Public Document Pack

Healthier Communities Select Committee Agenda

Wednesday, 29 May 2013
7.00 pm, Committee Room 1
Civic Suite
Lewisham Town Hall
London SE6 4RU

For more information contact: Salena Mulhere (Tel: 0208 314 3380)

Part 1

Members of the public are welcome to attend committee meetings. However, occasionally, committees may have to consider some business in private. Copies of agendas, minutes and reports are available on request in Braille, in large print, on audio tape, on computer disk or in other languages.

Healthier Communities Select Committee Members

Members of the committee, listed below, are summoned to attend the meeting to be held on Wednesday, 29 May 2013.

Barry Quirk, Chief Executive
Thursday, 16 May 2013

Councillor John Muldoon (Chair) Councillor Stella Jeffrey (Vice-Chair) Councillor Pauline Beck Councillor Peggy Fitzsimmons Councillor Helen Gibson Councillor Carl Handley Councillor Ami Ibitson Councillor Chris Maines Councillor Jacq Paschoud Councillor Alan Till Councillor Alan Hall (ex-Officio) Councillor Kevin Bonavia (ex-Officio)	

MINUTES OF THE HEALTHIER COMMUNITIES SELECT COMMITTEE

Tuesday, 16 April 2013 at 7.00 pm

PRESENT: Councillors John Muldoon (Chair), Stella Jeffrey (Vice-Chair), Pauline Beck, Peggy Fitzsimmons, Chris Maines, Jacq Paschoud and Alan Till.

APOLOGIES: Councillors Helen Gibson, Carl Handley and Ami Ibitson; Jonathan Beder,(Service Manager, SLaM) and Georgina Nunney (Principal Lawyer).

ALSO PRESENT: Sarah Wainer (Head of Strategy & Performance), Joy Ellery (Director of Knowledge, Governance and Communications, Lewisham Healthcare NHS Trust), Danny Ruta (Director of Public Health, NHS Lewisham), Diana Braithwaite (Director of Commissioning, Lewisham Clinical Commissioning Group), Salena Mulhere (Overview and Scrutiny Manager) and Roger Raymond (Scrutiny Officer).

1. Confirmation of Chair and Vice-Chair

1.1 **RESOLVED:** The Committee confirmed Cllr John Muldoon as Chair and Cllr Stella Jeffrey as Vice Chair.

2. Minutes of the meeting held on 19 March 2013

2.1 **RESOLVED:** That the minutes of the meetings held on 19 March 2013 be signed as an accurate record of the meeting.

3. Declarations of Interest

3.1 Councillor Muldoon declared a non-prejudicial interest as an elected Governor of the South London and Maudsley NHS Foundation Trust (SLaM) Council of Governors.

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4. Improving Health Services in Dulwich and Surrounding Areas - consultation by the Southwark Clinical Commissioning Group

4.1 Rebecca Scott, Programme Director – Dulwich; and Malcolm Hines – Chief Finance officer, introduced the report and the following key points were noted:

- The new Southwark Clinical Commissioning Group (SCCG) is aiming to improve community access to healthcare in the south of Southwark.
- Even though the health services are in Southwark, there are over 5,000 residents from Forest Hill ward registered with Southwark GPs, and a few hundred from Crofton Park, Telegraph Hill and Perry Vale.
- There was an initial ‘engagement period’ last year for 3 months, which had over 1,000 responses. This helped narrow the

proposals for the main consultation which runs from 28 February 2013-31 May 2013.

- Another aim of the consultation is to improve community access to health care related to long-term conditions. Services need to be reviewed as Southwark's population is predicted to increase 11-12% in the next 8-10 years, and a significant amount of that increase will be in the 20yo-40yo age range.
- The Business Case is scheduled to be approved in late 2013/early 2014, and services to be commissioned over the next two years.
- It's highly likely that Dulwich Community Hospital site will be developed in conjunction with Southwark Council as part of the improvement in services.
- The proposals suggest that services could be accessed via a local GP, a nearby GP or health centre, or a larger health centre, which is likely to be on the Dulwich Community Hospital site.
- Two options are proposed in the consultation document, Option A, which is a more centralised system, or Option B is a more decentralised system.

