Lewisham and Greenwich NHS Trust

Lewisham and Greenwich NHS Trust

Quality Account 2015-2016

Whilst making significant progress and improving quality and safety during 2015-16, our focus still remains on maintaining a strong operational and financial ‘grip’ on the business ensuring we meet all service quality and performance standards, consistently deliver a good patient experience and are able to demonstrate more efficient use of resources.

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Glossary

ACC	Accredited Clinical Coder
A&E	Accident and Emergency
AAR	After Action Review
CAS	Central Alerting System
CAP	Clinical Audit Programme
CCG	Clinical Commissioning Group
C. diff	Clostridium difficile
CD	Controlled Drugs
CEFM	Continuous Electronic Fetal Monitoring
CEO	Chief Executive Officer
CHKS	Independent provider of healthcare intelligence, benchmarking and quality improvement services
CRN	Comprehensive Local Research Network
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DoC	Duty of Candour
DNA	Did Not Attend
ED	Emergency Department
EDI	Equality, Diversity and Inclusion
ENT	Ear, Nose and Throat
EoT	End of Treatment
FFT	Friends and Family Test
GP	General Practitioner
HPA	Health Protection Agency
HQIP	Healthcare Quality Improvement Partnership
HRG	Healthcare Resource Group
HSCIC	Health and Social Care Information Centre
HWBE	Health and Well Being Events
IA	Intermittent Auscultation
ICD	Internal Classification of Diseases
IG	Information Governance
IT	InformationTechnology
LGT	Lewisham and Greenwich NHS Trust
LoS	Length of Stay
MRSA	Methicillin-resistant Staphylococcus aureus
MSK	Musculoskeletal
NEWS	National Early Warning Score
NGT	Nasogastric Tube
NHFD	National Hip Fracture Database
NHS	National Health Service
NHSE	National Health Service England
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
PbR	Payment by Results
PHE	Public Health England
PLACE	Patient-Led Assessments of Care Environment
PROMS	Patient Reported Outcome Measures
PUG	Patietn User Group
PWF	Patient Welfare Forum
QEH	Queen Elizabeth Hospital
QMS	Queen Mary's Sidcup Hospital
RAMI	Risk Adjusted Mortality Index
RCEM	Royal College of Emergency Medicine
R&D	Research and Development
SBAR	Situation Background Assessment Recommendation
SFFT	Staff Friends and Family Test
SHMI	Summary Hospital Mortality Indicator
SUS	Secondary Uses Service
UHL	University Hospital Lewisham
VTE	Venous Thromboembolism

Part 1
Statement of Quality from the Chief Executive

Welcome to the 2015–16 Quality Account for Lewisham and Greenwich NHS Trust.

This was our second full year as a new organisation and, once again, we have had a busy workload. I am proud of the way in which our staff have responded to the challenges in front of them as they have worked tirelessly to improve patient care.

I hope you find the report 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 on-going challenges and working with local people and other local organisations to improve healthcare in Lewisham, Greenwich and Bexley and beyond.

The past twelve months has been an extremely busy, demanding and challenging period for our organisation as we embarked on major ambitious projects to transform some of our services and deliver on quality and safety improvement plans following our CQC inspection in February 2014. I am pleased to report that we have achieved the majority of our safety improvement plans and priorities for 2015-16, the detail of which is outlined in this report.

Staff have also worked extremely hard throughout the year in supporting the organisation to respond to the increasing local demand for our services and to ensure the success of some of our major projects.

One of the highlights of last year was the opening of our new Birth Centre at Greenwich, which has gained extremely positive feedback from local mothers since it opened in May 2015. Indeed, our maternity team's hard work in meeting the needs of local people was recognised by the Royal College of Midwives (RCM), who selected Lewisham and Greenwich NHS Trust as "Team of the Year" in the RCM's annual awards. The judges were particularly impressed with the way the team have worked with local parents and taken on-board patient feedback to improve services.

During 2015-16 we have been running a recruitment and retention campaign to increase the number of permanent staff. This has increased staffing levels by seven per cent and I am pleased to report that over 2015-16 we consistently met the target for providing safe numbers of nursing staff on our wards. In 2016-17, we will continue to work to reduce the need for agency staff in areas where there is a national shortage of staff.

Whilst making significant progress and improving quality and safety during 2015-16, our focus still remains on maintaining a strong operational and financial 'grip' on the business ensuring we meet all service quality and performance standards, consistently deliver a good patient experience and are able to demonstrate more efficient use of resources.

A key priority going forward will be to continue to work with local partners to embed the emergency care pathways, develop a pathway for the frail and elderly, maximise the use of community and social care teams and further develop plans for effective integrated models of care in the community. We will also continue to focus on meeting all the quality and performance standards, building on recent progress – for example in providing more timely treatment for cancer patients. Of course, we do not work in isolation and are working closely with our partners to deliver improvements across the health and social care system as a whole.

I hope that you find the information contained in this Quality Account. The full document will also be available on our web site: www.lewishamandgreenwich.nhs.uk

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

Signed:

Tim Higginson
Chief Executive

Part 2

2.1 Our Quality priorities for 2016-17

We aim to provide patients with an excellent experience of care and to ensure we continue our commitment to improve the reduction of avoidable harm. This ambition is reflected in our strategic objectives.

Our quality aims and objectives for 2016-17 are to ensure that we improve our contribution to the provision of healthcare for our patients both in the community and in hospital settings as well as focus on the challenge of both our transformation of services and our challenging financial plans.

We have developed a set of priorities drawn from both the review of the work undertaken during 2015-16 and also areas which still require on-going improvements. These priorities form the basis of the Divisional business plans, our CQUIN initiatives, the Sign Up to Safety Pledges and the overall Trust Strategy and Operating plans.

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

Each of the priorities fits under the key themes of quality which form the NHS Outcomes Framework:

Patient Safety

Having the right systems and staff in place to minimize 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

Meeting our patient's emotional as well as physical needs.

How we chose our priorities

Throughout the year our progress towards achieving the 2015/16 priorities has been monitored presented and reported at meetings held across the Trust and with key stakeholders being present at these meetings, these include our local commissioners, local Healthwatch, Patient Welfare Forum and Patient User Groups.

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 where the priorities are focussed on basic safety practices and enhancing the patient experience. Therefore, we have committed to continuing our work to improve patient safety by reducing avoidable harm, being open and exercising our duty of candour and signing up to the national Sign up to Safety programme with our safety pledges. We have also committed to continue our work to improve the clinical patient pathways for patients to achieve better outcomes and experiences for patients.

For 2016/17 we will also continue to focus on using patient experience and feedback to influence and improve changes to practice.

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

As well as the highlighted quality priorities, we will continue with our overall plan to improve quality, safety and effectiveness and will continue to work on our plans to improve our emergency care pathways, to develop our pathway for the frail and elderly, to develop our ambulatory care model and to progress our transformation work to provide continual improvement to our services.

The following tables outline the 2016-17 quality priorities and why we have chosen them.

2.1.1 Patient Safety Priorities

Patient Safety Priorities

During 2016 – 17 we will continue to progress work started in the following areas in 2015-16. These contribute 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.

2016 constitutes Year 2, the Trust having already set the foundation for and / or achieved improvements in patient safety in all the following areas during year 1:

Our quality priorities and why we chose them	What success will look like
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 were 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
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 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. **Aim 2:** Eliminate all avoidable deaths from sepsis and septic shock by the end of year 3.
iii) Improving the Safety of Maternity Services Not only can babies be left severely harmed by failures in assessment of the wellbeing of the fetus 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 reducing and 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 intermittent auscultation (IA) or continuous electronic fetal monitoring (CEFM)
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 multiple co-morbidities raises the risk for patients of developing pressure ulcers. Significant progress was made during 15-16 with weekly pressure ulcer panels running with support from our CCGs to understand the root causes and contributory factors. This work has led a more focussed approach to addressing the challenges particularly within our community services and continued collaborative work is still required for 16-17.	Improve the accuracy of the recording of Waterlow score for patients in hospital and community services we provide and achieve at least 95% compliance with completion of scores -100% of eligible clinical staff in community services and 95% of all ward staff (from a Training Needs Analysis - TNA) to have undertaken the new electronic learning package on pressure ulcer prevention and management - Monitor incidence of grade 2, 3, and 4 pressure ulcers attributable to Trust for reporting and reduction
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

Our quality priorities and why we chose them	What success will look like
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 this 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.

2.1.2 Clinical Effectiveness

Clinical Effectiveness Priorities

Our quality priorities and why we chose them	What success will look like
i) To continue the work on embedding the process for mortality reviews across the Trust and implement new NHSE process During 2015-16 the Trust established a process for the review of patient mortality in all specialties. Whilst much work has been undertaken, the processes need to be further embedded across all specialties to ensure regular reporting of findings, learning from the reviews and sharing the learning across the organisation. The Trust mortality rate has improved during 2015-16 and although much of this has been the subject of focussed work, further, continued work will ensure that all elements which contribute to the mortality rates such as clinical practice decision-making, clinical documentation, comorbidity recording and clinical coding are fully reviewed, understood and action taken where required.	Continued improvement in Trust Mortality rate at each acute hospital site. Introduction of new NHSE processes and presentation of reviews and learning at Trust Wide Mortality group and Divisional Governance groups. Reduction in inaccurate clinical coding of deaths and improvement in data quality audit scores.
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 A&E 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, 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
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.

2.1.3 Patient Experience

Patient Experience Priorities	
Our quality priorities and why we chose them	**What success will look like**
i) We will continue to focus 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 it's 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.
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.
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.
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	Continued to roll out Sage and Thyme communication training Undertake bereavement survey. Embed 24/7 visiting for patient of families at the end of life ensuring they have the appropriate facilities available.

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 account and can be used to compare us with other organisations.

A review of our services

During the 2015-16 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 2015-16 represents 100 per cent of the total income generated from the provision of NHS services by the Trust for 2015-2016.

National Quality Indicators

For 2015/2016 there are nine statutory quality indicators which apply to acute hospital trusts. All trusts are required to report their performance against these indicators in the same format with the aim of making it possible for a reader to compare performance across similar organisations.

For each indicator our performance is reported with the national average and the performance of the best and worst performing trusts.

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 2015-16

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 a process in place for collating the data on venous thromboembolism assessments. During 2014-15 the Trust implemented it's electronic record at the Queen Elizabeth Hospital, the impact of the implementation did affect the ability to enter the VTE assessments within the system the appropriate way and therefore, the electronic IT system required a change to enable timely recording for VTE assessments
- During 2015-16 the University Hospital Lewisham site implemented its version of the electronic record (which was a different version of the electronic record implemented at the QEH site) and similar difficulties were encountered with the data entry for VTE assessments. This had a negative impact on the ability to record accurate data on the number of VTE assessment which had actually been undertaken. The University Hospital Lewisham site did resort to monthly manual checking of the VTE assessments undertaken, however, the Trust considered that not all data was captured. This was reflected in the summary percentage VTE assessments for the whole Trust. During 2015-16 the electronic IT system has undergone several changes to ensure that the Trust can record and enter VTE data accurately and in a timely way which has had a positive effect on the VTE assessments for the last quarter of 2015-16. However, the overall impact of the implementation of two different IT electronic patient record systems has resulted in the percentage of VTE assessments undertaken being understated. Data compared to peers, highest and lowest performers, and our own previous performance, as set out in the table below.

VTE assessment rate	2014/15	2015/16
Lewisham and Greenwich NHS Trust	**95.2%**	**88.9%**
Assessed	93,094	89,992
Admitted	97,765	101,121
Assessment Rate	95.2%	88.9%
National Average	96.1%	95.74%
Best performing Trust	100%	100%
Worst performing Trust	88.4%	82.29%

Source: www.england.nhs.uk

2.2.1 (ii) Patient Safety Indicator 2 – The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during 2015-16

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 2016.

The mandatory surveillance reporting is via Public Health England (PHE) who collect and publish the data on monthly 'counts' as opposed to rate per 100,000 bed days. Once per year in July, the PHE publish the data as a rate per 100.000 bed days. This data will not be available for the publication of the Trust Quality Accounts. Therefore, the Trust has calculated its rate per 100,000 bed days using the bed availability and occupancy data as referenced below.

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

- All cases are reported on the national mandatory enhanced surveillance system. The data on this is checked each month prior to sign off by the Chief Executive
- The Trust has strict control measures in place to monitor and continually improve clinical practice and antimicrobial prescribing

C. difficile rate per 100,000 bed-days	2014/15	2015/16
Lewisham and Greenwich NHS Trust		
Trust apportioned	37	37
Total bed days	320,575	334,716
Rate per 100,000 bed days (Trust apportioned)	11.5	11.0
National Average	15.1	TBC
Best performing Trust	3.8	TBC
Worst performing Trust	40.9	TBC

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

Data published by Public Health England is for the monthly counts' of *C.difficile*. The data below demonstrates the mandatory reporting made to Public Health England through 2015 – 2016 and also shows data from peer organisations:

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

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

Reporting Period: April 2015-March 2016

Trust Type	PHE Centre	Trust Name	April 2015	May 2015	June 2015	July 2015	August 2015	September 2015	October 2015	November 2015	December 2015	January 2016	February 2016	March 2016
NHS Trust	London	Barking Havering and Redbridge University Hospitals	2	5	0	4	4	4	2	5	5	4	2	1
NHS Trust	London	Barts Health	5	5	2	2	14	6	7	8	6	6	3	3
NHS Trust	London	Croydon Health Services	0	2	0	8	2	1	1	1	1	0	2	1
FT	London	Guy's & St. Thomas's	4	2	7	6	6	7	3	2	1	3	4	6
FT	London	Homerton University Hospital	1	0	3	1	1	2	0	1	1	0	0	0
FT	London	King's College Hospital	10	9	9	5	6	8	5	7	8	10	3	2
NHS Trust	London	Lewisham & Greenwich	4	4	3	7	5	2	5	3	0	2	2	0
NHS Trust	London	North Middlesex University Hospital	1	2	2	2	3	3	3	1	6	3	6	5

Source: https://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 enforce continual action plans where *C.difficile* has been isolated from samples taken
- Continuing to undertake antimicrobial and other ward rounds with the Consultant microbiologists and clinical teams and ensuring continual and regular review of antimicrobial prescribing
- Using up to date streamlined antimicrobial prescribing guidelines with monitoring of performance against these
- 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 2015-16

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 and therefore, to avoid duplication, all incidents resulting in severe harm or death are reported to the NRLS, who then report them to the Care Quality Commission.

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.

All incidents involving severe harm or death were declared and investigated as serious incidents and the reports 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].

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 table below

Patient Safety Incidents	Apr 14-Sept 14	Apr 15-Sept 15
Lewisham and Greenwich NHS Trust	**Published 19 April 2016 NRLS/NPSA**	
Total reported incidents	5,251	6,166
Incident reporting rate per 1,000 bed days	16.76	33.92
Incidents causing severe harm or death	34	5
% of incidents causing severe harm or death	0.60%	0.10%
Acute Non-specialised Trusts		
Lowest incident reporting rate per 1,000 bed days	0.24	18.34
Highest incident reporting rate per 1,000 bed days	74.96	74.67
Lowest incidents causing severe harm or death	0.0%	0.0%
Highest incidents causing severe harm or death	3.10%	3.60%
Acute Trusts average % of incidents causing severe harm or death	0.50%	0.40%

The table below shows the current reporting of patient safety incidents and the number where severe harm and death have occurred during the 2015-16 year to date, NRLS published data for Quarters 3 and 4 is not available at the time of writing this report.

Patient safety incidents reported within the Trust per month													
2015 - 16	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Running total**
Number	1028	990	1050	1049	1057	1073	1134	1136	1213	1409	1203	1225	13,567

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

Patient Safety Incidents where the impact may have caused severe harm or death													
2015 - 16	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
Severe harm	0	0	0	0	3	1	1	0	1	0	2	2	10
Death	0	0	0	0	0	0	2	0	1	0	0	1	4
Total	0	0	0	0	3	1	3	0	2	0	2	3	14

For the period between April 2015 and March 2016 a total of 17,733 incidents (includes clinical, patient safety and non-clinical incidents) were reported on the incident reporting system within the Trust, which is an increase over the previous year (15,869) of 1,864 or 8.5 per cent.

