregnancy in Diabetes (NPID)	Yes	Yes	Yes	Yes	1st January 2016 - 31st January 2017	16 cases	17 cases
14 Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	Yes	Yes	Yes	1st April 2015 – 31st March 2016	100%	100%
15 Diabetes Foot Health	Yes	No	Yes	N/A	14th July 2014 – 8th April 2016	101 cases	N/A
16 Elective Surgery (National PROMS Programme)	Yes	Yes	Yes	Yes	1st April 2016 – 30th September 2016	84.3% pre-op questionnaires 51.3% post-op questionnaires	
17 Endocrine and Thyroid National Audit	Yes	Yes	Yes	Yes	1st January 2016-31st December 2016	100%	
18 Falls and Fragility Fractures (National Hip Fracture Database)	Yes	Yes	Yes	Yes	1st January 2015 – 31st December 2015	159 cases	318 cases
19 Falls and Fragility Fractures (National Fracture Service Liaison Database – Facilities Audit)	Yes	Yes	Yes	Yes	21st September 2015 – 16th October 2015	100%	100%
20 Heart Failure	Yes	Yes	Yes	Yes	1st April 2014 – 31st March 2015	185 cases	258 cases
21 Inflammatory Bowel Disease – Biologics Registry	Yes	Yes	Yes	Yes	1st March 2015-29th February 2016	11 cases	26 cases
22 Lung Cancer (NLCA)	Yes	Yes	Yes	Yes	1st January 2015 – 31st December 2015	203 cases	
23 Moderate and Severe Asthma (Care in the Emergency Department)	Yes	Yes	Yes	Yes	1st August 2015 – 31st January 2017	100%	100%
24 National Cardiac Arrest Audit	Yes	Yes	Yes	Yes	1st April 2015 – 31st March 2016	100%	100%
25 National Comparative Audit of Blood Transfusion – Blood Management in Scheduled Surgery	Yes	Yes	No	Yes	3rd October 2016 – 23rd January 2017	100%	100%
26 National Comparative Audit of Blood Transfusion – Audit of Transfusion Associated Circulatory Overload (TACO)	Yes	Yes	Yes	Yes	1st March 2017 – 30th May 2017	In progress	In progress
27 National Audit of Dementia	Yes	Yes	Yes	Yes	1st April 2016 – 31st October 2016	100%	100%
28 National Emergency Laparotomy Audit	Yes	Yes	Yes	Yes	1st December 2013 to 30th November 2015	50% - 69% 123 cases	>70% 186 cases
29 National Joint Registry	Yes	Yes	Yes	Yes	1st January 2015 – 31st December 2015	413	90
30 Neonatal Intensive and Special Care (NNAP)	Yes	Yes	Yes	Yes	1st January 2016 – 31st December 2016	100%	100%
31 Oesophago-Gastric Cancer	Yes	Yes	Yes	Yes	1st April 2013 – 31st March 2015	81%-90% 136 cases	
32 Percutaneous Coronary Interventions	No	Yes	N/A	Yes	1st January 2014 – 31st December 2014	N/A	227 cases
33 Prostate Cancer	No	Yes	N/A	Yes	1st April 2014 – 31st March 2015	85% 177 cases	
34 Sentinel Stroke National Audit Programme – Organisational Audit (SSNAP)	Yes	No	Yes	N/A	1st July 2016	100%	N/A
35 Severe Sepsis and Septic Shock (Care in the Emergency Department)	Yes	Yes	Yes	Yes	1st August 2016 – 31st January 2017	100%	100%
36 Severe Trauma (Trauma Audit & Research Network)	Yes	Yes	Yes	Yes	1st January 2016 – 31st December 2016	167	148

**Table 2 - Audits on the HQIP list that did not collect data in 2016/2017**

Audit Title	
1	Learning Disability Mortality Review Programme (LeDeR)
2	Rheumatoid and Early Inflammatory Arthritis

**Table 3 – National Confidential Enquiries on the Healthcare Quality Improvement Partnership (HQIP) List for inclusion in Quality Accounts**

Enquiry Title	Eligible UHL	Eligible QEH	Participated UHL	Participated QEH	Reporting Period	% Submission Rate – UHL	% Submission Rate – QEH	
1	Maternal, Infant and Newborn Clinical Outcome Review (MBBRACE)	Yes	Yes	Yes	Yes	1st April 2016 – 31st March 2017	100%	100%
2	NCEPOD – Non-Invasive Ventilation	Yes	Yes	Yes	Yes	Organisational Questionnaire	100%	100%
		Yes	Yes	Yes	Yes	Clinician Questionnaires	100%	100%
		Yes	Yes	Yes	Yes	Case Note Extracts	100%	100%
3	NCEPOD – Chronic Neurodisability	Yes	Yes	Yes	Yes	Organisational Questionnaire	In progress	In progress
		Yes	Yes	Yes	Yes	Clinician Questionnaires	In progress	In progress
		Yes	Yes	Yes	Yes	Case Note Extracts	100%	100%
4	NCEPOD – Cancer in Children, Teens and Young Adults	Yes	Yes	Yes	Yes	Organisational Questionnaire	In progress	In progress
		Yes	Yes	Yes	Yes	Clinician Questionnaires	In progress	In progress
		Yes	Yes	Yes	Yes	Case Note Extracts	In progress	In progress

**Table 4 – Additional National Clinical Audits that Lewisham and Greenwich NHS Trust participated in during 2016-2017**

Enquiry Title	Eligible UHL	Eligible QEH	Participated UHL	Participated QEH	Reporting Period	% Submission Rate – UHL	% Submission Rate – QEH	
1	Cardiac Rehabilitation Audit	Yes	No	Yes	N/A	1st April 2016 – 31st March 2017	In progress	N/A
2	Hepatitis B in Pregnancy	Yes	Yes	Yes	Yes	1st April 2015 – 31st May 2016	In progress	In progress
3	National Audit Project – NAP 6 – Perioperative Anaphylaxis	Yes	Yes	Yes	Yes	5th November 2015 – 6th November 2016	100%	100%
4	National Audit of Small Bowel Obstruction (NASBO)	Yes	Yes	Yes	Yes	16th January 2017 – 30th April 2017	In progress	In progress
5	Potential Donor Audit	Yes	Yes	Yes	Yes	1st January 2016 – 30th September 2016	100%	100%
6	RCOG – Each Baby Counts	Yes	Yes	Yes	Yes	1st January 2015 – 30th June 2018**	In progress	In progress
7	Right Iliac Fossa Treatment (RIFT) Audit	Yes	Yes	Yes	Yes	13th March 2017 – 30th June 2017	In progress	In progress
8	7-Day Services Audit	Yes	Yes	Yes	Yes	17th September 2016 – 23rd September 2016	100%	100%

\*\* This audit will be continuing for 3 years.

## National Clinical Audit – Changes to practice

Speciality	Change to Practice
Children's Services	A local audit to assess the time to triage identified that patients were waiting longer than 30 minutes during busy periods to be seen, which was a cause for concern. As a result of the audit findings, clinicians in the Children's Emergency Department introduced a Rapid Triage Tool to allow patients to be assessed more rapidly, identifying the most unwell patients early. Having the Rapid Triage Tool in place will help the department achieve the Royal College of Emergency Medicine Vital Signs standards.
Emergency Department	The Emergency Department will be piloting the use of nasal end tidal CO2 monitoring to support the Royal College of Emergency Medicine sedation in adults standards. A local clinical guideline has also been developed to ensure the Emergency Departments across the Trust are compliant with the recommendations made following the 2015 National Procedural Sedation Audit.

## Clinical Service area local audits and reports of local audit recommendations and changes to practice

The reports of 367 local audits were reviewed by the Trust from 1st April 2016 to 31st March 2017. The examples below taken from across the Trust demonstrate some of the actions taken to improve the quality of our services. A full list of the local audits reviewed is attached in Appendix 1.

Speciality	Change to Practice
Emergency Department	Treatment of patients with Sepsis is audited quarterly in the Emergency Department (ED). An ED care set (implemented in January 2017) for Sepsis in FirstNet (an electronic system in the ED) should drive improved and appropriate blood test ordering. A business case for a point-of-care (POCT) solution for Creatinine/Urea measurement has been written which if implemented will allow the department to answer the new requirement by NICE to assess patients for Acute Kidney Injury (AKI).
Children's Services	For patients with suspected sepsis where antibiotic administration within the first hour is critical, the Division is producing 'bundle packs' for cannulation to minimise delay to administration.
Children's Services	Following an audit against NICE guidance on epilepsy which identified that patients were waiting a long time for a first review, a 'first fit' clinic has been established.
Children's Services	Prolonged jaundice clinic has stopped performing routine urine cultures as a result of the recorded outcomes identified by a recent audit.
Children's Services	The multi-professional ROCAIP training is now delivered as part of induction for new staff. This was identified as an outcome of a documentation audit.
Orthopaedics	Following a patient feedback project and service evaluation, the Community Hip and Knee team are developing new exercise handouts for their patients. The service is also introducing a Hip and Knee Club with the aim of patients being invited to the club approximately 6 weeks before surgery to obtain information about their planned procedure and recovery.
Pharmacy	As an outcome of audit results, the development of the role of the pharmacy technician and an extension of the support that pharmacy technicians provide to wards has benefited patients a great deal. This has enabled pharmacy technicians to become more involved in medicines reconciliation, which in turn frees up the pharmacists' time to enable them to carry out more clinical duties e.g. ward rounds, patient counselling, etc. Wards with a medicines management pharmacy technician (MMPT) have much higher levels of completed pharmacy led medicines reconciliation within the patient's first 24 hours of admission.
Maternity	An Induction of Labour (IOL) audit has resulted in the review and update of Trust IOL guidelines to ensure women with uncomplicated IOL are still able to deliver in the Birth Centre.

# Part 2

## 2.4 Participation in Research

### Overview

Lewisham and Greenwich NHS Trust strongly encourages participation in research as part of its commitment to providing healthcare services that are evidence-based. In a wider context, greater collaboration between NHS Trusts and the life-sciences industry is a high-level NHS objective so the Trust is further developing its commercial research.

Lewisham and Greenwich NHS Trust works collaboratively with the London South Comprehensive Research Network (CRN) whose remit includes the Trust's research in Rheumatology, Paediatrics, Age and Aging, Neurology, Critical Care, Dermatology, Respiratory Medicine and more recently Hepatology, Gastroenterology, Women's Health, Cardiology, Diabetes, Epilepsy and HIV. In addition, the Trust also hosts commercial research and supports a small number of other projects either forming part of a staff member's higher degree, or led by a local investigator in an area key to the Trust.

The Trust's research portfolio continues to expand, with an increase in the number of research studies opened and in the number of patients recruited into studies. The Trust's focus remains on studies that are of good quality and are relevant to the needs of the population it serves.

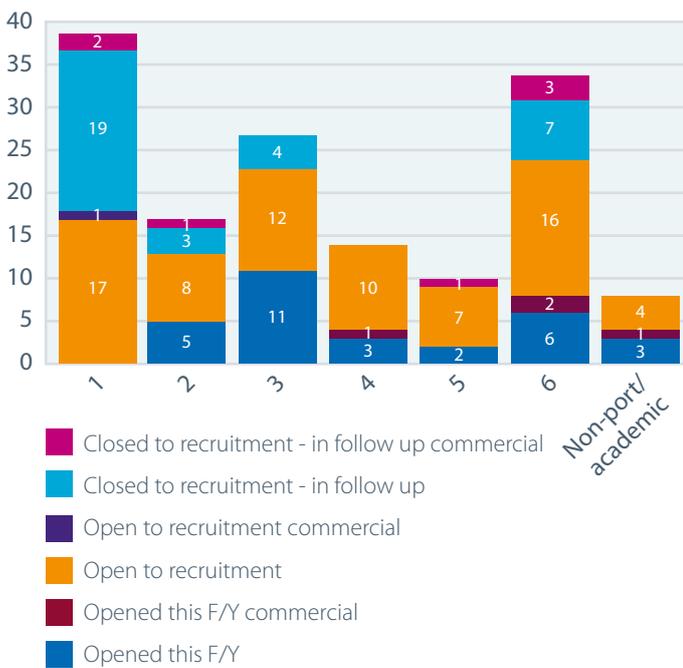
### Participation in Clinical Research

Lewisham and Greenwich NHS Trust continues to contribute to the achievement of the government's vision to embed research into every sector of healthcare. Now, more than ever, the Research and Development department of the Trust is committed to partnering with staff members and patients to promote research and ultimately, evidence-based healthcare. Therefore, participation in clinical research is a further demonstration of the Trust's commitment towards improving the quality of care we offer and the contribution and commitment that staff make to ensure successful patient outcomes.

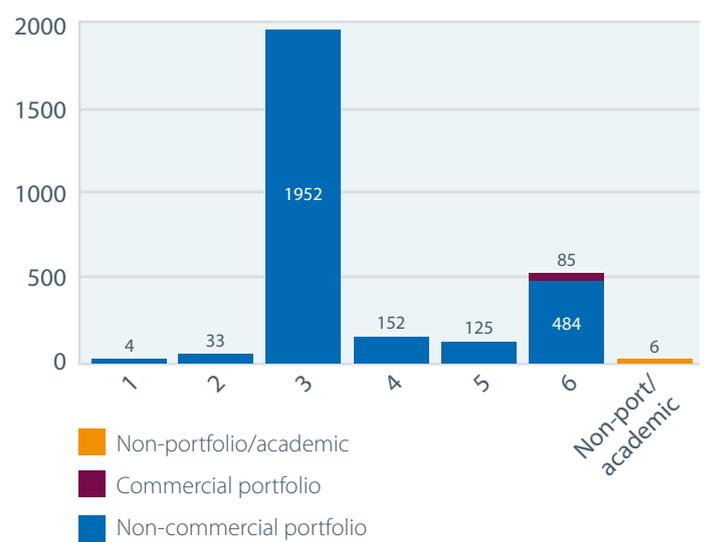
Lewisham and Greenwich NHS Trust has been involved in conducting 142 clinical research studies in a number of different specialties (see figure below).

- Division 1:** Cancer
- Division 2:** Diabetes, Stroke, Cardiovascular, renal, metabolic and Endocrine Disorders
- Division 3:** Children, genetics, Haematology, Paediatrics, reproductive Health and Childbirth
- Division 4:** Dendron, Mental Health and Neurology
- Division 5:** Primary Care, Age and Aging, Dentistry, Health Services Research, Public Health, MSK, Dermatology.
- Division 6:** Anaesthesia/Peri-operative Medicine and Pain management, critical care, Injuries/Emergencies, Surgery, ENT, Infectious Disease/Microbiology, Ophthalmology, Respiratory, Gastroenterology, Hepatology

## Research studies open by CRN Division



## Patients recruited to studies by CRN Division



The number of patients receiving NHS services provided or subcontracted by Lewisham and Greenwich NHS Trust in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 2,841.

The commitment of Consultants and other health professionals at Lewisham and Greenwich NHS Trust to support and promote clinical trials highlights the dedication of Trust staff and the continued efforts to ensure that as many patients as possible are offered the opportunity to participate in research relevant to them without having to travel to other organisations. This further emphasises the ongoing commitment to improving the health and care of patients through the establishment of a robust research base.

Our engagement with clinical research also demonstrates Lewisham and Greenwich NHS Trust's commitment to testing and offering the latest medical treatments and techniques.

The new R&D structure has been set up to strengthen capacity to deliver increasing recruitment of patients across the Trust. Developing the research function within the organisation will benefit patients and the skills and knowledge base of our staff, and also makes the Trust an attractive organisation to work in for clinicians interested in research. The aim is to ensure a balanced portfolio of interventional, observational and large observational studies, together with an increase in commercial activity across more specialties.