4.2 In response to questions, the Committee were informed that:

- South East London Doctors On Call (SELDOC) is still based at Dulwich Community Hospital, but it's not envisaged that it will permanently remain at the site.
- Dulwich Community Hospital is earmarked as the main health centre, as other potential sites are not central and do not have as much space.
- There is a Renal Dialysis Unit at Dulwich Hospital which could be moved if necessary; however Kings, who provide the service, are keen to remain on site.
- The consultation concentrates on the south of Southwark as the opportunity has arisen to improve the services in this area, and also provides an opportunity to release the £2m running costs for Dulwich Community Hospital.
- Officers recognise that public transport to the Dulwich Hospital site from the Forest Hill area is currently not ideal. They will explore this further with Transport for London (TfL).
- SCCG officers would be happy to visit the Local Assembly of Lewisham ward, primarily Forest Hill, to engage with residents.

4.3 **RESOLVED:** that

a) the Committee ask Southwark CCG to consult with the Forest Hill Local Assembly before the consultation closes on 31 May 2013; and

b) Southwark CCG returns to the Committee at its September meeting to update the Committee on the conclusions of the consultation.

5. Lewisham Hospital - Update

5.1 Joy Ellery - Director of Knowledge, Governance and Communications, Lewisham Healthcare Trust and Lynn Saunders - Director of Business Development and Planning Lewisham Healthcare Trust introduced the report and the following key points were noted:

- The Secretary of State for Health's decision on the TSA report for South London Healthcare Trust (SLHT) slightly altered the recommendations in the report.
- The Secretary of State for Health decided that Lewisham Hospital should have a smaller, fully-admitting Accident & Emergency (A&E).
- Lewisham Hospital, in light of the Secretary of State's decision, has been analysing the impact the recommendations will have on all of their services.
- The Judicial Review of the Secretary of State's decision in relation to Lewisham Hospital is due to be heard over a three day hearing between late May and mid-July. Its outcome will influence the planning of services.
- In terms of the TSA recommendation to merge Queen Elizabeth Hospital with Lewisham Hospital, Lewisham Healthcare Trust supports this recommendation.
- Lewisham Healthcare Trust are already planning for the proposed merger to ensure that there is a smooth and safe transition to the new organisation so it is working effectively from day one.
- It is proposed that it will be merger by acquisition, which means Lewisham will acquire Queen Elizabeth Hospital, with Lewisham's Board remaining in place.
- Work is being carried out to ensure that the bureaucracy for each work stream (e.g. finance, governance) is fully integrated once the merger is complete.
- Lewisham Healthcare Trust will be contacting stakeholder groups to engage with them as the planning for the merger continues.
- Work has commenced to produce a Business Plan for the merger, to be reviewed by the NHS Trust Development Authority (NTDA) at the end of May.
- The 'transaction date' for the merger has been set at 1 July, but is unlikely to happen at this time. The NTDA have appointed a Programme Director for Transactions who is currently reviewing the timetable.
- A Due Diligence questionnaire has been developed with legal advice, and submitted to SLHT, providing a comprehensive information request to see how the organisation is being run at present.
- The key Clinical appointments will soon be made in anticipation of theproposed merger.
- Consultation with staff at SLHT has begun to place. It is expected that staff at SLHT would be integrated into the merged organisation.
- The Foundation Trust application has being put on hold until the integration is complete.
- Lewisham Healthcare Trust have launched a 'Business As Usual' campaign to let residents know that Lewisham Hospital is operating as normal at the present time. Also a staff survey has shown that Lewisham Healthcare Trust is in the top 20% of organisations where

workers would recommend Lewisham Hospital to family and friends if they needed treatment.
- The original TSA Special Administrator Matthew Kershaw has now moved on to be the Chief Executive of Brighton and Sussex University Hospitals NHS Trust. The new TSA Special Administrator is Caroline Taylor.

