NHS
Lewisham and Greenwich
NHS Trust

Quality Account

2021/22

High quality care for every patient, **every day**

Glossary

ACS	Acute Coronary Syndrome
ACU	Ambulatory Care Unit
AKI	Acute Kidney Injury
A&E	Accident and Emergency
BI Hub	Business Intelligence Hub – System for reporting performance
BSI	Blood Stream Infection
CAS	Central Alerting System
CAP	Clinical Audit Programme
CCG	Clinical Commissioning Group
CD	Controlled Drug
CDI	Clostridium difficile infection
CDU	Clinical Decision Unit
C. difficile	Clostridium difficile
CEFM	Continuous Electronic Fetal Monitoring
CEO	Chief Executive Officer
CEPOD	Confidential Enquiry into Peri-operative Deaths
CHKS	Independent provider of healthcare intelligence, benchmarking and quality improvement services
CMC	Coordinate My Care
CNS	Clinical Nurse Specialist
CNST	Clinical Negligence Scheme for Trusts
COCA	Community-Onset, Community Associated
COHA	Community Onset Healthcare Associated
COIA	Community-Onset, Indeterminate Association
CRN	Comprehensive Local Research Network
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DH	Department of Health
DOAC	Direct Oral Anti-Coagulants
DSPT	Data Security and Protection Toolkit
D2A	Discharge 2 Access
ECIST	Emergency Care Intensive Support Team
ED	Emergency Department
EDI	Equality, Diversity and Inclusion
ENT	Ear, Nose and Throat
EoL	End of Life
EoLC	End of Life Care
EoT	End of Treatment
ESEL Pathology Partnership	East and South East London Pathology Partnership
FFT	Friends and Family Test
FT	Foundation Trust
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
F/Y	Financial Year
GDPR	General Data Protection Regulation
GiRFT	Getting it Right First Time
GP	General Practitioner
GSTT	Guy's and St Thomas's NHS Foundation Trust
HAT	Hospital Acquired Thrombosis
HEN	Home Enteral Nutrition
HES	Hospital Episode Statistics
HOHA	Hospital Onset Healthcare Associated
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
KCH	Kings College Hospital
KPI's	Key Performance Indicators
LGT	Lewisham and Greenwich NHS Trust
LoS	Length of Stay
LSL	Lambeth, Southwark and Lewisham Borough
MCCD	Medical Certificate of Cause of Death
MDT	Multidisciplinary Team
MEWS	Modified Early Warning Score
MSK	Musculoskeletal
MSW	Medication Safety Walkabouts
NCEPOD	National Confidential Enquiry into Patient Outcomes and Death
NEWS	National Early Warning Score
NGO	National Guardian Office
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
NIHR	National Institute for Health Research
NRLS	National Reporting Learning System
NRT	Nicotine Replacement Therapy
OHSEL	Our Healthier South East London
OSC	Overview and Scrutiny Committee
OWL	Outcomes with Learning
PALS	Patient Advice and Liaison Service
PbR	Payment by Results
PDSA	Plan, Do, Study, Act (part of an improvement methodology)
PEACE	Proactive Elderly Advance Care plan
PHE	Public Health England
PLACE	Patient Led Assessment of Care Environment
PROMS	Patient Reported Outcome Measures
PSI	Patient Safety Incident
PUG	Patients User Group
PWF	Patients Welfare Forum
QEH	Queen Elizabeth Hospital
QI	Quality Improvement
RCA	Root Cause Analysis
R&D	Research and Development
SBAR	Situation Background Assessment Recommendation
SELCCG	South East London Clinical Commissioning Group
SFFT	Staff Friends and Family Test
SHMI	Summary Hospital Mortality Indicator
SI	Serious Incident
SMR	Standardised Mortality Ratio
SLT	Speech and Language Therapy
SPC	Specialist Palliative Care
STP	Sustainability and Transformation Plans
SUS	Secondary Uses Service
TEP	Treatment Escalation Plan
UCC	Urgent Care Centre
UKSHA	United Kingdom Health Security Agency
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
WTE	Whole Time Equivalent
YSWD	You Said We Did posters (a method of communicating improvements to practice)

Contents

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 2022/23, statement of assurances from the Board Directors and review of quality performance.

Part 3:

Our performance in 2021/22 against our quality priorities and what our stakeholders say about us.

Part 1

1.0 Chief Executive Statement on Quality

Welcome to our Quality Account for 2021/2022. I hope that you find this a useful guide to the work we've done over the last year to improve the quality of our services.

Looking back, I am proud of what our staff have achieved over 2021/22. We faced unprecedented demand for our services, due to the Covid pandemic and to high numbers of patients coming through our emergency departments requiring treatment. However, against these challenges, our staff went the extra mile to provide great care – standing up for our local communities when they needed it most. Of course, we do not work in isolation, and I would also like to acknowledge the fantastic contribution of our volunteers and our partners across the health and care system.

In the following pages, we have described progress against the quality priorities for 2021/22. These priorities were identified through a review of our internal quality monitoring systems, as well as feedback from our partners and regulators. We did recognise that meeting all our objectives would be challenging due to COVID and associated pressures. As you can see, we have carried some of the actions into this financial year, to ensure that all our improvements are fully embedded.

Some examples of what we achieved in the last financial year specifically in relations to the quality priorities we set ourselves are outlined below:

- Gaining the Gold Standard UNICEF award for breastfeeding – which was awarded to the Infant Feeding Team at University Hospital Lewisham
- Ensuring that 100% of maternity records audited in 2021/22 had risk assessments completed for women, including a review of the intended place of birth
- Development of a co-produced Quality Improvement (QI) training programme which is now in place for service users, patients, and carers. Several service users have attended this training which empowers local people and staff to deliver key improvements to our services, developing our new patient experience strategy, as part of our focus on improving how we engage with those who use our services.

We continue to dedicate our efforts to continuous Quality Improvement (QI). Some of the highlights from our QI programme include:

- Reduction in smoking during pregnancy from 7.38% to 6%; leading to eight more babies per month being born smoke free in our maternity services
- Improved waiting times in the ambulatory care unit at the Queen Elizabeth Hospital site following a QI project to streamlines unexpected attendances. The Friends and Family Test data show that 92% of patients attending the Ambulatory Care Unit rate their experience as 'very good' or 'good'.
- Improved completion of falls and pressure-ulcer assessments by 100% across four surgical wards at the University Hospital Lewisham site.

Over 2022/23, we are continuing to focus on playing a more active role in working with our partners to tackle health inequalities – including ensuring that we are supporting sickle cell patients. We will also continue the recommendations from the national Ockenden report into maternity care and the implementation of the relevant aspect of the National Patient Safety Strategy.

I would like to take this opportunity to thank our staff, volunteers, our local communities and partners for your support and regular feedback. We look forward to continuing to work with you over 2022/23.

Declaration

In preparing our Quality Account, we have endeavoured to ensure that the information and data presented within is accurate and provides a fair and balanced reflection of our performance this year. To the best of my knowledge, the information in the document is an accurate and true account of the quality of our services.

Ben Travis

Chief Executive, Lewisham and Greenwich NHS Trust
May 2022

Part 2

2.1 Our Quality priorities for 2022/23

In the following section, we tell you about our chosen quality priorities for 2022/23. Our priorities reflect the breadth of services we provide on our acute Hospital sites to the population across Lewisham, Greenwich and Bexley boroughs, and community health services across Lewisham and other London boroughs.

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 our corporate objectives which include making improvements in quality and safety, so we are one of the best performing Trusts in the country.

We are committed to delivering quality services and we make every effort to work in partnership with our patients, carers, staff, and key stakeholders to identify what our quality priorities should be each year.

2.1.1 How we chose our priorities

For 2022/23, our quality priorities have been chosen to continue focus on areas that require further improvement in line with national and local quality priorities.

Throughout 2021/22, progress towards achieving the quality priorities that we set ourselves has been monitored via our Trust quality and governance committees. The priorities have been presented and reported at meetings held across the Trust, with our key stakeholders present at these meetings.

The review of our performance shows that whilst there have been improvements in 2021/22, progress has continued to be affected by the COVID-19 pandemic. Section 3.0 details the achievements and the improvement work planned for 2022/23.

The priority areas chosen for 2022/23 have been influenced by our engagement with local commissioners, through our quality and governance meetings, feedback from patient groups such as Healthwatch, feedback from patient experience surveys, lessons learned from incidents and the outcome of our CQC inspection. Furthermore, we have also consulted with our wider staff network, patients, and stakeholders via our website.

In response, we are committed to continue our focus to improve patient safety; improve patient experience and reduce health inequalities. These priorities are supported by our Trust Board, and Trust Quality, Safety and Patient Experience Committee.

National guidance states that NHS providers must align their quality priorities to the three quality domains as follows:

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.

Patient Experience

Treating patients with care, compassion, and dignity.

Clinical Effectiveness

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

Described below in Table 1 are our 2022/23 quality priorities in line with the three quality domains of patient safety, patient experience and clinical effectiveness

Table 1 – Quality Priorities 2022/23

Quality Domain	Quality Area of Focus	Quality Performance Indicator	Why we have chosen these priorities
Patient Safety	**Medication safety** – Ensuring timely communication with community pharmacists where changes to medications are made during a hospital admission.	■ Ensuring 1.5% of inpatients requiring medicines changes have this communicated with the community pharmacist within 48 hours of discharge.	This priority has been chosen in line with our continued focus on medication safety and is one of the Commissioning for Quality and Innovations (CQUINs) for the Trust in 2022/23.
	Reduction in Investigation Delays	■ We will reduce the delays in Radiology investigations follow up by 50% by utilizing a Quality Improvement approach.	This priority has been chosen to continue in 2022/23 as we remain focused on reducing the delays in timely follow up of radiology investigation results.
Patient Experience	**Reducing inequalities** – we will work to reduce the variation and improve equality of services.	■ We will undertake a baseline audit in Q1 2022/23 on the timeliness of analgesia administered to patients presenting to the Emergency Department with an acute sickle cell episode. ■ Based on the baseline audit we will improve the timeliness of analgesia administered to patients within 30 minutes who present with an acute sickle cell episode by 50% ■ Undertake a baseline audit in Q1 2022/23 on the number and timeliness of referrals to the Haematology Specialist Team for sickle cell patients admitted as an emergency. ■ Based on the baseline audit improve the timeliness of referrals within 12 hours to the Haematology Specialist Team for emergency admissions by 50%.	This is in line with our focus to reduce health inequalities.
	Delivering improvements in maternity care (Ockenden Review)	■ We will develop a co-produced outpatient Induction of Labour (IOL) information leaflet which clearly describes the safe pathways if IOL is delayed due to high activity or short staffing.	This priority has been chosen to ensure patients receive information on the care they receive and will improve the experience of women and birthing people.
	Responding to patient and staff feedback	■ We will continue to roll out the co-produced Quality Improvement Training package for patients, service users and carers. ■ We will ensure that the pool of trained service users work in partnership with the Trust to improve services and ensure co-production. ■ We will embed the 'What Matters to You' initiative across all our clinical service divisions.	These indicators have been chosen in line with our Trust priority to put patients at the heart of everything that we do and respond to the national patient survey results. We will do this by increasing co-production and rolling out the 'What matters to you' framework which helps us to ensure that we listen and engage patients with their health care decisions. This is also an initiative that encourages staff engagement.