## Part 2

### **2.5 Goals agreed with Commissioners (CQUINs)**

A proportion (2.5%) of the Trust's income in 2016/17 was conditional on achieving quality improvement and innovation (CQUIN) goals agreed between Lewisham and Greenwich NHS Trust and Lewisham, Greenwich and Bexley Clinical Commissioning Groups and NHS England

The Trust achieved 81% of its CQUIN goals for April 2016 – March 2017.

# Part 2

## 2.6 What others say about the provider

### Care Quality Commission (CQC)

Lewisham and Greenwich NHS Trust is required to register with the Care Quality Commission and its current registration status is 'registered without conditions'.

The Care Quality Commission has taken enforcement action against Lewisham and Greenwich NHS Trust in 2016/17 following an unannounced inspection of our Urgent, Emergency and Medical Care services at Queen Elizabeth Hospital Woolwich in June 2016. The CQC ratings resulting from this inspection are laid out below.

Urgent and emergency services				
Overall	Inadequate	Requires improvement	Good	Outstanding
Safe	Inadequate	Requires improvement	Good	Outstanding
Effective	Inadequate	Requires improvement	Good	Outstanding
Caring	Inadequate	Requires improvement	Good	Outstanding
Responsive	Inadequate	Requires improvement	Good	Outstanding
Well-led	Inadequate	Requires improvement	Good	Outstanding

Medical care				
Overall	Inadequate	Requires improvement	Good	Outstanding
Safe	Inadequate	Requires improvement	Good	Outstanding
Effective	Inadequate	Requires improvement	Good	Outstanding
Caring	Inadequate	Requires improvement	Good	Outstanding
Responsive	Inadequate	Requires improvement	Good	Outstanding
Well-led	Inadequate	Requires improvement	Good	Outstanding

Although the inspectors commented on progress made since the last inspection in 2014, including an improved pathway for all ED patients to UCC, opening of a clinical decision unit and Frailty Assessment Unit, the CQC requested a number of "must do" improvements, which included:

- Ensure patients are cared for in areas that are appropriate and have sufficient space to accommodate the number of people using the service at any one time
- Improve systems and processes for monitoring quality and safety in the emergency and medical services departments
- In medical care, all medicines must be stored safely, securely and in a temperature-controlled environment.

In response, the Trust produced an improvement action plan, with input from local commissioners.

This included:

- Management of patient flow through daily meetings on each hospital site.
- Agreeing a frailty pathway and developing ambulatory care pathways.
- Implementing a 'discharge to assess' pilot with Bexley Social Care.
- Introducing weekly ward rounds as part of "business as usual". This includes senior nursing staff monitoring the completion of observations, documentation of assessments and patient interviews, with immediate actions being put in place to address sub-standard performance. Results to be fed back to staff within wards.
- Weekly medicines safety audits, results monitored through Divisional Governance Boards.

In March 2017, the CQC undertook a planned comprehensive inspection of all the Trust services, including our community services. The Trust has not received the CQC draft or final report at the time of writing this report.

In their initial feedback following the visit, the CQC commented on the professionalism of staff, and on the caring attitude staff showed in ensuring that patients were treated with dignity and respect. The CQC recognised a number of areas of good practice and improvements since the last CQC visit in June 2016.

The CQC have also told us that we need to make changes more quickly, particularly with regard to the emergency care pathway. With our partners, we have developed and are progressing the implementation of our safety and improvement plan which aims to address the areas of feedback provided by the CQC.

We are working with our partners to deliver improvements across the health and social care system, and delivering the plan is our main priority as an organisation.

Internally, we have four workstreams, each led by an executive director:

- Improving patient flow
- Clinical engagement, leadership and changing practice
- Upgrading your working environment
- Monitoring safety and quality of care

The programme as a whole is overseen by Programme Directors who will be working with operational and clinical teams to ensure the necessary changes result in improved performance across the Trust.

CQC inspection reports can be viewed via the following link: <http://www.cqc.org.uk/provider/RJ2>

# Part 2

## 2.7 Data Quality

### Quality data is data that is:

Confidential, accurate, valid (that adheres to an agreed list of codes/descriptions), consistently understood and used across an organisation, comprehensive in its coverage, delivered to a timescale that fits the purpose for which it is used and held both securely and confidentially.

The Trust measures many different aspects of Data Quality – from the presence of a General Practitioner and NHS Number recorded within a patient record, to the detail and depth within the clinical coding associated with an admission.

Data quality is taken very seriously by the Trust as it can impact on the quality of patient care provided to patients. The Trust's Data Quality scorecard shows performance against key targets and is used to identify areas for improvement. The scorecard, which contains over 90 measures, is updated on a monthly basis, and key Data Quality metrics are included on the Trust Board scorecard.

Within the Clinical Coding teams and in the wider Trust, work is on-going to ensure that the data available for clinical coding purposes reflects the patients clinical condition, all co-morbidities and details the exact treatment received/procedure carried out. Recent Clinical Coding audits have noted that the level of accuracy for Primary Diagnosis is low, and that is impacting on the overall quality of the Trust clinical coding. After each coding audit an audit report is produced, which includes recommended actions. These recommendations are reviewed and are used to develop an action plan to be delivered. Recent recommendations have centred on improving the quality of information available in the form of source documentation. Members of the coding team meet with clinicians in order to feed back about the quality of the information and to

develop new data recording proformas to collect comorbidity details that historically have been poorly documented by clinical teams. As we move towards the implementation of a full Electronic Patient Record (EPR), work around the design of the data collection screens and how the data is subsequently presented for coding purposes will be key to ensuring that the implementation does not impact on the quality of Trust clinical coding.

Work continues to look at the Trust's depth of clinical coding, which is often used as a proxy for the complexity of the condition / how ill patients admitted to the Trust are.

A training plan is in place to deliver training to coding staff around how to extract relevant information from source documentation as this was the cause of a large number of the coder errors that were evidenced in the audit reports in 2015/16. The coding Engagement Lead has requested additional time to work with junior doctors to ensure that they understand the rules that apply to how coders translate the information as written down in source documentation into the appropriate code – because coders cannot make assumptions, but must follow nationally mandated rules on how they translate what is written using the appropriate classification (ICD10 and OPCS 4). The junior doctors complete most of the source documentation (paper and electronic) hence it is important that they understand what they record in the patient's case notes is used for. It not only forms part of the patient's health record, it is also used to calculate how much the Trust should be paid for treating that specific patient via the Payment by Results process. Additionally, it is a national record of the Consultant's clinical practice.

## NHS Number and General Medical Practice Code Validity

The Secondary Uses Service is designed to provide anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.

The Health and Social Care Information Centre (now NHS Digital) Secondary Uses Service has overall responsibility for delivering the Secondary Uses Service to users, Commissioners and Providers of NHS funded care.

The Secondary Uses Service provides a consistent environment for the management and linkage of data, allowing better comparison of data across the care sector, together with associated analysis and reporting tools.

The Trust submits data to the Secondary Uses Service (SUS) to support the commissioning and billing process and is also included in the Hospital Episode Statistics. The Trust monitors the quality of the SUS data and the percentage of records in the published data to ensure that the patient clinical information and clinical coded information is correct as this is important to the Trust for the above reasons.

The performance for 2016/17 is outlined below:

Which included the patient's valid NHS number was		
Admitted Care	LGT	99.22%
	UHL	99.06%
	QEH	99.33%
Outpatient Care	LGT	99.61%
	UHL	99.57%
	QEH	99.65%
Accident & Emergency Care	LGT	96.58%
	UHL	95.89%
	QEH	97.51%
Which included the patient's valid General Medical Practice Code		
Admitted Care	LGT	98.21%
	UHL	99.09%
	QEH	97.33%
Outpatient Care	LGT	99.02%
	UHL	98.46%
	QEH	99.57%
Accident & Emergency Care	LGT	96.76%
	UHL	98.00%
	QEH	95.52%



# Part 2

## 2.8 Information Governance Toolkit

Information Governance (IG) is the way by which the NHS handles all organisational information – in particular the personal and sensitive information of patients and employees. It requires organisations and individuals to ensure that personal information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care.

Every year the Trust is required to submit an annual Information Governance Toolkit submission. This is an online self-assessment which allows NHS and other related organisations to demonstrate whether they are compliant in basic information governance standards.

The Trust is required to upload evidence to support this assessment. Each control then scores each requirement from a Level 0 to 3. To achieve an overall 'Satisfactory' rating each control must be scored at a Level 2 or more.

For 2016/17, the Trust IGTK score was 77 per cent, achieving a satisfactory green pass rate in all IG controls. This provides the Trust Board with substantial assurance that appropriate controls are implemented and consistently applied to manage the information risks of the business.

NHS Digital (previously known as The Health and Social Care Information Centre (HSCIC)) requires all NHS providers to publish details of their information governance breaches – for example where there has been a loss of personal data or an unauthorised disclosure.

For 2016/17, the Trust had one serious incident which took place. In March 2017, we received a complaint about a breach of patient confidentiality from one of our patients. We have reported this as a level 2 incident. At the time of writing (April 2017), our investigation into the incident is still ongoing. This will help us identify what happened and identify any steps that need to be taken so that this does not happen again.

The Trust continues to embed and improve its current IG practices across the organisation and identify lessons learnt in future Policy/ Procedure revisions and Sharing the Learning Events.



# Part 2

## 2.9 Clinical Coding

### Payment by Results

Payment by Results (PbR) is the method by which the Trust receives payment for admitted patients within the acute setting. Trained staff extract information about patient's stays – treatments they receive and what is wrong with them; this along with other information such as the patient's age and how long they were in hospital for is used to allocate each patient to a nationally agreed category. The categories, which are called Healthcare Resource Groups (HRGs), have a national tariff which is used to determine the amount that the Trust is reimbursed for patient care.

The HRGs are based on the Clinical Coding recorded against each episode of care, it is important that the coding is an accurate record of the patient's conditions and care received so that the Trust is not over or under paid. In addition to this, the coded data forms part

of the patient's clinical record and is used to help identify where improvements in service can be made and to aid the planning of health service provision within the local healthcare economy. The data is also submitted nationally to the Secondary Use Service (SUS), who collect national data to allow them to look at trends and patterns across the NHS as a whole.

The Trust did not have its Admitted Patient Care Clinical Coding audited as part of any national audit programme in 2016/17; however qualified Coding auditors have completed clinical coding audits in year. The audit reports have been shared with the site based coding teams, with action and training plans developed around the audit recommendations.

The results demonstrated the following (completed clinical coding audits 2016/17 as at 31/03/17):

### Completed Clinical Coding Audits 2016/17 as at 31/03/2017

Area	FCEs in audit	FCEs - unable to audit	HRG changed	HRG changed/ error rate	Primary Diag - correct %			Secondary Diag - correct %			Primary Proc - correct %			Secondary Diag - correct %		
					% Correct	Correct	Incorrect	% Correct	Correct	Incorrect	% Correct	Correct	Incorrect	% Correct	Correct	Incorrect
General (UHL site) Medicine	80	2	4	5.3%	87.5%	70	10	80.5%	95	23	93.0%	66	5	96.5%	82	3
General (QEH site) Medicine	113	15	6	5%	91.8%	90	8	90.6%	460	48	87.5%	21	3	91.0%	30	3
Paediatric (UHL site) service	82	2	5	6.25%	91.3%	73	7	79.4%	73	19	85.7%	18	3	88.9%	8	1
QEH Site Specialty Audits - details below	260	0	25	0.10%	93.1%	242	18	91.6%	774	71	91.1%	214	21	93.9%	465	30
QEH T&O	160	0	22	13.75%	92.5%	148	12	88.9%	463	58	90.3%	140	15	93.3%	387	28
QEH Cardiology	65	0	2	3%	93.8%	61	4	96.2%	251	10	92.2%	59	5	96.8%	61	2
QEH Obstetrics	12	0	1	8%	83.3%	10	2	95.5%	21	1	80.0%	4	1	100.0%	2	0
QEH Gynaecology	18	0	0	0%	100.0%	18	0	100.0%	31	0	100.0%	8	0	100.0%	13	0
QEH Midwifery	4	0	4	0%	100.0%	4	0	77.8%	7	2	100.0%	3	0	100.0%	2	0
QEH Paediatrics	1	0	0	0%	100.0%	1	0	100.0%	1	0		0	0		0	0
Trust Clinical Coding Audits 16/17	535	19	40	7.8%	91.7%	475	43	89.7%	1402	161	90.9%	319	32	94.1%	585	37
Trust Clinical Coding Audits 15/16	390			6.4%				94.0%			95.8%			87.5%		
Trust audits 2014/15	317			7.3%	89.0%			90.5%			94.5%			82.4%		
National comparator - Median (capita)				7.0%	91.2%			88.6%			93.3%			82.6%		

# Part 3

## 3.0 Review of Quality Performance in 2016/17

### 3.1.1 Patient Safety Priorities

Our quality priorities and why we chose them	What success will look like	How did we do?
<p><b>3.1.1. (i) Improving our hand hygiene compliance</b></p> <p>Reduction in avoidable infections relies on good compliance with hand hygiene standards. Our CQC inspection found that although there are many areas where excellent compliance was observed, there were some areas where non-compliance was observed and through our own internal audits, there is still improvement to be made.</p>	<p>We will achieve 100% compliance across all departments</p>	<p><b>We partially achieved this.</b></p> <p>We acknowledged that achieving 100% compliance across all of our departments would be challenging, however, a great aspiration. We did achieve 100% compliance on most of our wards and averaged 96% across all areas for April 2016 – March 2017.</p> <p>The Infection Prevention and Control nurses have continued to ensure that hand hygiene forms part of all induction and mandatory training sessions, encouraging staff to challenge staff at all grades, when standards are not being met, and have worked with the Communications team on initiatives such as the next set of champion posters and supporting the Infection Prevention Society’s Global Hand Hygiene Torch Tour.</p>
<p><b>3.1.1. (ii) Early recognition and treatment of the deteriorating patient</b></p> <p>The early recognition and detection of deteriorating patients has been shown to improve the clinical outcomes for patients. Our review of incidents has shown that we need to improve the early detection of patients in whom their clinical condition has deteriorated by ensuring regular monitoring and recording of observations is carried out and ensuring proactive intervention of the results of these observations is taken.</p>	<p>We will continue the education and audit of the correct use of the NEWS charts and increase appropriate escalation of patients who trigger the NEWS score.</p> <p>Aim 1: 10% reduction in number of out of Critical Care in hospital cardiac arrests by the end of year 3 (March 2018), from January 2015 baseline.</p> <p>Aim 2: Eliminate all avoidable deaths from sepsis and septic shock by the end of year 3 (March 2018).</p>	<p><b>We achieved this.</b></p> <p>The Trust is on track to achieve the 10% reduction in the number of out of Critical care in hospital cardiac arrests by March 2018.</p> <p>During 2016/17, the Resuscitation team have standardised the early warning scores throughout the organisation, monitored progress by publishing run charts for each site and introduced a communication tool for use in clinical areas to support effective escalation and handover of patient care (SBAR).</p> <p><b>Sepsis</b></p> <p>A sepsis working group has been created to lead on improvements on sepsis screening and treatment across the Trust. Following the release of NICE guidance (July 2016), one of the focuses was to develop new screening tools. Acute and paediatric tools were developed during 2016/17 and these will be fully implemented during 2017/18.</p>