5.2 In response to questions, the Committee were informed that:

- The Due Diligence Process will examine the processes of the SLHT, including its finances. These will include questions such as PFI issues, governance issues, and impact on Lewisham Healthcare Trust's Risk Register.
- As part of the merger, there will be a 2-year plan to oversee the merger and it will include financial models and financial plans for Queen Elizabeth Hospital to deliver the merger and make it solvent.
- Lewisham Healthcare Trust has always been in favour of a merger with Queen Elizabeth Hospital. However the Secretary of State for Health's decision in relation to the TSA's recommendations has meant that the effect is unclear and will need to be analysed in terms of impact on services.
- In terms of re-employing those who have been made redundant from another healthcare organisation, SLHT has a Mutually Agreed Resignation Scheme. Once this is concluded staff will be identified for resignation. Therefore SLHT will have a list of staff who have been made redundant so the process will be very transparent,
- Lewisham Healthcare Trust is engaging with Queen Elizabeth Hospital staff about integrating them into the new proposed merged organisation.
- Lewisham Healthcare Trust commissioned an independent review with a healthcare provider on the usage of the current site. The review clearly showed that the TSA plans for the site were not feasible.
- In terms of the A&E Department decision by the Secretary of State of Health, modelling will have to be carried out to understand the clinical implications of treating up to 75% of the patients who currently use the A&E, alongside potential acute admissions.

5.3 **RESOLVED:** that the Report be noted, and 'Lewisham Hospital – Update' remains on every agenda for this municipal year to inform the Committee of developments when required.

6. Development of the Health and Wellbeing Strategy

6.1 Sarah Wainer, Head of Strategy & Performance, and Danny Ruta, Director of Public Health, NHS Lewisham, introduced the report and the following key points were made:

- It is a legislative requirement for Health and Wellbeing Boards to produce a Health and Wellbeing Strategy.

- The Council is committed to improving the health and wellbeing of citizens in Lewisham. In Shaping our future – Lewisham's Sustainable Community Strategy, one of the priority objectives that all partners will work towards is that the borough and its communities should be 'Healthy, active and enjoyable – where people can actively participate in maintaining and improving their health and wellbeing'.
- The engagement process has consisted of a number of events between December 2012-April 2013.
- Key messages arising from the engagement so far include:
    - The negative impact of social isolation on people's physical and mental health and wellbeing
    - The numerous barriers that hinder people from pursuing a healthy lifestyle, from cost and access to a lack of confidence to turn up and engage with existing activities.
    - The existence of a range of opportunities and activities, already provided within the community that could support people to feel healthier and maintain their independence.
- Lewisham produced its first Joint Strategic Needs Assessment, Health, Well-being and Care in 2010. It has subsequently produced an online version, accessible at www.lewishamjsna.org.uk. This has helped to form the priorities of the Shadow Health and Wellbeing Board.
- The CCG has worked to align its priorities with the key areas of focus identified by the Shadow Health and Wellbeing Board.
- The draft strategy has identified nine priority areas and they are as follows:
    - Increase the uptake of immunisation
    - Prevent the uptake of smoking among children and young people and reduce the numbers of people smoking
    - Reduce the harm caused by alcohol misuse
    - Promote healthy weight
    - Improve mental health and wellbeing
    - Improve sexual health
    - Delay and reduce the need for long-term care and support
    - Reduce the number of emergency admissions for people with chronic long-term conditions
    - Increase the number of people who survive colorectal, breast and lung cancer for 1 and 5 years.
- The priorities will be underpinned by specific interventions to ensure improvement is made in these areas.

6.2 In response to questions from Members, the following was noted:

- In respect of community representation, officers said that the Board will be asked to consider additional membership at its first meeting. There will also be an opportunity for people to sit on one of the

groups that support and feed directly into the health and wellbeing board.

- Feedback from all the engagement process will be collated, analysed, and will feed into the Action Plan.
- Review of the evidence contained in needs assessments has led to selection of the nine priority areas. This does not of course affect the work that continues to be done in other areas. In addition, the Strategy will be reviewed regularly.
- An objective will be to connect the strategy with the community and community groups, so it they can support the delivery of the strategy.
- Educating the public, and health professionals on health improvements is very important. Doctors do receive training on policies and protocols, for example the distribution of antibiotics.

6.3 **RESOLVED:** to make a referral to the first Health and Wellbeing Board meeting to:

a) welcome the development of the Health and Wellbeing Strategy.

b) recommend that the Health and Wellbeing Board specifically addresses the issue of engagement with service users, either through:

(i) appointments to the Health and Wellbeing Board; or
(ii) a second tier of user groups feeding directly to the Health and Wellbeing Board.