Quality Domain	Quality Area of Focus	Quality Performance Indicator	Why we have chosen these priorities
Clinical Effectiveness	**Treatment Escalation Plans (TEP)** – are a means of establishing a care plan that allows clinicians to discuss and record patient preferences in advance, not only regarding cardiopulmonary resuscitation (CPR), but all aspects of care and treatment in an emergency.	■ We will ensure that 80% of TEPs are completed within 48 hours of admission. ■ We will obtain feedback from service users and their Next of Kin (NoK) via a survey to assess and improve the TEP discussions based on patient/ NoK experience.	This is a chosen priority in line with the outcome of the CQC unannounced inspection in December 2020. The aim is to ensure that patient preferences are discussed and recorded in their care plan.
	Community Management of Venous Leg Ulcers	■ 70% of patients with Leg ulcers will have a Doppler scan and care plan initiated within 2 weeks of referral to the community team.	Timely investigation and the commencement of treatment care plans for venous leg ulcers is key in improving healing rates for patients. Ensuring timely access to Doppler scans and early commencement of a care plan should improve outcomes.
	Learning Disabilities Pathways	■ Continue to improve the timeliness of referrals within 24 hours to the Learning Disabilities Specialist Nurse for emergency admissions. Based on the audit in 2021/22 improve the timeliness of referrals within 24 hours to the Learning Disabilities Specialist Nurse for emergency admissions by 75%.	The Trust has developed a strategy for the learning disabilities service and key to this is the early identification of patients with a learning disability so that we can ensure reasonable adaptations are put in place to improve patient outcomes.

These quality indicators will be monitored by the Trust Quality, Safety and Patient Experience Committee and the Trust Quality Governance Committee.

Part 2

2.2 Statements of assurance from the Trust Board

This section contains mandated 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 2021/22 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 these services through its performance management framework and assurance processes.

The income generated by the NHS services reviewed in 2021/22 represents 100% of the total income generated from the provision of NHS services by the Trust for 2021/22.

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 identify service improvement opportunities. It provides healthcare professionals the chance to reflect on their individual practice and the wider practices across the clinical divisions and the Trust. Lewisham and Greenwich NHS Trust actively encourages all clinical staff 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, alongside relevant published National Institute for Health and Care Excellence (NICE) guidance. The programme also includes audits undertaken to monitor practice, with a focus on themes identified through the triangulation of learning from incidents, complaints and patient feedback.

National Audit and Confidential Enquiries Programme

Between April 2021 and March 2022, 53 National Clinical Audits and 6 National Confidential Enquiries studies covered NHS services that Lewisham and Greenwich NHS Trust provides. During that period Lewisham and Greenwich NHS Trust participated in 100% (53/53) National Clinical Audits and 100% (6/6) National Confidential Enquiries studies of the National Clinical Audits and National Confidential Enquiries studies which it was identified as eligible to participate in.

In response to the COVID-19 pandemic, in March 2020 NHS England and NHS Improvement wrote to NHS Trusts stating that mandatory participation in the National Clinical Audit and Patient Outcome Programme (NCAPOP) would be suspended. This suspension was lifted in May 2021.

Lewisham and Greenwich NHS Trust continued to submit data to all National Clinical Audits in 2021/22. Data submission was below the normal participation levels when compared to previous years due to the ongoing prioritisation of clinical capacity because of the pandemic.

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 2021 to March 2022.
- 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 2021 to March 2022, alongside the number of cases submitted to each audit or enquiry as a percentage or number of registered cases required by the terms of that audit or enquiry.

Audit Title	Eligible UHL	Eligible QEH	Participated UHL	Participated QEH	Reporting Period	% Submission Rate - UHL	% Submission Rate - QEH
No	**National Clinical Audits**						
1	Cardiac Arrest Audit	Yes	Yes	Yes	Yes	1st January 2021 – December 2021	100%	100%
2	Case Mix Programme (CMP-ICNARC)	Yes	Yes	Yes	Yes	1st April 2021 – 31st March 2022	100%	100%
3	Cardiac Rehabilitation Audit	Yes	No	Yes	N/A	1st January 2020 – 31st December 2020	100%	N/A
4	Diabetes – Adult	Yes	Yes	Yes	Yes	1st January 2020 – 31st March 2021	100%	100% (demographic data only)
5	Diabetes – Foot Health	Yes	No	Yes	N/A	1st April 2015 – 31st March 2018	160 cases	N/A
6	Diabetes – Paediatric	Yes	Yes	Yes	Yes	1st April 2019 – 31st March 2020	66 cases	45 cases
7	Diabetes – Pregnancy in Diabetes	Yes	Yes	Yes	Yes	1st January 2021 – 31st December 2021	15 cases	15 cases
8	Elective Surgery (National PROMS Programme)	Yes	Yes	Yes	Yes	1st April 2020 – March 2021	Pre-operative - 10% Post-operative – 100%	
9	Epilepsy – Paediatric (Epilepsy 12)	Yes	Yes	Yes	Yes	1st December 2018 – 31st January 2021	25 cases	
10	Falls and Fragility Fractures Audit Programme – Fracture Service Liaison Database (FSLD)	Yes	Yes	Yes	Yes	1st January 2019 – 31st December 2019	312 cases	1225 cases
11	Falls and Fragility Fractures Audit Programme – National Hip Fracture Database (NHFD)	Yes	Yes	Yes	Yes	1st January 2021 – 31st December 2021	160 cases	324 cases
12	Falls and Fragility Fractures Audit Programme – National Inpatient audit of Falls (NAIF)	Yes	Yes	Yes	Yes	1st January 2020 – 31st December 2020	In progress	
13	Emergency Medicine – Pain in Children – Care in the Emergency Department	Yes	Yes	Yes	Yes	1st October 2020 – 1st April 2021	198 cases	29 cases
14	Inflammatory Bowel Disease Registry (IBD)	Yes	Yes	Yes	Yes	1st April 2021 – 31st March 2022	16 cases	
15	Lung Cancer	Yes	Yes	Yes	Yes	1st January 2018 – 31st December 2018	320 cases	
16	Maternity and Perinatal Audit	Yes	Yes	Yes	Yes	1st October 2020 – 30th September 2021	6351 cases	
17	National Asthma Clinical Audit Programme – Asthma in Adults	Yes	Yes	Yes	Yes	1st April 2021 – 30th September 2021	33 cases	68 cases
18	National Asthma Clinical Audit Programme – Asthma in Children	Yes	Yes	Yes	Yes	1st April 2021 – 30th September 2021	13 cases	11 cases
19	National Asthma Clinical Audit Programme – Chronic Obstructive Pulmonary Disease	Yes	No	Yes	No	1st April 2021 – 30th September 2021	57 cases	161 cases
20	National Asthma Clinical Audit Programme – Pulmonary Rehabilitation	Yes	No	Yes	N/A	1st June 2019 – 30th November 2019	68 cases	N/A
21	National Audit of Breast Cancer in Older Patients (NABCOP)	No	Yes	N/A	Yes	1st January 2014 – 31st December 2018	N/A	100%
22	National Care at the End of Life (NACEL) Audit	Yes	Yes	Yes	Yes	1st April 2020 – 31st May 2020	100%	100%
23	National Cardiac Audit Programme - Acute Myocardial Ischaemia (MINAP)	Yes	Yes	Yes	Yes	1st April 2019 – 31st March 2020	29 cases	269 cases
24	National Cardiac Audit Programme - Cardiac Rhythm Management (CRM)	No	Yes	N/A	Yes	1st April 2014 – 31st March 2020	N/A	353 cases
25	National Cardiac Audit Programme – Heart Failure (HF)	Yes	Yes	Yes	Yes	1st April 2018 – 31st March 2019	19 cases	545 cases
26	National Cardiac Audit Programme - Coronary Angioplasty/ Percutaneous Coronary Interventions (PCI)	Yes	Yes	Yes	Yes	1st April 2019 – 31st March 2020	N/A	184
27	National Comparative Audit of Blood Transfusion - Patient Blood Management and NICE Guidelines	Yes	Yes	Yes	Yes	1st August 2021 – 31st December 2021	100%	100%
28	National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	Yes	Yes	8th May 2019 – 7th May 2020	90 cases	138 cases
29	National Emergency Laparotomy Audit (NELA)	Yes	Yes	Yes	Yes	1st December 2019 – 30th November 2020	100%	100%
30	National Gastro-intestinal Cancer Programme – Bowel Cancer	Yes	Yes	Yes	Yes	1st April 2019 – 31st March 2020	>80%	
31	National Gastro-intestinal Cancer Programme – Oesophago-gastric Cancer	Yes	Yes	Yes	Yes	1st April 2018 – 31st March 2020	<65%	
32	National Joint Registry (NJR)	Yes	Yes	Yes	Yes	1st April 2020 – 31st March 2021	51%	
33	National Neonatal Audit Programme (NNAP)	Yes	Yes	Yes	Yes	1st January 2020 – 31st December 2020	100%	100%
34	National Outpatient Management of Pulmonary Embolism	Yes	Yes	Yes	Yes	1st September 2021 – 31st October 2021	9 cases	7 cases
35	National Paediatric Diabetes Audit (NPDA)	Yes	Yes	Yes	Yes	1st January 2020 – 31st December 2020	130 cases	234 cases
36	National Prostate Cancer Audit (NPCA)	No	Yes	N/A	Yes	1st April 2019 – 31st March 2020	N/A	215 cases

Audit Title	Eligible UHL	Eligible QEH	Participated UHL	Participated QEH	Reporting Period	% Submission Rate - UHL	% Submission Rate - QEH
No	**National Clinical Audits**						
37	National Smoking Cessation Audit	Yes	Yes	Yes	Yes	1st July 2021 – 31st August 2021	100%	100%
38	Sentinel Stroke National Audit Programme (SSNAP)	Yes	No	Yes	N/A	Organisational Audit – 2021	100%	N/A
						Clinical Audit – 1st April 2020 – 31st March 2021	>90%	N/A
39	Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes	Yes	Yes	Yes	30th January 2020	13 cases	65 cases
40	Transurethral Resection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment (RESECT)	Yes	Yes	Yes	Yes	1st October 2020 – 31st October 2022	In progress 65 cases	
41	Trauma Audit and Research (TARN)	Yes	Yes	Yes	Yes	1st January 2021 – 31st December 2021	84%	100%
42	UK Cystic Fibrosis Registry	Yes	No	Yes	N/A	1st January 2020 – 31st December 2020	100%	N/A

Table 3 - Audits on the NHS England list that did not collect data in 2021/22

	Audit Title
1	National Diabetes Inpatients Audit (NaDIA)
2	National Comparative of Blood Transfusion - Audit of the perioperative management of anaemia in children undergoing elective surgery
3	National Audit of Dementia
4	Severe Sepsis and Septic Shock – Care in the Emergency Department

Table 4 - National Confidential Enquiries on the NHS England List for Inclusion in Quality Account 2021/22

	Enquiry Title	Eligible UHL	Eligible QEH	Participated UHL	Participated QEH	Reporting Period	% Submission Rate – UHL	% Submission Rate – QEH
1	Learning Disabilities Mortality Review Programme	Yes	Yes	Yes	Yes	1st January 2018– 31st December 2020	100%	100%
2	Maternal, Infant and Newborn Clinical Outcome Review (MBBRACE)	Yes	Yes	Yes	Yes	1st January 2021 – 31st December 2021	100%	100%
3	National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) – Epilepsy	Yes	Yes	Yes	Yes	1st January 2020 – 31st December 2020	100%	100%
4	National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) – Transition	Yes	Yes	Yes	Yes	1st July 2021 – 30th September 2021	In progress	In progress
5	National Perinatal Mortality Review Tool	Yes	Yes	Yes	Yes	1st January 2021 – 31st December 2021	100%	100%
6	Serious Hazards of Transfusion	Yes	Yes	Yes	Yes	1st April 2021 - 31st March 2022	100%	100%

Table 5 – Additional National Clinical Audits that Lewisham and Greenwich NHS Trust Participated in during 2021/22

	Audit Title
1	Antenatal and Newborn National Audit Protocol 2019 to 2022
2	Bariatric Surgery Registry
3	BSUG Urology Audit – Female Stress Urinary Incontinence
4	COVID 19 and analgesia, sedation and paralysis and delirium in ventilated patients
5	Endocrine and Thyroid National Audit
6	Fragility Fracture Post-Operative Mobilsation (FFPOM)
7	Infection Control – Care in the Emergency Department
8	Maternity TRANSFER Audit
9	National Pleural Procedures Organisational Audit
10	PANC Study: A National Cohort Study
11	South Thames Paediatric Network Appendectomy and Testicular Torsion

Reviewing Reports of National Clinical Audits and Confidential Enquiries

The reports of all National Clinical Audits and National Confidential Enquiries are reviewed by the Quality Assurance 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 47 National Clinical Audits and Confidential Enquiries published between January 2021 to December 2021 were reviewed by Lewisham and Greenwich NHS Trust.