Of these the majority 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 may not tally exactly with the published NRLS report.

We continue to work on encouraging reporting of all incidents and the numbers reported per month in the second half of 2015 – 16 have continued to show a small but steady increase.

Duty of Candour process

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 No 2936; Part 3 section 2.20 is a direct response to recommendation 181 of the Francis Inquiry which recommended the imposition of a statutory Duty of Candour on healthcare providers.

This sets a statutory basis for and expands on the previous 'Being Open' process which has been in operation throughout the Trust for several years, having previously been an NHS Litigation Authority risk management standard.

The Duty of Candour (DoC) regulation has effectively shifted incident reporting for all notifiable safety incidents from a voluntary to a statutory basis. The method of reporting for front line staff is via the Trust wide electronic incident reporting system.

During 2015 the Trust implemented its framework for DoC and has now fully embedded this into its incident reporting framework. Sections within both the Incident Report Form and the Manager's Report part of the form have been extended and formalised into the DoC legal framework.

Incident reporting is already included at Trust induction within the Patient Safety session and has been revised to include the DoC regulation.

Briefings on the main elements of the DoC regulation have been disseminated by all users email, including a Safety Signals bulletin from the Deputy Medical Director for Quality and Safety.

Briefing sessions have been held for Divisional Governance Managers and Associate Directors for Quality and Safety, and at Divisional Governance meetings. Further sessions are underway for other groups of staff including matrons and ward managers and for medical and other staff at various specialty meetings.

Monthly reports on Duty of Candour are also now included within Trust scorecards and reports are presented to the Trust Quality and Safety Committee.

2.2.2 Clinical Effectiveness

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

The Summary Hospital-level Mortality Indicator or 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 100. A score below 100 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 Health and Social care Information Centre [HSCIC] via the Secondary User Service [SUS]. The SHIMI is then calculated by the HSCIC;
- Data is compared to peers, highest and lowest performers, as set out in the table below.

Summary Hospital-level Mortality Indicator	Jan 14 – Dec 14 (published July 2015)		Apr 14 – Mar 15 (published Oct 2015)		Jul 14 – Jun 15 (published Jan 2016)		Oct 14 – Sept 15 (published Apr 2016)	
	SHMI	**Banding**	**SHMI**	**Banding**	**SHMI**	**Banding**	**SHMI**	**Banding**
Lewisham and Greenwich NHS Trust	1.04	Band 2 'As expected'	1.01	Band 2 'As expected'	0.98	Band 2 'As expected'	1.00	Band 2 'As expected'
Best Performing Trust	0.65	3	0.67	3	0.66	3	0.738	3
Worst Performing Trust	1.24	1	1.21	1	1.21	1	1.177	1

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

During 2015/16 the Trust has continued to monitor and publish its SHMI and through divisional patient mortality reviews, has ensured that all information related to and influenced by the SHMI calculation is recorded. The Trust has seen a decrease in its mortality rate during 2015/16 and a review of the patient's coded information has been a contributory factor. This coded information holds details of what diagnoses, co-morbidities and procedures the patient had whilst admitted at the Trust. If necessary, a case note review is carried out to ensure that the patient did receive the best quality care possible.

When the HSCIC 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 were receiving palliative care. The method used to calculate trusts SHMI score currently makes no adjustments for palliative care patients. This means that any trusts which have a high 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 diagnosis or specialty level for the trust is shown in the table below. The table also highlights the highest and lowest percentages nationally of palliative care patients treated each reporting period.

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. We have seen a decrease in the rate of deaths with palliative care coding but have a rate equalling that of the national rate. We are continuously working on improving our data quality for clinical coding and have developed, through reviews of mortality, a new approach to ensure the 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 services by:

- Continuing with the Divisional mortality reviews and identification of those patients who were palliative and required specialist palliative care input
- Ensuring that the Trust's 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.

Percentage of deaths with palliative care diagnosis coding	Jan 14 – Dec 14 (published July 15)	Apr 14 – Mar 15 (published Oct 2015)	Jul 14 – Jun 15 (published Jan 2016)	Oct 14 – Sept 15 (published Apr 2016)
England	Not available	Not available	Not available	26.5%
Lewisham and Greenwich NHS Trust	30.4%	29.3%	28.0%	26.6%
Lowest percentage Trust	7.7%	10.1%	12.4%	11.7%
Highest percentage Trust	48.3%	50.9%	52.9%	53.5%

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 type 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 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 the Health and Social Care Information Centre (HSCIC) after they have attempted to match the operation date with the dates recorded in the Hospital Episode Statistics (HES) data. If the HSCIC are 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. Because of this 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 2015-2016 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 December 2015.

i) Operations Lewisham and Greenwich NHS Trust have carried out in 2015-2016 and the number of questionnaires returned for each procedure up to December 2015

April 2015 - December 2015					
Procedure	Eligible patients	Number of operations performed (based on hospital data)	No. of Q1 Questionnaires received	No. of Q2 Questionnaires issued	No. of Q2 Questionnaires received
All procedures	**855**	**875**	**705**	**249**	**59**
Groin Hernia	257	277	176	102	35
Hip Replacement	147	173	161	30	12
Knee Replacement	217	225	276	59	0
Varicose Vein	234	200	92	58	12

The most recently published PROMS dashboard data for the period April 2015 – March 2016 (published in May 2016) identifies that there has been an increase in the number of Q2 questionnaires returned for each of the four procedures. Health gain data derived from these questionnaires will be available within the next three months for the Trust to review.

Procedure	No. of Q2 Questionnaires received up to 31st March 2016
All procedures	**138**
Groin Hernia	60
Hip Replacement	32
Knee Replacement	18
Varicose Vein	28

Proms	Measure	Lewisham & Greenwich - Adjusted Health Gain April 2014 – March 2015	Lewisham & Greenwich - Adjusted Health Gain April 2015 – December 2015	National Adjusted Health Gain April 2015 – December 2015	Best Performer - Adjusted Health Gain April 2015 – December 2015	Worst Performer – Adjusted Health Gain April 2015 – December 2015
Groin Hernia	EQ-5D	0.000	N/A – Fewer than 30 participants	0.086	0.155	0.024
	EQ-VAS	-1.446	-0.928	-0.799	4.322	-6.092
Hip	EQ-5D	0.392	N/A – Fewer than 30 participants	0.449	0.542	0.269
	EQ-VAS	9.336	N/A – Fewer than 30 participants	12.035	18.954	0.000
	Oxford Hip Score	20.325	N/A – Fewer than 30 participants	21.925	24.784	16.543
Knee	EQ-5D	0.297	N/A – Fewer than 30 participants	0.331	0.399	0.215
	EQ-VAS	5.165	N/A – Fewer than 30 participants	5.505	12.177	-0.554
	Oxford Knee Score	14.904	N/A – Fewer than 30 participants	16.653	20.292	12.444
Varicose Veins	EQ-5D	0.081	N/A – Fewer than 30 participants	0.100	0.147	0.035
	EQ-VAS	0.256	N/A – Fewer than 30 participants	-0.072	3.582	-5.622
	Aberdeen Varicose Vein Score	-4.438	N/A – Fewer than 30 participants	-8.949	0.250	-19.250

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

- The published data from HSCIC covers the reporting period April 2015 – December 2015
- The Trust has identified that the number of Q2 questionnaires returned for the procedures for hip and knee replacement and varicose vein surgery 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 re-admissions improves the overall patient experience of care and releases hospital beds for new admissions.

However the reasons behind a re-admission can be highly complex and a detailed analysis is required before it is clear whether a re-admission 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.

Currently, the national 28 day readmission data is only available up until 2011-12. The Trust has already reported on it last year as part of the 2013- 14 Quality Account. According to the national publication of emergency readmissions to hospital within 28 days of discharge indicators, the next version to be uploaded will be expected in August 2016. (indicators.hscic.gov.uk).

However, the readmission data for the year 2015-16 is available through CHKS as shown in the tables 1, 2, and 3 below but this not broken down by defined age groups.

The peer comparison has also been included to allow the organisation to benchmark its performance against peers. The details of the peer group have been included for the reference.

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 table below (table 1) shows an increase in the readmission rate for the Trust when compared to the peers for the period May – Dec 2015.

In April 2015, the Trust had a readmission rate much lower than the peer group.

At a Trust level, the Divisional and Speciality level breakdowns reveal higher than peer rates for the following Divisions and Specialities:

- Ear Nose and Throat (paediatrics)
- Acute Medicine
- Anaesthesia (pain management)

Work is underway across these and other specialities as part of the Trust and CCG collaborative programme to reduce readmissions and frequent attenders to the emergency department

For UHL (Table 2) the readmission rate across most of the year has been lower than the peers, with a slight increase observed in December 2015.

The trend across QEH site (Table 3) shows a readmission rate higher than the peers.

Much work has been undertaken throughout 2015-16 to review the readmission rates for the Trust and there is no doubt that the implementation of the new electronic patient record has had an overall impact on the way our data is recorded. Work is continuing to review the patient level data behind the readmission rates across all specialties in collaboration with our Trust informatics department.

It is hoped, with the development of new patient ambulatory care pathways and a planned new ambulatory unit for the University Hospital Lewisham site, that this will improve the Trust readmission rate during 2016-17 and beyond.

This is in conjunction with our 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 prevent patients attending or being admitted to hospital.

Table1: Lewisham and Greenwich NHS Trust readmission within 28 days

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Trust	6.9%	7.7%	7.7%	7.7%	7.7%	7.4%	8.2%	7.7%	7.9%	NA	NA	NA
Peer	7.4%	7.2%	7.3%	7.2%	7.2%	7.1%	6.9%	6.4%	6.2%	NA	NA	NA

Table 2: University Hospital Lewisham readmission within 28 days

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
UHL	5.1%	6.2%	6.4%	6.0%	6.4%	5.8%	6.9%	6.2%	6.6%	NA	NA	NA
Peer	7.4%	7.3%	7.3%	7.2%	7.2%	7.1%	6.9%	6.4%	6.2%	NA	NA	NA

Table 3: Queen Elizabeth Hospital readmission within 28 days

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
QEH	8.9%	9.6%	9.2%	9.6%	9.3%	9.2%	9.5%	9.2%	9.1%	NA	NA	NA
Peer	7.4%	7.2%	7.3%	7.2%	7.2%	7.1%	6.9%	6.4%	6.2%	NA	NA	NA

CHKS Peer Group

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

2.2.3 Patient Experience

2.2.3 (i) Patient Experience Indicator 1- The Trust's responsiveness to the personal needs of the patients

Patient Experience - responsiveness to personal needs of patients 2014 - 2015	2014	2015
Lewisham and Greenwich NHS Trust	63	65
Highest scoring Trust	88	88
Lowest scoring Trust	56	58

Source CQC National Inpatient Survey data 2015

The results of the Care Quality Commission's (CQC) national adult inpatient survey 2015 provides analysis of patient feedback across the NHS from July 2015.

This is the second inpatient survey to be carried out since Lewisham and Greenwich NHS Trust was established. We are delighted the hard work of all our staff has been reflected in overall improved rates of patient satisfaction. We improved in almost all the measures we are rated for; some key areas include:

- More patients saying they had confidence and trust in our staff
- More patients saying that they had been treated with respect and dignity and that they were well looked after.
- An increase in the number of patients who said they have received emotional support
- Patients reporting improved communication from staff
- An increase in the number of patients who reported there were enough nurses on duty to care for them.

Of course, there is no room for complacency and our goal is to improve so we are consistently one of the best performing Trusts. However, these results show that we are moving in the right direction and doing the right things. 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.

There are just three areas where we performed worse that other NHS Trusts. These relate to:

- The time patients say they spend on waiting lists before being admitted
- The number of patients saying their admission dates changed
- Patient perceptions around the availability of hand gel dispensers

On the first two issues, we are working with our commissioners to expand our surgery capacity and increase the number of staff this year, so we can treat more patients and improve waiting times. This will also help to reduce the number of times patients' appointments are rearranged.

It is disappointing that there is a perceived lack of hand gel dispensers, as we do have hand gel available in every ward and on every adult inpatient bed. Following this survey we will be look at how this is publicised on the wards.

CQC Inpatient Survey 2015 composite scores for question categories	2014	2015	Increase or Decrease
Emergency Department	8.3	8.6	0.3
Waiting lists and planned admission	8.2	8.2	0.0
Waiting for bed	6.6	7.1	0.5
Hospital and the ward	7.8	8.0	0.2
Doctors	8.0	8.4	0.4
Nurses	7.6	8.1	0.5
Care and Treatment	7.1	7.7	0.6
Operations and procedures	8.2	8.4	0.2
Leaving hospital	6.7	6.8	0.1
Overall view of care and services	5.5	5.5	0.0
Overall experience (0-10 scale)	7.4	7.8	0.4

Source CQC National Inpatient Survey 2016

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

The 2015 survey has provided the first opportunity to measure whether the improvement programme that was introduced since becoming a newly formed organisation has impacted on improving the patient experience, first in the newly formed organisation, and undertaken at a time of organisational change. Since then, the Trust has implemented its improvement plan in 2014 and 2015 across all services, and in particular had focused on communication among the clinical workforce, some of the estates constraints around privacy and dignity and a consistent approach to care as one Trust.

It is hoped that the impact of this can be seen in patient experience and overall, patients have reported an increase in satisfaction of 3.2% since 2014.

The Lewisham and Greenwich NHS Trust has taken the following actions to improve this score, and so the quality of its services, by developing an action plan to help address some of those specific issues.

For 2016/17 the Trust has set patient experience specific priorities which will form the work programme of a newly established Patient Experience and Quality Improvement Team.
These priorities include the following:

- Focus on Dementia
- Sources of feedback and actions – "You said, We did"
- Information Boards in Patient areas
- Trust wide approach – Divisional Patient experience plans capture, consistent, learning
- Staff engagement and wellbeing
- Develop ward councils and 'Just Do it' Programme – small things that make a difference
- Volunteering – staff programme, mealtime support
- Arts programme
- Engaging Patient Welfare Forum, Patient User Group, Healthwatch

Friends and Family Test

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.

Patient recommendation to family and friends					
	February-16	Lewisham and Greenwich NHS Trust	National Average	Highest scoring Trust	Lowest scoring Trust
A&E	Response rate	13.7%	13.3%	46.4%	0.20%
	Recommendation rate	93%	85%	100%	46%
Inpatient	Response rate	25.8%	24.1%*	62.2%	6.1%
	Recommendation rate	93%	95.00%	100%	74%

*Exc Ind Sector
Source: http://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/

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

The average national FFT response rate for A&E has declined with a drop also being seen with the highest scoring Trust. In 2015 the highest scoring Trust demonstrated a 53.8% response rate compared to the rate of 46.4% for February 2016. It is thought that this could be related to the pressures facing A&E units up and down the country.

The same trend has been seen with the Inpatient FFT scores. The average national FFT response rate for inpatients has dropped from 44.9% in 2015 to 24.1% in 2016. In 2015, the highest scoring Trust response rate was 81.08% with the lowest being 20.83%. These scores may reflect the fact that in 2015 there was a national CQUIN based on FFT which incentivised Trusts for response rates.

For 2016/17 the Trust will focus on introducing new ways in which to collect the FFT data using mobile technology and kiosks.

2.2.3 (ii) Patient Experience Indicator 2 – 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 enabling comparisons between similar trusts and to compare the experiences of staff in a particular trust with the national picture.
The table below demonstrates the overall response to the Staff Friends and Family Test (SFFT) questions within the 2015 Staff Survey. It demonstrates that:

- 60% of those who responded said they agreed or strongly agreed, they would recommend the Trust to friends and family as a place for treatment,
- 26% neither agreed nor disagreed that they would recommend the Trust to friends and family as a place for treatment.

This has improved from the 2014 survey where 57% of those who responded said they would recommend the Trust to friends and family as a place for treatment

Lewisham and Greenwich NHS Trust 2015 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 nor disagree	Agree	Strongly agree	Base (number of respondents)
5%	9%	26%	44%	16%	n 1,443

During 2015, the NHS Picker survey recognised that a number of Trusts had integrated to form combined acute and community based Trusts and as a consequence of this the survey is now broken down per Trust type.

