NHS
Lewisham and Greenwich
NHS Trust

Quality Account

2016-2017

Contents

Part 3

Appendix 1

Glossary

AKI	Acute Kidney Injury
A&E	Accident and Emergency
CAS	Central Alerting System
CAP	Clinical Audit Programme
CCG	Clinical Commissioning Group
CDI	Clostridium difficile infection
C. difficile	Clostridium difficile
CEFM	Continuous Electronic Fetal Monitoring
CEO	Chief Executive Officer
CHKS	Independent provider of healthcare intelligence, benchmarking and quality improvement services
CDs	Controlled Drugs
CRN	Clinical Research Network
CQC	Care Quality Commission
CQRG	Clinical Quality Review Group
CQUIN	Commissioning for Quality and Innovation
ED	Emergency Department
EDI	Equality, Diversity and Inclusion
ENT	Ear, Nose and Throat
EoT	End of Treatment
FFT	Friends and Family Test
FT	Foundation Trust
F/Y	Financial Year
GP	General Practitioner
HAT	Hospital Acquired Thrombosis
HES	Hospital Episode Statistics
HRG	Healthcare Resource Group
HSCIC	Health and Social Care Information Centre
HWBE	Health and Well Being Events
IA	Intermittent Auscultation
IG	Information Governance
IOL	Induction of Labour
LGT	Lewisham and Greenwich NHS Trust
LoS	Length of Stay
MEWS	Modified Early Warning Score
MMPT	Medicines Management Pharmacy Technician
MSK	Musculoskeletal
NEWS	National Early Warning Score
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NHFD	National Hip Fracture Database
NHS	National Health Service
NHS Digital	Aims to improve health and care by providing national information, data and IT services (formally known as HSCIC)
NHSE	National Health Service England
NHSI	National Health Service Improvement
NICE	National Institute for Health and Care Excellence
NICU	Neonatal Intensive Care Unit
NRLS	National Reporting Learning System
OHSEL	Our Healthier South East London
OSC	Overview and Scrutiny Committee
OWL	Outcomes with Learning
PALS	Patient Advice and Liaison Service
PDSA	Plan, Do, Study, Act (part of an improvement methodology)
PEACE	Proactive Elderly Advance CarE
PbR	Payment by Results
PHE	Public Health England
PROMS	Patient Reported Outcome Measures
PUG	Patient User Group
PSI	Patient Safety Incidents
PWF	Patient Welfare Forum
QEH	Queen Elizabeth Hospital
RAMI	Risk Adjusted Mortality Index
RCA	Root Cause Analysis
ROCAIP	Reason, Observation, Comment, Assessment/ Analysis, Intervention, Plan
R&D	Research and Development
SBAR	Situation Background Assessment Recommendation
SFFT	Staff Friends and Family Test
SHMI	Summary Hospital Mortality Indicator
SI	Serious Incident
SMR	Standardised Mortality Ratio
STP	Sustainability and Transformation Plans
SUS	Secondary Uses Service
UCC	Urgent Care Centre
UHL	University Hospital Lewisham
VTE	Venous Thromboembolism
Waterlow Score	A score of the estimated risk for the development of a pressure ulcer by a patient
WRES	Workforce Race Equality Standard
YSWD	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