Some of the key highlights and actions that Lewisham and Greenwich NHS Trust will be taking to improve quality are detailed below:

Audit/ Enquiry	Key Highlights/ Actions
National Neonatal Audit Programme (NNAP)	Queen Elizabeth Hospital was highlighted as an outlier for follow up at 2 years of age audit measure in the 2020 NNAP audit. The outlier status was noted to be due to the non-submission of data evidencing the 2 year follow up of patients for appointments carried out at another Trust. As a result of the alert the Trust agreed a process with Oxleas NHS Foundation Trust who undertake the follow up reviews, to obtain the required data to ensure that the LGT submission included all data pertaining to babies follow up care. The Trust developed a Standard Operating Procedure to underpin this process.
National Emergency Laparotomy Audit (NELA)	The Trust performed better than the national average in 10 of the process and outcome measures for the NELA audit in the Year 7 report (1st December 2019 – 30th November 2020).
Mothers and Babies Reducing Risk Through Audit and Confidential Enquiry (MBRRACE)	In line with the MBRRACE report recommendations the Trust developed a COVID-19 maternity guideline and information leaflet for women. The leaflet contained information about risk of COVID-19 and signs of deterioration in health women should be vigilant about.
National Hip Fracture Database (NHFD)	Queen Elizabeth Hospital and University Hospital Lewisham was in the top quartile in 2021 for perioperative medical assessment, physiotherapist assessment the day after surgery and nutritional risk assessments. In addition, Queen Elizabeth Hospital was also in the top quartile for mobilising patients out of bed by the day after Surgery.

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

The reports of 56 local audits were reviewed by the Trust from 1st April 2021 to 31st March 2022. 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 available from the Trust upon request by contacting the Quality Assurance Team (lh.clinicaleffectiveness@nhs.net).

Speciality	Change to Practice
Elderly Medicine	**Treatment Escalation Plan (TEP) audit** – to prompt timely completion of TEP for patients admitted to hospital as an emergency, an electronic alert was added to the Trusts electronic patient record. The alert notifies staff who open the patient record if a TEP has not been completed from 24 hours post admission.
Children's Services	**Infant Feeding Audit** – following an audit of infant feeding support offered by Health Visiting to new mothers, the service will be rolling out Virtual Weaning Hubs in early 2022/23 as a universal service for families.
Emergency Medicine	**Alcohol Withdrawal Guidelines** – following an evaluation of the identification and treatment of patients with alcohol withdrawal, a guidance leaflet was developed for staff to ensure accessible information was readily available outlining key treatment actions required.
Ear, Nose and Throat (ENT)	**Nasal Fracture Pathway Audit** – following an audit to assess adherence to the local nasal fracture management guidance, the referral and treatment pathway was streamlined to ensure timely management of the fractures. Audit results were disseminated, and posters created to raise greater awareness of the treatment protocol. As a result of the changes the re-audit identified an overall increase in the number of patients reviewed in 7 days to an average of 67.7% from a baseline of 23%.

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 portfolio.

Lewisham and Greenwich NHS Trust works collaboratively with the South London Clinical Research Network (CRN) to support the delivery of National Institute for Health Research (NIHR) portfolio research. 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's strategy.

In line with national recommendations, recruitment to all non-Urgent Public Health (UPH) studies was paused at the start of the pandemic and the Trust focussed primarily on opening UPH studies. This was intended to provide capacity for potential high recruiting SARS-CoV-2 studies, and in anticipation of significant staff sickness and redeployment of research staff into clinical roles. The Trust took a number of steps to ensure the safety of participants recruited into research studies. Two hundred amendments were processed to allow studies to continue safely and effectively and processes were put in place to ensure follow up of our participants, particularly with regard to patient safety and ensure continued access to trial medication.

The Trust opened several high profile COVID-19 studies including RECOVERY and SIREN. Both of these studies have been fundamental in developing treatment options for patients as well as significantly contributing to our understanding of the disease.

During this 12-month period, the trust has finally managed to un-pause all of its studies. We have focussed on recovering capacity and capability to support our existing research. Studies have been reviewed locally and nationally assessing for urgency of the research question and the ability to recruit to target within the existing timeframes or through the new care pathways that have emerged.

The Trust's focus is now on rebuilding a balanced portfolio with a mix of high recruiting observational and more complex interventional studies and to perform well against all NIHR metrics. The Trust's focus remains on studies that are of good quality and are relevant to the needs of the population it serves.

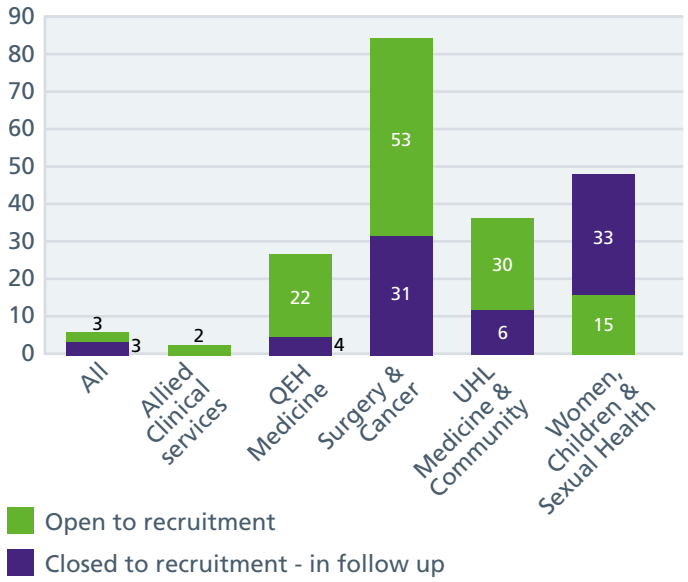
Participation in Clinical Research

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

Research studies open by Trust Division

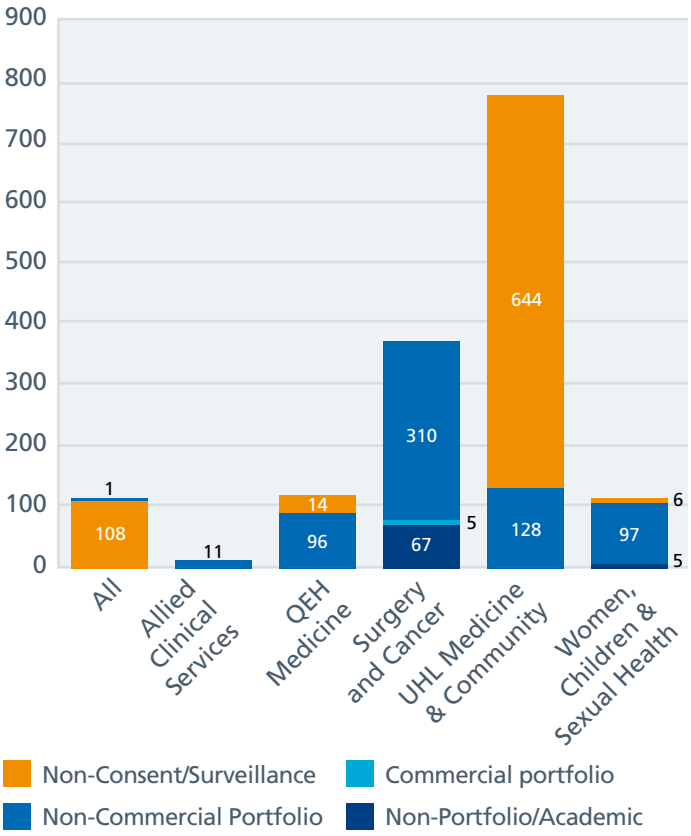
In 2021/22 Lewisham and Greenwich NHS Trust was involved in 184 clinical research studies.

Following is a breakdown of the studies currently running and are shown by Trust Division.



The number of patients receiving NHS services provided or subcontracted by Lewisham and Greenwich NHS Trust in 2021/22 that were recruited during that period to participate in research approved by a Research Ethics Committee, was 1494 (including non-consent & surveillance studies)

Following is a breakdown of this recruitment and is shown by Trust Division.



Patients recruited to studies by Trust Division

The commitment of the Research and Development team, 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 department is developing the research function within the organisation to benefit patients and increase 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, whilst focusing on patient safety and high-quality care.

Part 2

2.5 Quality and Innovation Goals agreed with Commissioners (CQUINs)

The Commissioning for Quality and Innovation (CQUIN) framework supports improvements in the quality of services and the creation of new, improved patterns of care.

A proportion (1.5%) of the Trust's annual income is conditional on achieving quality CQUIN goals agreed between Lewisham and Greenwich NHS Trust and Lewisham, the South East London Commissioning Group and NHS England.

Due to the COVID-19 pandemic, NHS England agreed that NHS providers would not be required to participate in the CQUIN programme in 2021/22, and block payments would be made to NHS providers covering the CQUIN income.

The Trust received 100% of its CQUIN income as a block payment covering April 2021 – March 2022.

2.6 Registration with the 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 with no conditions applied'.

The Trust received no inspections from the CQC during the reporting period of 2021/22.

The Trust has in place a robust improvement action plan in response to the CQC requirement notices from previous inspections in 2020. This is monitored by the Quality and Safety Improvement Group and the Quality Governance Committee.