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	
	2014	2015
Lewisham and Greenwich NHS Trust	3.59	3.66
National Average	3.7	3.73**
Highest scoring Trust	4.28*	4.22**
Lowest scoring Trust	2.99*	3.23**

* denotes scores for Acute Trusts only
** denotes score for combined acute and community Trusts
Source: NHS Picker Institute Annual Staff Survey 2015

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 2015 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	24	53,183
Lewisham and Greenwich NHS Trust	27	1,456
Best Performing Trust	17	323
Worst Performing Trust	37	3,918
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	86	36,395
Lewisham and Greenwich NHS Trust	83	980
Best Performing Trust	94	325
Worst Performing Trust	70	2,564

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

During 2015 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 2015 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, 250 nursing and nursing support positions were filled in 2015-16;
- Development and implementation of an online appraisal system, survey results demonstrate a 12% rise in appraisal rates;
- 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, survey results demonstrate a 4% improvement;
- Design and implementation of 100 day listening exercise for new recruits;
- Launch of bespoke 'One Organisation - Well Led' management development programme, inclusive of LGT management statement and principles;

Further analysis of the 2015 staff survey has been undertaken and shared across the organisation. This analysis included:

- Reviewing the data by division, site, staff group, and demographic group where possible.
- Comparing the outcomes with the Trust wide local survey carried out late 2014.
- Further interrogation to department/ ward level where useful, using web based portal provided by Quality Health, supporting development of local action plans.

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

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

The two key Trust wide areas of focus for 2016-17 are;

- 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 Chief Executive Officer [CEO] and participation from senior staff in Executive Walkabouts
- Continuation of the production of Weekly Bulletin advocating and celebrating success of the Trust.

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 Trusts 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 Trusts 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 that 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 2015 to March 2016, 56 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% (56/56) National Clinical Audits and 100% (4/4) National Confidential Enquiries which it was identified as eligible to participate in.

The tables below show:

- The National Clinical Audits and National Confidential Enquiries that Lewisham and Greenwich NHS Trust was eligible to participate in during April 2015 to March 2016
- 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 2015 to March 2016, 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.

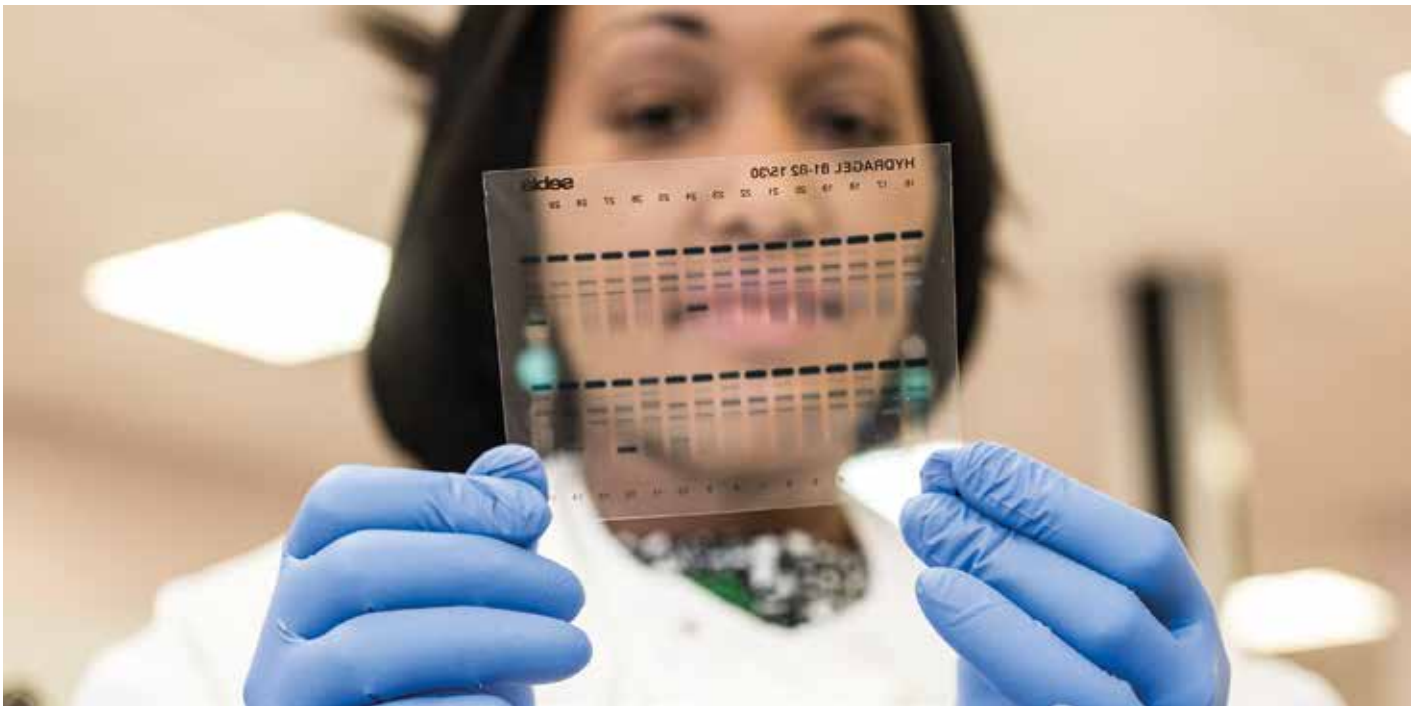


Table 1: National Clinical Audits on the Healthcare Quality Improvement Partnership (HQIP) Inclusion for the Quality Account

	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	In progress	In progress
	Acute Myocardial Infarction & Other ACS (MINAP Validation Study)	Yes	Yes	Yes	Yes	1st February 2016 – 16th March 2016	In progress	100%
2	Asthma – Paediatric	Yes	Yes	Yes	Yes	1st November 2015 – 30th November 2015	100%	100%
3	Adult Critical Care (ICNARC CMPD)	Yes	Yes	Yes	Yes	1st April 2015 – 31st March 2016	100%	100%
4	Bowel Cancer (National Bowel Cancer Audit)	Yes	Yes	Yes	Yes	1st April 2013 – 31st March 2014	103%	
5	Cardiac Arrhythmia (Cardiac Rhythm Management Audit)	Yes	Yes	Yes	Yes	1st April 2013 – 31st March 2014	62 cases	203 cases
6	Chronic Obstructive Pulmonary Disease (COPD) – Pulmonary Rehabilitation	Yes	No	Yes	N/A	12th January 2015 – 10th April 2015	100%	N/A
7	Community Acquired Pneumonia	Yes	Yes	Yes	Yes	1st December 2014 – 31st January 2015	14 cases	54 cases
8	Coronary Angioplasty (PCI)	No	Yes	N/A	Yes	1st January 2014 – 31st December 2014	N/A	100%
9	Cystic Fibrosis Registry	Yes	No	Yes	N/A	1st January 2014 – 31st December 2014	100%	N/A
10	Diabetes – National Adult Diabetes Inpatient Audit (NaDIA) – Patient Experience Questionnaires	Yes	Yes	Yes	Yes	21st September 2015 – 25th September 2015	42%	100%
	Diabetes – National Adult Diabetes Inpatient Audit (NaDIA) – Bedside Audit Questionnaires	Yes	Yes	Yes	Yes	21st September 2015 – 25th September 2015	100%	100%
11	Diabetes (National Adult Diabetes Audit)	Yes	Yes	Yes	Yes	1st January 2013 – 31st March 2014	100%	377 cases
12	Diabetes (National Adult Diabetes Audit)	Yes	Yes	Yes	Yes	1st January 2014 – 31st March 2015	100%	27 patients
13	Diabetes - Pregnancy in Diabetes (NPID)	Yes	Yes	Yes	Yes	1st January 2014 - 31st January 2015	100%	100%
14	Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	Yes	Yes	Yes	1st April 2013 – 31st March 2014	100%	100%
15	Diabetes (Paediatric Patient Reported Experience Measures)	Yes	Yes	Yes	Yes	19th October 2015 – 19th April 2016	In progress	In progress
16	Diabetes Foot Health	Yes	No	Yes	N/A	14th July 2014 – 10th April 2015	101 cases	N/A
17	Elective Surgery (National PROMS Programme)	Yes	Yes	Yes	Yes	1st April 2015 – 31st December 2015	83.8% pre-op questionnaires	
18	Emergency Use of Oxygen	Yes	Yes	Yes	Yes	15th August 2015 – 1st November 2015	100%	100%
19	Falls and Fragility Fractures (Inpatient Falls Audit)	Yes	Yes	Yes	Yes	12th May 2015 – 14th May 2015	100%	100%
20	Falls and Fragility Fractures (National Hip Fracture Database)	Yes	Yes	Yes	Yes	1st January 2014 – 31st December 2014	98.9%	150%
21	Falls and Fragility Fractures (National Fracture Service Liaison Database)	Yes	Yes	Yes	Yes	21st September 2015 – 16th October 2015	100%	
22	Heart Failure	Yes	Yes	Yes	Yes	1st April 2013 – 31st March 2014	100%	100%
23	Inflammatory Bowel Disease – Biologics Audit – Adult	Yes	Yes	Yes	Yes	12th September 2011 – 28th February 2015	< 6 cases	< 6 cases
24	Inflammatory Bowel Disease – Biologics Audit - Paediatric	Yes	No	Yes	N/A	12th September 2011 – 28th February 2015	0 eligible cases	N/A
25	Intermediate Care – Service Users Questionnaires	Yes	Yes	Yes	Yes	4th May 2015 – 24th July 2015	48 questionnaires	8 questionnaires
26	Intermediate Care – Patient Reported Experience Measures (PREM)	Yes	Yes	Yes	Yes	4th May 2015 – 24th July 2015	39 PREM	9 PREM
27	Lung Cancer (NLCA)	Yes	Yes	Yes	Yes	1st January 2014 – 31st December 2014	297 cases	
28	National Cardiac Arrest Audit	Yes	Yes	Yes	Yes	1st April 2015 – 31st March 2016	100%	100%
29	National Comparative Audit of Blood Transfusion – Blood Management in Scheduled Surgery	Yes	Yes	No	Yes	1st February 2015 – 30th April 2015	100%	100%
30	National Comparative Audit of Blood Transfusion – UK Lower GI Bleed Audit	Yes	Yes	Yes	Yes	1st September 2015 – 31st October 2015	100%	100%
31	National Comparative Audit of Blood Transfusion – Red Cell and Platelet Transfusion in Haematology	Yes	Yes	Yes	Yes	1st January 2016 – 31st January 2016	100%	100%

	Audit Title	Eligible UHL	Eligible QEH	Participated UHL	Participated QEH	Reporting period	% Submission rate - UHL	% Submission rate - QEH
32	National Emergency Laparotomy Audit	Yes	Yes	Yes	Yes	1st December 2013 – 30th November 2014	>50%	<50%
33	National Joint Registry	Yes	Yes	Yes	Yes	1st January 2014 – 31st December 2014	61%	
							302 cases	60 cases
34	Neonatal Intensive and Special Care (NNAP)	Yes	Yes	Yes	Yes	1st January 2015 – 31st December 2015	100%	100%
35	Oesophago-Gastric Cancer	Yes	Yes	Yes	Yes	1st April 2011 – 31st March 2013	>90%	
36	Parkinson's Disease	Yes	Yes	Yes	Yes	4th February 2015 – 30th September 2015	40 cases	
37	Percutaneous Coronary Interventions	No	Yes	N/A	Yes	1st January 2014 – 31st December 2014	N/A	227 cases
38	Procedural Sedation in Adults (Care in the Emergency Department)	Yes	Yes	Yes	Yes	1st August 2015 – 31st January 2016	100%	100%
39	Prostate Cancer	No	Yes	N/A	Yes	1st April 2015 – 31st July 2015	N/A	100%
40	Rheumatoid and Early Inflammatory Arthritis	Yes	Yes	Yes	Yes	1st February 2014 – 30th April 2015	88 questionnaires	24 questionnaires
41	Sentinel Stroke National Audit Programme (SSNAP) – Organisational Audit	Yes	Yes	Yes	Yes	1st April 2015	100%	100%
42	Severe Trauma (Trauma Audit & Research Network)	Yes	Yes	Yes	Yes	1st January 2015 – 31st December 2015	TBC	TBC
43	Vital Signs in Children (Care in the Emergency Department)	Yes	Yes	Yes	Yes	1st August 2015 – 31st January 2016	100%	100%

*Data submission and audit participation rates for Queen Elizabeth Hospital are published under South London Healthcare NHS Trust

Table 2: Audits on the HQIP list that did not collect data in 2015-16

	Audit Title
1	National Audit of Dementia*
2	National Complicated Diverticulitis Audit
3	Paediatric Pneumonia

*The National Audit of Dementia ran a pilot audit in 2015 which a limited number of Trusts were invited to participate in. Lewisham and Greenwich NHS Trust did not participate in the pilot audit but have planned to participate in the full audit in 2016.

Table 3: National Confidential Enquiries on the Healthcare Quality Improvement Partnership (HQIP) Inclusion for the Quality Account

	Enquiry Title	Eligible UHL	Eligible QEH	Participated UHL	Participated QEH	Reporting period	% Submission rate - UHL	% Submission rate - QEH
National Confidential Enquiry								
1	Maternal, Infant and Newborn Clinical Outcome Review (MBBRACE)	Yes	Yes	Yes	Yes	1st April 2015 – 31st March 2016	100%	100%
2	NCEPOD – Mental Health in Acute Care	Yes	Yes	Yes	Yes	Organisational Questionnaire	100%	100%
		Yes	Yes	Yes	Yes	Clinician Questionnaires	In progress	In progress
		Yes	Yes	Yes	Yes	Case Note Extracts	In progress	In progress
3	NCEPOD – Gastrointestinal Haemorrhage	Yes	Yes	Yes	Yes	Organisational Questionnaire	100%	100%
		Yes	Yes	Yes	Yes	Clinician Questionnaires	100%	86%
		Yes	Yes	Yes	Yes	Case Note Extracts	100%	100%
4	NCEPOD – Acute Pancreatitis	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%
5	NCEPOD – Sepsis	Yes	Yes	Yes	Yes	Organisational Questionnaire	100%	100%
		Yes	Yes	Yes	Yes	Clinician Questionnaires	100%	67%
		Yes	Yes	Yes	Yes	Case Note Extracts	100%	100%

Table 4: Additional National Clinical Audits that Lewisham and Greenwich NHS Trust Participated in during 2015-2016

	Audit Title	Eligible UHL	Eligible QEH	Participated UHL	Participated QEH	Reporting period	% Submission rate - UHL	% Submission rate - QEH
National Clinical Audits								
1	British Association of Endocrine and Thyroid (BAETS) Surgeons – Audit	Yes	Yes	Yes	Yes	1st April 2015 – 31st March 2016	In progress	In progress
2	British HIV Association – Routine Monitoring of Adults Living with HIV	Yes	Yes	Yes	No	1st January 2014 – 31st December 2015	100%	100%
3	British Association of Sexual Health – Audit on Management of 13-15 year old children attending sexual health services	Yes	Yes	Yes	Yes	1st April 2015 – 31st March 2016	100%	100%
4	Cardiac Rehabilitation Audit	Yes	No	Yes	N/A	1st April 2015 – 31st May 2016	In progress	N/A
5	End of Life Care	Yes	Yes	Yes	Yes	1st May 2015 – 31st May 2015	100%	100%
6	Hepatitis B in Pregnancy	Yes	Yes	Yes	Yes	1st April 2015 – 31st May 2016	In progress	In progress
7	National Diabetes Inpatient Audit (NaDIA) – Patient Experience Questionnaires	Yes	Yes	Yes	Yes	21st September 2015 – 25th September 2015	42%	100%
	National Diabetes Inpatient Audit (NaDIA) – Bedside Audit						100%	100%
8	RCOG – Each Baby Counts	Yes	Yes	Yes	Yes	1st January 2015 – 30th June 2018**	In progress	In progress
9	High Intensity Specialist Led Care – Point Prevalence Survey 2015	Yes	Yes	Yes	Yes	18th June 2015 – 18th July 2015	27% 103/386 Consultant Responses	
10	HIV/ STI Feasibility Study	Yes	Yes	Yes	Yes	1st April 2015 – 31st March 2016	100%	100%
11	London Quality Standards Audit	Yes	Yes	Yes	Yes	7th December 2015 – 21st January 2016	100%	100%
12	National Audit Project – NAP 6 – Perioperative Anaphylaxis	Yes	Yes	Yes	Yes	5th November 2015 – 6th November 2016	In progress	In progress
13	Potential Donor	Yes	Yes	Yes	Yes	1st April 2015 – 31st March 2016	100%	100%
14	7 Day Services Audit	Yes	Yes	Yes	Yes	30th March 2016 – 5th April 2016	100%	100%

** This audit will be continuing for 3 years.

Reviewing Reports of National Clinical Audits

The reports of all National Clinical Audits and National Confidential Enquiries are reviewed by the Clinical Effectiveness Department before being disseminated to all appropriate clinical leads and senior managers. All recommendations made as a result of a National Clinical Audit or National Confidential Enquiry are highlighted to the clinical leads and any actions identified are presented at the appropriate committee and service area for review, action and monitoring. A highlight report from each committee meeting is sent to the Trust Board for information and review.

