NHS
Lewisham and Greenwich
NHS Trust

Quality Account

2017-2018

Contents

Part 3

Appendix 1

Glossary

AKI	Acute Kidney Injury
A&E	Accident and Emergency
CAS	Central Alerting System
CAP	Clinical Audit Programme
CCG	Clinical Commissioning Group
CDI	Clostridium difficile infection
C. difficle	Clostridium difficile
CDOP	Child Death Overview Panel
CEFM	Continuous Electronic Fetal Monitoring
CEO	Chief Executive Officer
CHKS	Independent provider of healthcare intelligence, benchmarking and quality improvement services
CMC	Coordinate My Care
CNST	Clinical Negligence Scheme for Trusts
CRN	Comprehensive Local Research Network
CQC	Care Quality Commission
CQRG	Clinical Quality Review Group
CQUIN	Commissioning for Quality and Innovation
DOAC	Direct Oral AntiCoagulants
ED	Emergency Department
EDI	Equality, Diversity and Inclusion
ENT	Ear, Nose and Throat
EoL	End of Life
EoT	End of Treatment
FFT	Friends and Family Test
FT	Foundation Trust
F/Y	Financial Year
GiRFT	Getting it Right First Time
GP	General Practitioner
HAT	Hospital Acquired Thrombosis
HES	Hospital Episode Statistics
HRG	Healthcare Resource Group
HSCIC	Health and Social Care Information Centre
HWBE	Health and Well Being Events
IA	Intermittent Auscultation
IG	Information Governance
IOL	Induction of Labour
LGT	Lewisham and Greenwich NHS Trust
LeDer	Learning Disabilities Mortality Review Programme
LoS	Length of Stay
MEWS	Modified Early Warning Score
MSK	Musculoskeletal
MSW	Maternity Support Worker
NEWS	National Early Warning Score
NHFD	National Hip Fracture Database
NHS	National Health Service
NHS Digital	Aims to improve health and care by providing national information, data and IT services (formally known as HSCIC)
NHSE	National Health Service England
NHSI	National Health Service Improvement
NICE	National Institute for Health and Care Excellence
NICU	Neonatal Intensive Care Unit
NRLS	National Reporting Learning System
OHSEL	Our Healthier South East London
OSC	Overview and Scrutiny Committee
OWL	Outcomes with Learning
PALS	Patient Advice and Liaison Service
PDSA	Plan, Do, Study, Act (part of an improvement methodology)
PEACE	Proactive Elderly Advance Care plan
PbR	Payment by Results
PHE	Public Health England
PROMS	Patient Reported Outcome Measures
PUG	Patients User Group
PWF	Patients Welfare Forum
QEH	Queen Elizabeth Hospital
RAMI	Risk Adjusted Mortality Index
RCA	Root Cause Analysis
RCP	Royal College of Physicians
R&D	Research and Development
SBAR	Situation Background Assessment Recommendation
SFFT	Staff Friends and Family Test
SHMI	Summary Hospital Mortality Indicator
SI	Serious Incident
SMR	Standardised Mortality Ratio
SPC	Specialist Palliative Care
STP	Sustainability and Transformation Plan
SUS	Secondary Uses Service
TNA	Training Needs Analysis
UCC	Urgent Care Centre
UHL	University Hospital Lewisham
VTE	Venous Thromboembolism
Waterlow Score	A score of the estimated risk for the development of a pressure ulcer by a patient
WRES	Workforce Race Equality Standard
YSWD	You Said We Did posters (a method of communicating improvements to practice)

Introduction

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

This Quality Account is divided into three sections:

Part 1:

Statement on quality from the Chief Executive.

Part 2:

Our quality priorities for 2018/19, statement of assurances from the Board Directors and review of quality performance.

Part 3:

Our performance in 2017/18 against our quality priorities and what our stakeholders say about us.

Part 1

Statement on Quality from the Chief Executive

Welcome to the 2017/18 Quality Account for Lewisham and Greenwich NHS Trust.

I joined Lewisham and Greenwich NHS Trust in April 2018 and have been struck by how committed our staff are to doing their absolute best for patients. It is clear from the following pages that there is a huge amount of good work being carried out across the organisation, with staff going the extra mile every day.

It is also clear that staff have faced significant pressures over the last year. In particular, the CQC report highlighted some safety and quality issues, and there have been high levels of scrutiny from regulators and stakeholders. It has been a difficult winter, and we have faced challenges meeting national performance standards, as well as challenges managing our financial resources.

We are committed to making the necessary improvements to quality and safety while returning to financial stability. This means completing our CQC action plan and doing more to share all the good work that takes place within the Trust, celebrating and learning from what we do well, so we can get it right for every patient, every time. It is vital that we provide timely treatment for our patients, and we have been progressing with our plans to improve the quality and safety for our patients and meet key performance targets by the end of 2018/19.

We need to ensure that all our staff get the support they need, so that the Trust is a rewarding place to work. There are a range of initiatives that are already in place to help us do this and this will continue to be a major priority as detailed in section 2.1 over 2018/19.

I'm new to the organisation, and we have a new Trust Chair and Chief Nurse, so it's a good opportunity to review the Trust's core values. Our values form the framework for how we deliver services and relate to one another. We will be speaking to staff and partners to ensure that we have the right values in place, and then working to embed them across the organisation, from the wards to the board.

Linked to this, we are developing our clinical strategy along with a "roadmap" for the Trust. This will outline all of our priorities and key areas of work for the next couple of years. By setting out what we need to do, we can work with partners and staff to ensure that we are all pulling in the same direction, and working towards achieving the same goals.

There is much to do, but I am excited to be part of this organisation, and proud to work alongside so many amazing people. Like our chair, I believe that we have got a real opportunity to deliver significant improvements for patients, staff and local people.

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

I hope that you find the information contained in this Quality Account useful and representative of the continuing improvements we are making with quality and safety of our services. 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.

Ben Travis
Chief Executive Date: 15/05/2018

Part 2

2.1 Our Quality priorities for 2018/19

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

For 2018/19, we have developed a set of priorities chosen to reflect the continued improvement work required, to reflect on-going work post our Care Quality Commission inspection, new national initiatives and also the Trust Commissioning for Quality and Innovation (CQUIN) plan for 2018/19 which reflects national and local quality improvement initiatives.

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

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

Patient Safety

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

Clinical Effectiveness

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

Patient Experience

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

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

How we chose our priorities

Throughout the year our progress towards achieving the 2017/18 priorities has been monitored, presented and reported at meetings held across the Trust, with key stakeholders being present at these meetings.

The progress of our performance with these priorities has been reviewed and although there have been significant achievements made throughout the year, there is still room for improvement within our priorities around safety practices and enhancing the patient experience. Therefore, to maintain focus, we have committed to continuing our work to improve patient safety in a number of key areas. Implementing the seven day working standards and ensuring a safe and effective discharge for our patients are both national and local priorities, therefore are included within the clinical effectiveness priorities for 2018/19. We will also continue to focus on using patient feedback to influence positive changes to practice in order to improve our patient's experiences and implement our strategies for patients receiving end of life care and patients with dementia.

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

The following tables outline the 2018/19 quality priorities and why we have chosen them.

2.1.1 Patient Safety Priorities

The third and final year of the "Sign Up to Safety" programme has been completed and we have achieved the majority of our set goals. However, in some areas, on-going work to embed improvements and sustain high standards needs to continue as a focussed priority for 2018/19.

In addition, following our CQC planned inspection in March 2017 as part of our on-going action and improvement plan, we have proposed a continued programme of work to ensure we 'get the basics right and keep patients safe' and the priorities below outline what we will aim to deliver.

Our quality priorities and why we chose them	What success will look like
i) Getting the basics right, keeping patients safe within the Emergency Department (ED) and placing patients in the right place at the right time Following our CQC inspection in March 2017 and through work we have done throughout 2017/18, we have significantly improved patient safety within the Emergency Department. The Trust has already introduced daily Emergency Department quality and safety metrics and quality rounds which assess patient safety. The Trust already has a full programme of work on the emergency care pathway at both acute hospital sites and whilst keeping patients safe in the Emergency Department is an on-going priority, placing patients in the right place and right time is also a priority. At the right time the Trust will implement a robust Discharge to Assess pathway across the sites, with the aim of reducing the number of medically fit patients awaiting discharge. Following the CQC visit another area highlighted for improvement was within our medicines management practices. Although there had been much work undertaken throughout 2017/18, with improvements seen, further work is required to continually demonstrate improvement as follows: ■ Improvement in the compliance of Controlled Drugs checking ■ Fridge Temperature monitoring and in particular documenting when action has been taken where temperatures are out of range ■ Ensure robust processes for following up on all audit results and action plans agreed as part of the completion of the continuous audit cycle	**Emergency Department and escalation areas:** ■ Continued use of daily ED quality and safety metrics, NEWS monitoring, escalation process, safety huddles and demonstration of improved trends ■ The quality care plan and checklist for all patients in ED will be embedded across the sites ■ Quality and hourly senior nurse rounds supporting the implementation of quality of care will demonstrate improved patient experience ■ Reduction in length of stay across our Clinical Decision Units to 2 days ■ Implementation of Discharge to Assess pathways across the sites with multiagency system partners ■ Reduction in medically fit patients in hospital across all three boroughs **Medicines management** ■ Improved compliance across all clinical areas for Controlled Drug checking ■ Improved compliance across all clinical areas with Safe and Secure storage of medicines ■ Improved compliance with Fridge temperature monitoring and taking remedial action where required ■ Demonstrable evidence of action plan follow up, post presentation of audit results
ii) Reduction in the number of patient falls resulting in harm Through the Trust Sign up to Safety programme and Aspiring to Excellence programme, the Falls strategy has been introduced across the Trust. The Sign up to Safety Programme has entailed a number of different work streams within the Falls programme and a number of initiatives have been implemented. However, the Trust has seen an increase in the number of falls with harm and therefore, it is proposed to continue with this as a priority to aim to reduce the number of falls with harm. Focussed work on falls risk assessments, those patients with dementia, cohorting patients, staffing profiles and roll out of the pilot work on postural blood pressure monitoring will form part of the work stream.	■ Ensure improved compliance with falls risk assessments from baseline Q1 2018/19 ■ Through audit, demonstrate effectiveness of cohort bays within inpatient areas ■ By the end of March 2019 the Trust aims to have reduced the number of falls with harm by 5% from the Q4 2017/18 baseline

Our quality priorities and why we chose them	What success will look like
iii) Safer Maternity Care During 2017/18 the Trust's Sign up to Safety Programme included initiatives within maternity. The focus was to reduce stillbirths, increase detection of growth restricted babies and reduce poor neonatal outcomes associated with poor surveillance. Although a significant amount of work has been undertaken within all the initiatives and some progress has been made within some areas, maternity are continuing with the National Safer Maternity Care programme. With the introduction of the National Maternity Safer Strategy, work on these priority areas will continue to be the focus for the Trust quality and safety priorities within 2018/19.	■ Continue to work on 4 elements of Saving Babies Lives bundle with the aim of: ■ Continuing to reduce stillbirth rate (to maintain under <5.0 quarterly rate per 1000 births) ■ 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) 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. Throughout 2017/18 and through the work of the Sign Up to Safety programme significant achievements have been made with early recognition of the deteriorating patient. The completion of the NEWS has improved, accurate calculation has improved, with continued improvement in appropriate and correct escalation. The Trust has seen continued improvement throughout the year and has seen the number of serious incidents drop as a result. For 2018/19 continued work is required to embed and to achieve sustained improved performance in all areas of observations and documentation.	■ To achieve 100% compliance with completion of dated and timed observations ■ To achieve 100% compliance with all observations recorded on NEWS and achieve 100% in compliance with appropriate escalation as denoted by quarterly audit results ■ To ensure through the Sepsis programme, continued improvement in administration of antibiotics within 1 hour in those with suspected sepsis (national target >90%) ■ To achieve the implementation of the community NEWS and Sepsis Tool by December 2018.
v) Improving medication safety & learning from medication Nationally, medication incidents account for around 10% of all reported incidents. We will continue to raise staff awareness of the importance of reporting medication related patient safety incidents. The Trust has improved its level of medication incident reporting however recognises that there is still work to do. Medicine doses are often omitted or delayed in hospital for a variety of reasons. Whilst these events may not seem serious, for some critical medicines or conditions, such as patients with sepsis or those with pulmonary embolisms, delays or omissions can cause serious harm or death.	■ By the end of March 2019, increase the number of reported medication related patient safety incidents from 2017/18 figure by a further 5%. ■ Maintain focus on reducing number of inappropriately omitted critical medicines (against baseline as at March 2018). ■ Continue to identify themes in prescribing and administration incidents and share learning with staff at all levels. ■ Maintain focus on reducing the number of patient safety incidents related to the prescribing and administration of penicillin based antibiotics to patients with penicillin allergy, from 2017/18 figure.

2.1.2 Clinical Effectiveness

Through 2017/18 significant progress has been made with the chosen priorities. This will continue to be embedded throughout 2018/19 with a new indicator for the 'Getting it Right First Time' programme initiative.