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
i) Early recognition and treatment of the deteriorating patient 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. 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.	■ 10% reduction in the number of out of Critical Care 'in hospital' cardiac arrests from 2016/17 figure. ■ Eliminate all avoidable deaths from sepsis and septic shock by March 2018. ■ Implement the adult community MEWs and Sepsis screening tool to assist in the early identification of deterioration of our patients within the community.
ii) Improving the Safety of Maternity Services 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. 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. We will continue to implement the Trust's Maternity Strategy and national guidelines including NHSE's Saving Babies Lives.	■ Reduce stillbirths (to maintain under the Trust's current quarterly rate of <5.3 per 1000 births). ■ Increase detection of growth restricted babies in utero. ■ Reduce poor neonatal outcomes associated with poor/inadequate fetal surveillance in labour, whether by intermittent auscultation (IA) or continuous electronic fetal monitoring (CEFM).
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. 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. We will continue our focus and aim of reducing avoidable Trust attritibutable grades 3, 4 and unstageable pressure ulcers and pressure ulcers acquired within our provision of community services. 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. We will continue to offer and facilitate specialist 'Pressure Ulcer Prevention and Manangement' training in a variety of formats including e-learning packages.	■ Improve the accuracy of the Waterlow score for patients in hospital and achieve 95% compliance every month. ■ Develop and implement with partners, a tool for formal carers to monitor skin and to alert concerns to adult community nurses. ■ Amend the Trust Pressure Ulcer Policy to manage the risk to adult community patients in the absence of overnight care provision. ■ 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.

Our quality priorities and why we chose them	What success will look like
iv) Reduction in the number of patient falls and harm incurred 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. 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.	■ Reduction in the incidence of harm sustained from patient falls of 10% by the end of March 2018 (from March 2017 figure). ■ Meet pledges stated within NHSI Falls Improvement collaboration. ■ Implementation of first year of Falls Strategy.
v) Improving medication safety and learning from medication incidents 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. 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. 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.	■ Increase the number of reported medication related patient safety incidents from 2016/17 figure by 5%, by the end of March 2018. ■ Maintain focus on low numbers of inappropriately omitted critical medicines (level at March 2017 - 0.7%). ■ Continue to identify themes in prescribing and administration incidents, and share learning with staff at all levels. ■ 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.
vi) Getting the basics right and keeping patients safe within the emergency department and those areas used for escalation 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. 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. 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: ■ Documentation improvement in management of Controlled Drugs ■ Fridge Temperature monitoring and in particular documenting when action has been taken where temperatures are out of range ■ Ensuring robust process for following up on all audit results and action plans agreed as part of the completion of the continuous audit cycle 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.	**Emergency department and escalation areas:** ■ Quality and hourly senior nurse rounds supporting the implementation of quality of care will demonstrate improved patient experience. ■ The quality care plan and checklist for all patients in ED will be embedded across the sites. ■ Implementation of daily ED quality and safety metrics, NEWS monitoring and escalation process for safety and safety huddles and demonstration of improved trends. **Medicines management** ■ Improved CD and safer storage audit results from the baseline of April 2017 demonstrated throughout the year. ■ Demonstrable evidence of action plan and follow-up, post presentation of audit results.