The reports of National Clinical Audits and Confidential Enquiries were reviewed by Lewisham and Greenwich NHS Trust between January 2015 to December 2015 and some of the actions that Lewisham and Greenwich NHS Trust will be taking to improve quality are detailed below:

National Neonatal Audit Programme (NNAP) – Both University Hospital Lewisham (UHL) and Queen Elizabeth Hospital (QEH) have introduced feeding rooms to their Neonatal units to encourage and provide an environment conducive to breast feeding. This will aid the continued support provided to women to establish breastfeeding prior to babies discharge from hospital.

National Emergency Laparotomy Audit (NELA) – One of the key recommendations in the 2015 audit report was ensuring consultant-delivered service, 24 hours a day, 7 days a week. The Trust has appointed 7 new Anaesthetic Consultants to further support this model of care.

National Bowel Cancer Audit (NBOCA) – The Trust achieved >80% case ascertainment or data completeness for the key indicators captured by the audit. 100% of patients were seen by a Clinical Nurse Specialist.

Older People (Care in the Emergency Department) – Cognitive assessment was undertaken in 12% of patients at UHL and 11% of patients at QEH compared to a national median of 11%. Where assessments were undertaken all were done using a structured assessment tool. Communication of the findings of the cognitive assessment was shared with the admitting ward in 100% of cases audited at each site.

An Early Warning Scores (EWS) were recorded for 72% of patients at UHL and 88% of patients at QEH compared to a national median of 82% against a target of 100%.

National Pregnancy in Diabetes (NPID) Audit – In line with the recommendations made by the audit, the Trust has acknowledged the need for a dedicated pre-pregnancy service for all women with diabetes which would be held in the form of a Multidisciplinary Team (MDT) led clinic. The Diabetes leads will map the pathway for this service and re-apply for funding in 2016/17 to develop this service.

National Lung Cancer Audit (NCLA) – The Trust reported performance in line with or above the national average for most indicators recorded by the audit, including the number of patients being discussed at an MDT meeting, and patients with non-small cell lung cancer having surgery.

Initial Management of the Fitting Child (Care in the Emergency Department) – The Royal College of Emergency Medicine (RCEM) fundamental audit standard of which blood glucose of actively fitting children was checked and documented in the patient's clinical record was achieved at 75% at QEH and 100% at UHL in line with a national median and the RCEM standard of 100%.

Sepsis Study – The Trust continues to develop the in-house training offered to junior doctors upon induction to further ensure emphasis is placed on the recording of sepsis on any communication with the patients General Practitioner, and to ensure where applicable, sepsis is recorded on a patient's death certificate. The Trust has established a Mortality Review Committee which will support the review of patients whose death is sepsis related. Work also continues to promote the use of the sepsis screening tools available in the Trust, and further data gathered to evidence it's usage for the National Commissioning for Quality and Innovation (CQUIN) related to Sepsis will help to identify further areas for development.

National Hip Fracture Database (NHFD) – In-hospital falls resulting in hip fracture are reported as having fallen in the 2014 audit. At QEH 3% of patients sustained an in-hospital hip fracture with 2.1% of patients at UHL against a national average of 4.3%. For both hospital sites this is a downward trajectory and reflects the focus in the Trust on reducing falls in hospital.

The Trust was reported as having an above average Length of Stay (LoS) when compared to the national average 19.3 days. The LoS at QEH was 21 days whilst at UHL it was reported at 22.5 days. A number of schemes have been trialled by other Trusts and reported in the NHFD, some of these the Trust is considering implementing. One such scheme is the introduction of an early supported discharge service that facilitates patient's transition home. A Community based Orthopaedic Team can be accessed at UHL, although this team only provide a service to the hip fracture population when capacity allows. The Trust may consider exploring whether this team could be expanded to provide an early supported discharge service.

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

The reports of 277 local audits were reviewed by the Trust between 1st April 2015 to March 31st 2016. The examples below taken from across the Trust demonstrate some of the actions taken to improve the quality of our services. A full list of the local audits reviewed is attached in Appendix 1.

Speciality	Changes to Practice
Ear, Nose and Throat	The Ear, Nose and Throat (ENT) service has introduced a Tracheostomy Passport. The passport is used to document key information about the date of tracheostomy insertion and information about the size, make and duration of use of the tracheostomy and any other special requirements. The passport was introduced to improve the documentation and transfer of management plans when a patient was moved between wards.
Dietetics	The Dietetics department in conjunction with Clinical leads developed a Nasogastric Tube (NGT) booklet for use on all medical and surgical wards, to be used as a unified record to incorporate all documentation around NGT placements. This booklet is used by both nursing and medical staff to ensure documentation of initial placement; chest x-ray reporting and ongoing checks are all recorded in one place before feeding.
Sexual and Reproductive Health	The Genitourinary Medicine (GUM) service introduced a system of alerting patients to upcoming appointments via Short Message Service (SMS) 'Texts' instead of via letter. The change in practice resulted in a decrease in the number of patients who Did Not Attend (DNA) appointments and when surveyed, 82% of patients reported they preferred this method of communication.
General Medicine	The General Medicine service adopted the REDCOAT proforma (R= resuscitation status, E= expected discharge date, D= drug chart, C= cannula (duration and need), O= oxygen prescription, A= antimicrobial (duration and indication documented), T= thromboprophylaxis) to standardise record keeping on the Consultant post take ward round and to ensure all of the key elements included within the acronym were considered when admitting patients and commencing their course of treatment.
Elderly Medicine	The Falls team in conjunction with the Elderly Medicine service have refined and adopted an inpatient falls proforma and accompanying algorithm to guide the management of patients who have had a fall in hospital, which includes observations for a suspected head injury.
Diabetes	The Diabetes service introduced an educational intervention training programme for mental health staff and carers who support patients with diabetes and severe mental illness. The service recognised no such training was available to mental health staff and carers so introduced the training to support mental health care professionals in promoting the uptake of the nine key care processes for patients with diabetes.
Anaesthetics	The Anaesthetics services introduced hand held tablets into the anaesthetic room as a distraction technique to reduce anxiety levels in children prior to an operation, and to encourage children's co-operation with staff at the point of induction of anaesthesia.
Children's Services	Children's services have continued to review the pathway in place for the admission of paediatric haemoglobinopathy patients who require regular blood transfusions. In 2007 the average length of admission for paediatric haemoglobinopathy patients requiring transfusion was 8 hours and these were undertaken on a weekend. Due to changes in the pathway, which included changing the day patients were admitted to a weekday and assigning a dedicated doctor to the service, this has now been reduced to just over 5 hours.

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, ppilepsy 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 continues to focus on studies that are of good quality and are relevant to the needs of the population it serves.

The Trust has also developed its promotion of research, innovation and clinical quality activities by holding annual research and innovation events. Led by the Medical Director and Associate Directors for Research and Development, the 2015 Innovation Day saw thirteen oral presentations on research and innovation shared widely across the organisation, together with a further seventy eight abstract poster presentations representing all specialties.

The number of patients receiving NHS services provided or subcontracted by Lewisham & Greenwich NHS Trust in 2015/2016 that were recruited during that period to participate in research approved by a research ethics committee was **958**.

Statement of Patient Participation in Research

Nine hundred and fifty eight patients whose care was provided or subcontracted by Lewisham and Greenwich NHS trust were recruited to clinical research approved by a research ethics committee during 2015-16.

Participation in Clinical Research

Lewisham and Greenwich NHS Trust continue 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 was involved in conducting **135** clinical research studies in a number of different specialties (see figure below).

Research Active studies by CRN Divisions:

Division 1: Cancer

Division 2: Diabetes, Stroke, Cardiovascular, renal, metabolic and Endocrine Disorders

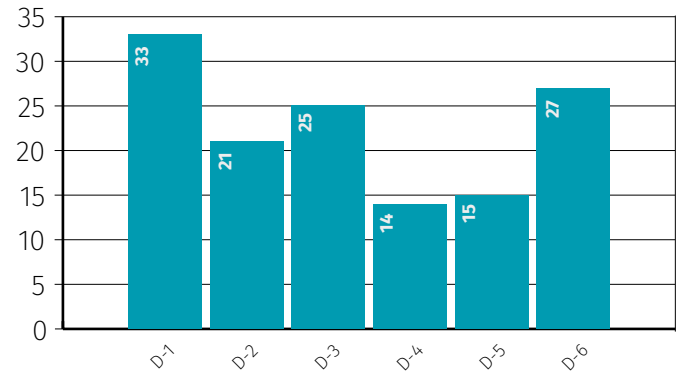
Division 3: Children, genetics, Haematology, Paediatrics, reproductive Health and Childbirth

Division 4: Dendron, Mental Health and Neurology

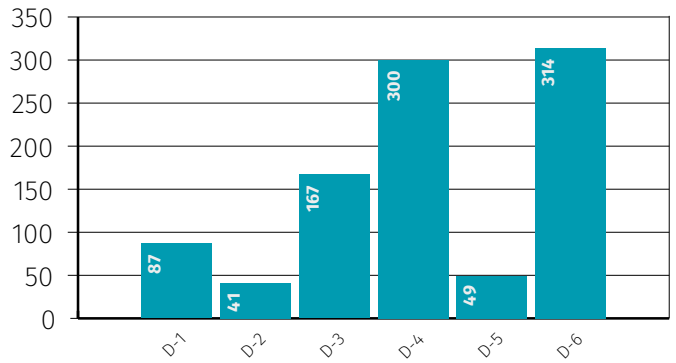
Division 5: Primary Care, Age and Aging, Dentistry, Health Services Research, Public Health, MSK, Dermatology.

Division 6: Anaesthesia/Peri-operative Medicine and Pain management, Critical Care, Injuries/Emergencies, Surgery, ENT, Infectious Disease/Microbiology, Opthalmology, Respiratory, Gastroenterology, Hepatology.

Research Studies open by CRN Division



Number of Patients recruited to research studies by CRN Division



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.

A new R&D structure will 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.

Part 2

2.5 Goals agreed with Commissioners (CQUINs)

A proportion (2.5%) of Trust's income in 2015-2016 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 89.225% of its CQUIN goals for April 2015-March 2016.

Part 2

2.6 What others say about the provider

Care Quality Commission (CQC)

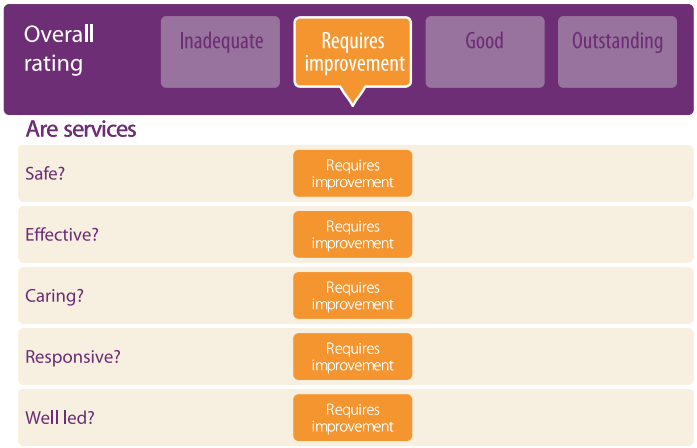
Lewisham and Greenwich NHS Trust is required to register with the Care Quality Commission and its current registration status is 'registered without conditions'.

The Care Quality Commission has not taken enforcement action against Lewisham and Greenwich NHS Trust in 2015-2016.

Lewisham and Greenwich NHS Trust is subject to periodic reviews by the Care Quality Commission (CQC) and the last review was on the 26th, 27th and 28th February 2014.

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

The CQC ratings for the Trust



Lewisham and Greenwich NHS Trust has not been inspected by the Care Quality Commission (CQC) since receiving a rating of "Requires Improvement" following the February 2014 inspection. We agreed a quality improvement plan with over 140 actions to address the issues raised by the CQC. Actions included:

- Making improvements to the emergency department at QEH to address safety issues.
- Introducing new ways to improve hand hygiene compliance, such as new hand hygiene foam or gel dispensers in public areas around our hospitals.
- Improving how we share information from incidents and complaints
- Ensuring audits are carried out on all our medical equipment
- Introducing more robust processes for dealing with medical waste.

Over 2015-16, progress against the plan was monitored by the Trust Board, as well as by:

- The Clinical Commissioning Groups (CCGs) for Lewisham, Greenwich and Bexley.
- The Trust Development Authority (TDA), which regulates Lewisham and Greenwich NHS Trust.

We completed the actions in our improvement plan by July 2015, recognising the need for ongoing focus in three key areas:

- Addressing infrastructure problems on the Queen Elizabeth Hospital (QEH) site, where more work is required to address historic engineering and maintenance issues. We have submitted plans for extra funding to address these issues.
- Continuing to improve emergency care at QEH and University Hospital Lewisham (UHL).
- Increasing the capacity of our endoscopy services to meet the increase in the local population needs and the additional demand created by the expanded National Bowel Cancer Scoping and Screening service.

Part 2
2.7
Data Quality

Quality data is data that is:

Confidential, accurate, valid (that is 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 extract 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, part of which is a number of recommended actions. These recommendations are reviewed and are used to develop an action plan that needs to be delivered. Recent recommendations have centred around improving the quality of information available in the form of source documentation – with members of the coding team meeting with clinicians to feed back around the quality of the information and developing new data recording pro-formas 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 he implementation dos not impact on the quality of Trust clinical coding.

A training plan is in place to deliver training to coding staff around how they 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 – how 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 why it is important that they understand what they record in the record is used for and how it forms part of the patients health record as well as being used to calculate how much the Trust should be paid for treating that specific patient via the Payment by Results process, as well as being a national record of the Consultants 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 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 data 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 2015-16 is outlined below:

Which included the patient's valid NHS number was:

99.41% for admitted care;
- UHL = 99.24%
- QEH = 99.55%

99.70% for out-patient care;
- UHL = 99.62%
- QEH = 99.79%

97.11% for accident and emergency care;
- UHL = 95.88%
- QEH = 98.62%

Which included the patient's valid General Medical Practice Code:

98.77% for admitted care;
- UHL = 98.96%
- QEH = 98.58%

99.21% for out-patient care;
- UHL = 99.27%
- QEH = 99.14%

97.36% for accident and emergency care;
- UHL = 97.74%
- QEH = 96.98%

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 allows organisations and individuals to ensure that personal information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care.

The Information Governance Toolkit published by the Department of Health provides the standards against which healthcare services are required to measure their Information Governance performance. This year (March 2016) the Trust has achieved an overall score of 76% and has been graded as satisfactory.