Lewisham and Greenwich NHS Trust overall rating has not altered since the last announced inspections in 2020, 2018 and 2017. Details of the current ratings are outlined in the dashboards here on the right:

University Hospital Lewisham Ratings – 2020

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018
Medical care (including older people's care)	Requires improvement → ← Jul 2020	Requires improvement ↓ Jul 2020	Good ↑ Jul 2020	Good ↑ Jul 2020	Good ↑ Jul 2020	Requires improvement → ← Jul 2020
Surgery	Good ↑ Jul 2020	Good ↑ Jul 2020	Good → ← Jul 2020	Good → ← Jul 2020	Good ↑ Jul 2020	Good ↑ Jul 2020
Critical care	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Requires improvement Aug 2017	Good Aug 2017
Maternity	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018
Services for children and young people	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017
End of life care	Requires improvement Sept 2018	Requires improvement Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Requires improvement Sept 2018
Outpatients	Requires improvement Aug 2017	N/A	Good Aug 2017	Requires improvement Aug 2017	Requires improvement Aug 2017	Requires improvement Aug 2017
Overall*	Requires improvement → ← Jul 2020	Requires improvement → ← Jul 2020	Good → ← Jul 2020	Good ↑ Jul 2020	Requires improvement → ← Jul 2020	Requires improvement → ← Jul 2020

Queen Elizabeth Hospital Ratings – 2020

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement → ← Jul 2020	Good → ← Jul 2020	Good → ← Jul 2020	Requires improvement → ← Jul 2020	Good ↑ Jul 2020	Requires improvement → ← Jul 2020
Medical care (including older people's care)	Requires improvement → ← Jul 2020	Good → ← Jul 2020	Good ↑ Jul 2020	Good ↑ Jul 2020	Good ↑ Jul 2020	Good ↑ Jul 2020
Surgery	Good ↑ Jul 2020	Good ↑ Jul 2020	Good → ← Sept 2018	Good ↑ Jul 2020	Good ↑ Jul 2020	Good ↑ Jul 2020
Critical care	Good ↑ Jul 2020	Good → ← Jul 2020	Good → ← Jul 2020	Good ↑ Jul 2020	Outstanding ↑ ↑ Jul 2020	Good ↑ Jul 2020
Maternity	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018
Services for children and young people	Requires improvement → ← Jul 2020	Good → ← Jul 2020	Good → ← Jul 2020	Requires improvement ↓ Jul 2020	Requires improvement → ← Jul 2020	Requires improvement → ← Jul 2020
End of life care	Requires improvement Sept 2018	Requires improvement Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Requires improvement Sept 2018
Outpatients	Good Aug 2017	N/A	Good Aug 2017	Requires improvement Aug 2017	Good Aug 2017	Good Aug 2017
Overall*	Requires improvement → ← Jul 2020	Good ↑ Jul 2020	Good → ← Jul 2020	Requires improvement → ← Jul 2020	Good ↑ Jul 2020	Requires improvement → ← Jul 2020

Community Health Services Ratings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017
Community health services for children and young people	Good Aug 2017	Outstanding Aug 2017	Good Aug 2017	Good Aug 2017	Outstanding Aug 2017	Outstanding Aug 2017
Overall*	Good Aug 2017	Outstanding Aug 2017	Good Aug 2017	Good Aug 2017	Outstanding Aug 2017	Outstanding Aug 2017

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

Part 2
2.7 Data Quality

Quality data is data that is:

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

The 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 are empowered to reach informed decisions about any treatment options
- Clinical governance relies on access to high quality patient data to allow them to identify areas where clinical care could be improved
- Improving the efficiency of clinical and administrative processes, for example communication with patients and carers, and appropriate allocation of resources needs data being used for these tasks to be of high quality
- Management and strategic planning - which relies heavily on high quality data about the volume and types of patient activity as the basis for planning 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
- Payment by Results and Service Level Agreement (SLA) monitoring.

NHS Number and General Medical Practice Code Validity

The Secondary Uses Service (SUS) is designed to provide anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health tasks, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development. 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 submitted records during 2021/22 data to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data

The validity of NHS Numbers and General Medical Practice Codes within the SUS submission are monitored and below are the percentage of records containing a valid NHS number or correct General Practitioner during Q4 2021/22:

NHS Number validity	Trust Total	UHL	QEH
Admitted Patient Care	99.50%	99.51%	99.50%
Outpatients	99.82%	99.85%	99.80%
Emergency Dept.	98.81%	98.76%	98.87%
Registered GP Practice accuracy	**Trust Total**	**UHL**	**QEH**
Admitted Patient Care	97.64%	96.33%	98.58%
Outpatients	98.70%	97.64%	99.74%
Emergency Dept.	98.25%	97.47%	99.20%

Part 2

2.8 Data Security and Protection 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 Data Security and Protection Toolkit (DSPT) published by the Department of Health outlines the Information Governance, Data Security and Protection performance that Trusts are required to fulfil. The requirements of the DSPT support key requirements under the General Data Protection Regulation (GDPR), identified in the NHS GDPR checklist.

The results of the DSPT are also considered by the Care Quality Commission in order to assess how organisations are assuring themselves that the 10 data security standards are being implemented as part of the 'well led' element of their inspections.

To meet the Standards, all mandatory evidence against the assertions must be completed and submitted into the DSPT national online portal.

Due to the COVID-19 pandemic, NHS Digital extended the submission deadline for the 2021/22 evidence to the 30th June 2022.

The Trust submitted its evidence (100 out of 100 mandatory evidence items provided) for the 2021/22 DSPT for all the mandatory assertions and has met all standards.

Data Security and Protection Toolkit 2021/22

Trust/ Local Authority and CCGs	30th June 2022 Submission
Lewisham and Greenwich NHS Trust	Standards Met

Part 2
2.9 Clinical Coding

Payment by Results

Payment by Results (PbR) has been the method by which the Trust usually receives payment for admitted patients within the acute setting, although in 2020/21, and 2021/22 this has been partially suspended due to the COVID-19 Pandemic.

The Trust undertakes an annual programme of internal clinical coding audits to monitor the quality of coding (accuracy and adherence to national rules) performance and to identify any deficiencies in the clinical documentation process. Outcome of audits are fed back to the individual clinical coder or the clinical team depending on who commissioned the audit. The results for the last 4 years are provided below:

Completed Clinical Coding Audits 2021/22 as at 31/03/2022

Area	FCEs in audit	FCEs - unable to audit	HRG changed	HRG changed/ error rate	Primary Diag - correct %		Secondary Diag - correct %			Primary Proc - correct %			Secondary Proc - correct %		
					% Correct	Correct	% Correct	Correct	Incorrect	% Correct	Correct	Incorrect	% Correct	Correct	Incorrect
2021/22 LGT Trust Coding Audit Total	827	0	79	9.6	90.3	747	90.3	3817	410	90.1	527	58	90.0	1000	111
2020/21 LGT Trust Coding Audit Total	650	0	131	20.2	90.6	589	93.5	3968	276	90.2	313	34	89.6	675	78
2019/20 Trust Coding Audit Total	254	0	27.5	10.8	91.7	233	97.3	1894	53	92	120	11	95	271	14
2018/19 Trust Coding Audit Total	300	0	27	9	90.3	271	96.32	1438	55	95	189	11	95	329	18

Audit Programme – Data Quality (Clinical Coding)

Clinical coding audit is a crucial part of a robust quality assurance framework supporting and helping to ensure the provision of statistically meaningful coded clinical data for local, national and international use, as well as used by national teams and application (eg GIRFT and Model Hospital) to look at the Trusts casemix and efficiency against standard metrics.

Clinical coding audits focused on data quality can take different forms:

1. a continuous clinical coding audit programme comprising several small audits undertaken throughout the course of the year as part of routine maintenance of standards
2. a single one-off audit of an area, which should then be re-audited within an agreed period to confirm any recommendations around documentation, process of coding practice have been completed.

For clinical coding audit results there are national standards (NHS Terminology and Classifications Delivery Service requirements) against which the Trusts accuracy data can be compared.

Trusts must meet or exceed the required percentage scores across all four areas in order to meet the attainment level set as acceptable by the NHS Terminology and Classifications Delivery Service.

	Acute Trust		LGT Trust	
	Level of attainment – Standards met	**Level of attainment – Standards exceeded**	**Level of attainment – Standards met**	**Level of attainment – Standards exceeded**
Primary diagnosis	≥90%	≥95%	**90.3%**	
Secondary diagnosis	≥80%	≥90%		**90.3%**
Primary procedure	≥90%	≥95%	**90.1%**	
Secondary procedure	≥80%	≥90%		**90%**

Lewisham and Greenwich NHS Trust undertakes the following actions to improve data quality within its Clinical Coding function:

- Regular Trust Data Quality Audits on areas of concern highlighted through benchmarking reports. Improvement plans are developed in response to the issues identified in the audit reports
- The provision of regular data quality reports for the Data Quality team to amend incorrect data entries relating to patient stays where appropriate following investigation
- Regular feedback and training as required to improve quality both for clinical and coding staff.

Part 2

2.10 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.

During 2021/22 1730 of Lewisham and Greenwich NHS Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 376 in the first quarter
- 393 in the second quarter
- 470 in the third quarter
- 491 in the fourth quarter.

By 31st March 2022, 329 case record reviews and 196 serious or red incident investigations have been carried out. In 5 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:

- 48 in the first quarter
- 138 in the second quarter
- 48 in the third quarter
- 62 in the fourth quarter.

There is a discrepancy of 33 – these reviews were carried out for deaths within the financial year but without a specific date provided, as to when it was undertaken.

One represents 0.06% of the patient deaths during the whole reporting period that 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:

- 1 representing 2.1% for the first quarter.
- 0 representing 0.0% for the second quarter.
- 0 representing 0.0% for the third quarter.
- 0 representing 0.0% for the fourth quarter.

The death investigated was deemed not to be Trust attributable after investigation.

These numbers have been estimated using the number of deaths (1) which were deemed either Definitely Avoidable, Strong Evidence of Avoidability or Probably Avoidable (more than 50:50) via the Structured Judgment Review methodology and divided by the number of deaths and multiplied by 100. The Structured judgment 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.

Twelve case record reviews and investigations were completed after 31st March 2021 which related to deaths which took place before the start of the reporting period.

None of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number is estimated from the avoidability of death judgement score (1-6; where 1-3 are degrees of avoidable and 4-6 are slight evidence of avoidability but not likely). These scores are given as part of Structured Judgement reviews.

The following learning was identified from the review of deaths in 2021/22 and shared with the Trust Mortality Review Committee, Quality, Safety and Patient Experience Committee and Quality Governance Committee:

- A need for better communication between the medical and intensive care teams was identified, as an outcome of an SJR.
- There is a focus on sepsis and the Mortality Review Committee (MRC) clarified some factors around sepsis definitions within the Trust.
    - The MRC shared learning from a 'Prevention of Future Deaths" order received from the Coroner in April 2021. This included:
    - The Trust did not provide the appropriate evidence for the inquest which confirmed that antibiotics were prescribed within the hour. The Trust apologised to the coroner for this oversight.
    - The Trust re-audited sepsis performance on all clinical wards against the Sepsis 6 Bundle Standards and actions have been taken to improve gaps in practice.
    - The Trust will ensure the Sepsis Assessment Bundle is readily available on wards in paper format.
    - The Trust is prioritising the implementation of an electronic Sepsis Bundle.
    - Learning from this case was presented to staff in ward safety huddles and local team meetings along with a reminder that prescribed critical medications are to be administered to patients within an hour of being prescribed.
    - A review of deaths of patients with hospital acquired COVID that died from June 2020 to January 2021, was undertaken and completed by August 2021. This showed that most deaths were not avoidable, with the most avoidable score being 4 (less that 50:50 chance of avoidance). Most of the patients who died were significantly frail. 2% to 2.2% of patients treated in hospital with COVID, were hospital acquired. There is no specific learning from deaths with COVID though learning from hospital acquired COVID infections was identified and shared.

Part 2

2.11 Performance against National Core Quality Indicators

One of our requirements as an NHS Acute and Community Trust is to report our performance against a core set of indicators, which is published by NHS Digital (an arms-length body of the Department of Health and the national provider of information and data).

For 2021/22, 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 the 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. Where there is no national data available, we have provided the Trust internal data position. It is important to note that there has been a delay to the publication of data due to the Covid-19 pandemic.