Our quality priorities and why we chose them	What success will look like	How did we do?
<p><b>3.1.1. (iii) Improving the Safety of Maternity Services</b></p> <p>Not only can babies be severely harmed by failures in assessment of the wellbeing of the foetus the impact of harm has life changing effects for the child and all members of their family. The loss of a baby as a stillbirth also has significant impact for parents. Our priority is set around minimising the risk of these events.</p>	<p>Reduction in stillbirths</p> <p>Increase detection of growth restricted babies in utero</p> <p>Reduce poor neonatal outcomes associated with poor / inadequate fetal surveillance in labour, whether by intermittent auscultation (IA) or continuous electronic fetal monitoring (CEFM)</p>	<p><b>We partially achieved this.</b></p> <p>The stillbirth rate at QEH was 4.6 per 1,000 births and 5.8 per 1,000 births at UHL. The most recently published figures relate to 2014 and the national average was 4.16 per 1,000 births. Traditionally, the London average is higher than the national average.</p> <p><b>Achievements during 2016/17 include:</b></p> <p>Development of a Fetal Wellbeing team comprising of midwives, trainee doctors and consultant obstetricians.</p> <p>Sonic aids for all Birth Centre staff and installation of central monitoring enabling discussions and teaching away from the bedside.</p> <p>Introduction of competency assessments for all grades and 2 day fetal monitoring master class training sessions.</p>
<p><b>3.1.1 (iv) Continue our focus on the aim to reduce the number of grade 2, 3, and 4 hospital acquired pressure ulcers and ensure where pressure ulcers are acquired within our provision of community services, timely completion of root cause analysis is undertaken and learning is shared across our community areas.</b></p> <p>Pressure ulcers can be serious and distressing and often result in extended lengths of hospital stay for patients; mortality rates can increase particularly from infection. An increasingly elderly and frail patient population in our area who often have several co-morbidities raises the risk for patients of developing pressure ulcers.</p>	<p>Improve the accuracy of the recording of Waterlow score for patients in hospital and community services we provide and achieve 95% compliance with completion of scores</p>	<p><b>We partially achieved this.</b></p> <p>During 2016/17 Waterlow score compliance has been maintained at around 95% compliance.</p> <p>Weekly pressure ulcer panels on both acute hospital sites take place. A weekly community panel incorporating CCG and the local authority staff also takes place.</p> <p>A tool has been developed for auditing the accuracy of pressure ulcer documentation and review of Trust equipment.</p>
<p><b>3.1.1 (v) Reduction in the number of patient falls and harm incurred</b></p> <p>Although the Trust has made significant progress with its work on patient falls, the Trust continues to have many patient falls reported. Older people and those who are frail are at risk of life changing harm and increased mortality if they sustain a fracture or a head injury as a result of the fall.</p>	<p>Reduce the incidence of harm sustained from patient falls by 20% by the end of year</p>	<p><b>We partially achieved this.</b></p> <p>During 2016/17, although we have made progress, for example, we had no falls resulting in severe harm to the patient or death; we did not manage to achieve the full 20% reduction during the year for falls resulting in moderate harm to the patient.</p> <p>During 2016/17, the Falls Strategy was revised, documentation standardised, implementation of "Falls Champions" in clinical areas and relaunch of the 3Cs of falls prevention. This work is being taken forward in 2017/18.</p>

Our quality priorities and why we chose them	What success will look like	How did we do?
<p><b>3.1.1 (vi) Help people to understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress</b></p> <p>Between 2005 and 2010 over half a million medication incidents were reported to the National Reporting and Learning System (NRLS) with 16% of these reporting actual harm. Research evidence indicates that the medicines administration error rate in hospitals is 3 – 8% and that the prescribing error rate is 7%.</p> <p>Pharmacy led audits at the Trust have highlighted issues with omission or delay of prescribed medications. Particular problems include the omission or delay of time critical medicines (which may result in actual patient harm) and lack of or poor documentation of the reasons for omission.</p> <p>Nationally, medication incidents account for around 10% of all reported incidents. This level of medication incident reporting has been achieved in the Trust in one quarter, but this level has not been consistent.</p>	<p>Increase the number of reported medication related patient safety incidents from baseline by 5%.</p> <p>Reduce number of inappropriately omitted medicines with a particular focus on critical medicines.</p> <p>Identify trends and themes in prescribing and administration incidents and share learning with staff at all levels.</p>	<p><b>We partially achieved this.</b></p> <p>Reporting of medication related patient safety incidents has remained the same overall. The pharmacy team continues to increase the awareness through training, attending ward meetings and through a variety of other communications.</p> <p>Medication Safety Walkabouts have had a positive impact and the Trust has seen an improvement in the proportion of inappropriately missed doses (5% to 1%).</p> <p>Review of medication incidents and trends at the multi-disciplinary Penicillin Working Group and Medication Allergy Incident Panel has shown a downward trend in penicillin related incidents. Issues highlighted are being tackled through local action plans.</p>



### 3.1.2 Clinical Effectiveness Priorities

Our quality priorities and why we chose them	What success will look like	How did we do?
<p><b>3.1.2 (i) To continue to work on embedding the process for mortality reviews across the Trust and implement the new NHSE process</b></p>	<p>Continued improvement in Trust mortality rates at each site.</p> <p>Introduction of the new NHSE processes and presentation of reviews and learning at Trust wide mortality and Divisional governance groups.</p> <p>Reduction in inaccurate clinical coding of deaths and improvement in data quality audit scores.</p>	<p><b>We fully achieved this.</b></p> <p>During 2016/17, the Trust continued to work towards consolidating the mortality and morbidity review process embedded across the organisation. The Trust mortality rate continued to show improvement during 2016/17. The Trust SHMI (Standardised Hospital Mortality Index) stayed within the 'as expected' banding throughout the year.</p> <p>The Trust mortality review process was reviewed in light of the Mortality Governance guidance received from NHSE (National Health Service England). In addition to the Divisional mortality review findings, any emerging trends from SMRs (Standardised Mortality Ratios) continue to be analysed and discussed at the Trust wide Mortality Review Committee to allow the Trust to address any underlying performance issues. Further, learnings from any SIs (Serious Incidents) and Inquests related to avoidable deaths continues to be discussed and shared by the Committee members.</p> <p>Following the launch of the Trust co-morbidity and clinical coding proforma, the Trust's consultants continue to work closely with the clinical coding team to ensure increased accuracy and quality of data. As part of the Trust's commitment to reduce the inaccurate clinical coding of deaths, there is ongoing work involving training for coders to improve accuracy of coding and to continue with the increased joint working with consultants and coders for shared learning.</p>
<p><b>3.1.2 (ii) To improve the clinical pathways for Frailty and improve outcomes for these patients</b></p> <p>Through the work carried out during 2015/16 on the Trust Emergency Care Pathways, the Frailty pathways from attendance at the ED to discharge have been identified as areas where improved screening, early assessment, dedicated service provision and early discharge planning could lead to improved outcomes for our patients.</p> <p>As part of the Trust's Medical Redesign programme, we aim to develop a model of service provision for the frail and elderly during 2016/17 with our commissioners and to implement agreed pathways.</p>	<p>Establishment of agreed Frailty Pathways and implementation of pathways during 2016/17.</p> <p>Successful outcomes in key performance indicators: Reduction in emergency admissions in defined cohort of patients by at least 10%.</p> <p>Reduction in Average Length of Stay by 1 day in defined cohort of patients.</p> <p>Ensure 75% of defined staff have been trained in Frailty Assessment and Screening.</p>	<p><b>We partially achieved this.</b></p> <p>During 2016 work has continued with the development and establishment of the Frailty pathway at QEH. Working with partners the Trust has achieved all but one of the indicators set out in 2016.</p> <p>The Trust has achieved this indicator and the length of stay for this group of patients at the QEH site has been reduced by 1 day.</p> <p>The Frailty training programme has been rolled out as part of the Frailty project and over 75% of staff in key areas have been trained.</p>

Our quality priorities and why we chose them	What success will look like	How did we do?
<p><b>3.1.2(iii) Informed by the London Asthma Standards and building on the gap analysis undertaken by OHSEL Asthma Working Group in 2015/16, the 2016/17 priority consolidates and expands the work undertaken locally on the Children's Asthma pathway redesign through 2015/16</b></p> <p>As a provider responsible for services for children across the hospital and community settings we are aiming to improve the care to be provided closer to home for Children and Young People. During 2016/17 we will advance the work undertaken on the pathway to allow for more seamless care across acute, community (including community pharmacy) and Primary Care.</p> <p>This will enable more specialist nurse-led care and facilitate integrated care between General Practice, community services and the Trust.</p>	<p>Develop new service model and pathways for the management of Asthma in Children and Young People in Acute, Community and Primary Care.</p> <p>Develop joint training and competency programme for Community and Primary Care Staff with GP leads.</p> <p>Develop and implement written information for patients and healthcare professional staff on the management of Asthma within Primary Care.</p>	<p><b>We partially achieved this.</b></p> <p>During 2016/17, a new service model and pathways for the management of Asthma in Children and Young People in Acute, Community and Primary Care were implemented.</p> <p>The Trust is finalising the development of the training with primary care staff, at which point the programme will then be implemented.</p> <p>The Trust is in the process of developing this information and will also be utilising resources from the London asthma standards.</p>

### 3.1.3 Patient Experience Priorities

Our quality priorities and why we chose them	What success will look like	How did we do?
<p><b>3.1.3. (i) We will continue to focus on providing individualised care for patients with dementia and their carers and continue to expand this work into intermediate and community care</b></p> <p>During 2015/16, the Trust built on its early work with dementia patients and their carers and established a 'dementia friendly' ward to improve the experience for dementia patients. The Trust also established its carer's survey which has provided much welcomed feedback on how to improve services for dementia patients. This year we will build on this work and will focus on a number of campaigns to continue to improve services and care provision for those with dementia and their carers.</p>	<p>Successful John's campaign.</p> <p>Successful Dementia Friends campaign with increased numbers in Dementia Friends.</p> <p>Implementation of an enhanced dementia volunteers programme.</p> <p>Establishment of a cross site dementia working group to develop services and support on both sites.</p> <p>Continue to improve on our staff dementia training programme.</p>	<p><b>We fully achieved this.</b></p> <p>As part of the sign up to John's campaign, the Trust has demonstrated its commitment to the ethos of the campaign in reviewing its visiting policy. Based on feedback from patients, the new policy was launched in November 2016 enabling open visiting for all adult inpatient wards.</p> <p>A successful Dementia Friends campaign was run during dementia awareness week in May 2016 and has continued to feature at clinical induction and team meetings throughout the Trust. A total of 1,268 staff of all disciplines were registered as Dementia Friends during the week.</p> <p>The first cohort of dementia volunteers was trained in December 2016 and these volunteers are now out on the wards running meaningful activities with dementia patients, such as arts and crafts, and spending time chatting with the patients whilst distributing the newspapers in the morning.</p> <p>A dementia working group was established in Quarter 1 with the aim of developing the Trust wide strategy for dementia. The Dementia Strategy was finalised and launched during Quarter 2/3 of 2016/17 setting out plans to improve dementia care over the next 3 years.</p> <p>The staff training programme for dementia is being further enhanced as a priority in the strategy and this will be a focus for 2017/18.</p>

Our quality priorities and why we chose them	What success will look like	How did we do?
<p><b>3.1.3. (ii) Ensuring that learning from feedback is used to affect change (from complaints, FFT, NHS choices, national and local surveys etc.) and shared across the organisation</b></p> <p>The Trust collects feedback from a range of sources including structured surveys, the Friends and Family Test, and complaints, compliments and concerns raised by individuals. Learning from all of these is shared locally by the services or individuals involved. We would like to ensure that where appropriate, learning is shared across services and across divisions.</p>	<p>Introduction and successful 'You said We Did' programme. Outcomes shared with patients and staff and continued use of patient stories in shared learning events.</p> <p>Divisional learning and outcomes captured and shared through all Divisional Governance, Complaints and Patient Experience Committee.</p> <p>Evidenced practice changes from learning from patient experience.</p> <p>Trust wide successful Sharing the learning events held throughout the year.</p>	<p><b>We fully achieved this.</b></p> <p>The 'You Said We Did' (YSWD) concept has been successfully rolled out during 2016/17. YSWD posters are now in place in all clinical areas.</p> <p>Teams are now encouraged through the production of Divisional improvement plans, to translate the learning from complaints and other feedback into actions. Teams are now focusing on making those small changes that can be easily achieved, that make a big difference to patients. The Patient Experience Committee has reviewed its terms of reference and membership and is structuring its meetings to enable outcome based actions to be achieved with the support of the Patient Experience Team to deliver these.</p> <p>Sharing the Learning events have continued on both sites throughout the year and a community focussed event has also been held.</p>
<p><b>3.1.3 (iii) Continued expansion for gaining patient feedback from all services</b></p> <p>During 2015/16 the Trust Patient Experience Team expanded the number of service specific Patient Experience Feedback Questionnaires to compliment the feedback gained from the Friends and Family Test and the national annual Patient Experience Survey. During 2016/17, the Trust will plan to implement more detailed patient experience surveys across areas which are included in our transformation plan and where services are developing new models of care provision.</p>	<p>Successful introduction of 'Ideas boxes' and feedback boards.</p> <p>Lay involvement in the development of services and evaluation through the use of surveys.</p>	<p><b>We fully achieved this.</b></p> <p>Comments boards with ideas boxes have been purchased and are now in place on the UHL site, with a plan for installation in place on the QEH site. These provide further opportunity for patients to share their ideas or comments with us.</p> <p>The Patient Experience Team have continued to support teams with delivery of both the national and local surveys to highlight where improvement is needed.</p>
<p><b>3.1.3 (iv) Improving the patient experience and quality of End of Life pathways</b></p> <p>During 2015/16 the Trust continued to embed the principles of care for the dying to ensure that patients received individualised care plans. The Trust participated in the National Care of the Dying audit and the results from this demonstrate that there is further work needed.</p>	<p>Continue to roll out Sage and Thyme communication training.</p> <p>Undertake bereavement survey.</p> <p>Embed 24/7 visiting for families of patients at the end of life, ensuring they have the appropriate facilities available.</p>	<p><b>We partially achieved this.</b></p> <p>The Trust has continued to deliver Sage and Thyme training across the organisation. Further members of staff have completed the training to facilitate the sessions. A total number of 196 staff have completed the training from April 2016 – March 2017.</p> <p>The Trust did not undertake a bereavement survey in 2016/17 however there is a plan to undertake a survey early in 2017/18 using a tool that has been developed in other NHS Trusts.</p> <p>The Trust revised its visiting policy incorporating John's campaign. This has been implemented across the organisation. Recliner chairs have also been purchased so that family members can stay with end of life care patients.</p>

# Part 3

## 3.2 An explanation of who has been involved

### Overview

#### Who has been involved?

The Trust has consulted widely on the content of this Quality Account, namely with the Trust Board, senior nursing, and medical staff, midwifery, clinical and managerial staff, patients and the public. The Patient Welfare Forum, the Patient User Group and the local Healthwatch organisations have also been consulted.

We have also been able to consult and gain feedback from three local Clinical Commissioning Groups and the membership of the Clinical Quality Review Group.

Feedback has also been requested from the local Overview and Scrutiny Committees.

The Trust has consulted widely about the content and the final version will incorporate all comments, being published at the end of June 2017.

### The Trust Board

The Trust Board has been actively involved in setting the quality priorities for the Trust. Items on quality are discussed at every Board meeting and at frequent Board seminars. Quality Account indicators are part of the Trust scorecards, which have been presented and discussed through the Integrated Governance reports to the Trust Board.

The Trust Board is also presented with a performance scorecard which is examined at every Board meeting to assess trends in performance and highlight any issues of concern. In addition, Board members undertake quality walk rounds, visiting clinical departments to increase their understanding of services provided and hear first hand of challenges that front line staff face on a day-to-day basis.