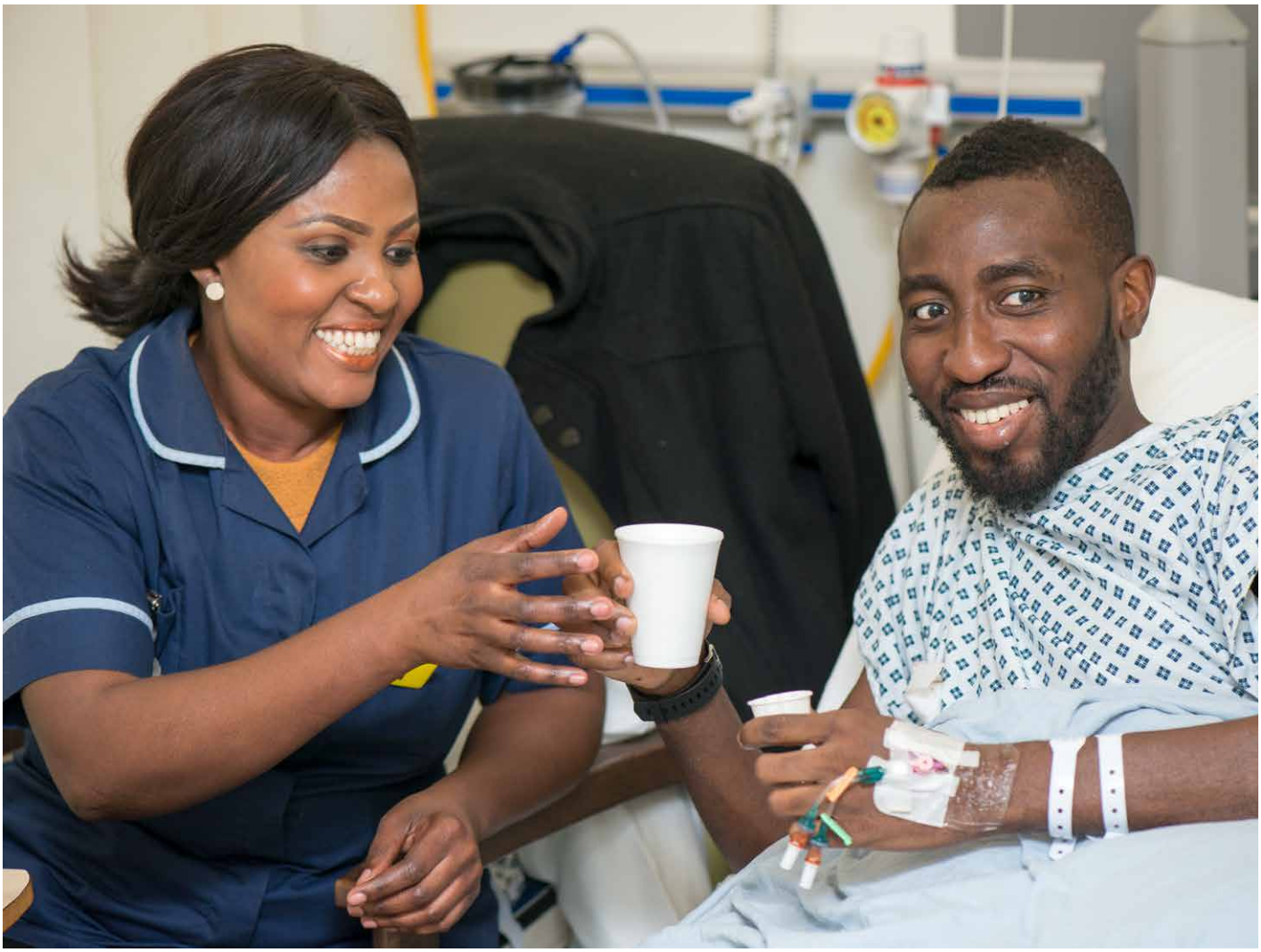
2.1.2 Clinical Effectiveness Priorities

Our quality priorities and why we chose them	What success will look like
i) Embedding processes for mortality reviews across the Trust 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.	■ Continue to work towards reducing the Trust SHMI to under the current level (1.00). ■ Implementation of the process for mortality reviews of patients with learning disabilities. ■ Full implementation of the new mortality review form by ensuring that medical staff are trained on its usage. ■ Increase the number of mortality reviewers by 10%. ■ Increase comorbidity recording in patients' medical records to improve on the current quality and accuracy of coding.
ii) Working towards delivering the seven day working standards – four clinical priorities 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. Plans for 7 day working also form part of the STP as well as being included in commissioner contractual requirements.	By the end of March 2018, full compliance with the four clinical priority standards: ■ Standard 2: Time to first Consultant review (Within 14 hours from patient's admission) ■ Standard 5: Timely access to diagnostics ■ Standard 6: Access to Consultant-delivered interventions ■ 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).
iii) Safe and effective discharge 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. 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.	■ 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. ■ Reduction in the number of inpatients medically fit and ready for discharge. ■ Implement the discharge to assess model as part of the Enhanced Care and Support Programme.
iv) Improving patient outcomes through measures for Adult Community Services 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.	■ Development of an adult community services quality dashboard to support individual team ownership of quality objectives that support the delivery of our Trust objectives.