The nine national core quality indicators are as follows:

National Prescribed Information	
1	**a)** The value and banding of the Summary Hospital-level Mortality Indicator (SHMI) for the trust for the reporting period; and **(b)** The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.
2	The trust's patient reported outcome measures scores for: **(i)** hip replacement surgery and **(ii)** knee replacement surgery during the reporting period.
3	The percentage of patients aged: **(i)** 0 to 15 and **(ii)** 16 or over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.
4	The trust's responsiveness to the personal needs of its patients during the reporting period.
5	The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.
6	Friends and Family Test – Patient. The data made available by National Health Service Trust or NHS Foundation Trust by NHS Digital for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency (types 1 and 2) *There is not a statutory requirement to include this indicator in the quality accounts reporting but provider organisations should consider doing so.*
7	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.
8	The rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.
9	The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

2.11 Patient Safety

2.11.1 National Core Indicator - Summary Hospital-level Mortality Indicator (SHMI) and Palliative Care Deaths

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

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

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

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

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

SHMI value and Banding

Summary Hospital-level Mortality Indicator	Jan 20 - Dec 20 (published May 2021)		Apr 20 – Mar 21 (published Aug 2021)		Jul 20 – Jun 21 (published Nov 2021)		Oct 20 – Sept 21 (published Feb 2022)	
	SHMI	Banding	SHMI	Banding	SHMI	Banding	SHMI	Banding
Lewisham and Greenwich NHS Trust	0.92	2	0.92	2	0.94	2	0.94	2
Best Performing Trust	0.70	3	0.69	3	0.72	3	0.71	3
Worst Performing Trust	1.18	1	1.20	1	1.2	1	1.19	1

Percentage of deaths with palliative care coding	Jan 20 - Dec 20 (published May 2021)	Apr 20 – Mar 21 (published August 2021)	Jul 20 – Jun 21 (published November 2021)	Oct 20 – Sept 21 (published February 2022)
Lewisham and Greenwich NHS Trust	32%	32%	32%	33%
Lowest percentage Trust	8%	8%	11%	12%
Highest percentage Trust	61%	63%	64%	63%

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

- Ongoing monthly monitoring of all reported deaths via the Trust Mortality Review Committee
- We will continue regular reporting of the clinical coding of the deaths of patients, to ensure accuracy in recording.

2.11.2 National Core Indicator - 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 two clinical procedures:

- Hip Replacement Surgery
- Knee Replacement 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, housework, family or leisure activities, pain/discomfort or anxiety /depression.

PROMS Performance – Lewisham and Greenwich NHS Trust

To respond to the challenges posed by the coronavirus pandemic NHS hospitals in England were instructed to suspend all non-urgent elective surgery for patients for parts of the 2020/21 and 2021/22 reporting periods. This directly impacted upon reported volumes of activity pertaining to Hip and Knee replacements reported in PROMS. In addition it is possible that behaviours around activities relating to the completion, return and processing of pre and post-operative questionnaires may have also been impacted when compared to earlier years data where behaviours and processes related to managing the current pandemic were not in place.

Mandated PROMS data collection resumed in May 2021.

The table below provides details of the number of operations Lewisham and Greenwich NHS Trust have carried out between April 2020 and March 2021 for the two procedures covered by PROMS and the provisional number of Q1 and Q2 questionnaires issued. At the time of writing this account, the 2021/22 data had not yet been published.

April 2020 – March 2021					
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	**150**	**172**	**13**	**6**	**6**
Hip Replacement	72	94	6	3	3
Knee Replacement	78	78	7	3	3

The table below shows the published finalised NHS Digital PROMs health gain data for the reporting period 1st April 2020 up to and including 31st March 2021 (published February 2022)

PROMS	Measure	Lewisham & Greenwich Adjusted Health Gain April 2020 – March 2021	National Adjusted Health Gain April 2020 – March 2021	Best Performer - Adjusted Health Gain April 2020 – March 2021	Worst Performer - Adjusted Health Gain April 2020 – March 2021
Hip	EQ-5D	<10 records	0.465	0.576	0.392
	EQ-VAS	<10 records	14.769	20.598	9.721
	Oxford Hip Score	<10 records	22.597	26.294	17.453
Knee	EQ-5D	<10 records	0.315	0.400	0.176
	EQ-VAS	<10 records	7.274	13.116	-4.314
	Oxford Knee Score	<10 records	16.714	20.153	11.793

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

- The finalised published data from NHS Digital covers the reporting period April 2020 – March 2021
- The Trust health gain performance for its PROMS cannot be compared to the national average for hip and knee replacement surgery as less than 10 records were returned for each procedure.
- The Trust has identified that the number of Q1 and Q2 questionnaires issued and returned between April 2020 and March 2021 has been impacted by the COVID-19 pandemic

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 pre-operatively and post-operatively to assess health gain
- 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.

2.11.3 National Core Indicator - 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. Readmission data for the year 2021/22 is available through the Business Intelligence (BI) hub as shown in the tables below.

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

As data is not available from NHS Digital at the time of writing we have provided internal published data

	Discharges following inpatient admission	Emergency Re-admission within 28 days of Discharge	% 28 Day Readmission rate
Lewisham and Greenwich NHS Trust	82,320	11,483	13.95%

2.11.4 Core Indicator – The Trust's responsiveness to the personal needs of the patients

The Trust participates annually in the Care Quality Commission's (CQC) national adult inpatient survey.

The 2020 survey is the seventh inpatient survey to be carried out since Lewisham and Greenwich NHS Trust was established in 2013.

Patient Experience – responsiveness to personal needs of patients	2019/20	2020/21
Lewisham and Greenwich NHS Trust		
National Average	79%	84%

The main themes seen in survey results were around engagement with health or social care professionals in discharge planning, communication, overall cleanliness and respect and dignity. The Trust saw improvements in the following areas: providing written/ printed information for patients on discharge, allowing own medication when needed and being asked for feedback. The ongoing COVID-19 pandemic had a significant impact on service delivery and business continuity during 2021/22 but the Trust remained committed to delivering a good patient experience.

In response to our patient survey results Lewisham and Greenwich NHS Trust is taking a number of actions including improving patient's experience of communication with staff through customer care training and improving patient experience of discharge by scaling up the successful QI project for patient experience of discharge from ward 22 to other wards.

In addition, the Trust continues to:

- use patient feedback with emphasis on patient co- design,
- continue to produce 'You said, We Did' posters.
- Strengthen our engagement with patients that seldom provide feedback, with a particular focus on those with learning disabilities, sight and hearing impairments, and younger patients.

We are building on existing links with community groups such as Carers Groups, BAME network and recently created Youth Board in September 2021. We will also continue to foster links with external stakeholders and voluntary organisations who contribute to our patient's experience.

2.11.5 National Core Indicator – 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 2021 Staff Survey responses to the Staff Friends and Family Test (SFFT) questions indicated that:

- 57.0% of those who responded agreed or strongly agreed, they would recommend the Trust to friends and family as a place for treatment

The 2021 SFFT score for staff recommending the Trust, as a place to receive treatment is 57.0% compared to 60.7% in 2020 – a reduction of 3.7%.

The Trust's score is 9.9 percentage points below the national average. The percentage points difference in 2020 was 13.6, which suggests a narrowing gap.

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	Percentage of staff recommending the trust as a place to receive treatment	
	2020	2021
Lewisham and Greenwich NHS Trust	60.7%	57.0%
National Average	74.3%	66.9%
Highest scoring Trust	91.7%	89.5%
Lowest scoring Trust	49.7%	43.6%

2.11.6 National Core Indicator – The percentage of patients who would recommend the Trust as a provider of care to their family and friends

The Friends and Family Test (FFT) survey is used to understand whether patients are happy with the service provided, or where improvements are needed. It's a quick and anonymous way for patients to provide feedback after receiving NHS care or treatment.

Friends and Family Test surveys are given out to patients and service users in the following areas:

- Community Services
- Emergency Department
- Outpatient Department
- Inpatient Wards
- Women's Services

The 2021/22 responses to the FFT questions for the areas surveyed have been included on the table below:

Month	Community		Emergency Department		Inpatients		Outpatients		Women's Services	
	No. Responses	Satisfaction %	No. Responses	Satisfaction %	No. Responses	Satisfaction %	No. Responses	Satisfaction %	No. Responses	Satisfaction %
Apr-21	394	98.76%	1401	79.59%	1281	95.55%	4465	92.00%	204	92.16%
May-21	514	97.86%	1464	78.35%	1546	95.73%	3712	90.54%	163	90.18%
Jun-21	771	95.33%	1346	75.19%	1524	95.87%	3778	90.44%	218	93.12%
Jul-21	727	97.39%	1276	69.83	1580	94.75%	3510	91.17%	98	94.90%
Aug-21	580	96.55%	1229	74.61%	1360	96.25%	2893	90.91%	149	93.29%
Sep-21	661	96.52%	1320	68.26%	1365	94.26%	3595	90.40%	96	88.54%
Oct-21	773	96.86%	1407	68.59%	1452	95.73%	3755	89.86%	65	87.69%
Nov-21	782	97.31%	1420	70.28%	1262	96.04%	3978	91.98%	65	95.83%
Dec-21	682	97.36%	1078	73.75%	1093	94.78%	2920	92.57%	48	97.92%
Jan-22	569	97.01%	1174	74.70%	934	95.82%	3723	91.89%	48	83.33%
Feb-22	689	96.23%	1231	72.95%	1190	95.13%	3645	91.00%	97	90.72%
Mar-22	615	97.72%	1435	67.67%	1448	93.23%	3594	89.90%	128	87.50%
Total	**7717**	**97.07%**	**15781**	**72.81%**	**16035**	**95.26%**	**43568**	**91.06%**	**1379**	**91.27%**

2.11.7 - National Core Indicator - The percentage of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism (VTE) during 2021/22

Venous thromboembolism (VTE) 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% of our patients are assessed for their risk of thrombosis (blood clots) and bleeding on admission to hospital.

In response to the ongoing operational pressures caused by the Delta and Omicron variant of the COVID-19 pandemic, in December 2021, NHS England and NHS Improvement wrote to NHS Trusts stating that all national clinical audit, confidential enquiries and national joint registry data collection, including for national VTE risk assessment, would continue to be suspended.

However, the Trust maintained an ongoing process to collate monthly data on VTE assessments and we have provided the internal performance data for 2021/22 (top right of the facing page) for the quality account:

We continue to undertake the following actions:

- Ongoing monthly monitoring of VTE assessment.
- Ensuring that Root Cause Analysis (RCA) is undertaken for all cases of Hospital Acquired Thrombosis (HAT) (VTE occurring within 90 days of hospital episode).
- Ensuring teaching on stocking application is provided and each ward has a VTE champion that attends regular VTE study days.

VTE assessment rate	2020/21	2021/22
Lewisham and Greenwich NHS Trust	95.74%	97.12%
Assessed (no. of patients with VTE assessment)	107,771	104,145
Admitted	111,526	107,235
Assessment Rate	95.74%	97.12%
National Average	**95.61%**	**Data not available**
Best performing Trust	**100%**	
Worst performing Trust	**68.35%**	

2.11.8 National Core Indicator - 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 2021/22

Clostridioides difficile (C. difficile) is a bacterium that's found in people's intestines. It can be found in healthy people, where it causes no symptoms (up to 3% of adults and 66% of babies).

It 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 demonstrated by inappropriate prescribing or cross infection by ribotyping.