Part 2
2.9
Clinical Coding

Payment By Results

Payment by Results (PbR) is the method by which the Trust receives payment for patients seen and treated within the Acute setting. Each patient's condition, what treatment they received, how they were treated 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 accurate so that the Trust is not over or under paid. In addition to this, the coded data forms part of the patients 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 2015/16, however both internally and externally managed clinical coding audits were completed in year. The audit reports have been shared with the site based coding teams and action plans developed around the recommendations

The results demonstrated the following:

Area	Spells	HRG Change / error rate	Primary Diag - correct %	Secondary Diag - correct %	Primary Proc – correct %	Secondary Diag - correct %
Pain Elective - UHL	154	7.1%	85.1%	90.0%	98.0%	93.8%
Hernia Elective - UHL	135	5%	94.1%	83.1%	94.0%	76%
Random Audit (Adults) - QEH	101	6.9%	89.0%	96.3%	94.44%	88.4%
Trust Clinical Coding Audits 15/16	390	6.4%		94.0%	95.8%	87.5%
Trust audits 2014/15	317	7.3 %	89%	90.5%	94.5%	82.4%
National comparator - Median (Capita PbR audit data 2012/13)		7.0%	91.2%	88.6%	93.3%	82.6%

The relatively low level of correctly coded Primary Diagnosis would put the Trust below the national average, with other indicators (secondary diagnosis, Primary procedure etc.) showing a higher level of accuracy. The Trust is working with the coding teams to ensure that all staff can access required training, as well as supporting staff who wish to undertake additional training to attain their Accredited Clinical Coder (ACC) qualification.

In addition to this the coding teams meet regularly with clinicians to review the coding against the case notes / clinical documentation to increase the clinicians awareness about how clinical terms should be used to improve coding accuracy, as well as ensuring that the coding staff are aware of any changes or developments in clinical practice that the coding needs to reflect.

Part 3

3.1

Review of Quality Performance in 2015-16

3.1.1 Priority 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 were 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 90% compliance across all departments	- **We fully achieved this.** - The Trust has promoted hand hygiene through the staff training programme as well as running a hand hygiene initiative - the ***'Clean hands save lives'*** campaign. This has included champion posters, a new Trust hand hygiene logo, hand hygiene roadshows as well as continuation of our regular audits of compliance with feedback to the wards and Divisions.
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 of observations is carried out and ensuring proactive intervention of the results of these observations is taken.	- We will ensure successful roll out of our new Early Warning Score Observation Charts across all sites - We will introduce the use of the SBAR communication tool in all clinical areas to support robust escalation and handover of care - We will implement the Sepsis toolkit across all areas and will conduct monthly audits on performance	- **We fully achieved this.** - The new observation charts including the updated Early Warning Score for Adults (NEWS) was standardised and rolled out across the Trust by the end of April 2015. As a result of standardising the Early Warning Score for adults, we also had to update our cardiac arrest audit tool to ensure it captures all data and the Early Warning Scores prior to cardiac arrest event. By the end of July 2015, baseline audits had been undertaken to identify the baseline of compliance with completion of physiological observations, scoring of the Early Warning Score (EWS), appropriate escalation and timely review, within adult, children and maternity areas. The baseline audit showed: Completion of observations – 98% EWS accuracy – 80% Escalation of a triggering patient – 58% Increased frequency of monitoring for triggering patient – 33%. This showed that additional training and support for front line nursing staff was required so focused teaching was introduced on all inpatient wards with additional development and support by Practice Development Nurses. Spot check audits on the implementation of NEWS were introduced in September 2015. **SBAR communication tool** An audit of current SBAR practice was completed in June 2015 which showed that use of the tool was patchy and inconsistent across the acute hospitals. A new SBAR tool is under development and the plan is to roll this out with training during 2016. **Implementation of Sepsis Toolkit.** Local protocols were put in place during 2015 – 16 to identify patients who required sepsis screening.
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.	- Achieving return to national comparable rate for stillbirths - Increase detection of growth restricted babies in utero - Reduce poor neonatal outcomes associated with poor / inadequate foetal surveillance in labour, whether intermittent auscultation (IA) or continuous electronic foetal monitoring (CEFM)	- **We partially achieved this.** - The Trust's stillbirth rate during 2015 – 16 was 4.7 per 1,000 births which is at about the national average. The 2014 MBRRACE date is due to be released this month. - We have appointed dedicated Fetal Wellbeing leads to lead the work across the Trust. - We have developed 5 workstreams to address the "saving babies lives" care bundle. - The Introduction of the Growth Assessment Protocol is an outstanding area of work which we are continuing to progress, but progress has been delayed due to capacity issues within the Ultrasound department. This is a national issue owing to a shortage of ultrasonographers. - We are working with partner Trust organisations to develop shared appointments to enable us to provide an enhanced USS (fetal dopplers) at 20 weeks which will detect women at high risk of growth restriction and therefore transferring to a high risk pathway. In addition to this all women will have a growth scan at 36 weeks. - There is ongoing work by our fetal wellbeing leads in supporting, teaching and competency testing all staff responsible for care during labour. - We are also in the process of reviewing a central monitoring system to implement across our labour wards for the near future.

Our quality priorities and why we chose them	What success will look like	How did we do?
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. Significant progress was made during 14/15 with weekly pressure ulcers panels running with support from our CCGs to understand the root causes and contributory factors. This work has led to a more focussed approach to addressing the challenges, particularly within our community services, and continued collaborative work is still required for 15/16	- Improve the accuracy of the Waterlow score for patients in hospital and community services we provide and achieve at least 90% compliance with completion of scores - 100% of eligible clinical staff in community services and 85% of all ward staff (from a Training Needs Analysis - TNA) to have undertaken the new electronic learning package on pressure ulcer prevention and management - Monitor incidence of grade 2, 3, and 4 pressure ulcers attributable to Trust for reporting and reduction	- **We have partially achieved this.** - During 2015-16 the Tissue Viability team have been undertaking mattress audits. This has involved on a given day reviewing every patient who is using a pressure relieving mattress in the acute hospitals. During the audits the completion and accuracy of the Waterlow score has also been assessed. This has shown some improvement in the completion rate of the Waterlow assessment during the year, however there remains an issue with accuracy. An action plan to address this is being written into the objectives for the workplan of the Pressure Ulcer Working Group for 2016-17 and the audits will continue quarterly to review progress. The Tissue Viability team have trained 450 staff regarding the completion of the Waterlow assessment tool. - The e-learning package was implemented during 2014-15 and a significant percentage of staff worked through it. During 2015-16 the number of staff completing the e-learning package has reduced as the requirement for mandatory training took precedence, however, work across all wards will continue during 2016-17. - The incidence of pressure ulcers of different grades continues to be monitored by the Trust and during 2015 – 16 the reported numbers were: Grade 2 = 568 Grade 3 = 77 but after investigation 9 were found not to have been attributable to the Trust but to the seriousness of the patient's medical condition at that stage in their illness. Grade 4 = 7 This represents a decrease in the number of grade 4 pressure ulcers attributable to the Trust over past years. The challenge in the year ahead is to continue this improvement and to reduce the numbers of grade 3 and grade 2 pressure ulcers. There has been an improvement in the documentation of nursing assessment when patients are admitted to hospital. Significant improvement in reducing pressure ulcers on noses and around ears resulting from breathing equipment has been achieved by staff in the critical care unit at QEH. This resulted from shared learning from the UHL unit where the same change had been made the previous year; they moved to full face masks rather than those covering just the nose and mouth. In addition critical care now have pressure relieving mattresses in place from admission for all patients on the unit which has helped to reduce the incidence and severity of pressure ulcers on the back and sacrum.
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 10% by the end of year	- **We have partially achieved this.** - During 2015 – 16 the total number of patient falls resulting in moderate harm was 29, and there were no incidents resulting in severe harm or death. This is an improvement over the previous year (2014 – 15) in which there were 38 moderate harm falls, 4 severe harm and 3 patient falls resulting in death, and represents a reduction in harm of 29%. - A Trust wide group has focused on methods to reduce the harm suffered from patient falls including ensuring risk assessments for each patient who may be susceptible to falling are undertaken on admission and if having to transfer to another ward. Implementing improved care plans to provide increased supervision for as many patients at high risk of falling as possible and implementing an 'arm's length initiative' to ensure that patients have their call bell within reach to call for assistance to mobilise. - The Trust will continue to work hard over the next year to reduce this level of harm even further and achieve the overall 10% reduction by end of 2017.
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 Embed the new organisational culture further to ensure that all staff know they are expected to report and learn from all incidents, serious incidents, complaints, claims and case reviews. The Trust's values and behaviours have been explained through training and staff focus groups. Policies for the new organisation, learning from the best of the legacy organisations, have been created and widely disseminated and include a policy about raising concerns ('whistleblowing'	- Increase in Incident reporting - Identify appropriate staff to undertake Root Cause Analysis Training - Promote and provide opportunities to share the learning identified by incident investigations, complaints and claims, CAS alerts, and other national initiatives - Ensure there is an annual staff awards process and ceremony to include a Patient Safety Award.	- **We fully achieved this.** - For the period between April 2015 and March 2016 a total of 17,733 incidents (includes clinical, patient safety and non-clinical incidents) were reported on the incident reporting system within the Trust, which is an increase over the previous year (15,869) of 1,864 or 8.5 per cent. - Quarterly reports on incident reporting are presented to the Quality and Safety Committee within the overarching Risk Management Report. - During the period 01.04.15 to 30.09.15 the Trust achieved a reporting rate to the National Reporting and Learning System (NRLS) of patient safety incidents of 35.78 incidents per 1,000 bed days. This was an increase above the rate in the previous 6 months of 34.89 per 1,000 bed days. - During the past year Root Cause Analysis training sessions have been offered monthly by a Patient Safety Manager, and these sessions are ongoing. - 'Safety Signals' one page alerts have been devised and disseminated throughout the Trust on the following topics during 2015 - 16: Nasogastric feeding tube placement, Penicillin Allergy, Do Not Resuscitate orders. - 'Take 5' is now a regular part of ward handover and well established throughout the acute wards. - Patient Safety flyers x4 have been produced specifically aimed at junior doctor. - Two 'Sharing the Learning' events were held (each seminar repeated on both hospital sites) in May 2015 and November 2015. These included sessions where relatives of patients attended and gave personal accounts of their relative's experience of care. A junior doctor also provided a personal reflection of an adverse event he had been involved in where the patient came to a degree of harm, including the changes subsequently made to improve patient safety in future. The sessions were attended by Trust staff, and representatives from the CCG, Trust Development Authority, and a local GP. The events were recorded by our Design and Photography department and videos of the patient stories have been used subsequently at Divisional and Directorate meetings to share the learning with other staff who were not able to attend the events. - Further Sharing the Learning seminars are planned for April / June and November / December 2016. - The Deputy Medical Director for Quality and Safety introduced a staff Patient Safety Award which is to continue as an annual event. The last award went to the junior doctor who had presented his reflection and resulting patient safety improvements at the Sharing the Learning event.

3.1.2 Priority 3 - Clinical Effectiveness

Our quality priorities and why we chose them	What success will look like	How did we do?
3.1.2. (i) To continue the work on embedding the process for mortality reviews across the Trust During 2014-15 the Trust established a process for the review of patient mortality in all specialties. Whilst much work has been undertaken, the processes need to be embedded across all specialties to ensure regular reporting of findings, learning from the reviews and sharing the learning across the organisation. The Trust mortality rate had increased during 13-14 and although much of this has been investigated, further, continued work will ensure that all elements which contribute to the mortality rates such as clinical practice decision-making, clinical documentation, comorbidity recording and clinical coding are fully reviewed, understood and action taken where required.	- Aim for Trust SHMI of 1.0 or less - Introduction of co-morbidity and clinical coding proforma for all deaths - Monthly reviews of those deaths in low risk groups - Presentation of reviews and learning at Trust Wide Mortality group and Divisional Governance groups - Introduction of co-morbidity and clinical coding proforma for all deaths - Reduction in inaccurate clinical coding of deaths	- **We have fully achieved this.** - **The Trust latest SHMI is 1.0** During 2015-16 the Trust fully reviewed its Mortality review processes, Trust structures for reviews of mortality and set up new processes, systems for the reviews of the Trust mortality, this included Consultant led coding and introduction of Mortality Review proformas. The Trust now has monthly Mortality Review Committee meetings with representation from all Divisions and all Divisions are required to report on their monthly mortality. All queries with coding are reported back to the coding department so accurate information can be ascertained. The Trust has introduced a new co-morbidity and clinical coding proforma to ensure all information is captured and coded in full. A regular report to the Trust Quality and Safety Committee from Divisions has been introduced which reports the outcomes of the reviews and any learning which has been shared.
3.1.2. (ii) We will continue to focus providing individualised care for patients with dementia and their carers and will expand this work into intermediate and community care	- Established dementia screening and assessment process for patients in intermediate and community care - Established Carer's Survey for carers within intermediate and community care settings Development of discharge plan and communication for GPs specific to dementia care for patients	- **We have fully achieved this.** The Trust has a robust system for screening all patients over the age of 75 who are admitted to the acute and intermediate beds for Dementia. As part of the Dementia CQUIN for 15-16, the Trust reported 100% for the whole year on Dementia screening and referral for follow up care. As part of the Trust's Dementia programme, Carer's Surveys have been introduced and Carer's drop in sessions have continued to be successful in supporting carer's. As part of the programme to ensure that communication is seamless across acute, community and primary care, all patients who have been screened and recommended for further follow up are identified and the GPs contacted with the information. This enables GPs to have the most recent updated information on their patients. Across the Trust, we are enabling open visiting at all times for immediate family (as identified in the care plan). This was the case for most of our services, and we are pleased to make it consistent across the Trust. As well as showing our commitment to **John's Campaign** this will benefit all patients. For visitors for maternity, children's and ITU/HDU wards the special visiting arrangements will be still in place. **Johns Campaign** We were one of the first 100 NHS hospitals to sign up to "Johns Campaign", a new initiative which includes giving the relatives or carers of those living with dementia the right to stay with them in hospital.
3.1. 2. (iii) Improving the quality and effectiveness of care to children and young people with complex needs and long term conditions. As the provider responsible for services for children across the hospital and community settings we aim to improve the care to be provided closer to home for children and young people: supporting reduction in length of stay and preventing readmission to hospital and re-attendance in the emergency department.	- We will scope and analyse the care and movement of children and young people with complex needs and long term conditions that could be shifted from hospital into community through rapid response and early discharge - We will redesign and develop collaborative pathways to pilot during quarter 4 of the year and will aim to introduce new pathways at the start of 2015/16	- **We have fully achieved this.** - Through the work of the Children's 15-16 CQUIN the Trust embarked on a large scale project to improve the quality and effectiveness of care for children and young people with long terms conditions. - During the early part of 15-16, the Trust investigated and analysed the movement of children and young people with complex needs and long term conditions that could be shifted from hospital into the community care through rapid response and early discharge. - The Trust also developed a series of events with stakeholder's and service users (CYP and their families) to ensure the local approach to pathway redesign met children's needs but also reflected the strategic and partnership priorities for community services for children and young people. - In joint collaboration with community and primary care partners, the Trust comprehensively tested the pathway for children with Asthma and for 2016-17 has set a strategic plan to implement the full pathway for Children with Asthma.
3.1.2. (iv) Delivering Safe Care to Children in Acute settings	- Reduction in incidence of harm to children due to failure to monitor	- **We have fully achieved this.** There were no cases of harm to children where failure to monitor has been identified as a root cause or contributory factor during 2014–15.