Our quality priorities and why we chose them	What success will look like
i) To continue the work on embedding the process for learning from deaths programme. During 2017/18, the new national mortality surveillance programme 'Learning from deaths' was introduced which included the introduction of a national requirement for structured mortality reviews for deaths and the new process for review of those with Learning disabilities. Significant work has been undertaken which now needs to be embedded across the Trust, so that learning from deaths and care delivery can be achieved.	■ Continue to work towards reducing the Trust SHMI. Aim to reduce current level to < 1.0 ■ Continue to embed the new national mortality review programme and mortality review for those deaths of patients with learning disabilities ■ Continue to increase the number of trained mortality reviewers ■ Promote sharing the learning events from the structured mortality reviews and share between divisions and across the Trust ■ Continue to increase the quality of comorbidity recording and coding quality, through reviews within Divisions
ii) Working towards delivering the seven day working standards – four clinical priorities The Trust had signed up to be a part of the NHS England (NHSE) led phase 2 delivery programme for the 4 priority clinical standards requiring 90% compliance by March 2019. Much work and progress had been made within this programme and the Trust will continue to embed these standards with the aim to achieve > 90% compliance by the end of March 2019	■ By the end of March 2019, compliance with the four clinical priority standards: ■ Standard 2: Time to Consultant review ■ Standard 5: Access to Diagnostics ■ Standard 6: Access to Consultant-directed Interventions ■ Standard 8: On-going review ■ Continued Trust wide audit of performance on a quarterly basis to inform plans for continued improvement in compliance
iii) Getting it Right First Time programme Through 2017/18, the Trust has focussed on work and outputs from the national GiRFT programme and where reports have been published using the work to compare and benchmark our performance using a gap analysis approach. This work has included a theme on claims and CNST premium. The work is also included within the Model Hospital programme and through 2018/19 the Trust will work with specialties to review the benchmarked data and work towards achieving reduced variation in clinical outcomes compared to local and national peers.	■ Introduce and implement reporting structure for GiRFT reporting and review of claims and litigation data ■ Continue gap analysis and work with divisions to draw up action plans from analysis and benchmark data ■ Combine work with Model Hospital data, with aim of addressing variance gaps ■ Develop GiRFT reporting scorecard for agreed indicators within each programme
iv) Implement Community Mobile Working Strategy	■ Implementation of a mobile solution across community services ■ Support a more agile workforce ■ Enable community clinicians to have access to accurate and timely information at the point of contact with patients

v) Transformation of Adult Community Services In 2018-2019 the Trust's community services will be developing a programme of work to redesign Adult Community Services. This redesign aims to ensure that adult community services are effective and delivering high quality services for patients of Lewisham.	■ Develop a programme of work to redesign Adult Community Services ■ Work with the Lewisham wide Adult Integration programme and the implementation of the Population Health System ■ Develop a set of quality outcome measures/ balanced scorecard for the redesign services ■ Involve patients and carers in the redesign of services
vi) Develop an integrated community service to support children and their families closer to home. Providing integrated pathways of care that improve access to advice, early identification of health needs, and integrated models of service delivery will result in fewer appointments for patients, less duplication, increased choice, and outcome focused care.	■ Establishment of nurse led clinics in GP surgeries and other community Hubs with the view to delivering care closer to home and improving access to specialist nurse led paediatric advice. ■ Development of a single point of access for children and young people requiring support from at least two therapies. ■ Pilot a drop in clinic for families with Children with Autism after they are discharged from services.

2.1.3 Patient Experience

We will continue our focus and expand on Quality Priorities from 2017/18, which are driven by our CQC feedback, patient experience feedback from surveys and End of Life Care and Dementia strategies.

Our quality priorities and why we chose them	What success will look like
i) We will continue to work with our patients, carers, staff and partners to deliver consistently excellent standards of dementia care to improve the experience of our patients that have a diagnosis of dementia as well as that of their Carers During 2016/17 the Trust developed its 3 year Dementia Strategy setting out the priorities for improvement and action. Good progress has been made with the priorities for 2017/18 and we will continue to build on this work and implementation of the delivery plan during 2018/19 to deliver the final year of the strategy.	■ Embed the use of the 'This is me' document for dementia patients ■ Review Medical Assessment documentation ■ Review and update Pain Assessment and Depression Tool ■ Continue to implement our Staff Dementia training programme, this includes increasing the amount of training and tailoring training for different staff groups. ■ Embed practice to identify and flag patients on iCare ■ Fully embed use of the Sensory room and implement actions from environmental audits ■ Embed activity programmes across the trust, review the success of them and implement adaptions where necessary ■ Embed the Dementia Strategy across community services
ii) We will continue to expand the ways in which we gain feedback from patients and service users and ensure that learning from feedback is used to support positive change During 2016/17 the Trust developed its 3 year Patient Experience Strategy setting the priorities for improvement and action. Good progress has been made with the priorities for 2017/18 and we will continue to build on this work and implement the delivery plan during 2018/19.	■ Continue to spread and embed the "You Said We Did" approach across the Trust ensuring the concept is locally owned and used in all areas. ■ Implement the use of patient stories as a learning tool across the Trust. ■ Implement a patient experience micro site to raise the profile and provide extended opportunities for patients to provide feedback through social media.
iii) Improving the quality of the End of Life Care pathways across the health care system Although the Trust has been making improvements in the care provided to patients identified as end of life, it recognises that there is much more that we need to do. During 2016/17 the Trust developed its 3 year End of Life Care strategy which outlines plans to meet the needs of end of life care patients, and those identified as important to them as well as ensuring that we provide our staff with the education and training required. Through 18/19 we will focus on the review of the strategy and delivery plan to embed practices across the organisation and will focus on the key elements within the strategy: ■ Recognition of patients who are at the end of their life ■ Involvement of patients and those identified as important to them in decisions and choices about treatment and care plans ■ Communication and embedding consistent practices from staff and all those involved in the care of the patients ■ Support and meeting the needs of the patients and those involved in their care ■ Plan and do, focussing on elements of care delivery through individualised care plans	■ Continued training on PEACE will be provided to increase the use of the tool. ■ All areas to have established link nurse practitioner with established governance links into the End of Life Care Steering Group. ■ Bereavement survey will be undertaken, results evaluated and recommendations implemented ■ Implement Trust Treatment Escalation plan and evaluate use of plan. ■ To embed the use of Co-ordinate My Care (CMC) across Adult Community Services and further implement the use of CMC within the ED to ensure that clinicians have access to up-to-date information on end of life care patients. ■ To ensure Specialist Palliative Care teams are inputting information into CMC for patients identified as EoL prior to discharge. ■ Ensure recommendations from previous National Care of Dying Audit have been implemented. ■ Develop role of End of Life volunteers ■ Develop the community EoLC pathway alongside the new Community Specialist Palliative Care provider

Our quality priorities and why we chose them	What success will look like
iv) To continue to develop our recruitment and retention initiatives to increase the number of substantive registered nurses/midwives in post. This includes the implementation of the Nursing Associate role across the organisation The Trust is experiencing very significant challenges in the recruitment and retention of Registered Nurses and midwives resulting in a dependency on bank and agency staff. This is reflected nationally. During 2017/18 the Trust has developed a number of initiatives to support recruitment and retention of staff. Also in October 2015 a new role was proposed and designed by Health Education England (HEE) supported by the Chief Nursing Officer. This is a role described as an Associate Nurse and is designed to bridge the gap between a registered nurse and a care support worker. This is a 2 year training programme and the Trust is committed to commencing this during 2018/19	■ 2 cohorts of 20 students to have commenced the Nursing Associate programme during 2018/19 ■ All adult areas to have completed a workforce review to establish safe staffing with the new Nursing Associate role established ■ To continue with the career clinics for band 5 registered nursing and midwifery staff as they complete their preceptorship, reviewing the success of these clinics. ■ To continue with the 'stay clinics' to support band 5 nursing and midwifery staff to gain new experiences within the organisation. ■ To hold regular open recruitment days throughout the year to support the recruitment of staff to vacant posts. ■ To see a reduction in the number of band 5 nursing staff leaving the organisation in their first 12 months.
v) Community services will continue to work with service users to enhance patient experience and commit to continually improving services. Engaging feedback from service users following the establishment of new nurse led and autism drop-in clinics, will enable services to be developed in line with patient feedback and identification of health needs.	■ Establish a Community Children's Service User forum in Kaleidoscope to involve and actively seek views of all children, young people and their families who use/ access Children's Community Services. ■ Development of a new enhanced, service specific, parent questionnaire to engage feedback from service users of the new Autism drop in clinic. ■ Development of a leaflet for patients accessing the nurse led drop in clinics at GP surgeries and the Autism drop in clinic. ■ Utilise the feedback from Children and Young People and their families in development of the Autism Drop in clinic in line with the existing Trust 'You Said, We Did' campaign.

Part 2

2.2 Statements of assurance from the Board of Directors

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

A review of our services

During the 2017/18 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 2017/18 represents 100% of the total income generated from the provision of NHS services by the Trust for 2017/18.

National Quality Indicators

For 2017/2018, there are nine statutory quality indicators which apply to acute hospital trusts. All trusts are required to report their performance against these indicators in the same format with the aim of making it possible for a reader to compare performance across similar organisations. For each indicator our performance is reported with the national average and the performance of the best and worst performing trusts, where this data is available.

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 2017/18

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

We believe our performance reflects the following, that:

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

VTE assessment rate	2016/17	2017/18
Lewisham and Greenwich NHS Trust	95.4%	96.72%
Assessed (no. of patients with VTE assessment)	73,449	108,475
Admitted	76,920	112,157
Assessment Rate	95.4%	96.72%
National Average	**95.6%**	**95.20%**
Best performing Trust	**100%**	**99.33%**
Worst performing Trust	**79.86%**	**83.41%**

Source: www.england.nhs.uk

2.2.1 (ii) Patient Safety Indicator 2 – The rate per 100,000 bed days of cases of Clostridium difficile infection (CDI) reported within the Trust amongst patients aged 2 or over during 2017/18

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

Whilst recognising the 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 2018.

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

C. difficile rate per 100,000 bed-days	2016/17	2017/18
Lewisham and Greenwich NHS Trust		
Trust apportioned	25	16
Total bed days*	327,142	365,517
Rate per 100,000 bed days (Trust apportioned)	7.6	4.4
National Average	**3.2**	National published data not available until July 2018
Best performing Trust	**3.3**	
Worst performing Trust	**34.1**	

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

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

Reporting Period: April 2017 -March 2018

Trust Type	PHE Centre	Trust Name	April 2017	May 2017	June 2017	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018
NHS Trust	London	Barking Havering and Redbridge University Hospitals	2	0	1	2	1	0	1	2	0	3	1	1
NHS Trust	London	Barts Health	9	9	8	10	6	6	6	11	8	2	4	6
NHS Trust	London	Croydon Health Services	2	1	2	1	1	1	4	0	0	0	0	2
FT	London	Guy's & St. Thomas's	2	1	2	5	3	2	3	2	2	1	3	0
FT	London	Homerton University Hospital	0	1	1	2	1	1	0	0	0	1	1	2
FT	London	King's College Hospital	5	6	10	10	8	4	3	7	11	10	7	7
NHS Trust	London	Lewisham & Greenwich	3	1	2	0	0	1	3	0	1	2	2	1
NHS Trust	London	North Middlesex University Hospital	4	2	4	2	2	3	0	1	2	2	8	6

Source: www.gov.uk/government/statistics/clostridium-difficile-infection-monthly-data-by-nhs-acute-trust

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

- Continuing to undertake antimicrobial and other ward rounds with the Consultant microbiologists and clinical teams.
- Ensuring continual and regular review of antimicrobial prescribing.
- Monitoring performance of antimicrobial prescribing through bi-monthly antimicrobial care bundle audits undertaken by the antimicrobial pharmacists which are fed back to individual Divisional governance meetings and the Infection Prevention and Control Committee.
- Working with our community partners to update antimicrobial prescribing guidelines for the community.
- Updating and standardising Trust antimicrobial prescribing.
- Linking with Greenwich CCG to participate in their review of community acquired C. difficile to identify any lapses in care or learning.
- Maintaining a strong and visible presence at ward level by the Infection Prevention and Control Team
- 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 2017/18

Number and Rate of Patient Safety Incidents Reported within the Trust

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

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

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

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

- There has been an increase in the number of reported incidents across the Trust over the last year. This is encouraging as staff feel able and supported to report incidents without feeling that any investigation will be handled in a punitive manner
- The Trust's Patient Safety Team is working with divisional leads to ensure that all patient safety incidents involving staff are managed using a 'fair and just culture' approach ensuring that staff are supported when an error has occurred that has caused harm.
- Data on patient safety incidents, including the severity of impact, is collated monthly and reported to the Trust Board.
- The Trust contributes to the national programme of learning from patient safety incidents and all clinical incidents are reported nationally via the NRLS.
- Although the formal Sign Up to Safety programme has now completed, the Trust will continue to further embed the safety improvement programme.

Patient Safety Incidents	Apr 16-Sept 16	Apr 17-Sept 17*
Lewisham and Greenwich NHS Trust		
Total reported incidents	6,547	7, 034
Incident reporting rate per 1,000 bed days	41.21	43.18
Incidents causing severe harm or death	5	5
% of incidents causing severe harm or death	0.1%	0.1%
Acute Non-Specialised Trusts		
Lowest incident reporting rate per 1,000 bed days	21.15	23.47
Highest incident reporting rate per 1,000 bed days	71.81	111.69
Lowest incidents causing severe harm or death	0.0%	0.0%
Highest incidents causing severe harm or death	1.9%	2.0%
Acute Trusts average % of incidents causing severe harm or death	0.4%	0.4%

*The data for April 2017 to September 2017 is the latest published data available – we await the national publication of more recent data.
Please note that the National data published for April 17-Sept 17 will not include those that have been de-escalated with agreement of the CCG.