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

Once per year in July, the UK Health Security Agency (UKSHA), formally Public Health England (PHE) publish this data as a rate per 100,000 bed days, with further updated data published in September.

The table below demonstrates monthly counts of trust-apportioned Clostridium difficile (C. difficile) infections by NHS acute trusts (Non specialty) and location of onset in patients aged 2 years and over. Published data is up to January 2022.

Counts of cases for this collection are lower than would be expected. It is clear that the global COVID-19 pandemic is having an effect on the number of cases reported to the surveillance of BSI and CDI.

C. difficile rate per 100,000 bed-days	2019/20	2020/21	2021/22
Lewisham and Greenwich NHS Trust	27	27	29
Hospital Onset Healthcare Associated (HOCA)	22	24	28
Community Onset Healthcare Associated (COHA)	8	14	6
LGT Overnight Occupied Bed Days - Patients aged 2 and over	333,419	274,273	317,893
Rate per 100,000 bed days (LGT Trust apportioned)	8.8	13.8	Data not yet published
Rate objective for LGT	8.6	No rate set due to pandemic	No rate set due to pandemic
National Average	**13.6**	**15.4**	Data not published until October 2022
Best performing Trust	**7.6**	**10.4**	
Worst performing Trust	**56.7**	**80.6**	

Prior Healthcare Exposure

From April 2017, reporting trusts were asked to provide information on whether patients with CDI had been admitted to the reporting trust within the three months prior to the onset of the current case. This allows a greater granulation of the healthcare association of cases.

Cases are split into one of four groups:

- Hospital-onset, healthcare associated (HOHA) - Specimen date is ≥3 days after the current admission date (where day of admission is day 1)
- Community-onset healthcare-associated (COHA) - Is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)
- Community-onset, indeterminate association (COIA) - Is not categorised HOHA and the patient was most recently discharged from the same reporting trust between 29 and 84 days prior to the specimen date (where day 1 is the specimen date)
- Community-onset, community associated (COCA) - Is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 84 days prior to the specimen date (where day 1 is the specimen date)

Monthly counts of C. difficile infection for patients aged 2 years and over by Acute Trust - Hospital-Onset Healthcare Associated (HOHA)*

Reporting Period: April 2021 - February 2022

Trust Type	PHE Centre	Trust Name	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	Totals
NHS Trust	London	Barking Havering and Redbridge University Hospitals	2	2	1	5	7	2	3	3	2	2	2	31
NHS Trust	London	Barts Health	7	6	6	4	4	7	3	9	9	12	7	74
NHS Trust	London	Croydon Health Services	0	1	3	2	1	2	3	1	0	0	2	15
FT	London	Guy's & St. Thomas's	3	2	5	6	5	2	4	3	5	2	2	39
FT	London	Homerton University Hospital	2	1	0	1	0	0	1	3	0	0	2	10
FT	London	King's College Hospital	6	5	7	8	6	2	8	8	4	5	3	62
NHS Trust	London	Lewisham & Greenwich	2	3	1	2	4	6	3	1	4	1	1	28
NHS Trust	London	North Middlesex University Hospital	2	1	2	1	4	1	0	0	2	0	2	15

*Date of onset is ≥ 3 days after admission (where admission is day 1)

Monthly counts of C. difficile infection for patients aged 2 years and over by Acute Trust - Community-Onset Healthcare Associated (COHA)**													
Reporting Period: April 2021 - February 2022													
Trust Type	PHE Centre	Trust Name	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	Totals
NHS Trust	London	Barking Havering and Redbridge University Hospitals	1	0	4	2	1	2	1	3	0	2	0	16
NHS Trust	London	Barts Health	5	3	3	2	1	2	2	3	2	1	1	25
NHS Trust	London	Croydon Health Services	2	0	0	0	0	0	0	0	0	1	0	3
FT	London	Guy's & St. Thomas's	0	0	1	1	0	1	1	1	0	1	0	6
FT	London	Homerton University Hospital	1	0	1	1	0	0	0	1	0	0	0	4
FT	London	King's College Hospital	6	0	7	2	2	3	4	3	3	3	1	34
NHS Trust	London	Lewisham & Greenwich	0	1	1	0	0	1	1	0	0	0	0	4
NHS Trust	London	North Middlesex University Hospital	0	1	0	1	0	4	0	1	0	0	0	7

**Date of onset is ≤ 2 days after admission and the patient was admitted to the Trust in the 28 days prior to the current episode days (where day 1 is date of discharge)

Source: Monthly counts of Clostridioides difficile (C. difficile) infection from January 2021 to January 2022. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1056958/Table_6_CDI_january_2022.xlsx

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

- All C. difficile patients are reviewed by a microbiologist in conjunction with the clinical team, at time of diagnosis.
- All C. difficile in patients are regularly reviewed on the ward by the Infection Prevention Nurses to monitor treatment and condition.
- We continue with site based multidisciplinary weekly C. difficile review groups, which allows for the review of care and progress of any patients with C. difficile.
- We continue to maintain a strong and visible presence of the Infection Prevention and Control Team at ward level, undertaking ward-based infection prevention audits.
- Continual and regular review of antimicrobial prescribing and updating of Trust prescribing guidelines.
- We monitor the performance of antimicrobial prescribing through bi-monthly antimicrobial care bundle audits undertaken by the antimicrobial pharmacists. These are fed back to individual Divisional governance teams by the pharmacy leads with oversight from the Infection Prevention and Control Committee.
- We continue to work with our community partners to update antimicrobial prescribing guidelines for the community.
- We undertake root cause analysis on all Trust attributable C. difficile cases to allow any learning for practice to be understood and shared.
- There is ongoing monitoring and oversight by the Trust Infection Prevention and Control Committee and Quality, Safety and Patient Experience Committee, with board level reports being produced and shared when C. difficile numbers exceed the set trust targets for the month.

2.11.9 National Core Indicator – 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 2021/22

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.

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

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

- 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.
- The Trust contributes to the national programme of learning from patient safety incidents and all clinical incidents are reported nationally via the NRLS.

Patient Safety Incidents	Apr 20 – Mar 21	Apr 21 – Mar 21
Lewisham and Greenwich NHS Trust		
Total reported incidents	13,183	12,891
Incident reporting rate per 1,000 bed days	48.9	37.57
Incidents causing severe harm or death	30	23
% of incidents causing severe harm or death	0.23%	0.18%
Acute Non-Specialised Trusts		
Lowest incident reporting rate per 1,000 bed days	34	Not Yet available Data published September 2022
Highest incident reporting rate per 1,000 bed days	53.8	*
Lowest incidents causing severe harm or death	0.03%	*
Highest incidents causing severe harm or death	2.79%	*
Acute Trusts average % of incidents causing severe harm or death	0.44%	*

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 Chief Medical Officer 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, Safety and Patient Experience Committee. Any compliance breaches are included on the Trust quality scorecard which is presented monthly to the Trust Board.

Part 2

2.12 Freedom to Speak Up

In its response to the Gosport Independent Panel report the Government committed to legislation requiring all NHS Trusts in England to report annually on staff who speak up (including whistleblowers). As part of this commitment for the Quality Account 2021/22, NHS Trusts are required to provide details on their approach to Freedom to Speak Up (FTSU). For Lewisham and Greenwich NHS Trust the Freedom to Speak up Guardian Service contributes to the Workforce Strategy key theme of creating inclusive workplaces.

The Trust has a "Speak Up" policy in place to encourage and support staff to raise concerns. This policy had a minor review during the year to reflect feedback from the freedom to speak up audit.

As part of the Respect and Compassion programme of work, and following a staff consultation, the Trust reviewed its Freedom to Speak up Guardian Provision in 2019/20. A new Guardian Service was implemented in June 2020 and the contract extended for 2021/22. This continued to provide the independence of the service and accessibility (24/7 for 365 days of the year) for Trust staff.

At Board level the Trust has an Executive and Non-Executive Lead for Speaking up, both of whom meet regularly with the Freedom to Speak up Guardians. This year the Board has completed the National Guardian Review tool kit and has an action plan for the next 12 months.

The Trust also has a Guardian of Safe Working to support junior doctors in the Trust and the two groups of Guardians liaise regularly to help ensure consistency across the two roles. The Trust Freedom to Speak up Guardians also liaise regularly with the National Guardians' office, and report quarterly on activity in line with the National Guardians' Office requirements.

Throughout 2021/22 the Trust have built on the work to improve its culture of openness and encourage all staff to be able to speak up and raise concerns. The Trust has 3,943 leaders and managers trained on our values and behaviours, which includes training on the skills and tools to help create a culture of speaking up. It has 150 wellbeing champions to help provide initial support and guidance to staff who have concerns, and our Trust Induction course to give a greater emphasis on speaking up and our culture. The Trust holds a regular Speak up workshop, open to staff and managers, and speaking up is a main part of the Trust Induction course, which all new staff attend.

During spring 2021 the Trust undertook an independent audit of whistleblowing and speaking up. Overall, the audit rated the Trust as significant assurance with minor improvement opportunities. There were 5 recommendations as a result of the audit, all of which were implemented by October 2021 and reported to the Trust Audit and Risk Committee.

As well as the above training, the Trust continues to promote awareness of the Freedom to Speak up Guardians through regular corporate communications. The Freedom to Speak up Guardian made 38 promotional visits in 2021/22, attending events and meetings, and being present across the Trust sites on a regular basis, though much of this activity had to been undertaken virtually due to the COVID-19 pandemic.

Data/Activity

There are many ways in which staff raise concerns, some through direct contact with the FTSU Guardians, some through their line managers, some through the Trust Incident reporting system and some through the Chief Executive Officer (CEO) open access route 'Ask Ben'.

Staff are supported through the various routes in which they raise concerns, however, much more work is now being undertaken to ensure staff are receiving timely support and feedback and to avoid any detriment being experienced by staff.

The Trust has raised the profile of the speak up Guardian by implementing a focused communications plan, including attending staff webinars, monthly Divisional visits, focusing on professional groups, linking with Patient Safety and Employee Relations teams.

During the year our Freedom to Speak up Guardian had 960 contacts (1,259 in 2020/21) made up as follows:

Contacts by medium	
Email	142
Telephone	161
Face to face	24

The Freedom to Speak up Guardian Service supported 59 cases over the year (86 in 2020/21).

- 29 concerns were escalated to the Trust within the period. All concerns that were escalated were responded to within the agreed timeframe.
- 14 cases remain open and 45 have been closed.

Open cases are continually monitored, and regular contact is maintained by the FTSUG with members of staff who have raised a concern to establish where ongoing support continues to be required. Where setbacks or avoidable delays are experienced in the progress of cases that have been escalated to the Trust, these would be raised with the Chief People Officer at regular monthly meetings.

The category of themes is defined by the National Guardian Office (NGO). Concerns raised are broken down into these categories as follows:

Main themes for cases

Themes	Number of concerns
Patient Safety	4
Management Issue	19
System and Process	17
Bullying and harassment	4
Discrimination / Inequality	6
Behaviour / Relationship	9
Worker Safety	0
Other	0
Total	59

Part 3

3.0 Review of Quality Performance in 2021/22

In this section we have highlighted our performance against last year's goals which cover the three quality domains of patient experience, patient safety and clinical effectiveness.