### Staff

The Trust's Management Executive, which comprises the Chief Executive, the Medical Director, Director of Nursing & Clinical Quality, Director of Finance & Information, Director of Estates & Facilities, Director of Workforce & Education, Director of Service Delivery, the Chief Information Officer and the six Divisional Directors, have been involved in discussions around and provision of information for the Quality Account.

Key leads and stakeholders from within each of the six Clinical Divisions have contributed to the content, the setting of priorities, and agreement of the key outcome measures and have provided the commitment to lead on each of the key priorities for 2017/18.

The Trust Integrated Governance Committee, Quality and Safety Committee and Patient Experience Committee, which have Executive, Non-Executive, Clinical Team and lay members, Patient Welfare Forum and Patient User Group members and members of our local Healthwatch, have the Quality Account as a standing agenda item and valuable input has been received from these committees.

The Divisional Governance and Risk meetings have also been used to consult widely on the Quality Account with Divisional Governance, Risk and Audit Leads participating in the review of the priorities.

# Part 3

## 3.3 Statements from Clinical Commissioners, local Healthwatch and the Overview and Scrutiny Committees

### **i) Commissioners/ Clinical Commissioning Group (CCG) NHS Bexley, NHS Greenwich and NHS Lewisham**

#### **Joint Statement on Lewisham and Greenwich NHS Trust's Quality Account**

June 2017

The three Clinical Commissioning Groups (CCGs) that commission health care services from the Lewisham and Greenwich NHS Trust (LGT) have reviewed the Trust's Quality Account for 2016/17. We thank the Trust for the opportunity to comment on the 2016/17 Quality Account and for seeking our views in its development.

Throughout the year commissioners from the three local CCGs have met with the Trust at our joint Clinical Quality Review Group where we have sought assurance of the quality of services at University Hospital Lewisham, community services in Lewisham and at Queen Elizabeth Hospital in Woolwich.

It is acknowledged that LGT has made progress in their performance across the three quality domains of patient safety, clinical effectiveness and patient experience. There are also however some key areas that require more work to ensure quality services are consistently delivered across the Trust.

A key focus over the last year has been to support the Trust to improve quality and performance in urgent and emergency care and specifically to reduce delays to starting treatment. In addition Cancer continues to be an area requiring improvement with regard to the 62 day referral to treatment target. The CCGs note that the Trust is actively working to address these areas in partnership with health and social care with a whole system approach.

With regard to the safety of maternity services it is noted that there are higher elective (planned) caesarean section rates at Queen Elizabeth Hospital and higher emergency caesarean section rates at University Hospital Lewisham. The CCGs note that there is positive work being undertaken within the Trust to reduce this. This includes reviewing each caesarean section to see how the decision was reached for the patient to have one, further education and training for staff and actively encouraging use of the birthing centres to women where appropriate. In addition focused work continues to reduce the number of still births.

It is good to see that the Trust has achieved three out of the four priorities in relation to patient experience. A Dementia Strategy has been launched and will remain a focus for 2017/18. In addition it is good to see that the Trust has successfully introduced 'ideas boxes'

and feedback boards at the University Hospital Lewisham site. The Trust has also implemented 'You said, We did' which is a valuable tool enabling patients to receive a response to their feedback. It would be helpful to see how patient engagement can be further developed across more areas of the organisation in 2017/18, particularly for groups such as children and young people and adults with learning disabilities.

It is positive to note that following the investigation of complaints an action plan is implemented to improve that service area where a shortfall has been identified. It would be useful to know how this learning is then shared across the Trust and what evidence there is that such improvements in services have led to sustainable change.

### **ii) Overview and Scrutiny Committees**

We have requested contribution from the OSCs but this will not be available until after the publication of this account.

### **iii) Local Healthwatch**

The Trust has sought statements on its services from our Local Healthwatch and has considered the recommendations to review the format of the Quality Account, the Trust will produce an easy read version for the public.

This is a joint response to the Lewisham and Greenwich NHS Trust Quality Account 2016-2017 from local Healthwatch in Lewisham, Greenwich and Bexley. The three local Healthwatch are consumer champions for residents across the boroughs where the Trust provides services. Local Healthwatch welcome the opportunity to comment on the quality of service provided across the Queen Elizabeth (QE) and University Hospital Lewisham (UHL) sites.

Review of Quality Performance in 2016/17 and Quality Priorities 2017/18.

#### **General Comments**

Healthwatch appreciates the statutory requirements and the level of information needed in the Quality Accounts. However a more accessible format and clear layout would make the document easier to understand for a lay person.

#### **Patient Safety**

Healthwatch is pleased with the ongoing priorities around: improving maternity safety, pressure ulcers, a new falls strategy and the Trust's priority to improve monitoring and detection of patients whose condition deteriorates. However, still births at both QE and

UHL sites are above the national average and whilst the document recognises that the London average is usually higher than the national average, it would be helpful to understand the reasons behind this and what is done to address this within the Trust. The introduction of a Foetal Wellbeing team is welcomed as a measure to improve this target, however further explanation of how the Trust is planning to meet this target would be appreciated.

Healthwatch welcomes improvements in the Trust's work around prevention of falls and recognises that this is a priority area due to the increased mortality risks associated with falls and poor outcomes. However, there are no figures relating to clinical pathways for frailty (3.1.2), and further clarification in this area will help us to understand the issue and enable us to comment further.

Healthwatch is pleased to see the improvements in care for dementia patients and their carers (3.1.3), especially the implementation of the dementia volunteer programme. We are happy that the patients are provided with meaningful activities as a direct result of this program. We also welcome the Trust's focus on dementia training provision for staff.

Healthwatch recognises a good achievement of 100% compliance in hand hygiene on most of the wards, however we feel more must be done to achieve the set target at all wards. Hand hygiene is a fundamental practice in infection control and Healthwatch would like to see a robust plan to bring the wards that fall behind the 100% compliance, to match the wards that do achieve the target.

We are happy there is progress in the inappropriate missed doses of medication from 5% to 1%. We would like to note the positive impact of Pharmacy Audits on picking up gaps in prescribing medication. It is reassuring that the Trust has taken steps to further improve in this area.

Healthwatch noted an upward trend in the patient safety incidents. We would welcome further narrative to better understand if this is a result of the better reporting or an actual increase in the number of safety incidents.

In the patient's readmission data (2.1.2), the readmission rates for under 15 years olds are double to those of 16 years and over. It would be valuable to understand the reasons behind the difference, and to be reassured of the measures in place to ensure improvement in this area.

### **Clinical Effectiveness**

We are happy to see the Trust fully achieved their target of reducing mortality rates across the both sites and we welcome the ongoing work to embed good practice.

Healthwatch is pleased to see a focus on improving patient outcomes in Adult Community Services. Healthwatch believes that this is particularly important as some of the patients may be housebound and vulnerable.

### **Patient Engagement**

Healthwatch is pleased to see that the Trust has achieved three out of four last year targets areas under the Patient Experience priority including: providing focus on patients with dementia and their carers, ensuring the patient feedback is used to drive service improvement, and continuing to expand the level and breadth of service specific patient feedback. We are pleased to see this is a priority area rolled over to 2017/2018. Healthwatch also recognises the value of the Dementia strategy and to the developments in this area.

Healthwatch welcomes the development of the Patient Experience Strategy and ongoing efforts to include and learn from patient and carers feedback, including patient satisfaction, complaints, the friends and family test, and Sharing the Learning events. We would welcome an insight of how the outcomes and learning from those activities will be measured.

Healthwatch noted the patient's feedback response rates for some services are very low or indeed missing, which means that statistics are not representable as a whole, and it is thus it is difficult to comment. We would appreciate a comparison from previous years to help understand the results

We welcome the 'you said we did' concept which is a simple way of providing patients with evidence of how their feedback has been used to drive service improvement. Further evidence of displays across the Trust would be appreciated. We are looking forward to the installation of the comments boards with ideas boxes at the QEH site.

Healthwatch is looking forward to the implementation of the patient experience micro site and the impact this would have on patients.

Healthwatch welcomes the slight improvement in the number of staff recommending the Trust for treatment, however it is worth noting that 1 out of 3 of staff members neither agree nor disagree with the statement, and a further explanation of the reasons and issues raised by the staff would be helpful.

There is no information about how the Trust attempts to engage with patients/carers with a learning disability and how feedback from this cohort is collected. People with learning disabilities usually have a poor experience of care and understanding their needs and experiences is an important part of improving overall patient care.

We also would like to note that the document states Quality Account as a standing agenda item at Patient Experience Committee, however in the experience of local Healthwatch, this is not the case. Healthwatch would value to have an ongoing dialogue with the Trust about quality of services.

In addition, Healthwatch would welcome relevant intelligence from our reports being used by the Trust to drive learning and service improvement.

## iv) Patient Welfare Forum (PWF) University Hospital Lewisham

The PWF is a volunteer group whose role is to act as a critical friend to the Trust. We are completely independent and represent the voice of the patient. We visit all of the wards and outpatient areas at UHL at least once a year. We have representatives on several Trust committees or groups, for example the Patient Experience Committee, Complaints Steering Group, and Catering Committee. We have also provided comments and suggestions on patient information leaflets.

During our visits, we review the facilities and talk to staff, and get feedback from patients about their care. We report to the hospital on our findings, and we ask for responses so we can check that concerns are addressed. We are grateful to the Patient Experience Team at the Trust for their support for our work.

In 2016-17, we made 80 visits to wards and clinics, speaking to 214 patients and relatives. We also continued to monitor issues of concern from the previous year as follows:

- **Staffing issues:** We are pleased to say that, again, almost all of the patients and relatives we spoke to were positive about their care. Staff were generally described as pleasant, approachable, helpful and caring. On a few of our visits, concerns were raised with us about staffing levels – either during a particular shift, or where the ward had vacancies and was therefore reliant on bank or agency staff. These concerns were fed back to the Trust in terms of any potential effect on patient care.
- **Wristbands:** We had previously raised concerns about matters such as handwritten or illegible wristbands, and patients with red wristbands not understanding why they have them. These issues are important in maintaining patient safety. Our feedback contributed to the Trust's work on this issue and over this year we have seen a marked improvement.
- **Signage:** We were concerned about the signage around the hospital as it can be difficult for patients and visitors to find their way around. This year we have continued to highlight areas for improvement, and we are pleased to see that this is now being addressed, although there is more to be done.
- **Food:** We were concerned about the distribution of snacks in the evenings – these are important because evening meals are usually served quite early. This year we've seen improvements in patient awareness of, and access to, these snacks.
- **'Who is caring for you' boards:** These show the names of the doctor and nurse caring for an individual patient. It is important for the patient (or relative) to know who to speak to about their care – and we have had concerns about the completion of these boards. Although there is still work to be done, we have seen much greater consistency in completion this year.

Other issues arising from our activities this year are set out below.

- **Information for patients:** We have raised a number of issues here. Following our involvement, there are clearer appointment letters for the Surgical Pre-assessment Unit and Suite 8, so that patients have better information on where to go and what to expect. There can be unavoidable delays in outpatient clinics – but it is important that patients are updated about waiting times. In some clinics we thought there could be better information about this, and following our feedback there have been improvements. For example, in Women's Health there is now a noticeboard so that patients can be notified about any delays. We remain concerned about the Discharge Lounge, in that patients aren't always given a clear indication about how long they may need to wait there (e.g. for medication to be arranged) before they can leave the hospital, although we note that the staff in the Discharge Lounge do their best to alleviate problems.
- **Maintenance and facilities issues:** We continue to raise issues with the Trust in this area. For example, we found inadequate furniture for patients and visitors on Hawthorn Ward – this has now been rectified. Damaged plasterwork in Suite 1 has now been repaired. Where we report relatively minor items such as lights not working, these are generally rectified by the time the ward responds to our report. Overall, we are pleased to say that we have generally seen a clear improvement in cleaning standards this year.
- **Committee work:** PWF members attend and contribute to the work of various Trust committees. For example, on the Complaints Steering Group, we have suggested a review of complaints about communication and information, to identify common themes and areas of improvement.

Overall the PWF continues to act as a permanent mechanism for improving standards throughout UHL. We have a good working relationship with Trust staff, and they are always receptive to our feedback and suggestions. As ever, we thank everyone in UHL for working with us and making us feel welcome in our role.

## (v) Patient User Group (PUG) Queen Elizabeth Hospital

The Patient User Group for Queen Elizabeth continues to work to improve the experience of those who have need to use the hospital. During the past year, we have restructured and now have a committee responsible for strategy working together with a team of Observers.

As observers, we have visited the majority of wards and most Outpatient clinics and have had, in the main, a positive story to tell. There have been a small number of maintenance issues identified most of which were remedied within a short space of time. Our numbers have grown so we are now in a position to check that the action plans agreed with ward managers and the Patient Experience Team at the conclusion of a visit are fulfilled, hence completing the "quality circle".

We continue to work collaboratively with the Patient Experience Team and have participated in a number of audits including availability of wheelchairs, the presence of PALs literature and the condition of the seating in public areas.

# Part 3

## 3.4 External Audit Limited Assurance Report

### Independent Auditor's Limited Assurance Report to the Directors of Lewisham and Greenwich NHS Trust on the Annual Quality Account

We are required to perform an independent assurance engagement in respect of Lewisham and Greenwich NHS Trust's Quality Account for the year ended 31 March 2017 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS Trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

#### Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following indicators:

- Rate of clostridium difficile infections
- Percentage of patient safety incidents resulting in severe harm or death

We refer to these two indicators collectively as "the indicators".

#### Respective responsibilities of directors and auditors

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).



In preparing the Quality Account, the directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specific data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material aspects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material aspects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by the Department of Health in March 2015 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- board minutes for the period April 2016 to June 2017;
- papers relating to quality reported to the Board over the period April 2016 to June 2017;
- feedback from Commissioners dated June 2017;
- feedback from Local Healthwatch;
- feedback from Patient User Group Queen Elizabeth Hospital;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulation 2009, dated 11/10/16;
- the latest national patient survey dated 31/5/17;
- the latest local patient survey dated 31/05/17;
- the latest national staff survey dated 31/5/17;
- the latest local staff survey dated 31/5/17;
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2017; and
- the annual governance statement dated May 2017.

We have not reviewed the Quality Account for consistency with feedback from the Overview and Scrutiny Committee as is required by the Guidance because this feedback on the Quality Account was not provided in line with the agreed timescale for publication.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of Lewisham and Greenwich NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Lewisham and Greenwich NHS Trust for our work or this report save where the terms are expressly agreed and with our prior consent in writing.

## Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicators tested back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

## Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of the Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Lewisham and Greenwich NHS Trust.

## Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the Quality Account is not prepared in all material aspects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material aspects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Grant Thornton UK LLP  
2nd Floor, St Johns House  
Crawley  
RH10 1HS  
June 2017

## Part 3

# 3.5 Statement of Directors' Responsibility in respect of the Quality Account

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts, which incorporates the legal requirements in the Health Act 2009 and the National Health Service Quality Accounts Regulations 2010 (as amended by the National Health Service Quality Accounts Amendment Regulations 2011).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the Quality Accounts presents a balanced picture of the Trust's performance over the period covered,
- the performance information reported in the Quality Account is reliable and accurate,
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice,
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review, and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board



Chair

Date: 13th of June 2017



Chief Executive

Date: 13th of June 2017

# Part 3

## 3.6 Feedback

Should you wish to provide the Trust with feedback on the Quality Account or make suggestions for content for future reports, please contact:

The Head of PALs, Complaints and Clinical Effectiveness,  
Lewisham and Greenwich NHS Trust  
Ranken House,  
Queen Elizabeth Hospital,  
Stadium Road,  
London SE18 4QH.