The table below shows the current reporting of patient safety incidents (clinical and non-clinical) and the number where severe harm and death have occurred during the year of 2017/18 to date.

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

2017/18	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Number	1457	1967	1477	1626	1669	1504	1592	1473	1608	1625	1474	1594	19066

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

2017/18	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Severe harm	1	0	0	1	2	0	1	1	1	1	1	1	**10**
Death	0	0	1	0	0	0	0	0	0	0	0	0	**1**
Total	**1**	**0**	**1**	**1**	**2**	**0**	**1**	**1**	**1**	**1**	**1**	**1**	**11**

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

For the period between April 2017 and March 2018 a total of 19066 incidents (including clinical, patient safety and non-clinical incidents) were reported on the incident reporting system within the Trust.

Of these the majority (85%) reported were considered to be patient safety incidents which are uploaded to the National Reporting and Learning System (NRLS) to help contribute towards national learning and improvements in patient safety.

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

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

Duty of Candour

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

Duty of Candour includes:

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

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

2.2.2 Clinical Effectiveness

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

Mortality

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

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

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

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

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

SHMI value and Banding

Summary Hospital-level Mortality Indicator	Jan 16 – Dec 16 (published June 2017)		Apr 16 – Mar 17 (published September 2017)		July 16 – Jun 17 (published December 2017)		Oct 16 – Sept 17 (published March 2018)	
	SHMI	Banding	SHMI	Banding	SHMI	Banding	SHMI	Banding
Lewisham and Greenwich NHS Trust	1.00	Band 2 'as expected'	1.00	Band 2 'as expected'	1.01	Band 2 'as expected'	1.01	Band 2 'as expected'
Best Performing Trust	0.690	Band 3	0.707	Band 3	0.726	Band 3	0.90	Band 3
Worst Performing Trust	1.189	Band 1	1.212	Band 1	1.227	Band 1	1.12	Band 1

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

Making sure that the 'as expected' SHMI banding achieved by the Trust is sustained and through ensuring that any SHMI scores that are higher than expected are reviewed by looking at the patient's coded information. 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 NHS Digital publishes the National SHMI scorings on a quarterly basis, they also publish a number of contextual indicators, including the percentage of patients who have died at each Trust and those who are receiving palliative care. The method used to calculate Trust SHMI scores currently makes no adjustments for palliative care patients. This means that any Trust with a higher number of palliative care patients may appear to have a higher number of deaths than expected using the SHMI scoring system. For example, a Trust which has an onsite hospice or palliative care unit would have a higher number of deaths than other Trusts.

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

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

Percentage of deaths with palliative care coding	Jan 16 – Dec 16 (published June 2017)	Apr 16 – Mar 17 (published September 2017)	Jul 16 – Jun 17 (published December 2017)	Oct 16 – Sept 17 (published December March 2018)
Lewisham and Greenwich NHS Trust	25.3	25.5	23.8	23.3
Lowest percentage Trust	**7.3**	**11.1**	**11.2**	**11.5**
Highest percentage Trust	**55.7**	**56.6**	**58.3**	**59.8**

Source: NHS Digital Indicator Portal

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

Lewisham and Greenwich NHS Trust treats a number of patients who require palliative care and has a specialist palliative care team, and through the continuous work of our End of Life care pathways, we have seen a slight increase of patients being coded as palliative care patients. We are continuously working on improving our data quality for clinical coding and have developed, through reviews of mortality, an approach to ensure that the relevant clinician confirms whether the patient should be coded as palliative care. For the purpose of the quality account we are required to publish data from the national reports. It is difficult to compare these rates, as the configuration for cancer services and cancer pathways across all NHS organisations is very different.

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

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

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

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

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

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

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

The questionnaires are named as the following:

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

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

The Q2 questionnaires are sent to patients who underwent Hip and Knee operations up to 6 months after the operation. For groin hernia and varicose vein operations these are sent out up to 3 months after. The operation dates are provided to the PROMS suppliers by NHS Digital after they have attempted to match the operation date with the dates recorded in the Hospital Episode Statistics (HES) data. If NHS Digital is unable to match the PROMS Q1 questionnaires to a HES record, the PROMS suppliers are instructed to allow an additional three months after the Q1 completion date, to ensure the three months minimum required time has passed before patients are invited to report on their post-operative health status. 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.

PROMS Consultation and changes to participation from October 2017

NHS England undertook a consultation on the national PROMs programme in 2016. As a result of the findings of that consultation, NHS England took the decision to discontinue the mandatory varicose vein surgery and groin-hernia surgery national PROM collections from 1st October 2017.

Along with the evidence found during the consultation, the rationale for this decision was that:

- Surgical treatment of varicose veins is currently much less frequent and the condition is usually not a major cause of patient debility;
- Groin hernia surgery is offered mainly to reduce the risk of requiring emergency surgery, rather than to relieve symptoms, which are often relatively minimal. This, along with the fact that there was no condition-specific PROM for groin-hernia surgery, meant that the existing PROM had limited value.

As these PROMs were perceived to be delivering limited value, the decision was taken to remove the burden on organisations of continuing to collect this data. NHS England will continue with hip and knee surgery PROM collections and are working with NHS Digital to make the national data on them easier to use and to provide a range of automated outputs that are tailored to the needs of trusts, Clinical Commissioning Groups and other users.

PROMS Performance – Lewisham and Greenwich NHS Trust

The table below provides details of the number of operations Lewisham and Greenwich NHS Trust have carried out in 2017 for the four procedures covered by PROMS, the number of patients eligible to participate in PROMS based on HES data, and the number of questionnaires returned for each procedure up to September 2017.

i) Operations Lewisham and Greenwich NHS Trust have carried out from 1st April 2017 up to 30th September 2017 and the number of questionnaires returned for each procedure up to 30th September 2017 – Groin Hernia and Varicose Vein

April 2017 – September 2017					
Procedure	**Eligible Patients (Based on HES Data)**	**Number of Operations Performed (Based on Hospital Data)**	**No. of Q1 Questionnaires Received**	**No. of Q2 Questionnaires Issued**	**No. of Q2 Questionnaires Returned**
All Procedures	**262**	**275**	**114**	**68**	**20**
Groin Hernia	199	240	114	68	20
Varicose Vein	63	35	< 30 records	0	0

ii) Operations Lewisham and Greenwich NHS Trust have carried out from 1st April 2016 up to 31st March 2017 and the number of questionnaires returned for each procedure up to 31st March 2017 – Hip and Knee Replacement

April 2016 – March 2017						
Procedure	**Eligible Patients (Based on HES Data)**	**Number of Operations Performed (Based on Hospital Data)**	**Pre-operative questionnaires Completed**	**No. of Q1 Questionnaires Received**	**No. of Q2 Questionnaires Issued**	**No. of Q2 Questionnaires Returned**
All Procedures	**554**	**620**	**625**	**112.8%**	**548**	**318**
Hip Replacement	227	289	249	109.7%	222	135
Knee Replacement	327	331	376	115.0%	326	183

The table below shows the published NHS Digital PROMs health gain data for the reporting period 1st April 2016 up to and including 30th September 2017.

Adjusted Health Gain – Lewisham and Greenwich NHS Trust April 2016 – September 2017 - Comparison with National Average and Best and Worst Performers

PROMS	Measure	Lewisham & Greenwich Adjusted Health Gain April 2017 – September 2017	Lewisham & Greenwich Adjusted Health Gain April 2016 – March 2017	National Adjusted Health Gain April 2016 – March 2017	Best Performer - Adjusted Health Gain April 2016 – March 2017	Worst Performer – Adjusted Health Gain April 2016 – March 2017
Groin Hernia	EQ-5D	0.798	0.050	0.086	0.135	0.006
	EQ-VAS	-1.800	-2.051	-0.241	3.273	-6.507
Hip	EQ-5D	< 30 records	0.435	0.437	0.533	0.328
	EQ-VAS	< 30 records	13.815	13.112	20.183	7.893
	Oxford Hip Score	< 30 records	21.307	21.379	25.044	15.968
Knee	EQ-5D	< 30 records	0.295	0.322	0.398	0.237
	EQ-VAS	< 30 records	5.775	6.850	14.443	0.465
	Oxford Knee Score	< 30 records	15.866	16.393	19.686	12.231
Varicose Veins	EQ-5D	< 30 records	< 30 records	0.092	0.155	0.010
	EQ-VAS	< 30 records	< 30 records	0.081	6.272	-4.904
	Aberdeen Varicose Vein Score	< 30 records	< 30 records	-8.248	2.117	-18.075

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

- The published data from NHS Digital covers the reporting period April 2016 – September 2017
- The Trust has identified that the number of Q2 questionnaires returned for period April 2017 – September 2017 for hip, knee and varicose vein procedures is fewer than that which is statistically significant for the recording of data for the PROMS
- The Trust performance for its PROMS is comparable to the national average for groin hernia surgery.

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

- Ensuring all eligible patients are invited to complete the hip and knee 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 following hip and knee replacement surgery to understand why and identify any areas for improvement in each of the procedure processes.

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

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

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

Lewisham and Greenwich NHS Trust monitors the readmission rate using the national data sources and also through CHKS, an independent leading provider of healthcare intelligence. Readmission data for the year 2017/18 is available through CHKS as shown in the tables 1, 2, and 3 below. Due to the coding time-lag of 3 months, the data in the tables below is the most recent published data. The peer comparison has also been included to allow the organisation to benchmark its performance against peers (Acute Trusts Nationally). It is not possible to include peer data for individual

hospital sites which form part of an NHS Trust, as CHKS peers are Trusts rather than sites.

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

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

- Trauma and Orthopaedics
- Acute Paediatrics
- Geriatrics

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

Lewisham and Greenwich readmission within 28 days

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Trust	8.93	8.99	8.98	9.12	9.55	9.10	8.77	8.05	8.35
Peer	7.95	7.77	7.77	7.77	7.82	7.87	7.81	7.76	8.01

University Hospital Lewisham readmission within 28 days

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Trust	7.81	6.87	6.65	6.99	7.28	6.10	6.49	5.70	6.23

Queen Elizabeth Hospital readmission within 28 days

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Trust	9.84	10.78	10.88	10.81	11.40	11.55	10.58	9.99	9.95

CHKS Peer Group

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

2.2.2 (iv) Clinical Effectiveness Indicator 4 – Learning from Deaths

Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work. In recent years, there has been increasing international interest in using mortality rates to monitor the quality of hospital care.

Following events in Mid Staffordshire (2010), a review of 14 hospitals with the highest mortality was carried out which revealed that the focus on aggregate mortality rates was distracting the Trust boards from the practical steps that can be taken to reduce genuinely avoidable deaths in NHS hospitals (Keogh, 2013).

This was reinforced by the findings of the Care Quality Commission (CQC) report Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England (December 2016) which found that learning from deaths was not being given sufficient priority in some organisations, and consequently valuable opportunities for improvements were being missed.

As a result, National Guidance on Learning from Deaths was published by the National Quality Board in March, 2017 as part of a national endeavour to ensure the NHS learns from reviewing the care provided to patients who die, to improve care for all patients.

Requirements:

- From April, NHS Trusts and Foundation Trusts must collect and publish, on quarterly basis, specified information on deaths, including those that are assessed as more likely than not to be due to problems in care, and evidence of learning and action that is happening as a consequence of this information.
- Adopt and roll out the use of the Structured Judgement Review (SJR) case note methodology to carry out detailed investigation into deaths with a focus on these leading to improvements in care.
- The data in the dashboard should be collected and published on a quarterly basis together with relevant qualitative information, interpretation of the data, and what learning and related actions your organisation has derived from it.

Between 1st April 2017 up to and including 31st March 2018 1873 of Lewisham and Greenwich NHS Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 435 in the first quarter; 424 in the second quarter; 447 in the third quarter; 567 in the fourth quarter.

By 31st March 2018, 449 case record reviews and 16 investigations have been carried out in relation to 1873 of the deaths included above.

In 16 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

6 in the first quarter; 6 in the second quarter; 3 in the third quarter; 0 in the fourth quarter.

3 representing 0.16% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of: 0 representing 0% for the first quarter;

0 representing 0% for the second quarter;

3 representing 0.16% for the third quarter;

0 representing 0% for the fourth quarter.

These numbers have been estimated using the number of deaths (3) which were deemed either Definitely Avoidable, Strong Evidence of Avoidability or Probably Avoidable (more than 50:50) via the Structured Judgement Review methodology and divided by the number of deaths and multiplied by 100.

These numbers have been estimated using the Structured Judgement Review (SJR) Methodology. Structured judgement review blends traditional, clinical-judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase.

The objective of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process. In order to answer these questions, there is a need to look at: the whole range of care provided to an individual; holistic care approaches and the nuances of case management and the outcomes of interventions.

An important feature of the method is that the quality and safety of care is judged and recorded whatever the outcome of the case, and good care is judged and recorded in the same detail as care that has been judged to be problematic. Evidence shows that most care is of good or excellent quality and that there is much to be learned from the evaluation of high-quality care.