2.1.3 Patient Experience Priorities

Our quality priorities and why we chose them	What success will look like
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. 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.	■ Ensure the new Visiting Policy is fully embedded across the Trust. ■ Implementation of the activities programme for dementia patients. ■ Establish and implement use of a sensory room on both acute sites. ■ Continue to implement our Staff Dementia training programme, this includes increasing the amount of training and tailoring training for different staff groups. ■ Ensure that the Dementia Strategy fully incorporates improvements within our community services including increasing the specialist nursing workforce.
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. 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.	■ 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. ■ Implement the use of patient stories as a learning tool across the Trust. ■ Implement a patient experience micro site to raise the profile and provide extended opportunities for patients to provide feedback through social media.
iii) Improving the quality of the End of Life Care pathways across the health care system. 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.	■ Training on PEACE (Pro-active Elderly Advance CarE) will be provided to increase the use of the tool. ■ All areas to have a link nurse practitioner with established governance links into the End of Life Care Steering Group. ■ Key clinical leads for End of Life Care to be identified. ■ Bereavement survey undertaken and results evaluated. ■ Use of End of Life Care volunteers to be established in the Trust. Adult Memorial Service to be held. ■ Implement the "Say goodbye to your pets" initiative. ■ Achievement of 95% training rate for qualified nursing staff in the T34 pump. ■ Review of current end of life care training and develop additional training programmes. ■ 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. ■ Implement the use of Principles of Care for the dying in Adult Community Services.

Our quality priorities and why we chose them	What success will look like
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.	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%
National Average	**95.74%**	**95.6%**
Best performing Trust	**100%**	**100%**
Worst performing Trust	**82.29%**	**79.86%**

Source: 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
National Average	**14.9**	**TBC**
Best performing Trust	**5.4**	**TBC**
Worst performing Trust	**36.2**	**TBC**

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.

Patient Safety Incidents	Apr 15-Sept 15	Apr 16-Sept 16*
Lewisham and Greenwich NHS Trust		
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%
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.

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.

All incidents reported onto the incident system (Clinical (including non-PSI) and Non-Clinical) per month

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	0	1	1	1	1	0	0	0	0	0	0	0	**4**
Death	0	0	0	0	0	0	1	0	1	1	1	0	**4**
Total	**0**	**1**	**1**	**1**	**1**	**0**	**1**	**0**	**1**	**1**	**1**	**0**	**8**

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.

Percentage of deaths with palliative care coding	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)
Lewisham and Greenwich NHS Trust	26.6	24.9	24.4	25.0
Lowest percentage Trust	**0.2**	**0.2**	**0.6**	**0.6**
Highest percentage Trust	**53.5**	**54.7**	**54.6**	**54.8**

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.

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

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.

PROMS	Measure	Lewisham & Greenwich Adjusted Health Gain April 2016 – September 2016	Lewisham & Greenwich Adjusted Health Gain April 2015 – March 2016	National Adjusted Health Gain April 2015 – March 2016	Best Performer - Adjusted Health Gain April 2015 – March 2016	Worst Performer –Adjusted Health Gain April 2015 – March 2016
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.

Lewisham and Greenwich 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%

University Hospital Lewisham readmission within 28 days

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Trust	6.74%	5.87%	6.02%	5.44%	5.31%	5.76%	5.59%	5.32%	6.14%

Queen Elizabeth Hospital readmission within 28 days

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Trust	9.92%	9.77%	9.72%	11.08%	11.48%	10.43%	10.41%	9.83%	10.63%

Lewisham and Greenwich NHS Trust readmission within 28 days by age

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
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/
*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
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	2,953
Worst Performing Trust	32	9,520
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	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.