Telephone: 020 8836 4669  
Email: [aoifecavanagh@nhs.net](mailto:aoifecavanagh@nhs.net)  
Web: [www.lewishamandgreenwich.nhs.uk](http://www.lewishamandgreenwich.nhs.uk)

# Appendix 1

## Full List of Local Audits reviewed during 2016/17

Division	Speciality	Project Title
Acute & Emergency Medicine	Accident and Emergency	Assessing the management of patients suspected of having sepsis with an emphasis on use of the sepsis screening tool and the effect of the outcome
Acute & Emergency Medicine	Accident and Emergency	Renal Colic - 2015 - UHL
Acute & Emergency Medicine	Accident and Emergency	How does the National Early Warning Score (NEWS) in the Emergency Department compare with routine metabolic blood markers in discriminating patients at risk of severe sepsis, escalation of care
Acute & Emergency Medicine	Accident and Emergency	Death in Department Checklist
Acute & Emergency Medicine	Accident and Emergency	Antibiotic prescribing for Urinary Tract Infection (UTI) in elderly patients in Rapid Assessment and Treatment Unit (RATU), Emergency Department.
Acute & Emergency Medicine	Accident and Emergency	Sepsis in A&E Re-Audit
Acute & Emergency Medicine	Accident and Emergency	Head Injury Audit
Acute & Emergency Medicine	Accident and Emergency	Documentation Audit - Accident and Emergency – 2016/17
Acute & Emergency Medicine	Accident and Emergency	Procedural Sedation
Acute & Emergency Medicine	Accident and Emergency	Fractured Neck of Femur Audit
Acute & Emergency Medicine	Care of the Elderly	Admissions from Care/ Nursing Homes Audit
Acute & Emergency Medicine	Care of the Elderly	Management and outcome non hip fracture older patients admitted UHL
Acute & Emergency Medicine	Care of the Elderly	Will an admissions proforma to a geriatric ward help with transfer of information to the GP on discharge?
Acute & Emergency Medicine	Care of the Elderly	Delirium screening audit
Acute & Emergency Medicine	Care of the Elderly	National Hip Fracture Database - QEH Mortality Audit
Acute & Emergency Medicine	Care of the Elderly	Ward round entries Re audit
Acute & Emergency Medicine	Care of the Elderly	Audit of Comprehensive Geriatric Assessment (CGA) on the Elderly Care Unit & Medical Wards
Acute & Emergency Medicine	Care of the Elderly	Patient Details Audit
Acute & Emergency Medicine	Care of the Elderly	Osteoporosis Fragility Fracture Audit
Acute & Emergency Medicine	Care of the Elderly	Survey of discharge summaries on inpatient fragility fractures
Acute & Emergency Medicine	Care of the Elderly	Auditing documentation on Neck of Femur Proformas
Acute & Emergency Medicine	Care of the Elderly	The Proportion of Patients Requiring Further Neuropsychological Care Post Stroke - Maple and Beech Stroke Units, UHL
Acute & Emergency Medicine	Care of the Elderly	Appropriate Usage of Consent forms for Orthogeriatric Patients

Division	Speciality	Project Title
Acute & Emergency Medicine	Care of the Elderly	Intermediate Care: Building bridges or bridging buildings?
Acute & Emergency Medicine	Diabetes	Insulin Pump Audit
Acute & Emergency Medicine	Diabetes	Normal Eating (DAFNE) Type 1 diabetes structured patient education curriculum?
Acute & Emergency Medicine	Diabetes	HbA1c reduction- Patients Referred to the Community Diabetes Team
Long Term Conditions & Cancer	Diabetes	Evaluation of Initial Management of Adult Diabetic Ketoacidosis
Acute & Emergency Medicine	Diabetes	Audit of DNAs to Community Diabetes Clinics
Acute & Emergency Medicine	Community Matrons, District Nursing & Continence Care	Trust wide Documentation Audit - Neighbourhood Nursing Team 3 2015/16
Acute & Emergency Medicine	Community Matrons, District Nursing & Continence Care	Snapshot audit of patients presently on sapphire ward
Acute & Emergency Medicine	Community Matrons, District Nursing & Continence Care	District Nursing (DN) Audit
Acute & Emergency Medicine	Community Matrons, District Nursing & Continence Care	Neighbourhood Nurse Teams - Documentation Audit 2016/17
Acute & Emergency Medicine	Community Matrons, District Nursing & Continence Care	Patient Experience - Living Our Values Survey - Neighbourhood Nursing
Acute & Emergency Medicine	Community Matrons, District Nursing & Continence Care	Crisis Management Tool
Acute & Emergency Medicine	General Medicine	PODIS Diabetic Foot Inspection
Acute & Emergency Medicine	General Medicine	A descriptive study looking at latent Tuberculosis infection treatment at a busy urban hospital with a high incidence of Tuberculosis
Acute & Emergency Medicine	General Medicine	Prescription practice when dose or route of drugs are changed
Acute & Emergency Medicine	General Medicine	IV fluid prescription on an acute medical take
Acute & Emergency Medicine	General Medicine	Fluid Balance Chart Audit
Acute & Emergency Medicine	General Medicine	Acute Medical Take: Time Taken to See Patients Post Referral
Acute & Emergency Medicine	General Medicine	Medical notes audit on the Acute Medical Unit
Acute & Emergency Medicine	General Medicine	Auditing clerking documentation for medical admissions
Acute & Emergency Medicine	General Medicine	Management of Suspected Sub-Arachnoid Haemorrhage (SAH)
Acute & Emergency Medicine	General Medicine	Have there been any changes in the quality of care received by acute inpatients with dysphagia at UHL following the introduction of a 'risk feeding' protocol?
Acute & Emergency Medicine	General Medicine	Reducing Hospital Readmission for People with Learning Disabilities in an Acute Hospital.
Acute & Emergency Medicine	General Medicine	A Comparison of Quality of Care of Stroke Patients Admitted to a Hyperacute Stroke Centre or Directly Admitted to a Stroke Unit.
Acute & Emergency Medicine	General Medicine	Hand Hygiene Facility Audit
Acute & Emergency Medicine	General Medicine	Audit of the use of NIV on medical wards and critical care units at UHL

Division	Speciality	Project Title
Acute & Emergency Medicine	Pharmacy	An Audit of Compliance with Inhaler
Acute & Emergency Medicine	Pharmacy	The impact of Electronic Prescribing on Patients in Women and Children's services
Acute & Emergency Medicine	Pharmacy	An audit measuring the incidence of medication errors and subsequent harm from errors using the NHS Safety Thermometer tool, at an acute district general hospital in London
Acute & Emergency Medicine	Respiratory Services	Smoking Cessation Referral
Acute & Emergency Medicine	Therapies	Medication Audit
Acute & Emergency Medicine	Therapies	In-Patient physiotherapy notes documentation
Acute & Emergency Medicine	Therapies	Clinical documentation Audit Neuro Physio
Acute & Emergency Medicine	Therapies	Clinical documentation Audit Community Physiotherapy
Acute & Emergency Medicine	Therapies	Does an exercise group improve patient satisfaction and outcomes in those with reduced mobility and/or a falls history compared to a control group
Acute & Emergency Medicine	Therapies	Ward Compliance with Diet and Fluid Recommendations for Patients with Dysphagia
Acute & Emergency Medicine	Therapies	Self-management and carers involvement within the Goal setting process
Acute & Emergency Medicine	Therapies	Trust wide Documentation Audit - Neuro Physiotherapy
Acute & Emergency Medicine	Therapies	Trustwide Documentation Audit - Community Physiotherapy
Acute & Emergency Medicine	Therapies	Physiotherapy Input to Patients who are Risk Fed
Acute & Emergency Medicine	Therapies	Comparison of Shoulder Class outcomes pre and post redevelopment of classes
Acute & Emergency Medicine	Therapies	Community SLT - Analysis of LATT Team use of MDT goal recording
Acute & Emergency Medicine	Therapies	Community SLT - Analysis of Unmet Therapy Goals in LATT
Acute & Emergency Medicine	Therapies	Evaluation of staff Physiotherapy Service
Acute & Emergency Medicine	Therapies	How long are voice patients staying in the service?
Acute & Emergency Medicine	Therapies	Impact of introduction of Voice Therapy Education Group on attendance rates for initial individual voice therapy appointments
Acute & Emergency Medicine	Therapies	Fractured Neck of Femur – A study into the time taken from theatre to rehabilitation. All patients and those that are medically fit
Acute & Emergency Medicine	Therapies	Improving access to physiotherapy for patients with fractures and acute soft tissue injuries
Acute & Emergency Medicine	Therapies	SCRehN Clinical Case note audit
Acute & Emergency Medicine	Therapies	Clinical documentation Audit Speech and Language Therapy (SLT)
Acute & Emergency Medicine	Therapies	Clinical documentation Audit LATT Occupational Therapy (OT)
Acute & Emergency Medicine	Therapies	Accessibility of notes across professionals

Division	Speciality	Project Title
Acute & Emergency Medicine	Therapies	WHAT information about Stroke and Aphasia is given WHEN to patients on the Stroke Care Pathway by SLTs. And how accessible is it?
Acute & Emergency Medicine	Therapies	An evaluation of housebound patients' experience of falls prevention exercises instructed by an NHS community physiotherapy team
Acute & Emergency Medicine	Therapies	Analysis of team use of a multidisciplinary goal recording tool & percentage of goal achievement
Acute & Emergency Medicine	Therapies	Analysis of unmet patient therapy goals
Acute & Emergency Medicine	Therapies	A retrospective analysis of the use and misuse of the swallow screen process currently in place at University Hospital Lewisham
Children Services	Children's Services	British Thoracic Society National Community Acquired Pneumonia Audit
Children Services	Children's Services	Neonatal Sepsis Audit
Children Services	Children's Services	The art and science of moving on
Children Services	Children's Services	Paediatric fractures & Child Abuse (NAI)
Children Services	Children's Services	Cow's Milk Allergy Audit
Children Services	Children's Services	Are we improving Type 1 Diabetes Control with Continuous Subcutaneous Insulin Infusion 'Pump' Therapy?
Children Services	Children's Services	Febrile Neutropenia: How well are we doing?
Children Services	Children's Services	Hirshprung Disease: Long term outcome and evaluation of the quality of life
Children Services	Children's Services	Paediatric diabetes patient questionnaire
Children Services	Children's Services	Quality improvement project- PSSU performance Audit
Children Services	Children's Services	Management of Bronchiolitis in January 2016
Children Services	Children's Services	Urine culture in prolonged neonatal jaundice
Children Services	Children's Services	Assessment of follow up for first presentation seizures in paediatric patients.
Children Services	Children's Services	Audit of Infection Control Standards - NICU
Children Services	Children's Services	Use of abbreviations in medical notes on the Children's Inpatient Ward.
Children Services	Children's Services	Audit of emergency equipment for patients on insulin infusion pumps
Children Services	Children's Services	NG029 - IV Fluid Therapy in Children & Young People in Hospital
Children Services	Children's Services	Sickle Cell Blood Transfusion Re Audit
Children Services	Children's Services	Paediatric Sepsis 6
Children Services	Community Children's Therapies Teams - UHL	Understanding emotional regulation within the multidisciplinary team through the use of the SCERTS model
Children Services	Children's Therapies	Report on PT and OT Patient Experience 2015-2016
Children Services	Children's Therapies	To ascertain the effectiveness of current physiotherapy intervention for CYPs with coordination difficulties.

Division	Speciality	Project Title
Children Services	Children's Therapies	Evaluating the effectiveness of and clinical reasoning for the provision of ankle foot orthoses by the Children's Community Physiotherapy Department
Children Services	Children's Therapies	Evaluating the effectiveness of and clinical reasoning for the provision of upper limb orthoses by the CYP Community Occupational Therapy Department
Children Services	Children's Therapies	CYP Occupational Therapy (OT) Specialist Seating Audit
Children Services	Children's Therapies	A multi-professional audit of the use of ROCAIP in clinical documentation in CYP Community Services.
Children Services	Children's Therapies	Mainstream Schools Core Service assessment and therapy protocol audit
Children Services	Community Paediatric Medical Team	Audit of Aetiological Investigations for Hearing Loss in Children - UHL
Children Services	Community Paediatric Medical Team - UHL	Gun and Knife Crime in Under 18's
Children Services	Community Paediatric Medical Team - UHL	CQUINS - Audit of Children with Complex Needs
Children Services	Health Visiting	Service evaluation of two year child health and developmental review study
Children Services	Health Visiting	Assessment of Emotional Health and Weight and Review of previous Health Recommendations
Children Services	Health Visiting	Post natal depression (PND) screening number two
Children Services	Health Visiting	Maternal Early Child Sustained Home visiting (MECSH)
Children Services	Health Visiting	Jaundice pathway
Children Services	Health Visiting	UNICEF Baby Friendly Audit
Children Services	Health Visiting	Post natal depression (PND) screening number three
Children Services	Health Visiting	Assessment of Emotional Health and Weight and Review of previous Health Recommendations
Children Services	Health Visiting	Clinic book audit
Children Services	Safeguarding	Audit of Pathway to Ensure those at Risk Of FGM are Identified and Referred
Children Services	Safeguarding	GCSB - Documentation Audit
Children Services	Safeguarding	Re-audit of use of Early Help Assessment
Children Services	Safeguarding	Audit of Safeguarding vulnerability pathway
Children Services	Safeguarding	Greenwich Safeguarding Children Board (GSCB) - Case File Audit
Children Services	Safeguarding	Audit into the appropriateness of the green risk assessments made in A&E at QEH
Children Services	School & Community Nursing/ Special Needs	Quality of Information Received about CVAD's Audit
Children Services	School & Community Nursing/ Special Needs	Professional Project Protocol 2014 - Child Health MSCLs - a local sleep service needed for children aged 5-19 years with complex needs?
Children Services	School & Community Nursing/ Special Needs	Re-Audit of Aseptic Non-Touch Technique Within Children's Community Nursing Team

Division	Speciality	Project Title
Children Services	School & Community Nursing/ Special Needs	6 monthly care plan review audit
Children Services	School & Community Nursing/ Special Needs	Writing up of initial assessments within 7 days of first visit
Children Services	School & Community Nursing/ Special Needs	Clinical Audit of Aseptic Non-Touch Technique within the community Children's nursing Team
Children Services	School & Community Nursing/ Special Needs	Audit of all referrals received by CCNT/Discharge Information Audit
Children Services	School & Community Nursing/ Special Needs	Outcome Recording
Children Services	School & Community Nursing/ Special Needs	Interventions following ENT sleep studies
Children Services	School & Community Nursing/ Special Needs	Wasted Home Visits
Children Services	School & Community Nursing/ Special Needs	Clinical audit of the documentation following CVAD insertion, communicated on discharge from hospital
Children Services	School & Community Nursing/ Special Needs	6 monthly care plan review
Children Services	School & Community Nursing/ Special Needs	Joint Working to Promote Toileting Independence Audit
Children Services	School & Community Nursing/ Special Needs	Audit of information on enteral feeding care plans
Children Services	School & Community Nursing/ Special Needs	Use of Patient Group Direction's
Children Services	School & Community Nursing/ Special Needs	User Engagement/ Drop In Re-audit - UHL
Pathology	Pathology	Clinical Audit of Enzyme activity below the laboratory reference range
Pathology	Pathology	Causes of Hypoamylasaemia/ Low Activity in Lab
Pathology	Pathology - Cross	Octaplex Re-audit
Pathology	Pathology (incl. Micro & Haem)	Hypertriglyceridaemia and Acute Pancreatitis
Pathology	Pathology - Cross	Audit on histopathological reporting turnaround times of colorectal cancer resection specimens 2015
Pathology	Pathology - Cross	An Audit on GI cancer MDT meeting discussions of BCSP-generated cancer cases 1 April 2015 – 31 March 2016, University Hospital Lewisham
Pathology	Pathology - Cross	An Audit on the Turnaround Time of Cervical Histology April to September 2016 Cellular Pathology Department, University Hospital Lewisham
Pathology	Pathology - Cross	An audit on the Bowel Cancer Screening Programme Polyps at the University Hospital Lewisham 1 April 2015 – 31 March 2016
Pathology	Pathology - Cross	Audit on the turnaround times of BCSP histology specimens, UHL, 2015/16
Pathology	Pathology - Cross	Pathologist attendance at cancer specific multidisciplinary team meetings University Hospital Lewisham 1 January – 31 December 2015