Judging the level of the avoidability of a death is a complex assessment that can be challenging to undertake. This is because the assessment goes beyond judging safety and quality of care by also taking account of such issues as comorbidities and estimated life expectancy. Recent evidence suggests the levels of agreement can be very low when assessing potential avoidability of death.

The judgement is framed by a six-point scale (6 – no evidence of avoidability, to 1 – definitely avoidable). This scale has been used in a number of recent national mortality review studies in Canada, the Netherlands and England.

Through the new process of the Structured Judgement Reviews, the Trust has gained significant learning from deaths. The recording and escalation of the deteriorating patient was found to be a common theme. The Trust has recognised the challenge of training all staff to recognise the deteriorating patient and has a well-established Trust wide Deteriorating Patient Working Group who are taking this forward, with support of the medical, outreach, resuscitation and clinical teams.

The Group has undertaken significant work in the last two years and more recently within the last 9 months, to ensure continual improvement in the ability of all staff to recognise the signs, symptoms and parameters of a deteriorating patient. The most recent audit (National Early Warning Scoring (NEWS Audit Nov 2017) has shown that 96% of patients who were actually deteriorating were escalated and managed in line with Trust policy. For the most recent audit, methodology was altered to focus on this identified patient group, and as such an exact comparison cannot be made to the original audit (March 2017), although further analysis of that data indicates 22% of patients that required escalation had been escalated.

Documentation and communication between teams remains an area of focus for improvement. The deteriorating patient group are continuing to work on the rollout of the Situation Background Action Review (SBAR) approach to improve communication and have introduced a sticker which is entered in the medical notes to indicate that the patient has been escalated.

Further learning from the review of deaths from the mortality reviews and of serious and red incidents has resulted in additional learning.

There is ongoing work to be done on learning from deaths in the Trust. As with the national report, unless the Trust is notified of a care management issue, patients who have had care at the trust and then die elsewhere are not routinely identified.

At present 40 staff have received training in the SJR process, ongoing training of more members of the multidisciplinary team is in progress.

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 2017 - 2018	2015/16	2016/17
Lewisham and Greenwich NHS Trust	65	60
Highest scoring Trust	86.2	86.2
Lowest scoring Trust	58.9	54.4

The results of the Care Quality Commission's (CQC) national adult inpatient survey 2017 provides analysis of patient feedback across the NHS from July 2017.

This will be the fourth inpatient survey to be carried out since Lewisham and Greenwich NHS Trust was established. The final results will not be published until Summer 2018. The Trust improved in 84% of questions from 2016. There were significant improvements across the admission process, helping patients keep clean, emotional support, and information around discharge.

Our goal is to improve so we are consistently one of the best performing Trusts. In 2018/19 we will continue to focus on improving patient experience with a focus on the wellbeing and personal needs of patients, and communication. Revised local surveys will further inform where we need to improve and will be used to ensure changes can be implemented in a timely way enabling us to be more responsive.

Data from the 2016 survey is shown below:

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

The results of the Care Quality Commission's (CQC) national Maternity Survey was last undertaken in 2017.

CQC Maternity Survey 2015 composite scores for question categories	2015	2017
Labour and birth	8.5	8.7
Staff during labour and birth	8.5	8.7
Care in hospital after the birth	7.6	7.4

A large amount of work has been done to ensure the service offered to women is respect of their wishes and we support the whole family during pregnancy, birth and postnatally. The Maternity services have run 3 "Whose Shoes" events in the last 12 months with one being dedicated to Fathers to be able to understand what patients want from the service.

The 2017 survey results have highlighted that further work is needed on postnatal care, the discharge process and care in the community when patients go home. To help improve post-natal care both in hospital and in the community, the service is looking at a range of initiatives. On the post-natal ward they are looking at ensuring that a support worker is on duty overnight and at weekends to help with additional feeding support; the introduction of quality ward rounds to identify any gaps in care; looking at the discharge process to enable women to be discharged in a timely manner and the quality of the information given when women are discharged will be reviewed and monitored.

Only 2 questions scored outside of the expected range in 2016, compared to 9 in 2015;

- Patient completely understood the explanation of what was wrong
- Taking part in cancer research discussed with patient

The Trust did not score above the expected range for any question. However, when asked to score their overall care on a scale of zero (very poor) to 10 (very good), respondents gave an average rating of 8.7.

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 which enable comparisons to be made between similar Trusts and the national average for similar Trusts.

The 2017 Staff Survey responses to the Staff Friends and Family Test (SFFT) questions indicated that:

- 54% of those who responded said they agreed or strongly agreed, they would recommend the Trust to friends and family as a place for treatment,

This is a decline when compared to the 2016 survey where 62% of those who responded said they would recommend the Trust to friends and family as a place for treatment.

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	
	2016	2017
Lewisham and Greenwich NHS Trust	3.68*	3.51*
National Average	3.71**	3.75**
Highest scoring Trust	4.20**	4.18**
Lowest scoring Trust	3.11**	3.38**

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

Part 2

2.3 Participation in Clinical Audit

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

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

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

National Audit and Confidential Enquiries Programme

During April 2017 to March 2018, 57 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% (57/57) National Clinical Audits and 100% (6/6) National Confidential Enquiries of the National Clinical Audits and 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 2017 to March 2018
- 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 2017 to March 2018, are listed alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

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

	Audit Title	Eligible UHL	Eligible QEH	Participated UHL	Participated QEH	Reporting Period	% Submission Rate - UHL	% Submission Rate - QEH
1	Acute Myocardial Infarction & Other ACS (MINAP)	Yes	Yes	Yes	Yes	1st April 2015 – 31st March 2016	30 cases	98 cases
2	BAUS Urology – Female Stress Incontinence	Yes	Yes	Yes	Yes	1st April 2017 – 31st March 2018	100%	100%
3	Bowel Cancer (NBOCAP)	Yes	Yes	Yes	Yes	1st April 2015 – 31st March 2016	100%	
4	Cardiac Rhythm Management (CRM)	Yes	Yes	Yes	Yes	1st April 2015 – 31st March 2016	60 cases	246 cases
5	Case Mix Programme (CMP)	Yes	Yes	Yes	Yes	1st April 2017 – 31st March 2018	100%	100%
6	Coronary Angioplasty/ Percutaneous Coronary Interventions (PCI)	No	Yes	N/A	Yes	1st January 2015 – 31st December 2015	N/A	241 cases
7	Diabetes – Adult (NDA)	Yes	Yes	Yes	Yes	1st January 2016 – 31st March 2017	100%	100% (demographic data only)
8	Diabetes – Paediatric (NPDA)	Yes	Yes	Yes	Yes	1st April 2016 – 31st March 2017	100%	100%
9	Elective Surgery (National PROMS Programme)	Yes	Yes	Yes	Yes	1st April 2016 – 31st March 2017	LGT – Hip and Knee 113%	
						1st April 2017 – 30th September 2017	LGT – Groin Hernia and Varicose Vein 44%	
10	Endocrine and Thyroid National Audit	Yes	Yes	Yes	Yes	1st February 2012 – 30th June 2016	46 cases	
11	Falls and Fragility Fractures Audit Programme – Fracture Service Liaison Database (FSLD)	Yes	Yes	Yes	Yes	1st January 2016 – 30th June 2016	191 cases	109 cases
12	Falls and Fragility Fractures Audit Programme – National Hip Fracture Database (NHFD)	Yes	Yes	Yes	Yes	1st January 2017 – 31st December 2017	145 cases	332 cases
13	Falls and Fragility Fractures Audit Programme – National Inpatient audit of Falls (NAIF)	Yes	Yes	Yes	Yes	16th and 17th May 2017	100%	100%
14	Inflammatory Bowel Disease Registry (IBD)	Yes	Yes	Yes	Yes	1st March 2015-29th February 2016	11 cases	26 cases
15	Learning Disability Mortality Review Programme (LeDeR)	Yes	Yes	Yes	Yes	1st July 2016 – 30th November 2017	100%	100%
16	Major Trauma (TARN)	Yes	Yes	Yes	Yes	1st January 2017 – 31st December 2017	83%-97%	100%
17	National Audit of Breast Cancer in Older Patients (NABCOP)	No	Yes	N/A	Yes	1st January 2015 – 31st December 2015	N/A	250 cases
18	National Audit of Intermediate Care (NAIC)	Yes	N/A	Yes	N/A	1st May 2017 – 14th July 2017	Bed Based 47 cases Home Based 97 cases PREM Q. 36 cases	N/A
20	National Bariatric Surgery Registry (NBSR)	Yes	Yes	Yes	Yes	1st April 2013 – 31st March 2016	85 cases	
21	National Cardiac Arrest Audit (NCAA)	Yes	Yes	Yes	Yes	1st April 2017 – 31st March 2018	100%	100%
22	National Chronic Obstructive Pulmonary Disease Audit (COPD)	Yes	No	Yes	N/A	1st February 2017 – 13th September 2017	115 cases	N/A
23	National Comparative Audit of Blood Transfusion -	Yes	Yes	Yes	Yes	1st March 2017 – 30th April 2017	100%	100%
24	National Comparative Audit of Blood Transfusion -	Yes	Yes	Yes	Yes	1st July 2017 – 31st July 2017	100%	100%
25	National Emergency Laparotomy Audit (NELA)	Yes	Yes	Yes	Yes	1st December 2015 to 30th November 2016	<50%	>80%
26	National Heart Failure Audit (HF)	Yes	Yes	Yes	Yes	1st April 2015 – 31st March 2016	173 cases	106 cases
27	National Joint Registry (NJR)	Yes	Yes	Yes	Yes	1st January 2016 – 31st December 2016	87%	
							452 cases	83 cases
28	National Lung Cancer Audit (NLCA)	Yes	Yes	Yes	Yes	1st January 2016 – 31st December 2016	270 cases	
29	National Maternity and Perinatal Audit (NMPA)	Yes	Yes	Yes	Yes	1st April 2014 and 31st March 2016	100%	100%
30	National Neonatal Audit Programme (NNAP)	Yes	Yes	Yes	Yes	1st January 2017 – 31st December 2017	100%	100%
31	Oesophago-Gastric Cancer (NAOGC)	Yes	Yes	Yes	Yes	1st April 2014 – 31st March 2016	71%-80% 112 cases	
32	Paediatric Pneumonia	Yes	Yes	Yes	Yes	1st November 2016 – 31st January 2017	100%	100%
33	Pain in Children (Care in the Emergency Department)	Yes	Yes	Yes	Yes	1st August 2017 – 31st January 2018	>100%	52%
34	Procedural Sedation in Adults (Care in the Emergency Department)	Yes	Yes	Yes	Yes	1st August 2017 – 31st January 2018	100%	56%
35	Prostate Cancer	No	Yes	N/A	Yes	1st April 2015 – 31st March 2016	N/A	223 cases

	Audit Title	Eligible UHL	Eligible QEH	Participated UHL	Participated QEH	Reporting Period	% Submission Rate - UHL	% Submission Rate - QEH
36	Sentinel Stroke National Audit Programme (SSNAP)	Yes	No	Yes	N/A	1st April 2016 to 31st March 2017	379 cases	N/A
37	UK Parkinson's Audit	Yes	Yes	Yes	Yes	1st May 2017 – 30th September 2017	SALT 64 cases	N/A
							Physiotherapy 95 cases	N/A
							Elderly & Neuro 20 cases	Elderly & Neuro 21 cases

Table 2 - Audits on the HQIP list that did not collect data in 2017/2018

	Audit Title
1	Pleural Procedures
2	Non-Invasive Ventilation - Adults
3	Adult Community Acquired Pneumonia
4	Paediatric Asthma
5	National Audit of Anxiety and Depression
6	National Audit of Psychosis
7	National Audit of Rheumatoid and Early Inflammatory Arthritis
8	National Audit of Seizures and Epilepsies in Children and Young People
9	National End of Life care audit

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

	Enquiry Title	Eligible UHL	Eligible QEH	Participated UHL	Participated QEH	Reporting Period	% Submission Rate – UHL	% Submission Rate – QEH
1	Maternal, Infant and Newborn Clinical Outcome Review (MBBRACE)	Yes	Yes	Yes	Yes	1st April 2017 – 31st December 2017	100%	100%
2	NCEPOD – Chronic Neurodisability	Yes	Yes	Yes	Yes	Organisational Questionnaire	N/A	N/A
		Yes	Yes	Yes	Yes	Clinical Questionnaires	100%	100%
		Yes	Yes	Yes	Yes	Case Note Extracts	100%	100%
3	NCEPOD – Young People's Mental Health	Yes	Yes	Yes	Yes	Organisational Questionnaire	100%	100%
		Yes	Yes	Yes	Yes	Clinical Questionnaires	100%	100%
		Yes	Yes	Yes	Yes	Case Note Extracts	100%	100%
4	NCEPOD – Cancer in Children, Teens and Young Adults	Yes	Yes	Yes	Yes	Organisational Questionnaire	100%	100%
		Yes	Yes	Yes	Yes	Clinical Questionnaires	N/A	100%
		Yes	Yes	Yes	Yes	Case Note Extracts	N/A	100%
5	NCEPOD – Acute Heart Failure	Yes	Yes	Yes	Yes	Organisational Questionnaire	100%	100%
		Yes	Yes	Yes	Yes	Clinical Questionnaires	100%	100%
		Yes	Yes	Yes	Yes	Case Note Extracts	100%	100%
6	NCEPOD – Perioperative Diabetes	Yes	Yes	Yes	Yes	Organisational Questionnaire	In progress	In progress
		Yes	Yes	Yes	Yes	Clinical Questionnaires	In progress	In progress
		Yes	Yes	Yes	Yes	Case Note Extracts	In progress	In progress