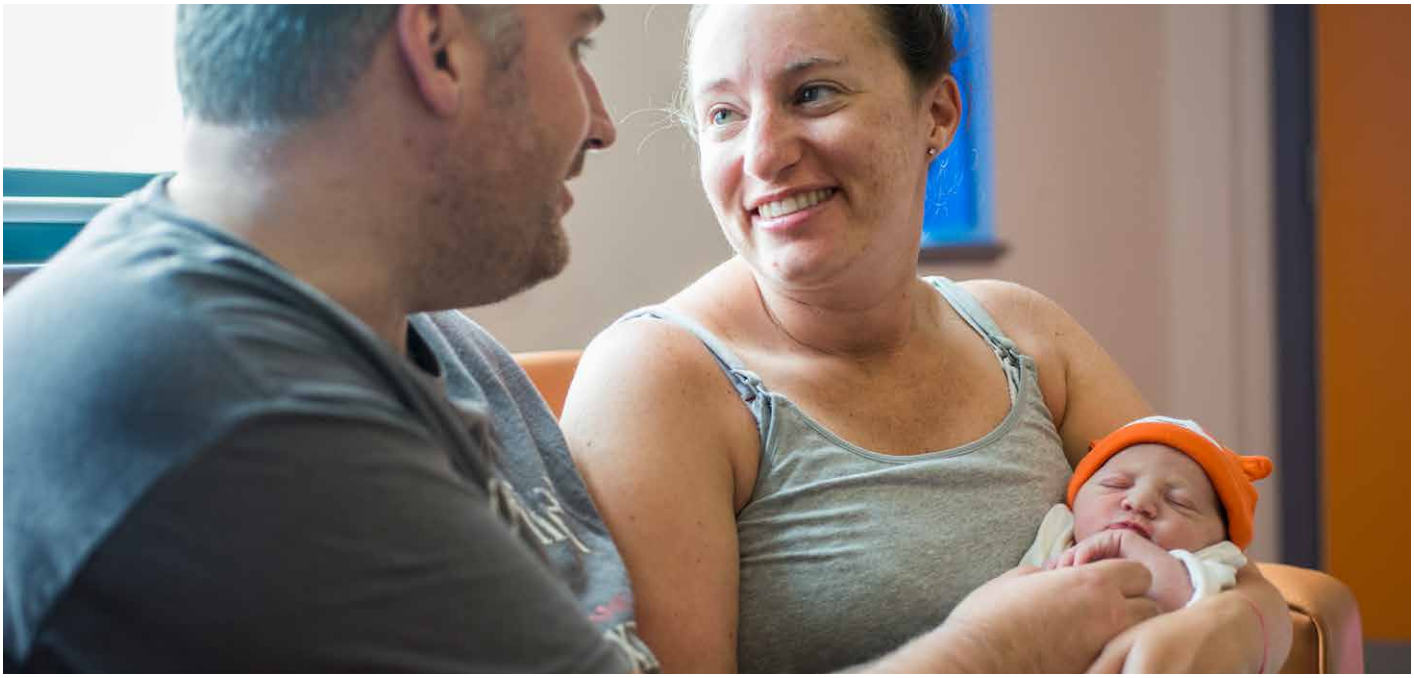
In addition to the above the Trust will:

- 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 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.



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 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	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

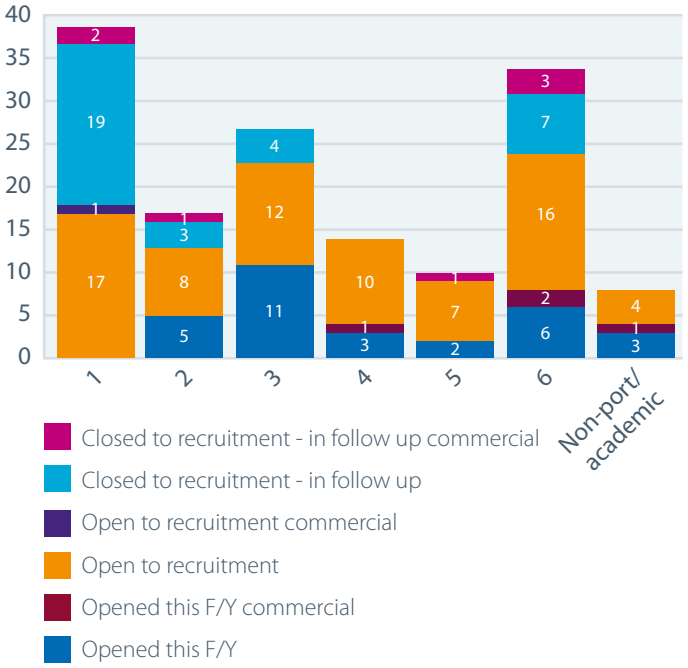
Division 3: Children, genetics, Haematology, Paediatrics, reproductive Health and Childbirth