Division	Speciality	Project Title
Pathology	Pathology - Cross	Pathologist attendance at cancer specific multidisciplinary team meetings University Hospital Lewisham 1 January – 31 December 2016
Long Term Conditions & Cancer	Cardiology	Glycaemic Control in Known Patient with Diabetes Admitted with Acute Coronary Syndrome to Ward 4
Long Term Conditions & Cancer	Cardiology	Cardiac Angiography Audit
Long Term Conditions & Cancer	Community Heart Failure Team	Trust wide Documentation & Data Quality Audit 2016/17
Long Term Conditions & Cancer	Community Heart Failure Team	Community Heart Failure Satisfaction Survey (2016/17)
Long Term Conditions & Cancer	Community Home Enteral Nutrition Team	Nutricia Bolus Tube Feeding Audit
Long Term Conditions & Cancer	Dermatology	Bullous Pemphigoid Audit
Long Term Conditions & Cancer	Dermatology	Closing the Loop: Phototherapy Services at University Hospital Lewisham
Long Term Conditions & Cancer	Dermatology	Dermatology Dept. Notekeeping Audit
Long Term Conditions & Cancer	Dermatology	Vitamin D levels in melanoma patients
Long Term Conditions & Cancer	Foot Health	CG10 - Diabetic Foot Assessments 2015
Long Term Conditions & Cancer	Gastroenterology	Re audit - Weight recording on an inpatient gastroenterology and cardiology ward
Long Term Conditions & Cancer	Gastroenterology	Audit of Acute Pancreatitis
Long Term Conditions & Cancer	Gastroenterology	ERCP audit
Long Term Conditions & Cancer	Gastroenterology	Endoscopy Mortality and Readmission Audit (Jan-Jun 2014)
Long Term Conditions & Cancer	Gastroenterology	Weight recording on an inpatient gastroenterology and cardiology ward.
Long Term Conditions & Cancer	MacMillan Cancer Services	Audit of preferred place of dying for patients registered on the community specialist palliative care caseload
Long Term Conditions & Cancer	Neurology	Report for Neurological inpatient activity September 2014 – September 2015
Long Term Conditions & Cancer	Neurology	18 Week Wait Audit - Neurology UHL
Long Term Conditions & Cancer	Nutrition & Dietetics	QS24/CG32 - Nutrition Support in Adults 2015
Long Term Conditions & Cancer	Nutrition & Dietetics	A service evaluation characterising the internal hospital food environment: to what extent do 6 London NHS hospitals promote healthy workplaces
Long Term Conditions & Cancer	Nutrition & Dietetics	Audit to determine the accuracy of the Nutritional Screening Tool
Long Term Conditions & Cancer	Nutrition & Dietetics	Lewisham and Greenwich NHS Trust Reaudit of adherence to NPSA alert PSA002: Reducing the harm caused by misplaced nasogastric feeding tubes in adults, children and infants. March 2011
Long Term Conditions & Cancer	Nutrition & Dietetics	Audit of Dietetic Snacks
Long Term Conditions & Cancer	Nutrition & Dietetics	'Cooked Breakfast' Provision Re-audit
Long Term Conditions & Cancer	Nutrition & Dietetics	Audit of 10 week weight reducing groups in 2015
Long Term Conditions & Cancer	Nutrition & Dietetics	PILOT of Dietetic Outcomes Critical Care June- August 2015
Long Term Conditions & Cancer	Nutrition & Dietetics	DNA analysis of Paediatric Dietician Allergy Clinic(2015)

Division	Speciality	Project Title
Long Term Conditions & Cancer	Nutrition & Dietetics	Nutritional Screening Tool Re-Audit
Long Term Conditions & Cancer	Nutrition & Dietetics	Audit of Dietetic Snack Bags
Long Term Conditions & Cancer	Nutrition & Dietetics	Weight reduction, Community Diabetes Dietician
Long Term Conditions & Cancer	Nutrition & Dietetics	Are Patients weighed within 24hours of admission?
Long Term Conditions & Cancer	Nutrition & Dietetics	Paediatric Inpatients Nutritional Risk Assessment – Re-audit
Long Term Conditions & Cancer	Nutrition & Dietetics	Paediatric Inpatients Nutritional Risk Assessment – Re-audit
Long Term Conditions & Cancer	Nutrition & Dietetics	Macmillan Dietetic Patient Satisfaction Survey
Long Term Conditions & Cancer	Nutrition & Dietetics	TPN Line Sepsis Audit
Long Term Conditions & Cancer	Nutrition & Dietetics	Audit of patient experience of transition from paediatric to adult care in cystic fibrosis service at Lewisham Hospital
Long Term Conditions & Cancer	Radiology	Diagnostic Accuracy of Ultrasound Guided FNAC/Core Biopsy of Axillary Nodes in Proven Breast Cancer - Retrospective
Long Term Conditions & Cancer	Radiology	Auditing reporting accuracy of non-permanent- agency x-ray reporting radiographer.
Long Term Conditions & Cancer	Radiology	MRI Patient Satisfaction Audit
Long Term Conditions & Cancer	Radiology	Appropriateness of CT Pulmonary Angiography Requests
Long Term Conditions & Cancer	Radiology	An audit to assess departmental adherence to recommendations for notification of urgent or significant unexpected GP ultrasound findings
Long Term Conditions & Cancer	Radiology	CT Brain for head injury - are we meeting the 1 hour target
Long Term Conditions & Cancer	Radiology	Audit into MRI Foot performed to investigate osteomyelitis of the foot in diabetic patients
Long Term Conditions & Cancer	Radiology	MRI scanning at QEH: cord compression and cauda equina
Long Term Conditions & Cancer	Radiology	Radiographer Image Reporting Audit
Long Term Conditions & Cancer	Radiology	An audit to assess compliance with NICE head injury guidelines regarding the appropriateness of scan and reporting times
Long Term Conditions & Cancer	Radiology	Audit of paediatric in-patient ultrasound waiting time
Long Term Conditions & Cancer	Radiology	Audit of 'Adequate Completion and Quality of Ultrasound referrals received from GPs'
Long Term Conditions & Cancer	Radiology	Radiographer Image Reporting audit
Long Term Conditions & Cancer	Radiology	DAT Scan audit at UHL
Long Term Conditions & Cancer	Radiology	Audit of MR Arthrograms of the shoulder
Long Term Conditions & Cancer	Radiology	Audit to Optimise CT RUB imaging in investigation of Renal Colic
Long Term Conditions & Cancer	Radiology	Imaging the Cervical Spine in Trauma
Long Term Conditions & Cancer	Radiology	UHL Annual MRI Safety Audit
Long Term Conditions & Cancer	Radiology	Retrospective audit of CXR conducted APvs PA
Long Term Conditions & Cancer	Radiology	Retrospective audit to determine the quality of PA CXr
Long Term Conditions & Cancer	Radiology	Audit of Neuro Radiologist review of in-house reporting
Long Term Conditions & Cancer	Rheumatology	Ankylosing Spondylitis Audit

Division	Speciality	Project Title
Long Term Conditions & Cancer	Rheumatology	TA130 - Rheumatoid arthritis - adalimumab, etanercept and Infliximab 2015
Long Term Conditions & Cancer	Rheumatology	Service evaluation of early arthritis clinic
Long Term Conditions & Cancer	Rheumatology	Audit of anti TNFa use in patients with psoriatic arthritis (PsA)
Long Term Conditions & Cancer	Rheumatology	Audit of anti TNFa use in patients with Ankylosing Spondylitis (AS)
Long Term Conditions & Cancer	Rheumatology	Audit on the frequencies of reporting important adverse prognostic features in colorectal cancer resection specimens UHL
Nursing and Clinical Quality	Health and Safety	CAS (Central Alerting System) Alerts Audit
Nursing and Clinical Quality	Infection Prevention and Control	Sharps Audit
Nursing and Clinical Quality	Infection Prevention and Control	Isolation Precautions - Laurel Ward
Nursing and Clinical Quality	Infection Prevention and Control	Personal Protective Equipment - Laurel Ward
Nursing and Clinical Quality	Infection Prevention and Control	Personal Protective Equipment - Mulberry Ward
Nursing and Clinical Quality	Infection Prevention and Control	Isolation Precautions - Mulberry Ward
Nursing and Clinical Quality	Infection Prevention and Control	Personal Protective Equipment - CCU-UHL
Nursing and Clinical Quality	Infection Prevention and Control	Personal Protective Equipment - Cherry Ward
Nursing and Clinical Quality	Infection Prevention and Control	Isolation Precautions - Cherry Ward
Nursing and Clinical Quality	Infection Prevention and Control	Isolation Precautions - Cedar Ward
Nursing and Clinical Quality	Infection Prevention and Control	Personal Protective Equipment - Cedar Ward
Nursing and Clinical Quality	Infection Prevention and Control	Personal Protective Equipment - Larch Ward
Nursing and Clinical Quality	Infection Prevention and Control	Isolation Precautions - Juniper Ward
Nursing and Clinical Quality	Infection Prevention and Control	Personal Protective Equipment - Juniper Ward
Nursing and Clinical Quality	Infection Prevention and Control	Isolation Precautions - Children's Inpatient Ward
Nursing and Clinical Quality	Infection Prevention and Control	Personal Protective Equipment - CHILDRENS INPATIENT WARD
Nursing and Clinical Quality	Infection Prevention and Control	Isolation Precautions - Maple Ward
Nursing and Clinical Quality	Infection Prevention and Control	Personal Protective Equipment - Maple Ward
Nursing and Clinical Quality	Infection Prevention and Control	Isolation Precautions - NICU
Nursing and Clinical Quality	Infection Prevention and Control	Personal Protective Equipment - NICU
Service Delivery	Resuscitation Services	DNA-CPR audit (UHL)
Service Delivery	Resuscitation Services	DNA-CPR Audit (QEH)
Service Delivery	Resuscitation Services	Early Warning Score Audit
Service Delivery	Resuscitation Services	Deprivation Of Liberty Safeguards (DOLS) Audit
Service Delivery	Resuscitation Services	Early Warning Score Audit
Surgery	Anaesthetic & Pain Relief	Cancellations on the day of Surgery
Surgery	Anaesthetic & Pain Relief	Midwifery knowledge on breastfeeding and analgesics
Surgery	Anaesthetic & Pain Relief	Scratching the surface: tackling pruritis due to neuraxial opiates

Division	Speciality	Project Title
Surgery	Anaesthetic & Pain Relief	Audit regarding Peri- and Postoperative Care of Elective Colorectal Surgical Patients at LGT NHS Trust
Surgery	Anaesthetic & Pain Relief	Investigating medication adherence in chronic pain patients
Surgery	Anaesthetic & Pain Relief	Postoperative Rescue Analgesia
Surgery	Anaesthetic & Pain Relief	Peri-operative antibiotics in joint replacement surgery
Surgery	Anaesthetic & Pain Relief	Audit of Labour epidurals and blood tests
Surgery	Anaesthetic & Pain Relief	Recognition and Treatment of Sepsis – A Questionnaire
Surgery	Anaesthetic & Pain Relief	Stop before you block
Surgery	Anaesthetic & Pain Relief	Epidural top-ups for C sections
Surgery	Anaesthetic & Pain Relief	Efficiency of Elective LSCS lists at UHL
Surgery	Anaesthetic & Pain Relief	Emergency Buzzer Audit
Surgery	Anaesthetics	Midwifery Understanding of epidurals for labour analgesia
Surgery	Anaesthetic & Pain Relief	Closed Loop Audit: ICU iCare discharge summary completion
Surgery	Community Hip Team	Re-audit of Patient Satisfaction Questionnaires 2015-2016 - UHL
Surgery	Community Hip Team	Re-audit of length of stay for patients who have had THR or TKR at Lewisham Hospital and have been discharged with the Community Orthopaedic Service - 2016/07
Surgery	Community Hip Team	Re-Audit of Patient Satisfaction Questionnaires
Surgery	ENT	The assessment of patients who have undergone pharyngeal pouches repair
Surgery	ENT	Audit on Patient's Compliance to Proton Pump Inhibitor Treatment
Surgery	ENT	Out-patient DNA rates on different days of the week
Surgery	ENT	Skin Margins and Total Excision for Skin Cancers
Surgery	ENT	Coblation of the turbinates in paediatric patients
Surgery	ENT	CG60 - Surgical Treatment of OME in children - comparison to NICE guidelines - Re-audit
Surgery	General Surgery	Readmission rate following colorectal resections within an ERAS programme
Surgery	General Surgery	An audit to identify the number of TRUS biopsy related sepsis with the type of bacteria at Queen Elizabeth Hospital between January 2014 and September 2015
Surgery	General Surgery	Management of Acute Pancreatitis at LGT
Surgery	General Surgery	Consultant Anaesthetic presence prior to laparotomies at QEH
Surgery	General Surgery	Clinical audit of management of Ipsilateral UDT and inguinal hernia in under 3 months of age
Surgery	General Surgery	Retrospective analysis of early laparoscopy cholecystectomy in UHL
Surgery	General Surgery	Audit of the quality of operative notes in emergency and elective General Surgery

Division	Speciality	Project Title
Surgery	General Surgery	Appropriate Gentamicin Dosing - Height, Weights and Dose Calculation
Surgery	General Surgery	An Audit of Antimicrobial Prophylaxis Prescribing in General Surgery and Obstetrics and Gynaecology at University Hospital Lewisham
Surgery	General Surgery	A review of appendectomy in the over 50's patient population in a DGH
Surgery	General Surgery	Accuracy of radiological staging of colorectal cancers
Surgery	ICU	Critical Care Audit on current nutrition policy, practice and compliance
Surgery	ICU	Assessment of ITU to Ward Step-downs at QEH ITU
Surgery	ICU	New Observation Booklet Trial
Surgery	ICU	Temperature monitoring on Critical care
Surgery	ICU	Critical care Family Need Inventory Audit
Surgery	ICU	Thromboprophylaxis prescription & documentation in patients in Intensive Care
Surgery	ICU	Junior Doctor satisfaction with ICU admission and daily ward round documentation
Surgery	Orthopaedics	Reliability of CT scan in hip fractures
Surgery	Orthopaedics	Consent Audit - Orthopaedics UHL
Surgery	Orthopaedics	Patient/ Carer Satisfaction with Consent
Surgery	Orthopaedics	Reaudit of patient satisfaction questionnaires
Surgery	Orthopaedics	Reaudit of length of stay for patients who have had THR or TKR at Lewisham Hospital and have been discharged with the Community Orthopaedic Service
Surgery	Orthopaedics	Audit on outpatient letters between the Trauma & Orthopaedics department and Primary care for completeness in clinical patient information
Surgery	Orthopaedics	Paediatric Orthopaedic Trauma Snapshot
Surgery	Theatres	Emergency appendectomy: assessing the true impact on patients following discharge
Surgery	Theatres	WHO (World Health Organisation) Safer Surgery Checklist Audit - QEH
Surgery	Theatres	International recruitment of nurses
Surgery	Theatres	WHO (World Health Organisation) Safer Surgery Checklist Audit - UHL
Surgery	Urology	Patient satisfaction in Urology Clinics QEH
Surgery	Urology	Patient satisfaction of Inpatient Services at QEH & UHL
Women & Sexual Health	Gynaecology	Margins/ Size of Treatment Biopsy to include LA/GA rate and reasons for GA
Women & Sexual Health	Gynaecology	Glandular Abnormalities
Women & Sexual Health	Gynaecology	Patient Satisfaction Survey of Colposcopy Outreach
Women & Sexual Health	Gynaecology	Waiting Times Audit