7. Changes in light of the Health and Social Care Act 2012 Report & Health Scrutiny Protocol (Revised)

7.1 Salena Mulhere, Overview and Scrutiny Manager introduced the report and the following key points were noted:

- The report lays out the organisational changes to the NHS and other bodies due to the enactment of the Health and Social Care Act 2012.
- The report notes that overview and scrutiny continues to have a statutory role to act across the whole health economy. In Lewisham, this will continue to be carried out by the Healthier Communities Select Committee.
- The original Health Scrutiny Protocol was agreed in the 2008-2009 municipal year. Its purpose is to agree how the various bodies would interact with the Committee as it exercised its statutory duties.
- The Protocol now needs to be revised in light of the changes enacted in the Health and Social Care Act 2012.
- If the Committee is in agreement to revise the Protocol, officers will work to bring a revised Protocol to the May meeting for confirmation.

7.2 In response to questions, the Committee were informed that:

- The Health Scrutiny Protocol is primarily concerned with local bodies in the health economy. However, this does not preclude other health bodies being invited and asked to give evidence to the Committee, as has been done on numerous occasions.

7.3 **RESOLVED:** that the Report be noted, and a draft Health Scrutiny Protocol be presented at the next Committee meeting in May.

8. NHS 111 – Update:

8.1 Diana Braithwaite, Director of Commissioning, Lewisham Clinical Commissioning Group, gave an update on the NHS 111 roll-out. The following key points were made:

- The NHS 111 areas that have been rolled out in South East London have been Bexley, Bromley and Greenwich, and this took place on 12 March.
- There have been some issues related to the roll out in these areas, leading to a delay in the NHS 111 rollout to Lambeth, Southwark and Lewisham.
- There have been improvements in the NHS 111 service since the initial problems.
- NHS Direct closed on 21 March, but it is still possible to contact SELDOC. They will be encouraging GPs to update their information so that patients are aware they can contact SELDOC now that NHS Direct is no longer operational.

8.2 In response to questions, the Committee were informed that:

- The South-East London Commissioning Unit is overseeing the roll-out of NHS 111.
- Committee members could be sent a more detailed briefing on the progress of NHS 111 since the roll-out began.
- A further NHS 111 update can be given at the Committee's May meeting to inform Members.

8.3 **RESOLVED:** that there be a further update on NHS 111 at the next Committee meeting in May.

9. Select Committee Work Programme 2013-14

9.1 Salena Mulhere, Overview and Scrutiny Manager introduced the report. The following key points were made:

- The proposed work programme for 2013-2014 is included in the agenda papers.
- Once all the work programmes are agreed, they will be presented to Business Panel so the work across the Select Committees is co-ordinated.

- The scoping paper for the Emergency Services Review is also included in the agenda papers. If the Committee agree to a carry out this review, all recommendations will be a collated with the other Select Committees who have agreed to participate in the review, and pulled together into an Overview and Scrutiny Emergency Services Review Report.
- If the duration of the Council was extended so that the local council elections were to coincide with the European Parliament Elections, an additional meeting of the Committee could be arranged as necessary.

9.2 Members suggested the following amendments to the work programme:

- HIV Services: be moved to the July meeting.
- Francis Report Update: an item to be added to the December meeting.
- Hepatitis B Update: should not be added to the Work Programme at this stage.
- Outcomes Based Commissioning: Members welcomed an informal an afternoon meeting with service users to be arranged for the afternoon of the July meeting.
- New Cross Gate Healthy Living: should be discussed at the next Agenda Planning meeting to decide if it needs to go to the next Committee meeting.
- Welfare Meals Contract: if there are substantive issues to be decided at the 1 May meeting of Mayor and Cabinet, Committee members should be sent the papers for that meeting.

9.3 **RESOLVED:**

a) the Committee agree the 2013-14 Work Programme, subject to the amendments outlined in 9.2.

b) the Committee agree the scoping report for its participation in the Emergency Services Review.

c) it was agreed that the items that would go the next meeting on 29th May 2013 will be:

- Emergency Services Review (evidence)
- CQC inspection Lewisham hospital and Local compliance manager update
- Community Mental Health Review
- Quality Accounts (Lewisham NHS and SLaM)
- Scrutiny Protocol
- NHS 111 – Update
- New Cross Gate Healthy Living (provisional)
- Lewisham Hospital - Update

10. Matters to be referred to Mayor & Cabinet

10.1 There were none. However it was agreed to make a referral to the Health and Wellbeing board as at 6.3:

a) welcome the development of the Health and Wellbeing Strategy.

b) recommend that the Health and Wellbeing Board specifically addresses the issue of engagement with service users, either through:

(i) appointments to the Health and Wellbeing Board; or
(ii) a second tier of user groups feeding directly to the Health and Wellbeing Board.