Division 4: Dendron, Mental Health and Neurology

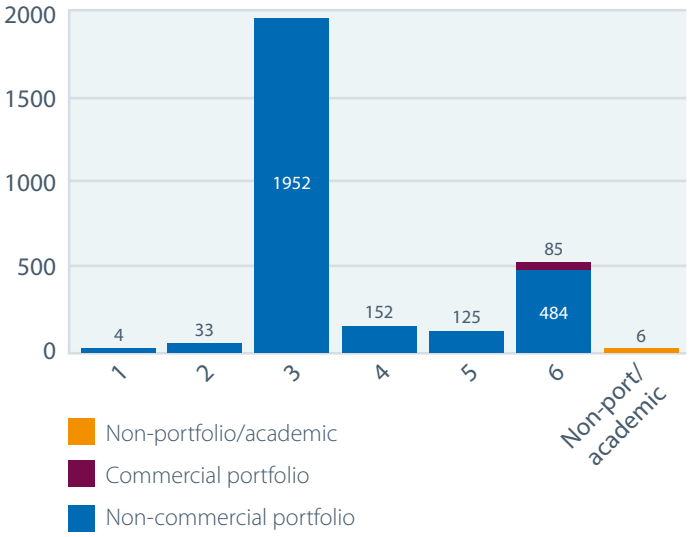
Division 5: Primary Care, Age and Aging, Dentistry, Health Services Research, Public Health, MSK, Dermatology.

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		Requires improvement		
Effective		Requires improvement		
Caring			Good	
Responsive		Requires improvement		
Well-led		Requires improvement		

Medical care				
Overall	Inadequate	Requires improvement	Good	Outstanding
Safe		Requires improvement		
Effective		Requires improvement		
Caring		Requires improvement		
Responsive		Requires improvement		
Well-led		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 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	Incorrect
General Medicine (UHL site)	80	2	4	5.3%	87.5%	70	10	80.5%	95	23	93.0%	66	5	96.5%	82	3
General Medicine (QEH site)	113	15	6	5%	91.8%	90	8	90.6%	460	48	87.5%	21	3	91.0%	30	3
Paediatric service (UHL site)	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?
3.1.1. (i) Improving our hand hygiene compliance 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.	We will achieve 100% compliance across all departments	**We partially achieved this.** 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. 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.
3.1.1. (ii) Early recognition and treatment of the deteriorating patient 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.	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. 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. Aim 2: Eliminate all avoidable deaths from sepsis and septic shock by the end of year 3 (March 2018).	**We achieved this.** 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. 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). **Sepsis** 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.

Our quality priorities and why we chose them	What success will look like	How did we do?
3.1.1. (iii) Improving the Safety of Maternity Services 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.	Reduction in stillbirths Increase detection of growth restricted babies in utero Reduce poor neonatal outcomes associated with poor / inadequate fetal surveillance in labour, whether by intermittent auscultation (IA) or continuous electronic fetal monitoring (CEFM)	**We partially achieved this.** 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. **Achievements during 2016/17 include:** Development of a Fetal Wellbeing team comprising of midwives, trainee doctors and consultant obstetricians. Sonic aids for all Birth Centre staff and installation of central monitoring enabling discussions and teaching away from the bedside. Introduction of competency assessments for all grades and 2 day fetal monitoring master class training sessions.
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. 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.	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	**We partially achieved this.** During 2016/17 Waterlow score compliance has been maintained at around 95% compliance. 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. A tool has been developed for auditing the accuracy of pressure ulcer documentation and review of Trust equipment.
3.1.1 (v) Reduction in the number of patient falls and harm incurred 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.	Reduce the incidence of harm sustained from patient falls by 20% by the end of year	**We partially achieved this.** 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. 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.