Division	Speciality	Project Title
Women & Sexual Health	Gynaecology	Hyponatremia in Labour
Women & Sexual Health	Gynaecology	Medical Education Audit about how satisfied medical students about the learning received at UHL Obs & Gynae Department.
Women & Sexual Health	Gynaecology	Audit of Ovarian cyst and Tumour marker trends
Women & Sexual Health	Gynaecology	Post Menopausal Bleeding (PMB) Audit
Women & Sexual Health	Maternity Services	Operative Vaginal Deliveries - QEH 2015
Women & Sexual Health	Maternity Services	Obesity Audit - QEH
Women & Sexual Health	Maternity Services	Joint Neonatal / Obstetric Antibiotic audit
Women & Sexual Health	Maternity Services	Active mothers in Bexley
Women & Sexual Health	Maternity Services	Postpartum Haemorrhage Audit 2016-17
Women & Sexual Health	Maternity Services	Intermittent Auscultation
Women & Sexual Health	Maternity Services	Electronic Fetal Monitoring
Women & Sexual Health	Maternity Services	Audit on Inpatient management of women with Severe Pre-Eclampsia (PET)
Women & Sexual Health	Maternity Services	Postnatal Readmissions Audit - Maternity QEH
Women & Sexual Health	Maternity Services	Third and fourth degree Tear Audit
Women & Sexual Health	Maternity Services	Interventions to reduce pre-term births in Lewisham: Preliminary Inquiry
Women & Sexual Health	Maternity Services	Evaluation of a Healthy Lifestyle Class Suitable for Pregnancy
Women & Sexual Health	Maternity Services	Operative Vaginal Deliveries
Women & Sexual Health	Maternity Services	Electronic Fetal Monitoring
Women & Sexual Health	Maternity Services	Audit of Hyponatraemia in Labour
Women & Sexual Health	Maternity Services	Induction of Labour Audit - UHL
Women & Sexual Health	Maternity Services	Obesity Audit - UHL
Women & Sexual Health	Maternity Services	Perineal Trauma Audit - UHL
Women & Sexual Health	Maternity Services	Postnatal Readmissions Audit
Women & Sexual Health	Maternity Services	Shoulder Dystocia Audit - UHL
Women & Sexual Health	Maternity Services	Vaginal Breech Audit - UHL
Women & Sexual Health	Maternity Services	Fetal Abnormality Audit - UHL
Women & Sexual Health	Maternity Services	Multiple Pregnancy Audit - UHL
Women & Sexual Health	Maternity Services	Oxytocin Use in Labour Audit - UHL
Women & Sexual Health	Sexual and Reproductive Health	Pill Prescribing patterns in trust Sexual Health Clinic

Lewisham and Greenwich NHS Trust

Trust Headquarters:

**University Hospital Lewisham**

Lewisham High Street

Lewisham

London

SE13 6LH

Telephone: 020 8333 3000

**Queen Elizabeth Hospital**

Stadium Road

Woolwich

London

SE18 4QH

Telephone: 020 8836 6000

Healthier Communities Select Committee		
Title	Information item: notes of meeting with Guy's and St Thomas' NHS Foundation Trust	
Contributor	Scrutiny Manager	Item 8
Class	Part 1 (open)	20 July 2017

## 1. Overview

This note advises members of a meeting on 15 June 2017 between Councillor Hall (Chair of Overview & Scrutiny), Councillor Muldoon (Chair of Healthier Communities Select Committee) and Amanda Pritchard (Chief Executive).

## 2. Recommendations

The Committee is recommended to note this information.

## 3. Summary of key points noted

- Guy's and St Thomas' NHS Foundation Trust (GST) contract with almost every CCG in the country, and many boroughs (e.g. for HIV services), so about 580 contracts in all.
- Around £300m of GST's income comes from south-east London, around £100m comes from south-west London, around £100m from North London, and around £500m comes from NHS specialist commissioning, which comes from all over the country.
- GST are working closer with partner organisations across south-east London to upskill and create local centres of expertise so that patients don't always have to come to London. Work is currently focused on a number of specific areas, including, for example, cardiovascular, paediatrics, and cancer.
- As well as money, quality and workforce are huge challenges. GST staff have been under relentless pressure for some time. Many are also struggling with accommodation costs and transport reliability. GST are also finding it harder to recruit specialists, and an increasing number of roles are going unfilled. The best way to get quality right across south-east London is not to compete, but to work together with partners.
- The financial position of healthcare providers in south-east London cannot be considered in a vacuum. It's in everyone's interest that all providers in the area are sustainable. GST has a real problem with the level of demand and the closure of another A&E in the area would lead to more unplanned demand – something that GST are concerned about.
- As GPs come together in bigger centres across south-east London, and more services are provided in different areas, it is hoped that this will help with managing demand on hospital-based services. South-east London needs more GPs, working extended hours and working differently. Neighbourhood hubs will be an important part of avoiding the need to come to hospital. Hospital staff and community-based staff employed by the Trust could work locally in GP centres.
- STPs are not going to solve national financial problems with the NHS. They will give providers an opportunity to do some things better via collaboration. King's Health Partners should be the driving force behind the south-east London STP strand on specialised services, for example. GST is also working on other models such as leading a Group of hospitals/ providers as part of the solution to address the

sustainability challenge. But there is no magic bullet for NHS financial problems. GST itself has to achieve significant savings of around £80/90m a year.

- GST are finding that the public are often confused about at what level decisions about different changes are being made, with STPs, CCGs and national commission. There are some moves back towards London-wide specialised commissioning.

If you have any questions about the content of this report please contact John Bardens (Scrutiny Manager) on 0208 314 9976 or [john.bardens@lewisham.gov.uk](mailto:john.bardens@lewisham.gov.uk).

Healthier Communities Select Committee			
Report Title	Developing Lewisham's Adult Social Care On-line Activity		
Contributors	Whole System Model of Care Project Manager Single Point of Access (SPA)	Item No.	9
Class	Part 1	Date:	11.07.2017

## 1. Purpose

- 1.1 This report provides members of the Healthier Communities Select Committee with an update on the development of on-line business processes in adult social care.

## 2. Recommendations

- 2.1 Members of the Healthier Communities Select Committee are invited to note the current objectives around the development of on-line business processes in adult social care, located at the Single Point of Access.

## 3. Strategic Context

- 3.1 The concept of 'Digital by Default' is a government initiative for the way in which the Government wishes to engage its citizens, Government Digital Strategy, Cabinet Department (2012).
- 3.2 This development also reflects the strategic direction articulated in:
- The NHS Five Year Forward View (October 2014) and the Next Steps (March 2017) which references the use of digital technologies for efficiencies.
  - The planning guidance published on 22 December 2015 which sets out the requirement for the NHS to produce five year Sustainability and Transformation Plans (STP) in which the digital vision is clear.
  - Care Act 2014 - places a duty on adult social care to provide residents with the right advice and information/guidance to not only promote independence and wellbeing, but also to delay/prevent/respond to the onset of frailty and deterioration in long term health conditions.

## 4. Local Context

- 4.1 Lewisham's Single Point of Access has a team of advisers supporting a variety of care and health services covering Adult Social Care (provided via the Social Care Access and Information Team/SCAIT), Community Nursing and Carer's Lewisham all available on one

phone number for the public to easily access. It acts as a gateway for both phone and digital/on-line contacts.

4.2 The importance of digital offers are also referenced locally in:-

- *Our Healthier South East London*, the STP for South East London published in November 2016. It encourages health and care partners to develop a digital road map.
- *Core Strategy Lewisham Local Development Framework Document (June 2011)* recognises that in order to harness growth digital technologies should be promoted.

4.3 Telephone demand in the Single Point of Access for all services remains high. By encouraging electronic uptake there is less pressure on telephone demand which makes it easier for those to make contact who have no electronic means.

## **5. What is the digital/on-line approach in adult social care?**

5.1 These new processes involve the public using the Council's adult social care website to navigate trusted electronic advice, information and guidance to help find tailored solutions to care and support needs. In so doing the overall aim of promoting better health, well-being and independence is achieved. Residents and their carers can also make electronic referrals direct to adult social care via a personal electronic account, should they be unable to find the right help themselves.

5.2 It is recognized that engaging the public electronically is a very effective way to disseminate trusted advice and information, particularly as it can be kept up to date easily. Through monitoring month on month it is shown that the numbers using the Lewisham adult social care website is steadily growing. <sup>1</sup> The information provided on the site spans all aspects of care, health, and support in the Borough ranging from that provided on behalf of the Council and Lewisham's Clinical Commissioning Group/Lewisham and Greenwich NHS Trust (LGT), to services provided by the voluntary sector. It covers all types of provision from where a local diabetes group meet, to where to get personal care for a loved one.

5.3 There are plans to make digital information more intuitive for residents by putting together tailored options to support lifestyle decision making. It builds on the current health and well-being directory held on the Council's website. <sup>2</sup>

5.4 Alongside the electronic advice and information held on the website there are currently two electronic forms which help to navigate electronic choices for care and health support. One form is to be completed by those who may need extra help and the other for carers. Both forms can be completed by a helper on behalf of someone else.

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<sup>1</sup> From Google analytics page visits to the Lewisham adult social care pages: April 2017 – 8000 hits and May 2017 - 12200 hits.

<sup>2</sup> Please refer to the Social Prescribing paper presented alongside this paper.

### **5.3.1 Well-being self-assessment for people who need care**

On this form, if a person thinks they need care or extra help, they can enter information about themselves to:

- help identify what support they need
- get a list of independent support providers
- find out if they are likely to be eligible for adult social care support
- get an idea of how much they might be charged for care.

It takes a few minutes to complete this form and as a result it generates helpful local information for self-care. They can also request a full adult social care assessment if they are unable to find the right help. On submission they are advised they will be contacted within five working days to agree the next steps with adult social care staff. To submit this form an account must be created using an email address.

### **5.3.2 Self-assessment for carers who need extra help**

On this form, a carer (an adult who cares for another adult) can enter detailed information to tell the Council about the care they provide, and in return receive useful information about support available for carers. The form takes about one hour to complete.

Once they have submitted the form they will be assessed as to whether they are eligible for extra help by adult social care staff, who again will contact them within five working days and agree next steps.

## **6. Lewisham's Single Point of Access on-line activity to date and next steps**

- 6.1 These new self-assessment forms were launched at the beginning of May 2017. Since that date there has been a 30% increase in web site traffic, with 27 referrals made electronically to adult social care.
- 6.2 The Lewisham Digital Go On campaign is working collaboratively to encourage digital take up in the Borough. <sup>3</sup>
- 6.3 Work continues with the web team to generate management reports to monitor the benefits from these new on line procedures.
- 6.4 Professionals are now encouraged to make contact via email to support the new electronic approach.
- 6.5 Plans are in place to further refresh the look and feel to the adult social care website to make it even more user friendly.

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<sup>3</sup> Lewisham is the second highest borough in London for electronic information uptake- this is shown in the way the public are utilising electronic GP appointments and electronic repeat prescriptions. This is significant as it reinforces the potential of this new electronic process. Data is provided by 'doteveryone' via a Gusto report commissioned by Lloyds bank (2017). As a high level summary it shows a 10% increase in on-line uptake of devices in Lewisham with the comparative average from other boroughs being around 4 %.

## **7. Communication and Engagement**

- 7.1 The benefits of these on-line tools are reported on a monthly basis to the Adult Social Care Improvement Board (ASCIB).
- 7.2 Collaboration continues with refreshing the website in line with comments from stakeholders. Most recently visits have been made to consult on these offers with the local bowel cancer support group and with the Parkinson's group.
- 7.3 The use of the fax line has been ended in accordance with data security guidelines (available for emergency use only as part of business continuity).

## **8 Financial Implications**

- 8.1 There are no financial implications arising from this report. Any future activity or commitments arising from activity to support the development of online activity will need to be agreed by the delivery organisations concerned and be subject to confirmation of resources.

## **9 Legal implications**

- 9.1 There are no legal implications associated with this level of on-line activity.

## **10 Crime and Disorder Implications**

- 10.1 There are no specific crime and disorder implications arising from this report.

## **11 Equalities Implications**

- 11.1 Significant attention has been paid to the equalities impact of this new service. It is recognised in adult social care that many, particularly older isolated residents may not have access to an electronic device.
- 11.2 Members are invited to note the following points which have been taken into account in order to extend benefits to all Lewisham residents, and at least ensure that none suffer a disadvantage:-
- Testing of this new platform prior to launch involved users of services and carers in Lewisham.
  - As a result of the implementation the Single Point of Access phone lines have become more available to those not able to use the on-line facility.
  - The library service will soon offer iPads for loan to the housebound via its mobile service (planned).
  - To promote uptake patients in University Hospital Lewisham with an electronic device will be supported to learn about this new help. It is hoped this should help discharge planning.
  - Digital champions in community hubs will help support the completion of these forms/using the website for information, intended for those who cannot access the internet.

- Staff in adult social care are well informed about the availability of advice and information and can supply similar advice to what is on the website over the phone.
- Staff in adult social care continue to process self-referrals via phone contacts.
- The forms font can be automatically increased, and other translations can be made available on request which will help those who do not have English as a first language.

## **12 Environmental Implications**

- 12.1 There are no specific environmental implications arising from this report.

## **13 Conclusion**

- 13.1 Members are invited to note the contents of the report.

*If you have problems opening this document, please contact [karen.crane@lewisham.gov.uk](mailto:karen.crane@lewisham.gov.uk)*



<b>Healthier Communities Select Committee</b>			
Title	Select Committee work programme		
Contributor	Scrutiny Manager	Item	10
Class	Part 1 (open)	20 July 2017	

## 1. Purpose

To advise Members of the proposed work programme for the municipal year 2017-18, and to decide on the agenda items for the next meeting.

## 2. Summary

- 2.1 At the beginning of the municipal year, each select committee drew up a draft work programme for submission to the Business Panel for consideration.
- 2.2 The Business Panel considered the proposed work programmes of each of the select committees on 22 May 2017 and agreed a co-ordinated overview and scrutiny work programme. However, the work programme can be reviewed at each Select Committee meeting so that Members are able to include urgent, high priority items and remove items that are no longer a priority.

## 3. Recommendations

3.1 The Committee is asked to:

- note the work plan attached at **Appendix B** and discuss any issues arising from the programme;
- specify the information and analysis required in the report for each item on the agenda for the next meeting, based on desired outcomes, so that officers are clear about what they need to provide;
- review all forthcoming key decisions, attached at **Appendix C**, and consider any items for further scrutiny;

## 4. The work programme

4.1 The work programme for 2017/18 was agreed at the Committee's meeting on 25 April 2017.

4.2 The Committee is asked to consider if any urgent issues have arisen that require scrutiny and if any existing items are no longer a priority and can be removed from the work programme. Before adding additional items, each item should be considered against agreed criteria. The flow chart attached at **Appendix A** may help Members decide if proposed additional items should be added to the work programme. The Committee's work programme needs to be achievable in terms of the amount of meeting time available. If the Committee agrees to add additional item(s) because they are urgent and high priority, Members will need to consider

which medium/low priority item(s) should be removed in order to create sufficient capacity for the new item(s).