The meeting ended at pm 9.25pm.

Chair:

Date:

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Committee	Healthier Communities Select Committee	**Item No.**	2
Title	Declarations of Interest		
Wards			
Contributors	Chief Executive		
Class	Part 1	**Date**	29 May 2013

Declaration of interests

Members are asked to declare any personal interest they have in any item on the agenda.

1 Personal interests

There are three types of personal interest referred to in the Council's Member Code of Conduct:-

(1) Disclosable pecuniary interests
(2) Other registerable interests
(3) Non-registerable interests

2 Disclosable pecuniary interests are defined by regulation as:-

(a) Employment, trade, profession or vocation of a relevant person* for profit or gain

(b) Sponsorship –payment or provision of any other financial benefit (other than by the Council) within the 12 months prior to giving notice for inclusion in the register in respect of expenses incurred by you in carrying out duties as a member or towards your election expenses (including payment or financial benefit from a Trade Union).

(c) Undischarged contracts between a relevant person* (or a firm in which they are a partner or a body corporate in which they are a director, or in the securities of which they have a beneficial interest) and the Council for goods, services or works.

(d) Beneficial interests in land in the borough.

(e) Licence to occupy land in the borough for one month or more.

(f) Corporate tenancies – any tenancy, where to the member's knowledge, the Council is landlord and the tenant is a firm in which the relevant person* is a partner, a body corporate in which they are a director, or in the securities of which they have a beneficial interest.

(g) Beneficial interest in securities of a body where:-

(a) that body to the member's knowledge has a place of business or land in the borough; and

(b) either
(i) the total nominal value of the securities exceeds £25,000 or 1/100 of the total issued share capital of that body; or

(ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the relevant person* has a beneficial interest exceeds 1/100 of the total issued share capital of that class.

*A relevant person is the member, their spouse or civil partner, or a person with whom they live as spouse or civil partner.

(3) Other registerable interests

The Lewisham Member Code of Conduct requires members also to register the following interests:-

(a) Membership or position of control or management in a body to which you were appointed or nominated by the Council

(b) Any body exercising functions of a public nature or directed to charitable purposes, or whose principal purposes include the influence of public opinion or policy, including any political party

(c) Any person from whom you have received a gift or hospitality with an estimated value of at least £25

(4) Non registerable interests

Occasions may arise when a matter under consideration would or would be likely to affect the wellbeing of a member, their family, friend or close associate more than it would affect the wellbeing of those in the local area generally, but which is not required to be registered in the Register of Members' Interests (for example a matter concerning the closure of a school at which a Member's child attends).

(5) Declaration and Impact of interest on members' participation

(a) Where a member has any registerable interest in a matter and they are present at a meeting at which that matter is to be discussed, they must declare the nature of the interest at the earliest opportunity and in any event before the matter is considered. The declaration will be recorded in the minutes of the meeting. If the matter is a disclosable pecuniary interest the member must take not part in consideration of the matter and withdraw from the room before it is considered. They must not seek improperly to influence the decision in any way. **Failure to declare such an interest which has not already been entered in the Register of Members' Interests, or participation where such an interest exists, is liable to prosecution and on conviction carries a fine of up to £5000**

(b) Where a member has a registerable interest which falls short of a disclosable pecuniary interest they must still declare the nature of the interest to the meeting at the earliest opportunity and in any event before the matter is considered, but they may stay in the room, participate in consideration of the matter and vote on it unless paragraph (c) below applies.

(c) Where a member has a registerable interest which falls short of a disclosable pecuniary interest, the member must consider whether a reasonable member of the public in possession of the facts would think that their interest is so significant that it would be likely to impair the member's judgement of the public interest. If so, the member must withdraw and take no part in consideration of the matter nor seek to influence the outcome improperly.

(d) If a non-registerable interest arises which affects the wellbeing of a member, their, family, friend or close associate more than it would affect those in the local area

generally, then the provisions relating to the declarations of interest and withdrawal apply as if it were a registerable interest.

(e) Decisions relating to declarations of interests are for the member's personal judgement, though in cases of doubt they may wish to seek the advice of the Monitoring Officer.