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) To further embed the Friends and Family Test across community and outpatient services The Trust has implemented the National Friends and Family Test (FFT) across all of its services. We have used feedback we have received to help us identify service improvements. Because the feedback is so useful we would like to ensure that all services are fully involved with the Friends and Family Test.	- 100% services will have FFT feedback. All services will be able to demonstrate that they have analysed and used the feedback to inform the service about quality	- **We fully achieved this.** - We continued the roll out of Friends and Family Test across community and outpatient services including our services at QMS. - By December 2015, all services run by the Trust had made the Friends and Family Test available to patients and most services run by the Trust were receiving feedback via the Test. - Work to engage patients in the hard to reach groups, included the recruitment of a temporary project manager in Community Nursing to support engagement and this was reflected in the gradual increase in feedback, particularly from District Nursing. - All services are provided with the scores achieved each month, and the free text comments so that they can see what people are saying about their services and make any necessary improvements. - Managers were asked to provide information about service improvements in response to feedback in their reports to the Patient Experience Committee. For example, the Acute and Emergency Medicine Division reported in November that Matrons had reviewed all the comments received since April for their wards at Queen Elizabeth Hospital and they had 666 responses of which 644 were positive and 22 negative (3.4%). Themes identified were about food & noise at night - Actions · Results shared with ward managers · Noise at night – ward managers to re-issue night shift guidelines · Bread & ice cream- ice cream can now be ordered via Facilities Management help desk.
3.1.3. (ii) To continue to roll out the After Action Review process within the Trust by incorporating AAR training in the Trust training programme and supporting the development of AAR conductors In 2014 the Trust planned and implemented a project to roll out After Action Review (AAR). AAR is a method to enable a structured conversation between the multi-disciplinary team to explore events and identify what has gone well and what has not gone well. It is a process for learning from mistakes and from good practice. The project has been successful and we would now like to train more staff to undertake AARs and to encourage the routine use of this type of structured conversation.	- AAR training is incorporated in the Trust training programme. Audit of AAR shows that staff understand the principles and are embedding it in their daily practice	- **We have fully achieved this.** During 2015. The Trust continued to provide training and support to staff to undertake After Action Review (AAR). **AAR Expect Training** During the first six months of implementation, more than 90 LGT staff attended an AAR Expect workshop across both sites. Initial training focussed on specific pilot areas, consisting of the 3 medical and 3 surgical wards at UHL. A lead manager was then identified in the Workforce Development Team and AAR Expect training was made available across site accessible through the Education & Development training team. Feedback about training held in 2015 was overwhelmingly positive, but after initial high take up of courses offered, attendance reduced to low levels in late 2015 and as a result the Trust has reviewed the requirement for number of courses. Access to information about AAR is available to staff on the website via the Workforce and Education page on the Trust intranet, but more needs to be done to promote AAR across services during 2016-17. **AAR Conductors** 28 trained AAR Conductors volunteered across LGT. These staff were trained to facilitate the more complex AAR's run in the organisation, when it is considered beneficial to have someone independent of the team and\or service involved in the AAR. Events were run to engage with and support these conductors. Unfortunately these events were not well attended and more work needs to be done to engage with trained conductors. **Changes following AAR's** - Protocols and Standard Operating Procedures being developed for the Birth Centres on both sites - New patient identification checks with armband in anaesthetic room introduced - Avoiding Drug errors - Surgical wards now display a poster regarding administration of Oxycodone MR. - Medical staff are given training by Pharmacy regarding writing on medication charts and part of the pharmacist role on the wards is to ensure prescriptions are clear so the correct formulation is given to the patient. - Ward has daily Pharmacist cover. - The ward Controlled Drugs registers are audited every 3 months and part of this audit is to ensure that the correct formulation of each CD is documented clearly on the register pages. - Avoidance of Falsely labelled C.Diff positive results. - C.Diff samples running twice daily with considerable improvement of the turnaround times allowing more rapid diagnosis. Staff moved to a card testing strategy. Benefits are that it lessens the demand on the machine and is easier to interpret and quicker. Every member of lab staff has a training folder with evidence of training.
3.1.3. (iii) To develop cross-divisional learning from patient stories and feedback 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.	- Learning is shared through structured discussions at the Patient Experience Committee. - Evidence of change through learning is reported.	- **We have fully achieved this.** - The Divisions were provided with a reporting format to the Patient Experience Committee to provide them with a structured way of reporting learning from patient experience, including complaints and compliments. The Divisions used this format and reports were received at the committee as planned. - Examples include: - Refresher sessions in complaint handling and de-escalating difficult situations arranged for neonatal medical staff following a disagreement between a doctor and parent in NICU. - Discharge lounge checklist introduced by Matron to ensure seamless transfer out of hospital with relevant information for patients and relatives following complaints about communication of discharge arrangements. - The committee is attended by representatives from all the of the clinical Divisions, and this reporting has enabled discussion and sharing of learning across all Divisions. - In addition, a new format was introduced for the Patient Experience Committee early on in 2015 with a topic for debate to be presented and discussed at each meeting. The topics were chosen by Divisional or patient representatives and included: - A discussion about the effects of a risk-averse culture on the approach to mobilising patients who were at risk of falling. - A discussion about DNA (did not attend) i.e. the reasons why and impact when patients fail to attend their appointments, and how the Trust can reduce DNA. - The issue of communication which is an on-going theme in complaints and other patient feedback. - A discussion about the small things that make a big difference to how people feel about their experience of services, such as acts or words of kindness. - The committee was restructured to devote the most time to the debate agenda item to enable each topic to be fully explored.

Our quality priorities and why we chose them	What success will look like	How did we do?
3.1.3 (iv) To improve the provision of 'welcome to the ward' information through the use of innovative design. The Trust is looking at ways of ensuring that patients receive and understand essential information about their stay in hospital.	- Pilot project to ensure key information is made available to patients is completed. - Patients report that they have seen and understood the information as measured through a patient survey to evaluate the pilot.	- **We have partially achieved this.** - The Trust explored different ways of presenting information to patients, and a small working group reviewed the options including refreshing the previously used format of a bedside folder and the use of table top mats which could be used to deliver messages, as well as provide key information to patients on the wards. - The bedside folders had been audited previously and issues included: - They were not always available by the bed - Copies were not kept clean so that cross-infection may be a risk - A patient survey identified that they were not making an impact and patients were not aware of the information they contained. - The Trust therefore looked at options used by other organisations including a table top mat for the over bed tables. - A design was developed for these and costings obtained for providing these in a disposable paper format. - A pilot ward was identified but due to a change of personnel on the pilot ward and in the corporate teams has meant this project has not yet progressed into the pilot stage. This work will continue during 2016-17
3.1.3. (v) 'Hello my name is' campaign The Trust has signed up to be part of the national 'Hello my name is' campaign, started by Dr Kate Granger and supported by NHS England.	- Project plan developed - Project milestones achieved - Surveys show that staff always introduce themselves	- **We have partially achieved this.** - Led by the Director of Nursing, the Trust launched the **'Hello my name is'** campaign in May 2015 at the International Nurses Day events held at Queen Elizabeth and Lewisham Hospitals. - All Staff including all Executives and non-executive Board members were encouraged to sign up to the campaign and tweet their support to the national campaign twitter address. - Throughout the summer, road show events were held to further publicise the campaign and recruit more staff to pledge their support. - **'Hello my name is'** is champions were identified to further promote the initiative within clinical services, and provided with materials to help them to support this including badges, stickers and lanyards.

Part 3
3.2 Involvement

Overview

Who has been involved?

The Trust has consulted widely about the content of this Quality Account, namely the Trust Board, senior nursing, midwifery, clinical and managerial staff, patients and the public. The Patient's Welfare Forum, 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 our Clinical Quality Review Group.

Feedback has also been requested from the local Healthier Communities Select Committees.

The Trust has consulted widely about the content and the final version will incorporate all comments, being published at the end of June 2016.

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. This year has seen the introduction of the Quality Account indicators being introduced onto 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, which visit clinical departments to better understand, in an informal setting, any issues that the staff feel could affect the quality and safety of services they deliver.

Staff

The Trust's Management Executive, which comprises the Chief Executive, the Medical Director, the Deputy Medical Director for Quality and Safety, the Executive Directors, the Director of Business Development, the Director of IT 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 2016 – 2017.

The Trust Integrated Governance Committee, Quality and Safety Committee and Patient Experience Committee, which have Executive, Non-Executive, Clinical Team members, Patient Welfare Forum members and members of our local Healthwatch, have 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 Healthier Communities Select 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 2016

The three Clinical Commissioning Groups that commission health care services from the Lewisham and Greenwich NHS Trust have reviewed the Trust's Quality Account for 2015/16. We thank the Trust for the opportunity to comment on the Quality Account and for seeking our views in its development.

Throughout the year commissioners from the three local Clinical Commissioning Groups 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 and Queen Elizabeth Hospital. Our key focus over the year, amongst many other areas of provision, has been to support the Trust to improve quality and performance in urgent and emergency care, to reduce delays to starting treatment and to improve the timeliness of responses to patient complaints. We recognise that whilst there has been deterioration in performance in some of the constitutional standards, for example the A&E four hour maximum waiting target, the Trust has worked hard to ensure the quality of care to patients has not been adversely affected. We have continued to monitor the implementation of actions resulting from the February 2014 Care Quality Commission inspection and supported the Trust's "Sign Up to Safety Pledges" and quality improvement strategies and plans.

The CCGs are particularly impressed with the "Sharing the Learning Events" held across the organisation, which allow staff to present, discuss and learn from incidents and patient stories. We thank the Trust for inviting us to take part in these events.

Over the year the Trust has made good progress in delivering its key quality priorities for 2015/16 against a wider background of increasing demand and challenges and have plans in place to deliver on areas where the expected goal was not met, for example increasing the number of patients that are given a venous thromboembolism assessment. The Trust has successfully recruited new staff to key clinical posts to ensure safety on the wards, consistently meeting its "Safer Staffing" for nursing targets.

As ever there is still much to be done and we will continue to work with the Trust to improve the quality of services in the coming year. We fully support the Trust's Quality Priorities for 2016 / 2017 which seek to build on 2015/16 priorities and will monitor and support these and a full range of quality indicators as part of our contract management and quality assurance processes.

Finally, we congratulate the Trust's midwives for being recognised as "Midwifery Team of the Year" by the Royal College of Midwives.

ii) Healthier Communities Select Committees

Lewisham Healthier Communities Select Committee

The Committee commends the improvements made over the last year by the Lewisham and Greenwich NHS Trust, and welcomes the recognition that there is work still to be done over 2016-17. In particular, the Committee praises the continuing work on the 'Hello my name is' campaign, and hopes the Trust will consider the introduction of 'Hello my name is' badges for all staff. The Committee would also like to thank the Lewisham and Greenwich NHS Trust Choir, which sang at the Council's AGM, and which does such great work raising the profile of not only the Lewisham and Greenwich NHS Trust, but the NHS more widely.

iii) Local Healthwatch

Local Healthwatch response to Lewisham & Greenwich Trust Quality Account 2015/16

We welcome the opportunity to comment on the 2015/2016 Lewisham and Greenwich NHS Trust Quality Account and have provided a joint response from Healthwatch Bexley, Healthwatch Lewisham and Healthwatch Greenwich. We have an established relationship with the Trust and all three local Healthwatch are members of the Trust's Patient Experience Committee (PEC).

Healthwatch are pleased to see that the achievements of the Trust highlighted, particularly the award from the Royal College of Midwives. We are pleased to see there has been a drive to recruit more staff and that it has been successful in increasing the number of permanent staff, as this helps to improve patient safety and patient experience.

Review of quality performance in 2015/2016

Healthwatch are pleased to see that the Trust has met the majority of the Patient Safety targets from 2015/2016 including improving hand hygiene compliance. Although the Trust did not fully meet the target for improving the safety of maternity services, it is good to see that progress has been made and there have been dedicated members of staff appointed to lead this work.

Healthwatch are glad the numbers of grade 4 pressure ulcers have fallen, but it would have been helpful if last year's figures had been included for comparison. There has been good progress in reducing the number of falls and reducing harm and we have seen and commented on the new Falls poster as a member of the PEC.

We are very pleased to see the Trust's achievements in learning from incidents outlined in this report. It is good to see that the number of incidents reported is increasing and that there seems to be more of a culture of transparency. We would like to highlight the 'Sharing the Learning' events as an example of good practice, particularly the involvement of patients' relatives

sharing their experiences, and we are glad there are more of these events planned.

The work around Dementia seems to be extensive and the Trust should be praised for achieving 100% of the target group being screened for dementia and referred for follow up care. We are pleased to see that there is integration between acute, community and primary care. Healthwatch also welcome that there has been work done with carers and that the Trust is committed to John's Campaign so carers can stay with the people they care for in hospital.

As previously mentioned, all three local Healthwatch are members of the Trust's PEC and so have seen the work that has been going on around the Friends and Family Test, and improving the number of responses. We are pleased to see the Trust has been using the comments to make improvements to the patient experience. We have also seen how the different divisions share feedback and learning at these meetings and feel the new format allows a variety of topics to be discussed in more depth.

We feel it is important that the work around 'welcome to the ward' information is prioritised as it is essential that patients have enough information during their stay in hospital. We look forward to seeing the results of the pilot project presenting the information in more innovative ways.

We would like to have seen some data around the number of complaints received by the Trust as this is an area where we have received feedback that there have been issues with complaints being resolved in a timely manner.

Priorities for 2016/2017

We acknowledge that many of the priorities remain the same as for 2015/2016 as the Trust enters the second year of a three year programme and we look forward to seeing the further progress on these priorities.

We welcome the increase of the Patient Safety target of improving hand hygiene compliance from 90% last year to 100% for the next year.

Healthwatch are pleased to see the target of 20% reduction in the number of patients falls and harm incurred, however would like to see how the Trust ensures that whilst implementing the strategy, patients' mobility which is important for independence after the discharge is sustained and muscle loss is prevented.

We are pleased to see the Trust has added a priority regarding improving the patient experience at End of Life, including implementing 24/7 visiting as this is something which has a big impact on patients and their families and carers.

We particularly welcome the Trust's pledge to use learning from patient's feedback to affect change. This is in line with the Healthwatch ethos that a good service design is based on patient feedback and need. We support the Trust's aim to truly embed patient experience and stories in a visible way by evidencing the change in practice. We are happy to see plans to introduce more detailed patient experience surveys for the new services and those undergoing a transformation. We hope to work with the Trust in partnership and hope that the evidence provided by Healthwatch is used as part of widening the Trust intelligence sources to drive improvement in care. However, from a patient experience point of view, we would like to see the Trust using alternative methods in addition to surveys to engage with patients and gather their feedback.

Quality indicators and audits

Healthwatch is pleased to see the reduction in incidents causing severe harm or death despite the increased incident reporting rate per 1000 bed days.

Healthwatch would like further explanation regarding the difference in readmission rates between the two Trusts and what work is being undertaken at the QEH site in particular to lower the readmission rates.

We are pleased to see that there has been a slight improvement in the number of staff who would recommend the Trust to friends and family, although the figure is still below the national average. We welcome the work that has been undertaken to improve this score over the past year and the future work planned.

It is good to see the Trust is using results from both national and local clinical audits to improve quality and patient experience in a number of different areas.

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 inspect all of the wards and virtually all of the outpatient areas at UHL, visiting them at least once a year. We have representatives on several Trust committees or groups, for example the Patient Experience Committee, Complaints Steering Group, and Quality and Safety Committee.

During our visits, we review the facilities and get feedback from patients about their care, and we report to the hospital on our findings. We ask for responses so we can check that concerns are addressed.

In 2015-6, we made 79 visits to wards and clinics, speaking to 289 patients and relatives. Following a restructure involving Patient Experience, the Trust confirmed its commitment and support for the PWF and we are pleased to continue to work with the Trust. Things continue to go well in many cases, but we work with the Trust to resolve any concerns that we raise.

This year we also supported the Trust in its audit of the checking of resuscitation trollies. It is important that these are checked and supplies replenished to make sure that they are ready for immediate use if necessary. So, during our visits, we asked about the checking procedures and looked at the records of what had been done, and fed our results back to the Trust. We did not find any significant problems.

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

- **Staffing issues:** We continued to find that most of the patients and relatives who we spoke to were happy with their care, and complimentary about the staff. When we visited one particularly busy ward, we were concerned about the pressures on staffing - and the potential effect on patient care – because it had to rely quite heavily on bank and agency staff at that point, with new recruits still in their induction period. We raised our concerns with the Trust, and when we revisited the ward a few months later we were pleased to hear that the situation had much improved.
- **Food:** We have been monitoring the distribution of snacks in the evenings – evening meals tend to be served quite early so it is important that patients have access to these snacks. We found that in some cases, patients were not being told about them, and in others the snacks were not being offered. The Trust has taken action on this, but we will continue to seek feedback from patients to make sure that they have access to these items. Separately, when we visited

the Neonatal Intensive Care Unit, we found that there was no food available on the Unit for parents who were staying with their babies. After we raised this with the Trust, we revisited the Unit and were pleased to find that our recommendation had resulted in parents being able to order food when necessary.