We have used the following colours to denote how well we performed against the quality priorities: -

Green/Achieved
This means the target set has been achieved

Amber/Mostly Achieved
This means our performance is 5% or less below the set target

Red/Not achieved
This means our performance is 6% or more below the set target

3.1.1 Patient Safety Priorities

Our quality priorities and why we chose them	What success will look like	How did we do?
i) Improving Medication Safety We chose this priority in line with our continued focus on medication safety following the 2020 CQC inspection.	■ We will ensure 95% of POD (Patients Own Drugs) lockers containing medicines are locked	**We mostly achieved this target** Throughout the year our audit results were consistently at 93% or above (indicating the occurrence of 1 or 2 non-compliant wards across the Trust). Any consistencies in non-compliant wards are flagged, and action plans are implemented at ward level to monitor performance until compliance is achieved.
	■ We will ensure that appropriate action is taken when a fridge temperature is out of range – (95% target).	**We did not achieve this.** Over the year, our audit results provided documented evidence that appropriate action was taken on average 65%of the time a fridge temperature was out of range. Routinely temperature excursions occur on a single day and are classified as an 'in use' excursion i.e. a small fluctuation due to routine use of the drug fridge. Appropriate action is taken but not documented.
i) Reduction in Investigation Delays This is a chosen priority following our review of themes from our incident reports. This is to ensure we embed learning.	■ We will reduce the delays in the Radiology investigations follow up by 50% by utilizing a Quality Improvement approach.	**We partially achieved this.** A Quality Improvement (QI) project focused on reducing the delays in follow up of Radiology investigation results was undertaken in ENT. The project commenced in March 2021 and using QI methodology, reviewed the pathway from radiology request to endorsement of results to identify any barriers to timely review. Due to the planned implementation of a new Radiology Imaging System (RIS) in May 2022, the project was unable to measure a reduction in the time taken to endorse results, however the new RIS contains an inbuilt reporting system, which will provide monthly feedback to services and track improvements going forward for this group of patients. This is an ongoing piece of work and will continue to be a quality priority for the Trust into 2022/23.

3.1.2 Clinical Effectiveness Priorities

Our quality priorities and why we chose them	What success will look like	How did we do?
ii) Treatment Escalation Plans (TEP) This is a chosen priority in line with the outcome of the CQC unannounced inspection in December 2020. The aim is to ensure that patient preferences are discussed and recorded in their care plan.	■ We will ensure that 80% of TEPs are completed within 48 hours of admission.	● **We partially achieved this.** An audit was undertaken of TEPs completed for a sample of adult emergency inpatient admissions in 2021/22 (n=26,422). The audit indicated that 48% of patients had a TEP completed, and where this was completed 82% were within 48 hours of admission. Where a TEP wasn't completed the audit identified these patients were for full escalation. To ensure that all emergency admissions have an explicit indication of 'full escalation' a check box has been added to the electronic patient records whereby clinicians can record the full escalation decision without the need to complete a detailed form.
	■ We will improve documentation of TEP discussions with patients and/ or their Next of Kin to 90%.	● **We partially achieved this.** The audit completed looked at a sample of patients where the TEP indicated a ceiling of treatment (n=119). In 82% there was documented evidence of a discussion with the patient and/ or their Next of Kin (NoK). Where there was no documented evidence of a discussion, these patients had been admitted to hospital with an existing community TEP or Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place. The Trust continues to promote the documentation of discussions with patients and/ or their NoK when community plans remain in place in the acute setting.
i) Community Management of Venous Leg Ulcers Timely investigation and the commencement of treatment care plans for venous leg ulcers is key in improving healing rates for patients. Patients with venous leg ulcers are assessed after 12 weeks and 24 weeks of treatment to monitor progress and assess how ulcers are healing. Ensuring timely access to Doppler scans and early commencement of a care plan should improve outcomes.	■ 70% of patients with Leg ulcers will have a Doppler scan and care plan initiated within 2 weeks of referral to the community team.	● **We did not achieve this.** Whilst 87% of patients with leg ulcers were being seen and having a Doppler scan within the 4-week community referral to treatment pathway, only 13% received the doppler scan within 2 weeks of referral. 100% of patients had care plans initiated once seen in line with the 4-week treatment pathway, but none were initiated within 2 weeks. During the pandemic the service was impacted by staff turnover whereby the focus was placed on ensuring that the 4-week referral to treatment pathway was maintained. In support of improving performance to achieve compliance with the 2-week targets, the service is providing additional training to ensure new staff are trained to undertake doppler scans.
ii) Learning Disabilities Pathways The Trust is in the process of developing a strategy for the learning disabilities service and key to this is the early identification of patients with a learning disability so that we can ensure reasonable adaptations are put in place to improve patient outcomes. By identifying this as a quality account priority there will be visibility and focus on this patient cohort for whom it is recognised through reports such as Learning Disability Review Programme (LeDeR) often have poorer outcomes.	■ Undertake a baseline audit on the number and timeliness of referrals to the Learning Disabilities Specialist Nurse (Q4 2020/21).	● **We achieved this.** An audit was undertaken reviewing the timeliness of referrals to the Learning Disability Team at UHL in Q4 2020/21. 42% (n=18) of patients that were identified as having a Learning Disability (LD) were referred to the LD Specialist Nurse. Where patients were referred, 75% were referred within 24 hours of admission.
	■ Based on the baseline audit improve the timeliness of referrals within 24 hours to the Learning Disabilities Nurse for emergency admissions by 50%.	● **We achieved this.** An audit was undertaken reviewing the timeliness of referrals to the Learning Disability (LD) Teams at both the UHL and QEH site between April 2021 and March 2022. A random sample of the referrals received across the year by each team was reviewed. 75% (n=48/64) of patients that were identified as having an LD at QEH were referred to the LD Specialist Nurse within 24 hours of admission. 82% (n=56/68) of patients that were identified as having an LD at UHL were referred to the LD Specialist Nurse within 24 hours of admission.

3.1.3 Patient Experience Priorities

Our quality priorities and why we chose them	What success will look like	How did we do?
i) Reducing Inequalities – we will work to reduce the variation and improve equality of services. We chose this priority in line with our focus to reduce health inequalities.	■ We will achieve the Gold Standard UNICEF award for breastfeeding to enhance the public health strategy on infant feeding.	● **We achieved this.** Following submission of the required audits and supporting data in December 2021 the Gold Standard was awarded to the Infant Feeding Team at University Hospital Lewisham.
ii) Delivering improvements in Maternity Care. This priority was chosen in response to the Ockenden Review and is one of the indicators within the Immediate and Essential Actions. It is important to note that this is just one indicator. The Trust reports on all the Immediate and Essential Actions to improve care and safety in Maternity Services. This has been reported on a quarterly basis to the Trust Board and the Quality Governance Committee.	■ We will ensure that 95% of completed risk assessments for women include review of the intended place of birth.	● **We achieved this.** In 2021/22 an ongoing audit of 1% of antenatal records indicated that 100% of risk assessments completed for women included a review of the intended place of birth.
i) Responding to patient and staff feedback These indicators were chosen in line with our Trust priority to put patients at the heart of everything that we do and respond to the national patient survey results. We did this by increasing co-production and rolling out the 'What matters to you' framework which helped us to ensure that we listen and engage patients with their health care decisions. This was also an initiative that encouraged staff engagement.	■ We will train and develop a pool of service users to work in partnership with the Trust to improve services and ensure co-production.	● **We achieved this.** At the end of 2021/22, 13 service users, patients and carers had undergone co-production and QI training delivered via two training sessions and were available to work with the Trust on co-design.
	■ We will implement a co-produced Quality Improvement (QI) training package for patients, service users and carers.	● **We achieved this.** The co-produced QI training package was launched in November 2021. At the end of 2021/22, 13 patients, service users and carers had undertaken the training with further dates arranged for 2022/23.
	■ We will embed the 'What Matters to You' initiative for staff and patients within the QEH Medicine and Lewisham Medicine Acute and Community Divisions.	● **We achieved this.** The QEH Medicine and the Lewisham Medicine Acute and Community divisions continued to collect feedback from staff in 2021/22 asking the 'What Matters To You' question.

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 in June 2022.

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 Quality and Performance 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, Chief Nurse and Chief Operating Officer, Chief Finance Officer, Director of Strategy, Chief People Officer, the Chief Information Officer and the five 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 five 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 2022/23.

The Trust Quality Governance Committee, Quality, Safety and Patient Experience 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 and Patient Experience Committee and Quality Governance Committee have all reviewed and contributed to the setting of priorities for 2022/23.

A consultation on the priorities for 2022/23 was undertaken via an online survey. This was shared widely with staff and patients to ask for their input to the quality priorities and this was well received with staff and patient 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)

South East London Clinical Commissioning Group Statement on Lewisham and Greenwich NHS Trust Quality Account 2021/22.

South East London Clinical Commissioning Group was formed in April 2020 from a merger of the six-borough based Clinical Commissioning Groups in Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark and is grateful to Lewisham and Greenwich NHS Trust for the opportunity to comment on its 2021/22 Quality Account. The South East London Clinical Commissioning Group wishes to acknowledge the enormous amount of work undertaken by Lewisham and Greenwich NHS Trust during and following the pandemic and would like to thank staff for their continued endurance, compassion and commitment shown by all the staff.

The CCG would like to acknowledge the Trust's continued participation in research and its collaboration with the South London Clinical Research Network in support of the National Institute for Health Research portfolio. In particular, the undertaking of several high profile Covid 19 studies which has led to developing treatments for patients with Covid 19 and a greater understanding of the disease.

The CCG recognises the work undertaken to achieve the quality priorities set in 2021/2022 and acknowledged that some were affected due to the pandemic. The work undertaken to improve medication safety is noted and as has the fact that the Trust has consistently maintained 93% compliance against a target of 95%. The Trust accepts that whilst it did not achieve compliance for the maintenance of fridge temperatures it will continue to embed the importance of documentation in recording temperatures and the CCG looks forward to seeing the improvement.

The CCG would like to congratulate the Trust on achieving its priority in improving Learning Disabilities Pathways following the implementation of a new strategy to ensure the early identification of patients with learning difficulties who are then referred within 24 hours of admission to the Learning Disability Specialist Nurse. Achievement was also accomplished against the patient experience priorities.

We are pleased to see the Trust focus on the community management of venous leg ulcers through timely investigation and access to dopplers, and the commencement of treatment care plans to improve healing outcomes for patients.

The Trust has undertaken a Quality Improvement project to reduce the delays in radiology investigation follow ups by 50% which is ongoing. The new Radiology Imaging System has an inbuilt reporting system which will assist in measuring improvements in 2022/23 against this priority area.

The Quality Priorities demonstrates a continuum of improvement at the Trust. We commend the work undertaken to date and look forward to their continued determination in providing a quality service and endorse the new quality priorities for 2022/2023.

We commend the improvement work the Trust continues to undertake and welcome their continued engagement with the CCG and active partnership to address priorities and deliver integrated care as a system to further improve the quality of lives of the population we serve.

Kate Moriarty Baker
Chief Nurse
Caldicott Guardian
NHS South East London CCG

ii) Healthwatch Greenwich

Healthwatch Greenwich Response to Lewisham and Greenwich NHS Trust (LGT) 2021/22 Quality Account

Healthwatch Greenwich is the independent champion for people who use health and social care services in Royal Borough of Greenwich. We're here to make sure that those running services, put people at the heart of care.

Our purpose is to understand the needs, experiences and concerns of people who use health and social care services, to speak out on their behalf, and work for improvements with those who provide health and care services.

