Lewisham and Greenwich NHS
NHS Trust

Summary of Quality Accounts 2016/17

Prepared for: Healthier Communities Select Committee

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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

Patient Safety Quality Priorities	
(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
Clinical Effectiveness Quality Priorities	
(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
Patient Experience Quality Priorities	
(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

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 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 below.

C. difficile rate per 100,000 bed-days	2015/16	2016/17
Lewisham and Greenwich NHS Trust		
Trust apportioned	37	25
Rate per 100,000 bed days (Trust apportioned)	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*.

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

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*
Lewisham and Greenwich NHS Trust		
Total reported incidents	6,166	6,547
Incidents causing severe harm or death	5	5
% of incidents causing severe harm or death	0.1%	0.1%
ACUTE NON-SPECILISED TRUSTS		
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 1st April 2016 up to 30th September 2016 and the number of questionnaires returned for each procedure up to 30th 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**
All Procedures	**560**	**648**	**408**	**86**	**40**
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
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: 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
Key Finding 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	**%**	**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	-
Key Finding 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	**%**	**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 themeselves 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 from1st 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	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.

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	Requires improvement	Requires improvement	Requires improvement	Requires improvement	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

Patient Safety Priorities		
(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
Clinical Effectiveness Priorities		
(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	
Patient Experience Priorities		
(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.