- **Wristbands:** We highlighted this issue in our last report. During this year we have had further concerns - in particular we have found examples of handwritten wristbands, patients with red wristbands not understanding why they have them and wristbands that have become illegible through wear. However, we are pleased to say that following our feedback there is an increased awareness of the importance of wristbands in maintaining patient safety. The Trust has recently updated its Patient Identification Policy and our concerns have been addressed as part of this work.
- **'Who is caring for you' board:** This shows the names of the doctor and nurse caring for an individual patient. We said in last year's report that we would like to see a more consistent completion of these boards, because it is important for the patient (or relative) to know who to speak to about their care. From our ward visits this year we still have concerns about the completion of these boards. The Trust has an ongoing staff campaign to emphasise the importance of patients knowing who is caring for them, but we will continue to monitor this area.
- **Medication storage for patients:** Last year we had a concern on a particular ward – storage containers were not secure, so there was a risk of spillage, or even mixing up of the drugs. The Trust is implementing a system for secure storage of individuals' medication, and the ward in question now has this secure storage, so the issue has been resolved.
- **Maintenance and facilities issues:** We have raised a number of issues with the Trust this year and following our involvement we have seen improvements in several areas. These include child-friendly stickers above hot and cold taps in children's wards and outpatient areas (we were worried that in some cases the water was very hot and there was no warning of this for children), the replacement of worn and insecure drugs cupboards in the Neonatal Intensive Care Unit, and the movement of a phototherapy machine to a separate room in Dermatology, enabling the two machines in the clinic to be used simultaneously. We are still concerned about the signage around the hospital - especially while building works are taking place – as it can be difficult for patients and visitors to find their way to the relevant ward or clinic. We will continue to monitor this.

Overall the PWF continues to act as a permanent mechanism for improving standards throughout UHL. We have a good working rapport with Trust staff, and we thank everyone in UHL for working with us and making us feel welcome in our role.

(v) Patient User Group Queen Elizabeth Hospital

Queen Elizabeth Hospital Patients User Group; Quality Account 2015 -2016

The Patients User Group (PUG) is a small group of volunteers which meets on a 4-6 weekly basis at the hospital. Its aim is to undertake inspections or informal visits of wards or departments within the hospital, looking at the environment and care provided, from a patient's point of view. We hope to extend this, to the views of patients' relatives, especially where the patient suffers from dementia.

There were challenges at the beginning of the year with reduced membership and acquisition of honorary contracts. In March 2016 the new Patient Experience Team put a lot of work into remedying the situation and membership has since increased. Over the year we have carried out a food inspection of Ward 17, and general visits to Safari Children's Ward, Children's ED, Ward 14b, Ward 20, the INR department and an inspection of Ward 7 (the Delivery Suite.) Members have taken part in PLACE inspections at both Lewisham and Queen Elizabeth Hospitals.

PUG members have been well received by both staff and patients, and have found patients generally impressed by the standard of the environment and care they receive. A frequent comment is that staff are very busy, and sometimes there aren't enough of them.

We were made aware of issues around patients not getting prescribed food supplements, inappropriate storage and in some cases concerns with the frequency of drinks and snacks when these have been advised. Liquid intake is not being recorded in some cases where it should be, and water jugs not always present. We have had good support from dieticians, Catering and management in remedying these issues. We found the Maternity Ward well organised but in need of decoration. It is now undergoing a full refurbishment. Concerns at the proposal to increase capacity to 5000 births p.a., which we feel will only be achieved by an increase in resources.

Our aims for the future are to increase our membership, and thus our visibility in the hospital and to improve our skills of observation and information gathering. This could be in partnership with Lewisham Patient Welfare Forum, where appropriate, but certainly with the on-going support from the Patient Experience Team and Voluntary Services.

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 2016 ("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 2016 subject to limited assurance consist of the following indicators:

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

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 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 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 respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by DH 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 2015 to June 2016;
- papers relating to quality reported to the Board over the period April 2015 to June 2016;
- feedback from the Commissioners;
- feedback from Local Healthwatch;
- feedback from Healthier Select Committees;
- feedback from Patient User Group Queen Elizabeth Hospital;
- feedback from Patient Welfare Forum – University Hospital Lewisham;
- the Trust's complaints report published under regulation
- 18 of the Local Authority, Social Services and NHS Complaints
- (England) Regulations 2009;
- the latest national patient survey dated 8/6/2016;
- the latest national staff survey dated 22 March 2016;
- the Head of Internal Audit's annual opinion over the trust's
- control environment dated 24/3/2016;
- the annual governance statement dated 31/5/2016; and
- the Care Quality Commission's Intelligent Monitoring Report
- dated 13 May 2014.

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 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 indicator 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 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 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 2016

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects 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
Fleming Way
Crawley
West Sussex
RH10 9GT

30 June 2016

Part 3

3.5 Statement of Directors' Responsibilities 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).

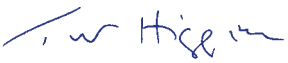
In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- 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: 30.06.2016



Chief Executive Date: 30.06.2016

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 Communications,
Lewisham and Greenwich NHS Trust
Waterloo Block,
University Hospital Lewisham,
Lewisham High Street,
London SE13 6LH.

Telephone: 020 8333 3297
Email: communications.lewisham@nhs.net
Web:www.lewishamandgreenwich.nhs.uk

Appendix 1
Full List of Local Audits Reviewed during 2015 - 2016

Division	Speciality	ProjectTitle
Acute & Emergency Medicine	Accident and Emergency	Consultant Sign Off
Acute & Emergency Medicine	Accident and Emergency	DVT
Acute & Emergency Medicine	Accident and Emergency	Severe Sepsis Re-audit - UHL
Acute & Emergency Medicine	Accident and Emergency	Audit to assess the impact of the Admissions Avoidance Team on reducing admissions to hospital
Acute & Emergency Medicine	Accident and Emergency	Head Injury 2015 - UHL
Acute & Emergency Medicine	Accident and Emergency	Fractured Neck of Femur 2015 - UHL
Acute & Emergency Medicine	Accident and Emergency	Sepsis 2015 - A&E
Acute & Emergency Medicine	Accident and Emergency	Antibiotic Prescribing - UHL 2015
Acute & Emergency Medicine	Accident and Emergency	Pain Audit - 2015 - UHL
Acute & Emergency Medicine	Accident and Emergency	Risk stratification care pathway for Emergency Department (ED): Support for Nurses' in triage decision making for patients' with acute, undifferentiated chest pain.
Acute & Emergency Medicine	Care of the Elderly	Trust Wide Documentation Audit 2015-2016 COE QEH
Acute & Emergency Medicine	Care of the Elderly	Discharge Summary Audit
Acute & Emergency Medicine	Care of the Elderly	An Evaluation of the factors influencing the prevalence of 'Found-on-Floor' falls in Queen Elizabeth Hospital (An acute hospital environment)
Acute & Emergency Medicine	Care of the Elderly	Ward Round Documentation on Ward 20
Acute & Emergency Medicine	Care of the Elderly	PEACE - Documentation Re-audit
Acute & Emergency Medicine	Care of the Elderly	Perioperative Management of HB in NoF # Patients
Acute & Emergency Medicine	Care of the Elderly	Audit of nasogastric insertion and use stroke wards at UHL
Acute & Emergency Medicine	Care of the Elderly	Diagnosis and Prevention of UTI's in over 65's
Acute & Emergency Medicine	Community Matrons, District Nursing and Continence Care	Trust Wide Documentation Audit - Community Matrons
Acute & Emergency Medicine	Community Matrons, District Nursing and Continence Care	Safe and Secure Handling of Medicines Audit - District Nursing
Acute & Emergency Medicine	General Medicine	Time to Review Audit
Acute & Emergency Medicine	General Medicine	REDCOAT Audit
Acute & Emergency Medicine	General Medicine	Consultant Accuracy on iCare
Acute & Emergency Medicine	General Medicine	Cardiac Arrest Debriefing
Acute & Emergency Medicine	General Medicine	VTE risk assessment
Acute & Emergency Medicine	General Medicine	REDCOAT containing ward round proforma versus normal ward round for oxygen, antibiotic and thromboprohylaxis prescription
Acute & Emergency Medicine	General Medicine	Trust Wide Documentation Audit 2015-2016 General Medicine QEH
Acute & Emergency Medicine	General Medicine	The prescription of renal adjusted medications
Acute & Emergency Medicine	General Medicine	Prescription of hypoglycaemia rescue agents
Acute & Emergency Medicine	General Medicine	Intravenous fluids, including special circumstances when a patient has heart failure and/or electrolyte disturbance
Acute & Emergency Medicine	General Medicine	UHL Medical Admissions Audit
Acute & Emergency Medicine	Therapies	Functional Electrical Stimulation Service for SCReHN Patients patients in the community
Acute and Emergency Medicine	Therapies	Implementation of daily exercise programme in addition to standard physiotherapy treatment in ICU patients
Acute and Emergency Medicine	Therapies	Audit of Knee Clinic
Acute and Emergency Medicine	Therapies	Upper Limb Standards of Care: The Shoulder

Division	Speciality	ProjectTitle
Acute and Emergency Medicine	Therapies	Management of Tracheostomy Care on the Ward
Acute and Emergency Medicine	Therapies	Neuro-medical Patients Level of OT Input
Acute & Emergency Medicine	Therapies	Trachestomy Care re-Audit
Acute & Emergency Medicine	Therapies	Provision to communicate within Critical Care amongst intubated and tracheostomised patients
Acute & Emergency Medicine	Therapies	Re-audit of ward compliance to SLT advice in relation to diet and fluid advice across UHL & QEH Acute services
Acute & Emergency Medicine	Therapies	Clinical Documentation Audit
Acute & Emergency Medicine	Therapies	Assessment and Management of Low Back Pain
Acute & Emergency Medicine	Therapies	Ward Compliance with Diet and Fluid Recommendations for Patients with Dysphagia
Acute & Emergency Medicine	Therapies	Written information given to stroke patients on Beech ward: How accessible is this?
Acute & Emergency Medicine	Therapies	Review of current rehab provision on critical care
Acute & Emergency Medicine	Therapies	An audit into the clinical effectiveness of the staff physiotherapy service
Acute & Emergency Medicine	Therapies	Oxygen and Suctioning Safety Audit
Acute & Emergency Medicine	Therapies	Does opt in/out letter reduce non-attendance (DNA) initial assessment rates within a voice outpatient service?
Acute & Emergency Medicine	Therapies	Adult Musculoskeletal
Children's Services	Children's Services	Surveillance and management of vitamin D status in children with cancer.
Children's Services	Children's Services	Trust Wide Documentation Audit - Children's Occupational Therapy 2014-15
Children's Services	Children's Services	Management of DKA - QEH
Children's Services	Children's Services	Trust Wide Documentation Audit 2015-2016 - Children's Services
Children's Services	Children's Services	Neonatal Hypogycaemia
Children's Services	Children's Services	Patient Awareness of Names and Roles of Health Care Professionals
Children's Services	Children's Services	Pre-chemotherapy assessments
Children's Services	Children's Services	Audit of additional Obstetric ultrasound Scans
Children's Services	Children's Services	Trust Wide Documentation Audit - CYP - UHL
Children's Services	Children's Services	Juvenile Arthritis and Uveitis screening
Children's Services	Children's Services	Paediatric Audit - Diabetic Control
Children's Services	Children's Services	Ensure frequency of transcranial dopplers are meeting national standards recommended
Children's Services	Children's Services	Audit of sickle cell service provision to infants diagnosed with sickle cell on newborn screening
Children's Services	Children's Services	Re-audit for timeline of blood transfusions on haemoglobinopathy patients
Children's Services	Children's Services	NICE CG84 - Gastroenteritis Audit
Children's Services	Children's Services	NICE CG98 - Identification of significant jaundice in Neonates
Children's Services	Children's Services	Deliberate Self Harm Audit
Children's Services	Children's Services	Audit of Management of Croup
Children's Services	Children's Services	Naso-Pharyngeal Aspirates in Infants
Children's Services	Children's Services	Trust Wide Documentation Audit – Children's Services - UHL
Children's Services	Children's Services	Use of prednisolone in viral induced wheeze
Children's Services	Children's Services	UTI in Paediatric Emergency Department
Children's Services	Children's Services	The Management of GORD in children and young people in Paediatric Emergency Department
Children's Services	Community Children's Therapies Teams	Trust Wide Documentation Audit - Children's Physiotherapy 2014-15
Children's Services	Community Children's Therapies Teams	Evaluating the effectiveness of and clinical reasoning for the provision of upper limb orthoses by the CYP Community Occupational Therapy Department
Children's Services	Community Children's Therapies Teams	Trust Wide Documentation Audit - Combined Community Therapies 2015 - 2016

Division	Speciality	ProjectTitle
Children's Services	Community Children's Therapies Teams	Multi-professional annual audit of Clinical Documentation
Children's Services	Community Children's Therapies Teams	Goal Attainment scaling audit
Children's Services	Community Children's Therapies Teams	Mainstream Schools Core Service assessment and therapy protocol audit
Children's Services	Community Children's Therapies Teams	Trust Wide Documentation Audit - Children's Speech and Language Therapy 2014-15
Children's Services	Community Children's Therapies Teams	Report on PT and OT Patient Experience
Children's Services	Health Visiting	UNICEF - Baby Friendly Initiative
Children's Services	Health Visiting	Breast Feeding mothers
Children's Services	Health Visiting	Bottle feeding mothers
Children's Services	Health Visiting	Staff Baby Friendly interview
Children's Services	Health Visiting	Vulnerable antenatal pathway
Children's Services	Health Visiting	UNICEF Baby Friendly Audit
Children's Services	Health Visiting	Post natal depression (PND) screening number one
Children's Services	Health Visiting	Post natal depression (PND) screening number two
Children's Services	Health Visiting	Jaundice in Babies – assessing clinical staff awareness of the Jaundice Pathway
Children's Services	Health Visiting	Vulnerable ante natal pathway
Children's Services	Safeguarding	Complete Record Keeping Audit - Safeguarding
Children's Services	Safeguarding	Safeguarding Supervision Audit
Children's Services	Safeguarding	DNA Policy Audit
Children's Services	Safeguarding	ED Risk Assessments Audit
Children's Services	Safeguarding	Lewisham integrated care pathway
for looked after children	Safeguarding	ED Risk Assessments Audit
2015	Safeguarding	Lewisham integrated care pathway for looked after children2015
Children's Services	Safeguarding	Review audit of young people who attend Emergency Department (ED) with deliberate self-harm are fully examined (with consent of young person)
Children's Services	School and Community Nursing/ Special Needs	Aseptic Non-Touch Technique (ANTT) Re-audit
Children's Services	School and Community Nursing/ Special Needs	Effectiveness of Pee's and Poo's group
Children's Services	School and Community Nursing/ Special Needs	6 monthly care plan review
Clinical Business Unit	Pathology	NICE TA287 - Rivaroxaban for PE - UHL
Clinical Business Unit	Pathology	Audit Lipaemic Lab Results - Added Lab Comments
Clinical Business Unit	Pathology	Audit of GI Cancer MDT meeting discussions of BCSP-generated cancer cases
Clinical Business Unit	Pathology	An audit on the Bowel Cancer Screening Programme Polyps at the University Hospital Lewisham
Clinical Business Unit	Pathology	Double reporting of colorectal BCSP polyp cancers at UHL
Clinical Business Unit	Pathology	An audit on the use of BCSP polyp/polyp cancer proformas
Clinical Business Unit	Pathology	Audit of the frequencies of reporting important adverse prognostic features in colorectal cancer resection specimens
Clinical Business Unit	Pathology	Audit of histopathological reporting turnaround times of colorectal cancer resection specimens
Clinical Business Unit	Pathology	Pathologist attendance at cancer specific multidisciplinary team meetings
Clinical Business Unit	Pathology	Trust Wide Documentation Audit (Haematology) 2015-2016
Clinical Business Unit	Pathology	Service Evaluation of Sickle Cell Service
Clinical Business Unit	Pathology	An audit of compliance with key aspects of BCSH guidelines on diagnosis, investigation and management of chronic lymphocytic leukaemia
Clinical Business Unit	Pathology	Audit on the use of RCPath minimum dataset for the reporting of cervical cancer resections 2014 and 2015