Table 2 - Additional National Clinical Audits that Lewisham and Greenwich NHS Trust Participated in during 2017-2018

	Audit Title
1	Adult Bronchiectasis Audit
2	Adult Bronchoscopy Audit
3	BHIVA Survey and audit of psychological well-being and support, and use of alcohol and other drugs
4	Cardiac Rehabilitation Audit
5	Cystic Fibrosis Registry UK
6	Diabetes - Foot Health
7	Diabetes - National Inpatient Diabetes Audit
8	Diabetes - Pregnancy in Diabetes
9	Each Baby Counts
10	Falls and Fragility Fractures Programme - Physiotherapy Hip Fracture Sprint Audit
11	Generating Evidence in MS Services National Patient Survey
12	Hepatitis B in Pregnancy Audit
13	National Audit of Small Bowel Obstruction 2017
14	Paediatric Bronchiectasis Audit
15	Potential Donor Audit
16	Psoriasis Audit
17	Right Iliac Fossa pain Treatment (RIFT) Audit
18	SNAP-2
19	UK Midwifery Study System - Birth Centres
20	UK Midwifery Study System - Neonatal Admissions

Reviewing Reports of National Clinical Audits and Confidential Enquiries

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 all National Clinical Audits and Confidential Enquiries published were reviewed by Lewisham and Greenwich NHS Trust between January 2017 to December 2017 and some of the actions that Lewisham and Greenwich NHS Trust will be taking to improve quality are detailed below:

Audit/ Enquiry	Changes to Practice
National Audit on Psychological Aspects of HIV Care	The Trust performed poorly in the audit in relation to the documentation of the assessment of psychological care, including substance misuse. In response, an annual screening checklist has been produced to prompt and facilitate the documentation of psychological aspects of patients care. The service has also moved to using electronic patient records, and additional questions have been added to the record to facilitate the recording of this information. The British HIV Association (BHIVA) report recommended that Trusts should have a lead for psychological care in the HIV service. This is being reviewed by the service leads to agree how the to take this action forward.

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

The reports of 347 local audits were reviewed by the Trust from1st April 2017 to 31st March 2018. 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
Dermatology	Following a significant increase in 2 week wait (2ww) referrals for skin cancer to the Dermatology clinics at Queen Elizabeth Hospital Woolwich, a service evaluation of clinic capacity was undertaken. To address the demand and ensure patients are treated as per the national guidance, a 'mega clinic' was introduced. These 'mega-clinics' are held once monthly or as required to manage seasonal 2ww demand and staff annual leave. A high number of new 2ww patients (average 25-30) are booked in a single list under a named consultant who simultaneously supervises all junior doctors seeing these patients. See and treat service is also offered on these dates. This initiative is a good example of team working and is greatly appreciated by trainees, as they find it as a good opportunity for learning. It is also an innovative economical way to manage increasing cancer demand, ensure patients are seen on time and avoid breaches.
Children's Services	Following a review of patient satisfaction with play provision for children in hospital on the children's inpatient ward at Lewisham, medical student volunteers are now providing 2 hours of play provision on Saturdays where there was previously no formal support for children to have therapeutic play at weekends.
Foot Health	Following a review of our new patient pathway, we have redesigned the pathway for new patients with musculoskeletal related foot problems. Their referral now by-passes our new patient clinics and goes direct to our biomechanics service, reducing the waiting time to see a specialist by 6 weeks
Diabetes	Following an audit of referrals to paediatric diabetic clinics, an opt-in system has been employed for booking paediatric diabetic appointments. This has seen the Do Not Attend (DNA) rates for the clinics fall from 26% to 10%.
Health Visiting	Following a Maternal Mental Health audit and feedback from the health visiting staff, the service devised an information leaflet for clients that the health visitors give out during the antenatal period. This leaflet provides information to clients to be aware of their own mental health, and provides them the tools to access help at the earliest point if required. This promotes early intervention with the aim to reduce adverse impact on the health and well-being of the family.
Community Head and Neck Team	Following a geographical move to the Waldron Health Centre from the previous base in Camberwell, London, the Community Head and Neck Team (CHANT) assessed their access to patient records and the impact the varying types of access had on clinical practice. CHANT is a 6 borough service working in 9 clinic locations across 5 organisations as well as seeing patients on a domiciliary basis. As such, access to the electronic record on RiO was proving challenging, and consultations were having to be written up on paper and then transferred to the clinical record once staff returned to the office. The team rolled out to mobile working with laptops in 2017 which has given them access to RiO on the go and has provided opportunity for more flexible working practices to utilise clinical time efficiently.
Pharmacy	Annual medicines reconciliation audits have indicated that the proportion of drug histories undertaken by medicines management pharmacy technician (MMPT) has increased over the past year enabling pharmacist time to be released to undertake other clinical duties in-line with the Carter plan e.g. patient counselling at ward level and pharmacist led DOAC clinics.
Orthopaedics	Inpatient length of stay (LOS) for patients discharged with the Community Orthopaedic Service is audited yearly. An increase in LOS for Total Knee Replacements (TKR) was noted in 2016 audit. In response, the Community Orthopaedic Service implemented a trial in late 2017 where patients awaiting TKR are visited at home by a rehabilitation assistant. Pre-operative education including expected LOS and some simple exercises are discussed and provided. Trial to be evaluated May 2018 to assess any impact on LOS.
Pathology	Following an audit to assess the documentation of key information and observations for patients receiving blood products, an Integrated Care Pathway (ICP) was developed and trialled. The ICP has demonstrated significant benefits to patient safety in ensuring that all documentation relating to the transfusion are contained within one place in the patient record. Formal approval and ratification to roll the document out Trustwide will be requested in early 2018
Respiratory	An initial audit of oxygen prescribing demonstrated that only 66% of patients on oxygen had had it prescribed on their drug charts. The results were presented at the team academic meeting to clinical staff, and daily teaching at ward rounds was undertaken to educate staff on the requirement to prescribe oxygen on the drug chart in addition to recording in the medical record. A re-audit completed at the end of 2017 concluded that 94% of patients on oxygen had it prescribed on their drug charts.
Therapies	A review of Parkinsons service provisions led to the establishment of newly diagnosed Parkinson Disease groups in the community, allowing for early education, prevention and to enable self-management of symptoms. These are two hourly groups run quarterly by Physiotherapy, Speech and Language Therapy and Parkinson's disease specialist nurse team. The groups are aimed to provide individuals with early information around their diagnosis.

Part 2

2.4 Participation in Research

Overview

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

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

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

Participation in Clinical Research

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

Lewisham and Greenwich NHS Trust was involved in conducting 167 clinical research studies in a number of different specialties (see figure below).

Division 1: Cancer

Division 2: Diabetes, Stroke, Cardiovascular, Renal, Metabolic and Endocrine Disorders

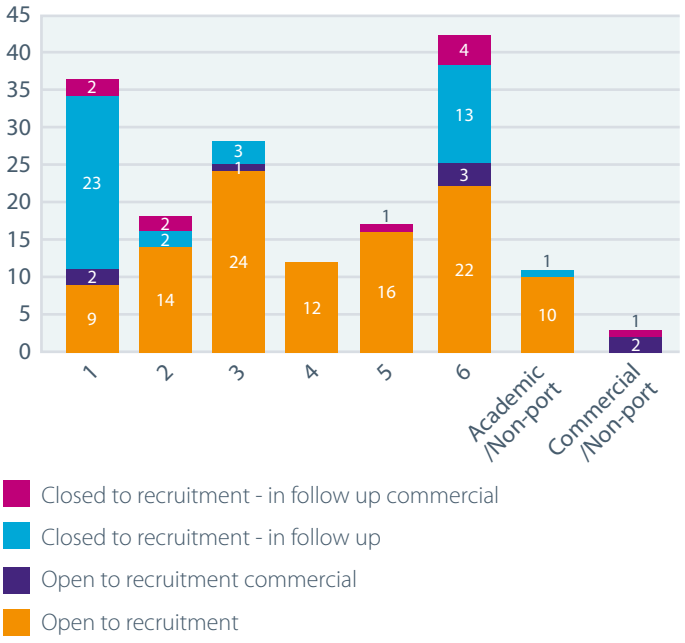
Division 3: Children, Genetics, Haematology, Paediatrics, Reproductive Health and Childbirth

Division 4: Dendron, Mental Health and Neurology

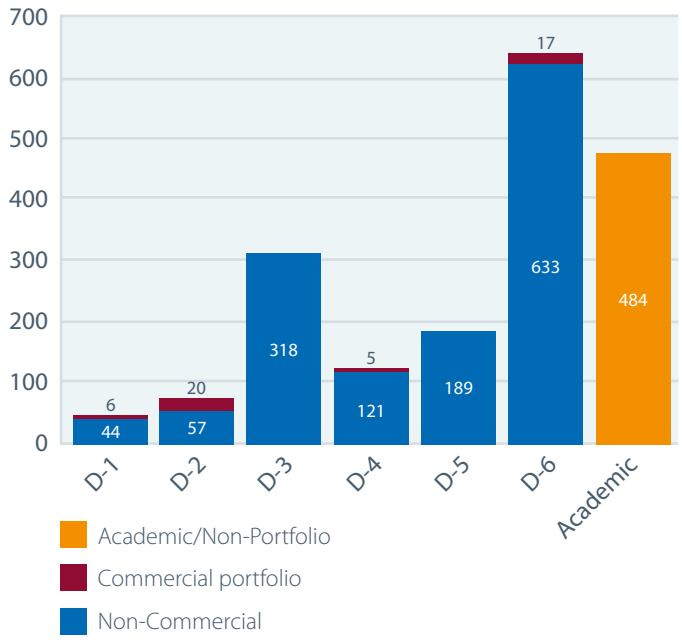
Division 5: Primary Care, Age and Aging, Dentistry, Health Services Research, Public Health, MSK, Dermatology.

Division 6: Anaesthesia/Peri-operative Medicine and Pain management, Critical care, Injuries/Emergencies, Surgery, ENT, Infectious Disease/Microbiology, Ophthalmology, Respiratory, Gastroenterology, Haematology

Research studies open by CRN Division



Patients recruited to studies by CRN Division



The number of patients receiving NHS services provided or subcontracted by Lewisham and Greenwich NHS Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 1894.

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

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

The Research and Development structure has been set up to strengthen capacity to deliver increasing recruitment of patients across the trust. Developing the research function within the organisation will benefit patients and the skills and knowledge base of our staff. The aim is to ensure a balanced portfolio of interventional, observational and large observational studies, together with an increase in commercial activity across more specialties.

Part 2

2.5 Goals agreed with Commissioners (CQUINs)

A proportion (2.5%) of Trust's income in 2017/18 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 88% to be added in when Commissioners confirm final year achievement of its CQUIN goals for April 2017 – March 2018.

Part 2

2.6 What others say about the provider

Care Quality Commission (CQC)

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

The Care Quality Commission has taken enforcement action against Lewisham and Greenwich NHS Trust in 2017/18.

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

In March 2017, the CQC undertook a planned comprehensive inspection of all the Trust services, including our community services.

The report was published in November 2017 with the following ratings;

Our ratings for Lewisham and Greenwich NHS Trust

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

Our Community Services for Children and Young People achieved an 'Outstanding' rating, with our Community Services for Adults achieving a 'Good' rating.

Our ratings for Community Services

	Inadequate	Requires improvement	Good	Outstanding
Community health services for adults				
Safe			Good	
Effective			Good	
Caring			Good	
Responsive			Good	
Well-led			Good	
Overall			Good	
Community health services for children, young people and families				
Safe			Good	
Effective				Outstanding
Caring			Good	
Responsive			Good	
Well-led				Outstanding
Overall				Outstanding
Overall community				
Safe			Good	
Effective				Outstanding
Caring			Good	
Responsive			Good	
Well-led				Outstanding
Overall				Outstanding

The CQC commented on the professionalism of staff, and on the caring attitude staff showed in ensuring that patients were treated with dignity and respect. The CQC recognised a number of areas of good practice and improvements since the last CQC visit in June 2016. However, the CQC also told us that we need to make changes more quickly, particularly with regard to the emergency care pathway.

The CQC findings were summarised under three Regulation Breaches:

- Regulation 12 Safe Care and Treatment
- Regulation 17 Good Governance
- Regulation 18 Staffing.

The Trust response, together with the Integrated System wide programme had been developed to address the findings within the CQC report.

Following the publication of the report in November 2017 and following the CQC Quality Summit, a system wide approach was taken to address the key elements and 'must do' actions cited within the report. The Trust also developed its internal action plan for key 'must do' and 'should do' actions. The Trust has an established Quality and Assurance Delivery group which oversees the monitoring and progress against the actions set out in the Trust's internal action plan.