Our quality priorities and why we chose them	What success will look like	How did we do?
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 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%. 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. 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.	Increase the number of reported medication related patient safety incidents from baseline by 5%. Reduce number of inappropriately omitted medicines with a particular focus on critical medicines. Identify trends and themes in prescribing and administration incidents and share learning with staff at all levels.	**We partially achieved this.** 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. 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%). 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.

3.1.2 Clinical Effectiveness Priorities

Our quality priorities and why we chose them	What success will look like	How did we do?
3.1.2 (i) To continue to work on embedding the process for mortality reviews across the Trust and implement the new NHSE process	Continued improvement in Trust mortality rates at each site. Introduction of the new NHSE processes and presentation of reviews and learning at Trust wide mortality and Divisional governance groups. Reduction in inaccurate clinical coding of deaths and improvement in data quality audit scores.	**We fully achieved this.** 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. 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. 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.
3.1.2 (ii) To improve the clinical pathways for Frailty and improve outcomes for these patients 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. 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.	Establishment of agreed Frailty Pathways and implementation of pathways during 2016/17. Successful outcomes in key performance indicators: Reduction in emergency admissions in defined cohort of patients by at least 10%. Reduction in Average Length of Stay by 1 day in defined cohort of patients. Ensure 75% of defined staff have been trained in Frailty Assessment and Screening.	**We partially achieved this.** 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. 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. 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.

Our quality priorities and why we chose them	What success will look like	How did we do?
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 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. This will enable more specialist nurse-led care and facilitate integrated care between General Practice, community services and the Trust.	Develop new service model and pathways for the management of Asthma in Children and Young People in Acute, Community and Primary Care. Develop joint training and competency programme for Community and Primary Care Staff with GP leads. Develop and implement written information for patients and healthcare professional staff on the management of Asthma within Primary Care.	**We partially achieved this.** 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. The Trust is finalising the development of the training with primary care staff, at which point the programme will then be implemented. The Trust is in the process of developing this information and will also be utilising resources from the London asthma standards.

3.1.3 Patient Experience Priorities

Our quality priorities and why we chose them	What success will look like	How did we do?
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 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.	Successful John's campaign. Successful Dementia Friends campaign with increased numbers in Dementia Friends. Implementation of an enhanced dementia volunteers programme. Establishment of a cross site dementia working group to develop services and support on both sites. Continue to improve on our staff dementia training programme.	**We fully achieved this.** 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. 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. 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. 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. 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.

Our quality priorities and why we chose them	What success will look like	How did we do?
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 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.	Introduction and successful 'You said We Did' programme. Outcomes shared with patients and staff and continued use of patient stories in shared learning events. Divisional learning and outcomes captured and shared through all Divisional Governance, Complaints and Patient Experience Committee. Evidenced practice changes from learning from patient experience. Trust wide successful Sharing the learning events held throughout the year.	**We fully achieved this.** 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. 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. Sharing the Learning events have continued on both sites throughout the year and a community focussed event has also been held.
3.1.3 (iii) Continued expansion for gaining patient feedback from all services 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.	Successful introduction of 'Ideas boxes' and feedback boards. Lay involvement in the development of services and evaluation through the use of surveys.	**We fully achieved this.** 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. The Patient Experience Team have continued to support teams with delivery of both the national and local surveys to highlight where improvement is needed.
3.1.3 (iv) Improving the patient experience and quality of End of Life pathways 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.	Continue to roll out Sage and Thyme communication training. Undertake bereavement survey. Embed 24/7 visiting for families of patients at the end of life, ensuring they have the appropriate facilities available.	**We partially achieved this.** 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. 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. 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.

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 (QEH) 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 QEH 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
Web: 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	Hirshpurung 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 MScIs - 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 TNFα use in patients with psoriatic arthritis (PsA)
Long Term Conditions & Cancer	Rheumatology	Audit of anti TNFα 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	Depravation 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 Pomp 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

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