Division	Speciality	ProjectTitle
Clinical Business Unit	Pathology	Audit on the SNOMED coding of cervical histology cases at UHL April 2014 – March 2015
Audit on the SNOMED coding of cervical histology cases at UHL April 2014 – March 2015	Pharmacy	Wrong Route Cytotoxics Audit 2013
Clinical Business Unit	Pathology	Colposcopy MDT meeting attendance by a consultant histopathologist - UHL 2014
Clinical Business Unit	Pathology	Colposcopy MDT meeting attendance by a consultant histopathologist UHL 2015
Clinical Business Unit	Pharmacy	Clinical Pharmacy Interventions
Clinical Business Unit	Pharmacy	NPSA Omitted Doses Audit - 2014-15
Clinical Business Unit	Pharmacy	Unlicensed Medicines Policy 2014-15
Clinical Business Unit	Pharmacy	Audit of Safe and Secure Handling of Medicines in Community Clinics - 2014-15
Clinical Business Unit	Pharmacy	Audit of Compliance against Pharmacy Endorsement Standards - 2014-15
Clinical Business Unit	Pharmacy	An audit of the accuracy of documentation of medication administration record (MAR) charts for patients in intermediate care at Brymore House
Clinical Business Unit	Pharmacy	Medicines Returns Audit - 2014-15
Clinical Business Unit	Pharmacy	Wrong Route Cytotoxics Audit
Clinical Business Unit	Pharmacy	Medicines Adherence Audit 2015
Clinical Business Unit	Pharmacy	Medicines Reconciliation Audit 2015
Clinical Business Unit	Pharmacy	NPSA Omitted Doses Audit 2015
Clinical Business Unit	Pharmacy	Audit of Compliance with Prescribing Standards 2015
Clinical Business Unit	Pharmacy	Chemotherapy Prescribing Audit 2015
Clinical Business Unit	Pharmacy	Medication Safety Thermometer
Clinical Business Unit	Pharmacy	Information on Medicines at Transfer of Care 2015
Clinical Business Unit	Pharmacy	Controlled Drug and Safe Storage Audits Q3 14/15, Q4 14/15 and Q1 15/16
Clinical Business Unit	Pharmacy	A re-audit of the prescribing of antibiotic prophylaxis in general surgery at Queen Elizabeth Hospital NHS Trust
Clinical Business Unit	Pharmacy	A Review of Pregabalin Prescribing at University Hospital Lewisham
Clinical Business Unit	Pharmacy	Baseline audit on the transfer of care documentation from secondary to primary care using iCare
Long Term Conditions and Cancer	Cardiology	Evaluations Of indications CT coronary angiogram (CG 95)
Long Term Conditions and Cancer	Cardiology	Trust Documentation Audit 2014-15 - Cardiology - UHL
Long Term Conditions and Cancer	Cardiology	A subtherapeutic INR in patients taking warfarin causes significant delay in DCCV
Long Term Conditions and Cancer	Cardiology	Documentation Audit - Cardiology QEH 2015-2016
Long Term Conditions and Cancer	Cardiology	CG95 - Comparison of European Society of Cardiology (ESC) and NICE guidelines for patients with suspected CAD
Long Term Conditions and Cancer	Cardiology	Comparison of Clinical Efficacy and Cost of a Cardiac Imaging Strategy versus a traditional Exercise Test
Long Term Conditions and Cancer	Community Head and Neck Team	CHANT 'Did Not Attend' Audit
Long Term Conditions and Cancer	Community Head and Neck Team	Community Heart Failure Satisfaction Survey
Long Term Conditions and Cancer	Community Home Enteral Nutrition Team	Care Pathways
Long Term Conditions and Cancer	Dermatology	A Retrospective Case Notes Review of Cases Referred to the 2 Week Wait Dermatology Clinic for Suspected Skin Cancer
Long Term Conditions and Cancer	Dermatology	Audit of the QEH phototherapy equipment
Long Term Conditions and Cancer	Dermatology	Cancer Patient Satisfaction Survey - South East Skin Cancer Network Audit
Long Term Conditions and Cancer	Dermatology	Dermatology Treatment Cards Documentation Re-audit
Long Term Conditions and Cancer	Diabetes	Audit of DNAs to Community Diabetes Clinics
Long Term Conditions and Cancer	Diabetes	DKA Audit - QEH
Long Term Conditions and Cancer	Diabetes	Insulin Administration by non-registrant staff in Lewisham Community
Long Term Conditions and Cancer	Diabetes	Prescription of hypoglycaemia rescue agents

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Long Term Conditions and Cancer	Diabetes	Reduction in HbA1c:Patients Referred to Community Diabetes Team
Long Term Conditions and Cancer	Foot Health	Trust Wide Documentation Audit 2015-2016 - Foot Health
Long Term Conditions and Cancer	Foot Health	Nail Surgery 2015
Long Term Conditions and Cancer	Foot Health	Foot Health - Environmental Audit 2015
Long Term Conditions and Cancer	Gastroenterology	Coeliac Screening in "2 week wait" Patients:Biopsy or Serology?
Long Term Conditions and Cancer	Neurology	Datscan Audit
Long Term Conditions and Cancer	Neurology	An audit of the current care received by People with Parkinson's disease who suffer from mental health problems
Long Term Conditions and Cancer	Nutrition and Dietetics	Audit of 10 week weight reducing group 2015
Long Term Conditions and Cancer	Nutrition and Dietetics	Snacks re-audit
Long Term Conditions and Cancer	Nutrition and Dietetics	Lewisham and Greenwich NHS Trust Re-audit 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 and Cancer	Nutrition and Dietetics	Audit of Dietetic Snacks
Long Term Conditions and Cancer	Nutrition and Dietetics	Nutrition Screening Tool Audit 2015
Long Term Conditions and Cancer	Nutrition and Dietetics	Audit of Kaleidoscope Dietetic Clinic
Long Term Conditions and Cancer	Nutrition and Dietetics	Audit of paediatric and neonatal outpatient referrals with regard to feeding problems
Long Term Conditions and Cancer	Nutrition and Dietetics	Re-Audit to determine compliance with recommended best practice guidelines for checking the correct position of NG feeding tubes
Long Term Conditions and Cancer	Nutrition and Dietetics	Cooked breakfast and Snacks Audit
Long Term Conditions and Cancer	Nutrition and Dietetics	Low Fodmap Diet
Long Term Conditions and Cancer	Nutrition and Dietetics	Appropriate TPN Referral Audit
Long Term Conditions and Cancer	Radiology	Access to Lung Scintigraphy / CT Pulmonary Angiography
Long Term Conditions and Cancer	Radiology	Adequacy of imaging the cervical spine in trauma referrals from emergency department (NICE CG56)
Long Term Conditions and Cancer	Radiology	Audit of adequate completion and quality of ultrasound referrals received from GPs'
Long Term Conditions and Cancer	Radiology	CT Brain Lens Included Audit
Long Term Conditions and Cancer	Radiology	Malignant breast disease: Audit of classification of breast images in a symptomatic setting
Long Term Conditions and Cancer	Radiology	Out of hours CT for head injury-Compliance with 1 hour target
Long Term Conditions and Cancer	Radiology	To audit adequacy of endotracheal tube position of neonatal chest x-ray
Long Term Conditions and Cancer	Radiology	CT colonoscopy doses
Long Term Conditions and Cancer	Radiology	Assessing the number of imaging requests and speed of outsourced reporting out of hours
Long Term Conditions and Cancer	Radiology	GP Fracture Action Audit
Long Term Conditions and Cancer	Radiology	Ultrasound guided fine needle aspiration (FNA) of thyroid nodules
Long Term Conditions and Cancer	Radiology	An Audit Comparing Dose Length Products (DLPs) of CT Colonoscopies for both Bowel Cancer Screening Programme and Non- Bowel Cancer Screening Programme Patients with the National Reference Level
Long Term Conditions and Cancer	Radiology	Evaluating the comprehensiveness of CT sinuses reports made to facilitate proposed function endoscopic sinus surgery
Long Term Conditions and Cancer	Radiology	X-ray Confirmation of Nasogastric Tube Placement
Long Term Conditions and Cancer	Rheumatology	Giant Cell Arthritis Re-audit
Long Term Conditions and Cancer	Rheumatology	Audit on the treatment of psoriatic arthritis with biologics
Long Term Conditions and Cancer	Rheumatology	Audit of Anti TNF use in patients with Ankylosing Spondylitis (AS)
Long Term Conditions and Cancer	Rheumatology	Patient satisfaction survey for patients self-injecting subcutaneous methotrexate at home.
Surgery	Anaesthetic and Pain Relief	Mobile epidural audit
Surgery	Anaesthetic and Pain Relief	What do trainees think of their consultant anaesthetists in 2015?
Surgery	Anaesthetic and Pain Relief	Post Operative Analgesia after Caesarean Section Re-audits
Surgery	Anaesthetic and Pain Relief	Management of Pre-operative Anaemia Audit - ERAS Orthopaedics
Surgery	Anaesthetic and Pain Relief	Cannulation Audit

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Surgery	Community Orthopaedics Team	Trust Wide Documentation Audit 2015-16
Surgery	Community Orthopaedics Team	Re-audit of Patient Satisfaction Questionnaires - UHL
Surgery	Community Orthopaedics Team	Re-audit of length of stay for patients who had THR or TKR at Lewisham Hospital and have been discharged with the community Orthopaedic Services
Surgery	Ear, Nose and Throat	Re-audit of surgical site marking in clinical documentation
Surgery	Ear, Nose and Throat	Tracheostomy Transfer Documentation Data Audit
Surgery	Ear, Nose and Throat	Consent Audit 2015-2016 - ENT
Surgery	Ear, Nose and Throat	Re-audit of ENT OPD remuneration (initial audit 3642)
Surgery	Ear, Nose and Throat	Efficacy of ultrasound guided core biopsies for the diagnosis of lymphoma in the head and neck
Surgery	Ear, Nose and Throat	Audit on effectiveness of revision mastoidectomy using cartilage sheet obliteration
Surgery	Ear, Nose and Throat	Audit on Outpatient services remuneration in ENT OPD
Surgery	Ear, Nose and Throat	Trust Wide Documentation Audit 2015-2016 - ENT
Surgery	Ear, Nose and Throat	Audit on feasibility of instituting a telephone clinic
Surgery	General and Vascular Surgery	Audit of Time Taken to Perform and Report an Emergency CT Scan
Surgery	General and Vascular Surgery	Laparoscopic Cholecystectomy for Acute Cholecystitis
Surgery	General and Vascular Surgery	Post Take Ward Round Communication Audit
Surgery	General and Vascular Surgery	Post Take Ward Round Communication Re-Audit
Surgery	General and Vascular Surgery	Does the Consent Process at QEH's General Surgery Department meet the guidelines of the Royal College of Surgeons?
Surgery	General and Vascular Surgery	Antibiotic Care Bundle Compliance in General Surgery
Surgery	General and Vascular Surgery	Does Intravesical injection of OnabotulinumtoxinA (Botox®) Efficacy and Durability Change with Repeated Injections
Surgery	General and Vascular Surgery	Documentation Audit 2015-2016 - General Surgery QEH
Surgery	General and Vascular Surgery	Clinical Note-keeping Audit
Surgery	General and Vascular Surgery	Evaluation of fracture clinic services at QEH
Surgery	General and Vascular Surgery	Last Letters Audit - Typing Delays - General Surgery
Surgery	General and Vascular Surgery	Trust Wide Documentation Audit 2015-2016 - General Surgery UHL
Surgery	General and Vascular Surgery	Fluid Balance Audit Report
Surgery	General and Vascular Surgery	CRABEL Audit - Method for Auditing Medical Recording
Surgery	General and Vascular Surgery	Is the weekend surgical handover at QEH in line with Royal College of Surgeons guidelines?
Surgery	General and Vascular Surgery	Using the CRABEL score to audit medical records keeping
Surgery	General and Vascular Surgery	Is there a role for imaging as part of the assessment of hernias
Surgery	Intensive Care Unit	Family Satisfaction Re-Audit 2015
Surgery	Intensive Care Unit	Audit of New CVC Insertion
Surgery	Intensive Care Unit	Trust Wide Documentation Audit 2015-2016 ICU UHL
Surgery	Intensive Care Unit	Evaluation of tidal volumes delivered to mechanically ventilated ICU patients
Surgery	Intensive Care Unit	Renal Replacement Therapy Practice Audit - UHL
Surgery	Orthopaedics	Consent Audit - Orthopaedics - QEH
Surgery	Orthopaedics	Consent Audit 2015-2016
Surgery	Orthopaedics	Consent form
Surgery	Orthopaedics	Auditing the timing of the initial administration of both chemical and mechanical thromboprophylaxis in surgical and orthopaedic admissions to QEH
Surgery	Orthopaedics	Trauma Theatre Utilisation
Surgery	Orthopaedics	Trust Wide Documentation Audit 2015-2016 - Orthopaedics UHL
Surgery	Orthopaedics	Orthopaedics Last Letters Re-audit
Surgery	Orthopaedics	Optimising pre-operative anaemia in elective Orthopaedic Surgery
Surgery	Specialist Nurses	Audit of Recurrence of Colorectal Cancer Post Curative Resection - UHL
Surgery	Theatres	Clinical Documentation Audit

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Surgery	Theatres	WHO (World Health Organisation) Safer Surgery Checklist Audit - UHL
Women's and Sexual Health	Sexual and Reproductive Health	EMA Audit - UHL
Women and Sexual Health	Sexual and Reproductive Health	STI acquisition in the first year after HIV diagnosis - evidence of ongoing risk-taking?
Womens and Sexual Health	Women's Services	Electronic Foetal Monitoring
Womens and Sexual Health	Women's Services	Operative Vaginal Deliveries - UHL
Womens and Sexual Health	Women's Services	Bladder Care - QEH
Womens and Sexual Health	Women's Services	Referral when Fetal Abnormality Detected - QEH
Womens and Sexual Health	Women's Services	Operative Vaginal Deliveries - QEH
Women's and Sexual Health	Women's Services	Severe Pre-Eclampsia - UHL
Womens and Sexual Health	Women's Services	Vaginal Birth after Caesarean - QEH
Womens and Sexual Health	Women's Services	Admissions to Neonatal Unit - QEH
Womens and Sexual Health	Women's Services	Severely Ill Women - QEH
Womens and Sexual Health	Women's Services	Amnisure
Womens and Sexual Health	Women's Services	Supporting choice in place of delivery - Re-Audit CQUIN 5a
Womens and Sexual Health	Women's Services	Vulnerability , High Risk social factors - Re-Audit
Womens and Sexual Health	Women's Services	Use of Oxytocin
Womens and Sexual Health	Women's Services	Perineal Trauma
Womens and Sexual Health	Women's Services	Severe Pre-Eclampsia - QEH 2015
Womens and Sexual Health	Women's Services	High Dependancy Care - QEH 2015
Womens and Sexual Health	Women's Services	Rubella Equity Audit
Womens and Sexual Health	Women's Services	Electronic Fetal Monitoring - QEH
Womens and Sexual Health	Women's Services	Care of Women in Labour - QEH
Womens and Sexual Health	Women's Services	Mental Health - QEH
Womens and Sexual Health	Women's Services	Handover of Care Onsite - QEH
Womens and Sexual Health	Women's Services	Immediate Care of the Newborn - QEH
Womens and Sexual Health	Women's Services	Postnatal Care - QEH
Womens and Sexual Health	Women's Services	Maternal Antenatal Screening Tests - UHL
Womens and Sexual Health	Women's Services	Handover of Care Onsite - UHL
Womens and Sexual Health	Women's Services	Jaundice Meter Audit
Womens and Sexual Health	Women's Services	Risk assessment at booking
Womens and Sexual Health	Women's Services	Emergency Caesarean Section – Continuous audit UHL
Womens and Sexual Health	Women's Services	Shoulder Dystocia – Continuous audit UHL site
Womens and Sexual Health	Women's Services	Severe Pre-eclampsia UHL
Womens and Sexual Health	Women's Services	Perineal Trauma UHL
Womens and Sexual Health	Women's Services	Induction of Labour
Womens and Sexual Health	Women's Services	Vaginal Birth after Caesarean Section (VBAC)
Womens and Sexual Health	Women's Services	Trust Wide Documentation Audit - Maternity Services UHL 2015
Womens and Sexual Health	Women's Services	Pre-Existing Diabetes - UHL
Womens and Sexual Health	Women's Services	Obesity - UHL
Womens and Sexual Health	Women's Services	42 Day Readmission Re-audit (UHL&QEH)

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