Key elements of the Action plan were focussed in the following areas and to date many actions have been completed:

- Safety of patients through assessment, review, monitoring, escalation and placement
- Emergency department flow, capacity (in and out of hospital), demand
- Management of escalation areas and safety of patients within the ED (QEH)(review 'boarding' of patients)
- Governance, Incident reporting/feedback, Risk Assessment and escalation
- Medicines Management work programme, safe and secure storage (with specific focus on key identified areas)
- Fridge Temperature monitoring
- End of Life programme for all areas across the Trust
- Critical care strategy and work programme across the Trust
- Infection Control and management of waste across key identified areas
- Clinical & Medical Engagement, Leadership, Recruitment and Retention work Programmes

To date, a significant amount of work has been undertaken with many improvements in quality and safety, below is a summary of the progress made to date with all actions detailed within our plan;

- **Regulation 12 Safe Care and Treatment** – Total of 12 'Must do' Actions, 9 of which have been fully completed,2 have been over 95% completed awaiting additional evidence/or evidence of sustainable improved performance and 1 amber rated action linked to the delayed development of the End of Life Care scorecard
- **Regulation 17 Good Governance** – Total of 21 'Must do' actions, of which 11 have been fully completed, 8 have been over 95% completed awaiting additional evidence/or evidence of sustainable improved performance, with 1 amber and 1 red action, related to the End of Life Care pathways and Specialist Palliative care provision
- **Regulation 18 Staffing** – Total of 1 action related to staffing split across specific Divisions, this action is not complete and is amber rated due to delayed impact of recruitment programme
- **The Trust also had 7 'Should do' actions**, 3 of which have been fully completed, 3 are rated amber due to non-attainment of Trust Mandatory training compliance (85% target), delayed impact on recruitment and the remaining action rated green as on target to complete by target date, linked to QEH space and decant programme.

Part 2

2.7 Data Quality

Quality data is data that is:

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

The importance of data quality relates to:

- Patient care – data recorded needs to be accurate in particular to minimise both clinical and non clinical risk and the effectiveness of care delivered
- Information for patients – to ensure they reach informed decisions about any treatment options
- Clinical governance which depends upon high quality patient data for the identification of areas where clinical care could be improved
- The efficiency of clinical and administrative processes, for example communication with patients and carers, and appropriate allocation of resources
- Management and strategic planning - which relies heavily on high quality data about the volume and types of patient activity as the basis for future service delivery
- Information for other NHS and Social Care organisations, including service agreements for healthcare provision: healthcare commissioners, who depend on the patient related data that we send to them and need to have confidence in the quality of Trust data
- Freedom of Information and Access to Records requests – information collected needs to be accurate to respond appropriately to such requests
- The extraction of data from the Trusts system and where appropriate the onward transmission to the Secondary User Service (SUS)
- Payment by Results, SLA monitoring outside PbR and Foundation Trust status

Trust measures to improve data quality

Benchmarking Reports:

The Trust measures many different aspects of Data Quality through external and internal benchmarking reports. The Trust's Data Quality scorecard provides internal benchmarking for the Trust showing performance against key targets and is used to identify areas for improvement. The scorecard, which contains over 80 measures, is updated on a monthly basis, and key Data Quality metrics are included on the Trust Board scorecard and is discussed at monthly Information Governance meetings. Metrics include the correct recording of a General Practitioner and the presence of a valid NHS Number.

NHS Number and General Medical Practice Code Validity

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

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

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

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

The validity of NHS Numbers and General Medical Practice Codes are monitored via SUS and below are the % of records containing a valid NHS number or correct General Practitioner during the period YTD Q4 2017/18:

Which included the patient's valid NHS number was		
Admitted Care	LGT	99.36%
	UHL	99.35%
	QEH	99.36%
Outpatient Care	LGT	99.65%
	UHL	99.56%
	QEH	99.77%
Accident & Emergency Care	LGT	97.70%
	UHL	97.23%
	QEH	98.39%
Which included the patient's valid General Medical Practice Code		
Admitted Care	LGT	94.82%
	UHL	92.29%
	QEH	97.36%
Outpatient Care	LGT	95.85%
	UHL	97.66%
	QEH	94.05%
Accident & Emergency Care	LGT	95.11%
	UHL	95.32%
	QEH	94.90%

Mandatory Training and Refresher Courses:

The Trust provides mandatory training sessions for staff involved in collecting, receiving, analysing and using data with relevant gravity added to the importance of good data quality. A Trust wide training register monitors the date and area of training that staff involved in the generation and use of data has received and includes a review date by which refresher training must be completed.

Specific Workstreams to support improvement in Data Quality:

Prescribed information	Comment
The action taken by the provider to improve data quality.	Lewisham & Greenwich NHS Trust will be taking the following actions to improve data quality: ■ Regular Trust Data Quality Audits on areas of concern highlighted through benchmarking reports. Improvement plans should be made based on the issues raised during the audits. ■ The provision of regular data quality reports to Divisions highlighting individual patient records for correction or completion by front line staff. ■ The provision of regular data quality reports for the Data Quality team to amend incorrect data entries where appropriate following investigation. ■ The provision of regular benchmarking reports alongside regular meetings with Trust senior management to discuss improvement plans.

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 2018) the Trust has achieved an overall score of 89% and has been graded as satisfactory.

Benchmarked data for Information Governance Toolkit

The following table demonstrates the performance against the compliance of the Information Governance Toolkit for the Trust and compares it to our local organisations.

The performance of the Trust has improved since the 2016 and now is the second highest when compared to acute hospital organisations.

The Trust has explored how GSTT managed to improve their performance from 2016 and this was based around a year's work within GSTT working on auditing policies and demonstrating results from their audits.

LGT for 2017/18 worked on updating all its policies with particular reference to Information Security, Cyber Security and Information Technology (IT) policies, together with ensuring that all GDPR requirements were built into all other existing policies. For 2018/19 LGT will work on the auditing of policies in preparation for the new 2018/19 toolkit which will be based around GDPR requirements.

TABLE 1: Information Governance Toolkit submission 2017/18 benchmark data comparing local organisations.

Trust/ Local Authority and CCGs	V13 2015-2016	V14 2016-2017	V14.1 2017-2018
Lewisham and Greenwich NHS Trust	75%	77%	88%
Guys and St. Thomas's NHS Foundation Trust (GSTT)	74%	92%	92%
Kings College Hospital	74%	79%	79%
Croydon Healthcare Services	67%	69%	66%
St George's University Hospital NHS Foundation Trust	73%	68%	66%
Oxleas NHS Foundation Trust	87%	90%	84%
South London and Maudsley NHS Trust	89%	91%	90%
Barts and the London NHS Trust	76%	77%	Not Started
London Borough of Bexley	66%	66%	66%
London Borough of Greenwich	Not Started	83%	83%
London Borough of Lewisham	82%	66%	76%
London Borough of Lambeth	69%	66%	66%
London Borough of Southwark	46%	66%	66%
Bexley CCG	100%	100%	100%
Greenwich CCG	66%	84%	89%
Lewisham CCG	82%	88%	94%

Part 2

2.9 Clinical Coding

Payment by Results

Payment by Results (PbR) is the method by which the Trust receives payment for admitted patients within the acute setting. Trained staff extract information about patient's stays – treatments they receive and what is wrong with them; this along with other information such as the patient's age and how long they were in hospital for is used to allocate each patient to a nationally agreed category. The categories, which are called Healthcare Resource Groups (HRGs), It is these codes (HRG4+ in 2017/18) that are used to determine the amount that the Trust is reimbursed for patient care based published NHS National tariff alongside any local tariffs agreed with Commissioners..

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

The Trust did not have its Admitted Patient Care Clinical Coding audited as part of any national audit programme in 2017/18; however qualified Coding auditors have completed clinical coding audits in year. The audit reports have been shared with the site based coding teams, with action and training plans developed around the audit recommendations.

The results demonstrated the following (completed clinical coding audits 2017/18):

Completed Clinical Coding Audits 2017/18 as at 31/03/2018

Area	FCEs in audit	FCEs - unable to audit	HRG changed	HRG changed/ error rate	Primary Diag - correct %			Secondary Diag - correct %			Primary Proc - correct %			Secondary Diag - correct %		
					% Correct	Correct	Incorrect	% Correct	Correct	Incorrect	% Correct	Correct	Incorrect		Correct	Incorrect
Gastroenterology (UHL site)	207	3	7	3.4%	92.7%	189	15	89.5%	527	62	97.1%	198	6	94.7%	250	14
Paediatrics and Neonatology (QEH site)	200	0	13	6.5%	95.5%	191	9	89.1%	156	19	94.1%	16	1	100%	2	0
2017/19 Trust Coding Audit Total	407	3	20	5%	94%			89%			96%			94%		
Trust Clinical Coding Audits 16/17	535	19	40	7.8%	91.7%	475	43	89.7%	1402	161	90.9%	319	32	94.1%	585	37
Trust Clinical Coding Audits 15/16	390			6.4%				94.0%			95.8%			87.5%		
Trust audits 2014/15	317			7.3%	89.0%			90.5%			94.5%			82.4%		
National comparator - Median (capita)				7.0%	91.2%			88.6%			93.3%			82.6%		

Part 3

3.0 Review of Quality Performance in 2017/18

3.1.1 Patient Safety Priorities

Our quality priorities and why we chose them	What success will look like	How did we do?
3.1.1. (i) Early recognition and treatment of the deteriorating patient The early recognition and detection of deteriorating patients has been shown to improve the clinical outcomes for patients. Our review of incidents has shown that we need to improve the early detection of patients in whom their clinical condition has deteriorated by ensuring regular monitoring of observations is carried out, these are documented and that proactive intervention of observation results is taken. During 2016/17, a Sepsis Working Group was established which took the lead on improvement work on sepsis screening and treatment across the Trust. In 2017/18, the Trust will implement a new Sepsis screening tool, in line with recent NICE guidelines and seek to introduce an electronic early warning system.	■ 10% reduction in the number of out of Critical Care 'in hospital' cardiac arrests from 2016/17 figure. ■ Eliminate all avoidable deaths from sepsis and septic shock by March 2018. ■ Implement the adult community MEWs and Sepsis screening tool to assist in the early identification of deterioration of our patients within the community.	**We achieved this.** During the sign up to safety programme the Trust saw a 40% reduction in out of critical care 'in hospital' avoidable cardiac arrests. **We have not achieved this** Implementation of community MEWs has not been achieved. This is due to conflicting national evidence about the most appropriate tool to use. Once this has been agreed then an implementation plan will be developed. Recommendations have been made in terms of the agreed tool and a process will be undertaken in early 2018/19 to procure the appropriate medical devices to enable implementation.
3.1.1. (ii) Improving the Safety of Maternity Services Not only can babies be severely harmed by failures in assessment of the wellbeing of the foetus, the impact of harm has life changing effects for the child and all members of their family. The loss of a baby as a stillbirth also has significant impact for parents. Our priority is set around minimising the risk of these events. In 2017/18 we are looking to build upon the previous year's achievements of the Fetal Wellbeing team, which included development of a competency framework, new fetal monitoring guidelines and teaching of weekly fetal monitoring workshops. We will continue to implement the Trust's Maternity Strategy and national guidelines including NHSE's Saving Babies Lives.	■ Reduce stillbirths (to maintain under the Trust's current quarterly rate of <5.3 per 1000 births). ■ Increase detection of growth restricted babies in utero.	**We achieved this** The Trust still birth rate per 1000 births was 3.92 in 2017, 4.52 at QEH and 3.22 at UHL A pathway has been developed for women with a low PAPP-A result following their 11-14 week ultrasound scan which includes increase in maternal and fetal surveillance in addition to low dose Aspirin. There is ongoing work to agree a pathway for the detection of Small for Gestational Age babies (ultrasound pathway)
	■ Reduce poor neonatal outcomes associated with poor/inadequate fetal surveillance in labour, whether by intermittent auscultation (IA) or continuous electronic fetal monitoring (CEFM).	Multidisciplinary reviews of all babies admitted to neonatal unit are undertaken. Also weekly workshops of current cases where there is learning regarding fetal monitoring. All staff providing intrapartum care are competency assessed yearly. A pathway has been developed to support staff involved in incidents with an individualised plan. ATAIN (Avoiding Term Admissions to Neonatal units) plan in place with project leads and plans on different components (Asphyxia, Jaundice, Hypoglycaemia etc)

Our quality priorities and why we chose them	What success will look like	How did we do?
3.1.1. (iii) Continue our focus on the aim to reduce the number of avoidable grade 3, 4 and unstageable Trust attributable pressure ulcers and ensure where pressure ulcers are acquired within our provision of community services, timely completion of root cause analysis is undertaken and learning is continually shared across all areas. All patients are potentially at risk of developing a pressure ulcer. However, they are more likely to occur in people who are seriously ill, have a neurological condition, impaired mobility, impaired nutrition, or poor posture or a deformity. Pressure ulcers can be serious and distressing and often result in extended lengths of hospital stay for patients. Mortality rates can increase particularly after infection. We will continue our focus and aim of reducing avoidable Trust attributable grade 3, 4 and unstageable pressure ulcers and pressure ulcers acquired within our provision of community services.	■ Improve the accuracy of the Waterlow score for patients in hospital and achieve 95% compliance every month. ■ Develop and implement with partners, a tool for formal carers to monitor skin and to alert concerns to adult community nurses. ■ Amend the Trust Pressure Ulcer Policy to manage the risk to adult community patients in the absence of overnight care provision. ■ Implement the pressure ulcer e-learning package in the adult community services. By the end of March 2018, 50% of eligible clinical adult community staff (from a training needs analysis - TNA) to have undertaken the new electronic learning package on pressure ulcer prevention and management. Relaunch the training package across the rest of the Trust in conjunction with this.	**We partially achieved this** During 2017/18 Waterlow score compliance has been maintained at around 95% compliance. Audits focussing on the accuracy of the score recorded commenced in 2018 and will continue to be undertaken throughout 2018-2019. **We achieved this** A new Care Plan for Carers was developed and piloted in one of the Neighbourhood Nursing Teams, with roll out across all community services scheduled for April 2018. **We partially achieved this** The Trust Pressure Ulcer Policy was reviewed and updated as planned. The new version will be launched in Q1 of 2018. **We partially achieved this** The pressure ulcer e-learning package was launched in the adult community services during 2017. Due to issues with the online training provider unfortunately the system was unavailable for a significant period of time during the course of the year. The problem is now rectified and this training target will be a priority for 18/19.
3.1.1 (iv) Reduction in the number of patient falls and harm incurred Although the Trust has made significant progress through its Falls Steering Group, data highlights that there is still work to be done to minimise the number of falls in our hospitals. Within 2016/17, a Falls Strategy was developed, which focuses on three C's; Continence, Collapse and Confusion, and this was taken forward in 2017/18. The Trust has signed up to an NHS Improvement programme in relation to falls and will be working towards pledges and the delivery of this through the Plan, Do, Study, Act (PDSA) methodology.	■ Reduction in the incidence of harm sustained from patient falls of 10% by the end of March 2018 (from March 2017 figure). ■ Meet pledges stated within NHSI Falls Improvement collaboration. ■ Implementation of first year of Falls Strategy.	**We did not achieve this** The number of falls resulting in moderate harm increased from quarter 1 to quarter 3. These are being investigated as serious or red incidents. The number of falls has also increased by 20% over this time period. This is under review by the Trust Falls Group The Falls Collaborative has now completed and we will be taking the learning and embedding it into our processes. Results from the Royal College of Physicians National Falls audit 2017 show some improvements but also highlight areas the Trust has already identified for improvement, such as the assessment for delirium. The Trust was also commended by the RCP for the improvements made in medication review with results increasing from under 10% at UHL to over 90% and from 40% at QEH to 100%.