## 5. The next meeting

5.1 The following reports are scheduled for the meeting on 7 September 2017:

Agenda item	Review type	Link to Corporate Priority	Priority
<b>Sustainability and transformation plan update</b>	Standard item	Active, healthy citizens	High
<b>Social prescribing in-depth review evidence session</b>	In-depth review	Active, healthy citizens	Medium
<b>CQC inspection of Lewisham and Greenwich NHS Trust</b>	Standard item	Active, healthy citizens	High
<b>Devolution pilot update</b>	Standard item	Active, healthy citizens	Medium
<b>Healthwatch annual report</b>	Standard item	Active, healthy citizens	Medium

5.2 The Committee is asked to specify the information and analysis it would like to see in the reports for these items, based on the outcomes the Committee would like to achieve, so that officers are clear about what they need to provide for the next meeting.

## 6. Financial Implications

There are no financial implications arising from this report.

## 7. Legal Implications

In accordance with the Council's Constitution, all scrutiny select committees must devise and submit a work programme to the Business Panel at the start of each municipal year.

## 8. Equalities Implications

8.1 The Equality Act 2010 brought together all previous equality legislation in England, Scotland and Wales. The Act included a new public sector equality duty, replacing the separate duties relating to race, disability and gender equality. The duty came into force on 6 April 2011. It covers the following nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

8.2 The Council must, in the exercise of its functions, have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- advance equality of opportunity between people who share a protected characteristic and those who do not.
- foster good relations between people who share a protected characteristic and those who do not.

8.3 There may be equalities implications arising from items on the work programme and all activities undertaken by the Select Committee will need to give due consideration to this.

## **9. Date of next meeting**

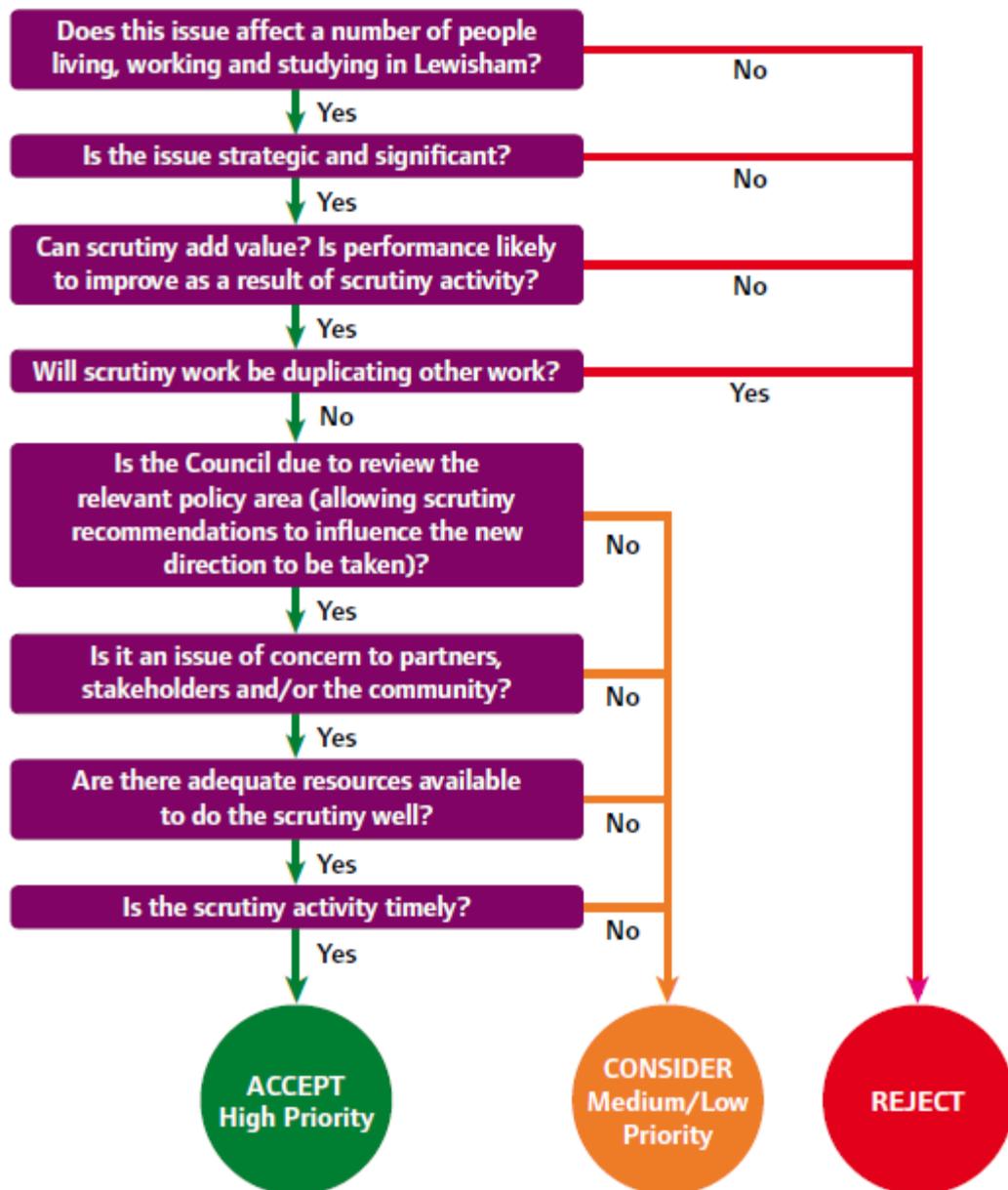
The date of the next meeting is Thursday 7 September 2017.

### **Background Documents**

Lewisham Council's Constitution

Centre for Public Scrutiny: the Good Scrutiny Guide

## Scrutiny work programme – prioritisation process



Healthier Communities Select Committee work programme 2017/18

Programme of work

Work item	Type of item	Priority	Strategic priority	Delivery deadline	25-Apr	13-Jun	20-Jul	07-Sep	01-Nov	30-Nov	24-Jan	06-Mar
Lewisham future programme	Standard item	High	CP9	Ongoing								
Sustainability and transformation plan	Standard item	Medium	CP9	Apr								
Confirmation of Chair and Vice Chair	Constitutional req	High	CP9	Apr								
Select Committee work programme 2017/18	Constitutional req	High	CP9	Apr								
CCG update on primary care changes	Standard item	Medium	CP10	Apr								
In-depth review	In-depth review	Performance	CP9	Dec		Scope		Evidence session	Evidence session	Report		
SLaM quality account	Performance monitoring	Medium	CP9	Jun								
Neighbourhood care networks update	Standard item	Medium	CP9	Jun								
Adult Safeguarding Board introduction	Performance monitoring	High	CP9	Jul								
Grove Park Health Centre	Standard item	High	CP10	Jul								
Lewisham and Greenwich NHS Trust Quality Account	Performance monitoring	Medium	CP9	Jul								
CCG review of access to urgent care	Standard item	High	CP10	Jul								
Information item: notes of meeting with GST	Standard item	Medium	CP9	Jul								
Information item: Developing Lewisham's Adult Social Care On-line Activity	Standard item	Medium	CP9	Jul								
CQC inspection of Lewisham and Greenwich NHS Trust	Performance monitoring	Performance	CP9	Sep								
Devolution pilot update	Standard item	Medium	CP10	Sep								
Healthwatch annual report	Standard item	Medium	CP9	Sep								
Lewisham Safeguarding Adults Board	Standard item	Medium	CP9	Nov								
Lewisham hospital update (systems resilience)	Standard item	High	CP9	Nov								
Public health annual report	Performance monitoring	Medium	CP9	Nov								
Partnership commissioning intentions	Performance monitoring	Medium	CP9	Nov								
Adult social care charging framework	Standard item	High	CP9	Jul								
Integration review update	Performance monitoring	Medium	CP9	Nov								
CQC update on care homes	Performance monitoring	Medium	CP9	Sep								
CQC inspections of SLaM	Performance monitoring	High	CP9	Nov								
Leisure centre contract	Performance monitoring	Medium	CP9	Nov								
Transition from children's to adult social care	Standard item	Medium	CP9	Nov								
Adult safeguarding	Performance monitoring	High	CP9	Jan								
Adult learning Lewisham annual report	Performance monitoring	Medium	CP9	Jan								
Delivery of the Lewisham Health & Wellbeing priorities	Performance monitoring	High	CP9	Mar								

	Item completed
	Item on-going
	Item outstanding
	Proposed timeframe
	Item added

Meetings						
1)	Tuesday	25 April		5)	Wednesday	01 November
2)	Tuesday	13 June		6)	Thursday	30 November
3)	Thursday	20 July		7)	Wednesday	24 January
4)	Thursday	7 September		8)	Tuesday	6 March

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## FORWARD PLAN OF KEY DECISIONS

### Forward Plan July 2017 - October 2017

This Forward Plan sets out the key decisions the Council expects to take during the next four months.

Anyone wishing to make representations on a decision should submit them in writing as soon as possible to the relevant contact officer (shown as number (7) in the key overleaf). Any representations made less than 3 days before the meeting should be sent to Kevin Flaherty, the Local Democracy Officer, at the Council Offices or [kevin.flaherty@lewisham.gov.uk](mailto:kevin.flaherty@lewisham.gov.uk). However the deadline will be 4pm on the working day prior to the meeting.

A "key decision"\* means an executive decision which is likely to:

- (a) result in the Council incurring expenditure which is, or the making of savings which are, significant having regard to the Council's budget for the service or function to which the decision relates;
- (b) be significant in terms of its effects on communities living or working in an area comprising two or more wards.

August 2016	<b>The Wharves Deptford - Compulsory Purchase Order Resolution</b>	21/06/17 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
May 2017	<b>Evaluation of the Sustainable Community Strategy</b>	21/06/17 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Joe Dromey, Cabinet Member Policy &		

**FORWARD PLAN – KEY DECISIONS**

Date included in forward plan	Description of matter under consideration	Date of Decision Decision maker	Responsible Officers / Portfolios	Consultation Details	Background papers / materials
			Performance		
May 2017	<b>Memorandum of Understanding on Participation of Central London Forward for Purposes of Employment and Skills Devolution and joint working procurement of Work and Health Programme</b>	21/06/17 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
March 2017	<b>CRPL Business Plan 2017-18</b>	21/06/17 Council	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
February 2017	<b>New Homes Programme</b>	28/06/17 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
February 2017	<b>Beckenham Place Park Programme Update</b>	28/06/17 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Rachel Onikosi, Cabinet Member Public Realm		
February 2017	<b>Deptford Southern Housing Sites - Part 1 &amp; Part 2</b>	28/06/17 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
March 2017	<b>Response to Consultation on</b>	28/06/17	Aileen Buckton,		

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	<b>Policy for Supported Travel Young People Attending College and Adults Eligible for Adult Social Care</b>	Mayor and Cabinet	Executive Director for Community Services and Councillor Chris Best, Cabinet Member for Health, Wellbeing and Older People		
May 2017	<b>Medium Term Financial Strategy</b>	28/06/17 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
February 2017	<b>IT Network re-procurement Brent and Lewisham shared service</b>	28/06/17 Mayor and Cabinet (Contracts)	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
May 2017	<b>Contract Award Bulge Class Sandhurst school</b>	11/07/17 Overview and Scrutiny Education Business Panel	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
March 2017	<b>Achilles Street Regeneration Proposals</b>	19/07/17 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
	<b>Air Quality Campaign 17-18</b>	19/07/17	Aileen Buckton,		

**FORWARD PLAN – KEY DECISIONS**

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		Mayor and Cabinet	Executive Director for Community Services and Councillor Rachel Onikosi, Cabinet Member Public Realm		
January 2017	<b>Catford Regeneration Programme Parts 1 and 2</b>	19/07/17 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
February 2017	<b>Extending the shared IT service to Southwark</b>	19/07/17 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Kevin Bonavia, Cabinet Member Resources		
May 2017	<b>Financial Monitoring 2017/18</b>	19/07/17 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
	<b>Joint Strategic Depot Review</b>	19/07/17 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Rachel Onikosi, Cabinet Member Public Realm		
	<b>Medium Term Financial Strategy</b>	19/07/17 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and		

<b>FORWARD PLAN – KEY DECISIONS</b>					
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			Councillor Kevin Bonavia, Cabinet Member Resources		
May 2017	<b>Housing Acquisitions Part 2</b>	19/07/17 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
May 2017	<b>Lewisham Future Programme 2018/19 Revenue Budget Savings</b>	19/07/17 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
May 2017	<b>Lewisham Adoption Service Statement of Purpose and Children's Guides</b>	19/07/17 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
May 2017	<b>Lewisham Fostering Service Statement of Purpose and Children's Guides</b>	19/07/17 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
	<b>New Homes Programme Parts 1 &amp; 2</b>	19/07/17 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and		

**FORWARD PLAN – KEY DECISIONS**

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			Councillor Damien Egan, Cabinet Member Housing		
	<b>PLACE / Deptford: Precision Manufactured Temporary Accommodation</b>	19/07/17 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
May 2017	<b>Transfer of the Applications Support Function to the LB Brent Shared Service</b>	19/07/17 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
	<b>Modification to Decision to expand Addey and Stanhope School - Delayed implementation</b>	19/07/17 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
	<b>Amalgamation of Sandhurst Infant School and Sandhurst Junior School - Permission to consult</b>	19/07/17 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
	<b>Delivering additional school places for Children and Young People with Special Educational Needs and</b>	19/07/17 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin,		

**FORWARD PLAN – KEY DECISIONS**

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	<b>Disabilities (SEND) - Permission to consult</b>		Cabinet Member for Children and Young People		
	<b>Gypsy and Traveller Local Plan Update</b>	19/07/17 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
April 2017	<b>Proposed revision to the contract structure of the Downham Health &amp; Leisure Centre PFI</b>	19/07/17 Mayor and Cabinet (Contracts)	Aileen Buckton, Executive Director for Community Services and Councillor Joan Millbank, Cabinet Member Third Sector & Community		
May 2017	<b>Sydenham Park Footbridge Contract Award</b>	19/07/17 Mayor and Cabinet (Contracts)	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
February 2017	<b>Telephony re-procurement</b>	19/07/17 Mayor and Cabinet (Contracts)	Kevin Sheehan, Executive Director for Customer Services and Councillor Kevin Bonavia, Cabinet Member Resources		
May 2017	<b>Sangley and Sandhurst Road Highway Improvement Scheme Contract Award</b>	19/07/17 Mayor and Cabinet (Contracts)	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		

**FORWARD PLAN – KEY DECISIONS**

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	<b>Interim Food and Garden Waste Contract</b>	25/07/17 Overview and Scrutiny Business Panel	Kevin Sheehan, Executive Director for Customer Services and Councillor Rachel Onikosi, Cabinet Member Public Realm		
	<b>Update and preferred provider position refurbishment of Ladywell Playtower.</b>	13/09/17 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
May 2017	<b>Audited Accounts and Pension Fund Accounts 2016/17</b>	20/09/17 Council	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
May 2017	<b>Financial Regulations and Directorate Schemes of Delegation</b>	20/09/17 Council	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
May 2017	<b>Report of the Barriers to Participation Working Party</b>	20/09/17 Council	Janet Senior, Executive Director for Resources & Regeneration and Councillor Suzannah Clarke, Chair Planning Committee C		
May 2017	<b>Community Services Youth Review</b>	04/10/17 Mayor and Cabinet	Aileen Buckton, Executive Director for		

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		(Contracts)	Community Services and Councillor Joan Millbank, Cabinet Member Third Sector & Community		
	<b>Deptford Lounge &amp; Tidemill School Facilities and Centre Management</b>	06/12/17 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		

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