Healthwatch Greenwich welcomes the opportunity to comment and provide an assurance statement on the Lewisham and Greenwich Trust Quality Account 2021/22. Firstly, we would like to thank the Lewisham and Greenwich Trust and all its dedicated staff, for their continued hard work and commitment over the

[1] https://www.sicklecellsociety.org/no-ones-listening/

last twelve months. We recognise the legacy of the pandemic, and recovery of services, provides significant pressure for the organisation, and challenges the ambitions of service delivery and progress.

In your Quality Account, we find assurance that despite the additional recovery pressures, the Trust continues to meet its aspirations.

We have reviewed the 2021/22 Lewisham and Greenwich NHS Trust's Quality Account to assess the extent to which it:

- Reflects peoples' real experiences as shared with Healthwatch Greenwich.
- Demonstrates a learning culture that uses people's real experiences to drive improvements.
- Identifies challenging priorities for improvement, focused on improving patient experience, and appropriate measurements to assess change.

The Trust is required to write the Quality Account in a way that makes it easy for a lay reader to understand. We are pleased to report that, overall, the report is written in a non-technical way and is accessible for a lay audience.

2022/23 Quality Priorities

Priority 1: Patient Safety - Medication Safety and Reduction in Investigation Delays:

We commend LGT on all work planned to improve medication safety and to reduce investigation delays. While we are unable to comment on follow up of radiology investigation results specifically, we have heard from many service users frustrated with cancellations and delays to scheduled appointments across several departments. We would have liked to have seen a focus on reducing this backlog (because of COVID pressures) as a priority for patient safety.

Priority 2: Patient Experience - Reducing Inequalities:

Failings (nationally) in sickle cell treatment and the lack of understanding of people with sickle cell is a serious and longstanding issue. We are pleased to see LGT taking initial steps – within the emergency department - to create baselines and, as a result, make improvements to the administration of pain relief and haematology referrals. The All-Party Parliamentary Group (APPG) on Sickle Cell and Thalassemia make several recommendations in their report 'No-Ones Listening[1]'. We would have liked to have seen a more comprehensive approach by LGT to not only joining up sickle cell care, but including raising awareness amongst healthcare professionals, and addressing negative attitudes towards sickle cell patients.

Priority 2: Patient Experience – Delivering Improvements in Maternity Care (Ockenden Review):

LGT has undertaken a full review of maternity services and actions to improve the quality of care and patient safety. However, service users continue to contact Healthwatch Greenwich with poor experience of maternity services at Queen Elizabeth Hospital (QEH). This includes, poor communication, women not feeling listened to, or their concerns not taken seriously, or a general lack of empathy. Delays in accessing pain relief, or requests for pain relief not being taken seriously, a lack of feeding support, poor hygiene, and noise on post-natal wards. Although numbers are small, in comparison to the total number of birthing women using QEH, it is worrying that some feel so traumatised they are frightened to return or use QEH maternity services in the future. While the production of a leaflet, as the priority quality performance indicator for maternity services, is important, it is not clear how other maternity service concerns[2] we have bought to the attention of the Trust will be addressed.

Priority 2: Patient Experience – Responding to Patient and Staff Feedback:

Quality Improvement Training Package: We welcome the continuation of the Quality Improvement Training package for patients, service users and carers. Our volunteers have attended two of these public, open access on-line sessions and note that on both occasions, attendance was very low. At one session – this amounted to 6 people. Given the resources required by LGT to develop and deliver these sessions - we would like to encourage LGT to work in partnership with Healthwatch Greenwich and other community stakeholders to facilitate greater community uptake of these valuable opportunities.

Pool of trained service users: We have received positive feedback from patients and the public on LGT's use of volunteers both on wards, and in public areas, to offer support, directions, or just a reassuring smile.

'What Matters to You': We don't find the information reported particularly clear but believe it to be a useful indicator.

The LGT Quality Account notes the three indicators above have been chosen partly to respond to the National Patient Survey Results[3] in which, of the 45 questions, LGT scored worse than expected on 23 questions, compared with all other Trusts, and about the same (compared with all other Trusts) on 22 questions. It's not clear how the three indicators chosen will address this.

In addition, the cohort providing responses to the National Patient Survey are unlikely to reflect the true diversity of the local population using LGT's services. Moreover, this is only one method of collating patient experience, and we would have liked to have seen greater emphasis on working with local stakeholders, such as Healthwatch Greenwich, to collect and utilise patient experience information.

Priority 3: Clinical Effectiveness – Treatment Escalation Plans (TEP):

We support LGT's plans to put patients at the centre of decisions made about their treatment by increasing the number of patients with a TEP, and including a wider remit of treatment options in the TEP than a 'Do Not Resuscitate' (DNR) order.

Priority 3: Clinical Effectiveness – Community Management of Venous Leg Ulcers:

All activity to improve timely access to scans and referrals is welcomed.

[2] For example – see our April 2022 Feedback Report. [3] https://nhssurveys.org/all-files/02-adults-inpatients/05-benchmarks-reports/2020/

Priority 3: Clinical Effectiveness – Learning Disabilities Pathways:

We have previously raised issues regarding specialist support for patients with learning disabilities and we are pleased to see action taken to address this.

Review of Quality Performance 2021/22

Overall, we note of the 13 quality indicator targets set by LGT last year, only 7 have been achieved, with progress made on 4, and 2 not met. We look forward to receiving updates on targets still in progress or not met.

We are pleased to see all 5 of the patient experience quality improvement priorities have been met. We congratulate the Gold Standard achievement awarded to the infant feeding team at University Hospital Lewisham. There is no mention of a similar achievement at Queen Elizabeth Hospital – and we look forward to QEH achieving a similar award.

We commend LGT on achieving the targets for delivering improvements in maternity care. However – as noted earlier – Healthwatch Greenwich continue to hear poor maternity experiences from women and their families birthing at Queen Elizabeth Hospital.

Responding to patient feedback by training 13 service users to co-produce with LGT is a positive approach. We hope the Trust continues this important work, and we encourage greater partnership working with community stakeholders and Healthwatch Greenwich to build on this approach. We would also encourage LGT to include information on 'what matters to you' on the LGT website – currently a search does not provide any information on this Initiative.

iii) Healthwatch Lewisham

Healthwatch Lewisham is pleased to be able to respond to the Lewisham and Greenwich NHS Trust Quality Account for 2021-22

Firstly we are pleased to note, despite the difficulties and pressures of the past few years, the achievements for 2021/22 for Lewisham and Greenwich NHS Trust. Alongside our operational day to day engagement with the Trust, we are pleased to be represented on the Patient Experience Committee, where our contribution and feedback from patients, carers and families in Lewisham has been welcomed. With the effect of the Covid pandemic reducing, there is evidence that wider initiatives to address problems and improve quality are starting to kick in.

A number of consistent themes emerge which the Trust is taking steps to address. These are illustrated in some of the national core indicators, reported on in this Quality Account. The **Trust's responsiveness to the personal needs of patients**, reported in the results of the Care Quality Commission's (CQC) national adult inpatient survey, highlights themes around communication, respect and dignity. We know that these themes are reflected in complaints made to the Trust as well as those reported to us by Lewisham citizens. In fact, feedback to us about their experience during the pandemic, many people told us that that as long as communications, staff attitudes and care and treatment are good it made it easier to cope with long waits - including for elective surgery.

We are, therefore, pleased to see continued efforts by the Trust to improve communication and engagement – with individual patients, with people that seldom provide feedback, with younger patients through establishment of a Youth Board and with wider community networks. We hope that our digital inclusion report, published in 2021, will contribute to learning from people's experience during the pandemic about equality of access. We are pleased to note that the Trust has built the foundations of a strategy for services for people with learning disabilities. Key to this is early identification so that the Trust can ensure reasonable adaptations are put in place to improve patient outcomes. Improvements around engagement with health or social care professionals in discharge planning – another theme from the CQC survey – can improve the experience of these patients as well as older people.

Two other national indicators also highlight common themes. We note that the **percentage of staff employed by the Trust who would recommend the Trust as a provider of care to their families and friends** is below the national average and, in line with other Trusts, has deteriorated this year. The experience of staff during the pandemic has been challenging. However, we note the action that the Trust is taking to address recruitment and retention difficulties, to promote the well-being of staff and to build confidence, particularly in patient engagement. By contrast, the **percentage of patients who would recommend the Trust as a provider of care to their family and friends** held steady achieving 97.07% in Community Services, 95.26% in Inpatients, 91.06% in Outpatients and 91.27% in Women's Services. Only in Emergency Department did satisfaction fall notably again, perhaps also affected by particular circumstances. These surveys are limited but, together with other feedback including that from local Healthwatch, they provide useful indicators of patient experience and areas for further improvement.

Quality priorities for 2021/22

It is understandable, given continued pressures in dealing with the Covid 19 pandemic, that the Trust's performance against last year's targets across the three quality domains presents a mixed picture:

Patient safety

- **Improving Medication Safety.** We note that the Trust reports improvement in auditing and checking to ensure lockers containing patients' own medicines are secured but that recording when a fridge temperature is out of range is not yet consistently applied to assure safety.
- **Reduction in Radiology Investigation Delays.** We note that, using a Quality Improvement approach, the Trust has partially achieved its target and will continue to build on this as a quality priority in 2022/23.

Clinical effectiveness

- **Treatment Escalation Plans (TEP)** – The principle of ensuring that patients are able to discuss preferences and for this to be recorded in their care plan is fundamental to good person-centred care. The Trust reports that their priority targets in this area were partially achieved. However, we welcome that advance discussion and recording of preferences in all aspects of care and treatment in an emergency is a chosen quality priority area for further improvement in the coming year.
- **Community Management of Venous Leg Ulcers** – We note that targets designed to improve outcomes in this area were not achieved and this is at least in part attributed to the impact of staff turnover during the pandemic. We trust the action now in place will result in timely access to treatment.
- **Learning Disabilities Pathways** – We are pleased to see achievements in this area and look forward to hearing more about how the Trust is building upon the baseline audit and referral process to the Learning Disabilities Specialist Nurse to improve the accessibility and quality of care for people with learning disabilities in 2022/23.

Patient experience

- **Reducing Inequalities** – We congratulate the Infant Feeding Team at University Hospital Lewisham for being awarded the UNICEF Gold Standard for breastfeeding, a key part of the public health strategy to reduce variation and improve equality.
- **Delivering improvements in Maternity Care** – We also commend other improvements in maternity care, whilst noting that the Trust action plan following publication of the Ockendon report will set out wider priorities to act upon and monitor in the coming year.
- **Responding to patient and staff feedback** – Despite difficulties faced this year, the Trust has made notable progress improving its structures for improving engagement with patients, people with experience using services and staff, achieving all three priority targets in this area, particularly using Quality Improvement approaches. The challenge will be to consistently embed these approaches into the practice of confident and engaged staff into 2022/23.

Quality priorities for 2022/23

We are pleased to note that feedback from local citizens, including via Healthwatch, has helped to shape the Trust's quality priorities for 2022/2023 and that priorities will build on learning through the pandemic. In the changing context of integrated and partnership working, there will undoubtedly be much whole system learning to build upon too. We look forward to further positive engagement with the Trust in the interest of improving quality for people that call upon health and social care services, carers and families in Lewisham in the coming year.

Part 3

3.4 External Audit Limited Assurance Report

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

In light of pressures caused by COVID-19, on 15th January 2021 NHS England and NHS Improvement published a communication confirming that they would be continuing the revised arrangements put in place in 2020, and NHS providers would no longer be expected to obtain assurance from their external auditor on their Quality Account for 2021/22.

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
Chair Date:

Ben Travis
Chief Executive Date:

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:

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