Our quality priorities and why we chose them	What success will look like	How did we do?
3.1.1 (v) Improving medication safety and learning from medication incidents Nationally, medication incidents account for around 10% of all reported incidents. The Trust has improved its level of medication incident reporting, however recognises that there is still work to do. We will continue to raise staff awareness of the importance of reporting medication related patient safety incidents. Medicine doses are often omitted or delayed in hospital for a variety of reasons. Whilst these events may not seem serious, for some critical medicines or conditions, such as patients with sepsis or those with pulmonary embolisms, delays or omissions can cause serious harm or death. We will continue to build upon 2016/17 achievements which included the implementation of Medication Safety Walkabouts and the development of a Medication Allergy Incident Panel in order to identify trends and respond to these.	■ Increase the number of reported medication related patient safety incidents from 2016/17 figure by 5%, by the end of March 2018. ■ Maintain focus on low numbers of inappropriately omitted critical medicines (level at March 2017 - 0.7%). ■ Continue to identify themes in prescribing and administration incidents, and share learning with staff at all levels. ■ Reduce the number of patient safety incidents related to the prescribing and administration of penicillin based antibiotics to patients with a reported penicillin allergy from 2016/17 figure by 3%, by the end of March 2018.	Reporting of medication incidents has increased beyond the 5% target set. Regular review of medication incidents allows themes to be identified. Lessons learned from medication incidents continue to be shared with staff across the Trust in a variety of ways including the 'Med Alert' Medication Safety Newsletters, Just 5 Nursing handovers, doctors teaching, participating in the Trust 'Sharing the Learning' events, Medication Safety Updates and Trust Safety Signals. Issues are raised and discussed through the Aspiring to Excellence Medicines Management Working Group. A theme in the reporting of prescribing and administration of penicillin based antibiotics in patients who had a documented allergy to these drugs. In response to this, a Medication Allergy Incident Review Panel and multidisciplinary working group were set up. New stickers were designed and launched for use across the Trust. The Medication Allergy Review Panel allowed for greater scrutiny of such incidents allowing themes to be more easily identified. In 2017/18 there were 13 reported prescribing and administration incidents involving penicillin compared to 33 the previous year. **Period** / **Number of reported medication related patient safety incidents** 2015/16 (quarterly average): 291 2016/17 (quarterly average): 298 2017/18 (quarterly average to date): 359 Administration and prescribing incidents remain those most frequently reported. Omitted and delayed doses are the most frequently reported administration incidents. Staff are actively encouraged to report omitted or delayed doses of critical medicines. Omitted doses of critical medicines continue to be monitored through monthly MSWs. Quarterly average of omitted critical medicines as a percentage of all doses prescribed is currently 0.44% (200 out of a prescribed 45,932 doses)

Our quality priorities and why we chose them	What success will look like	How did we do?
3.1.1 (vi) Getting the basics right and keeping patients safe within the emergency department and those areas used for escalation Following our planned CQC inspection in March 2017 concerns were raised with reference to the emergency care pathway at QEH and the use of escalation areas for patients awaiting ward beds. The Trust had already introduced Quality Rounds which are undertaken by Matrons every two weeks, but the CQC felt that the monitoring and tracking of patients within the ED and escalation areas should be improved. The Trust has planned a full programme of work on the emergency care pathway at both acute hospital sites and has already implemented daily checks on patients within the ED and escalation areas (when used) which we are tracking daily. Following the CQC visit, another area highlighted for improvement was within our medicines management practices. Although there had been much work undertaken throughout 2016/17, further work was required to continually improve. CQC provided feedback on observations made and recommended further work be undertaken in ensuring a robust process for the review and follow up of controlled drugs and safe and secure management of drugs audit results as part of the completion of the continuous cycle. The following areas will be our focus for the next year: ■ Documentation improvement in management of Controlled Drugs ■ Fridge Temperature monitoring and in particular documenting when action has been taken where temperatures are out of range ■ Ensuring robust process for following up on all audit results and action plans agreed as part of the completion of the continuous audit cycle An overall theme from the learning of our preparation for and during the CQC inspection was the follow up on actions from quality reviews, audits and published reports. In response to this our quality improvement programme will include a focus on action planning and the follow-up cycle of tracking and monitoring actions associated with audit and report findings.	**Emergency Department and escalation areas:** ■ Quality and hourly senior nurse rounds supporting the implementation of quality of care will demonstrate improved patient experience. ■ The quality care plan and checklist for all patients in ED will be embedded across the sites. ■ Implementation of daily ED quality and safety metrics, NEWS monitoring and escalation process for safety and safety huddles and demonstration of improved trends. **Medicines Management:** ■ Improved Controlled Drug and safer storage audit results from the baseline of April 2017 demonstrated throughout the year. Demonstrable evidence of action plan and follow-up, post presentation of audit results.	**We achieved this.** Quality rounds commenced in March 2017, alongside the implementation of daily ED quality and safety metrics. The quality care plan and checklists were piloted in April 2017 and rolled out in the ED from October 2017. **We partially achieved this.** Quarterly controlled drugs audits have continued. These have shown significant improvement although we still have not achieved full compliance in all areas. This continues to be an area of focus with reinforcement of the importance of this in team meetings, through trust briefings and governance structures. This will continue into 18/19.

3.1.2 Clinical Effectiveness Priorities

Our quality priorities and why we chose them	What success will look like	How did we do?
3.1.2. (i) Embedding processes for mortality reviews across the Trust During 2016/17, the Trust's mortality rate has improved. However, with the new national mortality surveillance programme being introduced throughout 2017/18 and with the introduction of the national requirement for mortality reviews for those with learning disabilities, the Trust will carry out further work in relation to mortality reviews during 2017/18.	■ Continue to work towards reducing the Trust SHMI to under the current level (1.00). ■ Implementation of the process for mortality reviews of patients with learning disabilities. ■ Full implementation of the new mortality review form by ensuring that medical staff are trained on its usage. ■ Increase the number of mortality reviewers by 10%. ■ Increase comorbidity recording in patients' medical records to improve on the current quality and accuracy of coding.	**We fully achieved this.** Work continues to improve the Trust's SHMI, including close work with our coding department and the abolition of the use of 'dummy' codes. The Trust has implemented the new mortality review processes for both Adults and patients with Learning Disabilities, the latter via the Learning Disabilities Mortality Review Programme (LeDeR). Child deaths continue to be reviewed via the Child Death Overview Panels (CDOP) 40 Trust staff have been trained to undertake Structured Judgement Reviews and provide cascade training to others within the organisation. Work has been undertaken with clinicians and as part of our documentation audits to improve the quality and accuracy of coding.
3.1.2. (ii) Working towards delivering the seven day working standards – four clinical priorities The Trust has signed up to be a part of the NHSE led Phase 2 delivery programme for the 4 priority clinical standards, requiring full compliance by March 2018. Participating in this phase will enable shared learning across the sector and will allow access to national learning through the NHSE 7 day team. Plans for 7 day working also form part of the STP as well as being included in commissioner contractual requirements.	By the end of March 2018, full compliance with the four clinical priority standards: ■ Standard 2: Time to first Consultant review (Within 14 hours from patient's admission) ■ Standard 5: Timely access to diagnostics ■ Standard 6: Access to Consultant-delivered interventions ■ Standard 8: On-going Consultant-directed review (every patient should be seen face to face by a Consultant every day or twice daily in high dependency areas).	**We partially achieved this.** The Trust achieved compliance with the required 90% standard set by NHS Improvement. The Trust has delivered significant improvement in compliance against the standards during 17/18 and as a result participated in a shared learning event across London. Delivery of the standard is closely linked to pathway improvements relating to emergency flow. An internal action plan continues to be monitored through a clinical group led by the medical director. Achievement of the standard at the end of March 2018 will be assessed by audit with the results available at the end of June 2018.
3.1.2. (iii) Safe and effective discharge There is considerable evidence for the harm caused by poor patient flow. Delays lead to poor outcomes for patients, create financial pressures and impact on key NHS performance measures. Delayed discharge has serious impact across health and care systems, reducing the ability of Emergency Departments to respond to people's needs, and increasing costs to local health economies. Inappropriate, early discharge carries risks to patients and therefore requires close monitoring of readmission rates. 2017/18 is the first year of a two year CQUIN programme.	■ Increase the proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 2.5% from identified 2017/18 Q1 baseline, in line with the CQUIN. ■ Reduction in the number of inpatients medically fit and ready for discharge. ■ Implement the discharge to assess model as part of the Enhanced Care and Support Programme.	Through the various pathway initiatives, such as EDDT, discharge to assess and the focus of the ward /ED teams the Trust achieved 51.5%, an increase of 12.1% Discharge to Assess pilot commenced in 2017/18. The team will continue in the pilot form through 2018/19

Our quality priorities and why we chose them	What success will look like	How did we do?
3.1.2. (iv) Improving patient outcomes through measures for Adult Community Services Capturing, monitoring and responding to data is a crucial part of continuous quality improvement. Although the Adult Community services have robust processes in place to monitor data it is recognised that improvements can be made to these current systems, which include all staff being able to readily access up-to-date information regarding performance and quality.	■ Development of an adult community services quality dashboard to support individual team ownership of quality objectives that support the delivery of our Trust objectives.	**We achieved this.** Quality scorecards were developed and implemented for adult community nursing teams. The teams maintain ownership of the scorecards, and these are available to staff via the Trust intranet. The scorecards are presented and discussed at ward/ department meetings with the senior nurses and Director of Nursing. In addition, quality and outcome level data for adult community services is shared via a quality dashboard with local Commissioners on a monthly basis. The quality scorecards will be extended to the integrated care and therapy services going forward.

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) i) We will continue to work with our patients, carers, staff and partners to deliver consistently excellent standards of dementia care to improve the experience of our patients who have a diagnosis of dementia as well as that of their Carers. During 2016/17 the Trust developed its 3 year Dementia Strategy setting out the priorities for improvement and action. Good progress has been made with the priorities for 2016/17 and we will continue to build on this work and implementation of the delivery plan during 2017/18.	■ Ensure the new Visiting Policy is fully embedded across the Trust. ■ Implementation of the activities programme for dementia patients. ■ Establish and implement use of a sensory room on both acute sites. ■ Continue to implement our Staff Dementia training programme, this includes increasing the amount of training and tailoring training for different staff groups. ■ Ensure that the Dementia Strategy fully incorporates improvements within our community services including increasing the specialist nursing workforce.	**Partially achieved** ■ The policy has been launched and has been well received by patients. Further work is required to ensure the policy is consistently applied across all areas and this is being embedded in a number of ways. ■ Volunteers have been trained and are undertaking some activities with dementia patients. ■ The sensory room on the UHL site has been utilised during 2017/18. The identified space on the QEH has been utilised for another care pathway but it is expected that this will be converted to the sensory room during 2018/19 ■ Staff working on Care of the Elderly wards have have accessed specific training during 2017/18 to increase their knowledge and skills. ■ The Trust has reviewed the Specialist Nursing team for dementia and has appointed new staff to the team.

Our quality priorities and why we chose them	What success will look like	How did we do?
3.1.3. (ii) We will continue to expand the ways in which we gain feedback from patients and service users and ensure that learning from feedback is used to support positive change. During 2016/17 the Trust developed its 3 year Patient Experience Strategy setting the priorities for improvement and action. Good progress has been made with the priorities for 2016/17 and we will continue to build on this work and implement the delivery plan during 2017/18.	■ Continue to spread and embed the "You Said We Did" approach across the Trust ensuring the concept is locally owned and used in all areas.	**We achieved this** The initiative was rolled out in the inpatient, outpatient and community settings. The team meet with key staff monthly to review feedback and discuss service improvements which are showcased in the form of a 'You said We Did' Poster. Posters are displayed within the departments for patients, carers, visitors and staff to view and on the Trust notice boards, the intranet and to the public including the Trust membership via the internet on a dedicated page of the Trust website. Feedback and service improvements are also shared with staff at team and governance meetings. Sixty one (61) posters were produced in 2017-2018.
	■ Implement the use of patient stories as a learning tool across the Trust.	**We achieved this** The first draft patient story was recorded in Q4. The aim of patient stories is to ensure the voices of patients are heard and identified themes are used in training, for service development and at Board Meetings. These will be held in an easily accessible library for all staff to use.
	■ Implement a patient experience micro site to raise the profile and provide extended opportunities for patients to provide feedback through social media.	**We partially achieved this** The micro site is underdevelopment and will be fully accessible to patients in Quarter 1 2018-19. The Patient Experience Team work closely with the Communications team to review and disseminate the feedback received via social media.

Our quality priorities and why we chose them	What success will look like	How did we do?
3.1.3. (iii) Improving the quality of the End of Life Care pathways across the health care system. Although the Trust has been making improvements in the care provided to patients identified as end of life, we recognise that there is much more that we need to do. During 2016/17 the Trust developed its 3 year End of Life Care strategy which outlines plans to meet the needs of end of life care patients, and those identified as important to them, as well as ensuring that we provide our staff with the education and training required.	■ Training on PEACE (Pro-active Elderly Advance CarE) will be provided to increase the use of the tool.	**We have partially achieved this:** Some patients are being discharged with PEACE plans but there is further work that needs to be undertaken to embed this.
	■ All areas to have a link nurse practitioner with established governance links into the End of Life Care Steering Group.	**We have partially achieved this:** The number of link nurse practitioners has increased but there are still some key areas who do not have a link nurse.
	■ Key clinical leads for End of Life Care to be identified.	**We have achieved this** The Trust has an appointed Trust Non Executive lead and a medical lead for EoLC.
	■ Bereavement survey undertaken and results evaluated.	**We have not achieved this** The Bereavement survey has been delayed until 2018/19. However, the questions have been reviewed and the survey format has been agreed and is ready to launch in early 2018/19.
	■ Use of End of Life Care volunteers to be established in the Trust. Adult Memorial Service to be held.	**We have not achieved this** The EoLC Steering group made the decision not to hold an Adult memorial service in 2017/18 but a service is planned for October 2018.
	■ Implement the "Say goodbye to your pets" initiative.	**We have partially achieved this:** Patients can have their pets brought into the hospital biut further work is required to embed this
	■ Achievement of 95% training rate for qualified nursing staff in the T34 pump.	**We have achieved this** All appropriate registered nursing staff are trained and complete agreed competencies.
	■ Review of current end of life care training and develop additional training programmes.	The review has commenced with a planned focus on the Trust's principles of care for dying patients in early 2018/19. Training for this has already been identified and agreed. However further work on the education and training requirements of key staff will continue in 2018/19.
	■ Implement the use of 'Coordinate my Care' within adult community services, as part of the 2017/18 CQUIN. This will also link into the acute sites through the Specialist Palliative Care Team at UHL.	**We have achieved this** The Lewisham Community nursing team have been trained to complete CMC and have been completing this information in line with the CQUIN milestones.
	■ Implement the use of Principles of Care for the dying in Adult Community Services.	**We have achieved this** The specific principles of care for the dying for Adult community have been agreed and uploaded to the Trust intranet. These have been implemented across the service.

Our quality priorities and why we chose them	What success will look like	How did we do?
3.1.3. (iv) Improving the Trust's Staff Recognition processes – Expanding the existing staff recognition processes within the Trust. The Trust has a well-established record of recognising the achievements of staff. Recognition is an important mechanism to positively influence organisational culture and ultimately the quality of care provided to patients using our services. Many research papers support this argument. A recognition event provides a spotlight on the attributes and behaviours which are strongly valued by the organisation and its patients' and encourages others to replicate these. Recognition events also publicly 'thank' individuals and teams, thereby raising morale and commitment to the organisation and the work being done. The existing processes do not cover the vast majority of Trust staff.	To implement outlined recognition events during the year and therefore provide more opportunity for involvement/ engagement and contribution by staff and service users. **Implement events:** Academic prize giving: reinstate the UHL academic prize- giving ceremony. External awards: advertise, encourage and support the entry into national and local recognition events and awards. **Expansion proposals:** Annual staff recognition event, recognition scheme in maternity services, and the long service awards.	The Academic prize giving ceremony will be reinstated on both hospital sites, and is planned to commence from September 2018 onwards. Staff were provided with a longer period of time in 2017-2018 to nominate colleagues for recognition awards. Divisions were encouraged to and ran local recognition schemes alongside the Trust event. Two medical recognition awards were included within the annual staff ceremony in 2017, alongside the long service awards for staff. Additional categories were introduced for the Staff Awards in 2017 which was a resounding success. Going forward the Trust is planning to expand the categories included in the 2018 award process to make them more encompassing. A larger venue is being scoped to host the ceremony to ensure a greater number of staff and colleagues are able to attend the event.

Part 3

3.2 An explanation of who has been involved

Overview

Who has been involved?

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

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

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

The Trust has consulted widely about the content and the final version will incorporate all comments, being published at the end of June 2018.

The Trust Board

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

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

Staff

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

Key leads and stakeholders from within each of the six Clinical Divisions have contributed to the content, the setting of priorities, and agreement of the key outcome measures and have provided the commitment to lead on each of the key priorities for 2018/19.

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 Accounts 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 Accounts with Divisional Governance, Risk and Audit Leads participating in the review of the priorities.

The Patients Welfare Forum, Patient User Group and the Local Healthwatch organisations have also been consulted.

The Patient Experience Committee, Quality Safety Committee and Integrated Governance Committee have all reviewed and contributed to the setting of priorities for 2018/19.

A survey monkey was conducted and shared widely with staff to ask for their input to the quality priorities and this was well received with staff contributions.

Part 3

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

The Trust works closely with local people and patient groups, including Healthwatch, the Patient Welfare Forum (PWF) at University Hospital Lewisham and the Patient User Group (PUG) at Queen Elizabeth Hospital.

i) Commissioners/ Clinical Commissioning Group (CCG)

NHS Bexley CCG, NHS Greenwich CCG and NHS Lewisham CCG Joint Statement on Lewisham and Greenwich NHS Trust's Quality Account June 2018.

The three Clinical Commissioning Groups: Lewisham CCG, Greenwich CCG and Bexley CCG welcome the opportunity to review and comment on the Lewisham and Greenwich Trust Quality Account for 2017–2018.

The report illustrates the work the trust has undertaken over the past year to improve quality and safety for patients highlighting the services delivered to the population they serve. The CCGs continue to work with the trust to provide quality assurance on the services commissioned through a Clinical Quality Review Group (CQRG) in partnership across Bexley, Greenwich and Lewisham as part of South East London Commissioning Alliance of CCGs.

The trust continues to build on improvements in aspects of quality regarding patient safety, clinical effectiveness and patient experience and the quality account highlights areas of improvement and continuing work.

There is a continuing focus on the quality and performance of emergency care with the positive introduction of daily patient safety metrics and quality rounds centred on patient safety. The CCGs appreciate the continued emphasis upon National Early Warning Score (NEWS) used to identify patients with sepsis and rapidly deteriorating health conditions, with escalation processes, safety huddles and the demonstration of improved trends in patient safety as positive initiatives.

Ensuring patients who are well enough to go home do so in a timely way is an imperative for the CCGs and the work the trust continues to undertake with CCG support is vital to achieve this aim. The CCGs look forward to continuing to build and enhance this in the future.

Patient falls resulting in harm are an area of concern for the CCGs and we will continue to work with the trust to ensure a reduction in the number of falls over the forthcoming year.

CCGs wish to see continuing improvement for maternity care with the introduction of the National Safer Maternity Care Programme over 2018/2019.

It is good to see the trust has described approaches to improving quality by drawing together information from a number of sources and processes to learn from deaths to improve patient care and safety. A continued emphasis on patient feedback and strategies to further improve patient experience and care are particularly appreciated by the CCGs, in particular the three year dementia strategy; and the CCGs fully support this being embedded into everyday good practice within the trust.

Workforce is key to delivering safe effective and responsive care for patients. The CCGs recognise the challenges the trust is experiencing in attracting and retaining registered nurses, midwives, doctors and other clinicians and will continue to support the trust in developments such as the Nursing Associate programme.

Greenwich, Lewisham and Bexley CCGs will continue to work to promote and drive quality initiatives, innovation and improvements to enhance the quality of care commissioned for their populations and look forward to continuing to work in partnership with Lewisham and Greenwich NHS Trust to achieve this aim.

ii) Overview Scrutiny Committees

Due to timing of committee meetings, feedback will be sought post presentation of the Quality Account.

iii) Patient Welfare Forum (PWF) University Hospital Lewisham

Over the course of the year PWF members visited all of the wards and outpatient clinics in University Hospital Lewisham, reporting our findings to the Trust – including feedback from patients, carers and staff. We work with the Trust's Patient Experience Team, and through them we have again contributed to a range of improvements. These include the provision of new breast pumps for women breastfeeding babies in neonatal intensive care, a more efficient procedure for babies needing antibiotics (also in neonatal intensive care) and the availability of healthier snacks in the Emergency Department. Our members continue to represent the patient voice at Trust-wide committees, such as patient experience, complaints and catering, and this year PWF members also joined the stakeholder panels for the selection of the new Chair and Chief Executive of the Trust.

(iv) Patient User Group (PUG) Queen Elizabeth Hospital

The Patient User Group (PUG) for Queen Elizabeth Hospital continues to work for the benefit of patients and visitors. Our aim is to contribute to continuous improvement. The last year has seen us change direction slightly in that we have not undertaken as many observations of wards as in the past, but have worked with the Patient Experience Team on improving 5 key areas:

- Internal communication
- Food
- Emergency Department
- Focused observations
- Complaints

We have talked to patients, visitors, staff and other service providers and have made recommendations to the Patient Experience Committee particularly in relation to food. We will continue to be involved in many aspects of hospital life, offering comments and observations via the Food Focus Group and the Complaints Committee and to vet all hospital literature to ensure it is patient friendly and fit for purpose as we strive to improve the patient experience.

Part 3

3.4 External Audit Limited Assurance Report

Independent Practitioner's Limited Assurance Report to the Board of Directors of Lewisham & Greenwich NHS Trust on the Quality Account

We have been engaged by the Board of Directors of Lewisham & Greenwich NHS Trust to perform an independent assurance engagement in respect of Lewisham & Greenwich NHS Trust's Quality Account for the year ended 31 March 2018 ("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, as subsequently amended in 2011, 2012, 2017 and 2018 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to the limited assurance engagement consist of the following indicators:

- The percentage of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism (VTE);
- The rate per 100,000 bed days of cases of Clostridium difficile infection (CDI) reported within the Trust amongst patients aged 2 or over during 2017/18.

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

Respective responsibilities of the directors and Practitioner

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health and NHS Improvement 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 and NHS Improvement 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 the Department of Health in March 2015 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and 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 2017 to June 2018
- papers relating to quality reported to the Board over the period April 2017 to June 2018
- feedback from commissioners dated June 2018;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated May 2018;
- the national patient survey dated May 2018;
- the local patient survey dated May 2018
- the national staff survey dated March 2018;
- the local staff survey dated March 2018;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 21 May2018;
- the annual governance statement dated May 2018;
- the Care Quality Commission's inspection report dated November 2017

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

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

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Board of Directors of Lewisham & 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 & Greenwich NHS Trust for our work or this report, except 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;
- limited testing, on a selective basis, of the data used to calculate the indicators tested against 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 that can result in materially different measurements and can affect 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 of these criteria, 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 and NHS Improvement. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

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

Our audit work on the financial statements of Lewisham & Greenwich NHS Trust is carried out in accordance with our statutory obligations. This engagement will not be treated as having any effect on our separate duties and responsibilities as Lewisham & Greenwich NHS Trust's external auditors. Our audit reports on the financial statements are made solely to Lewisham & Greenwich NHS Trust's directors, as a body, in accordance with the Local Audit and Accountability Act 2014. Our audit work is undertaken so that we might state to Lewisham & Greenwich NHS Trust's directors those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Lewisham & Greenwich NHS Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such directors as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Lewisham & Greenwich NHS Trust and Lewisham & Greenwich NHS Trust's directors as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018

- 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 identified as having been 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

Grant Thornton UK LLP
Chartered Accountants
30 Finsbury Square
London
EC2A 1AG

28/06/2018

Part 3

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

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

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

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

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

By order of the Board

Val Davison
Trust Chair Date: 26/06/2018

Ben Travis
Chief Executive Date: 26/06/2018

Part 3

3.6 Feedback

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

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

Telephone: 020 8836 4669
Email: Rachel.sugarman@nhs.net
Web:www.lewishamandgreenwich.nhs.uk

Appendix 1

Full List of Local Audits reviewed during 2016/17

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

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

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

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

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

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

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

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

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

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

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

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

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