(6) Sensitive information

There are special provisions relating to sensitive interests. These are interests the disclosure of which would be likely to expose the member to risk of violence or intimidation where the Monitoring Officer has agreed that such interest need not be registered. Members with such an interest are referred to the Code and advised to seek advice from the Monitoring Officer in advance.

(7) Exempt categories

There are exemptions to these provisions allowing members to participate in decisions notwithstanding interests that would otherwise prevent them doing so. These include:-

(a) Housing – holding a tenancy or lease with the Council unless the matter relates to your particular tenancy or lease; (subject to arrears exception)
(b) School meals, school transport and travelling expenses; if you are a parent or guardian of a child in full time education, or a school governor unless the matter relates particularly to the school your child attends or of which you are a governor;
(c) Statutory sick pay; if you are in receipt
(d) Allowances, payment or indemnity for members
(e) Ceremonial honours for members
(f) Setting Council Tax or precept (subject to arrears exception)

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Healthier Communities Select Committee			
Title	Emergency services review:	Item	3
Contributor	Overview and Scrutiny Manager		
Class	Part 1 (Open)	Date	29 May 2013

1. Purpose of paper

1.1 The Overview and Scrutiny Committee has agreed that its select committees will carry out a review of emergency services in Lewisham. The Healthier Communities Select Committee has been tasked with determining the potential impact of changes in relation to Hospital Accident and Emergency Services and the London Ambulance Service.

1.2 At its meeting in March, the Committee requested that officers provide further information about how it might approach this task. A scoping report was considered by Members at their meeting on the 16th April 2013 and it was agreed that the Committee would invite a relevant senior officer/clinician from Lewisham Healthcare NHS Trust, and Lewisham CCG, and Graham Norton, Ambulance Operations Manager Lewisham to attend the meeting. This paper sets out some of the key information required for the Committee's consideration of the fire service proposals.

2. Recommendations

The Committee is asked to:

- consider the content of the report and appendices, and direct questions to:
  - Graham Norton and Kevin Brown, London Ambulance Service
  - Lewisham CCG representative
  - Lewisham Healthcare NHS Trust representative

3. Background

3.1 Significant changes are being implemented, or are planned, to the way in which emergency services are delivered across London. This includes the three local emergency services in Lewisham: Metropolitan Police, London Fire Brigade and the London Ambulance Service; and also the provision of accident and emergency services across South-East London.

3.2 At its meeting on the 11 February 2013 the Overview and Scrutiny Committee considered a scoping report, which set out the terms of reference for a review into emergency services in Lewisham. At the meeting, it was decided that the review would be co-ordinated across all select committees. Members of the O&S Committee considered the proposed terms of reference and they agreed that the review would aim to:

- clarify the key policy initiatives and financial constraints impacting on emergency services locally
- identify the local implications for services
- consider the potential impact of any service changes

3.3 As part of the review, the Committee resolved that the Healthier Communities Select Committee would:

- Clarify the policy initiatives and financial circumstances impacting on the London Ambulance Service and A&E provision in Lewisham
- Identify the related impact on services and performance locally
- Consider the potential impact of any service changes

4. Key lines of enquiry

4.1 The terms of reference for the review have been established by the Overview and Scrutiny Committee. The terms agreed for the Healthier Communities Select Committee are to:

- Clarify the policy initiatives and financial circumstances impacting on the London Ambulance Service and A&E provision in Lewisham
- Identify the related impact on services and performance locally
- Consider the potential impact of any service changes

4.2 The scoping paper agreed by the Committee in April 2013 suggested that these key questions could be asked as part of the review:

<u>Perception</u>

- How will people be reassured that they will continue to be safely treated at the most appropriate location?
- How will information about potential service changes be effectively communicated to people?
- How is information about the appropriate place to go to for healthcare needs effectively distributed and communicated?
- How will perception of proposed changes be effectively dealt with?
- How will the maternity proposals impact on emergency provision in relation to maternity circumstances
- Will the emergency maternity changes impact on routine ante natal care and patient choices in relation to ante natal care

<u>Response</u>

- Has modelling been carried out on patient flows and patient numbers across Lewisham A&E and other South East London A&Es to map expected service usage over coming years?
- Do neighbouring A&E services have the capacity to take on a potential increased number of patients from Lewisham?
- Could the proposed changes have a negative impact on A&E services across South East London, and particularly at neighbouring hospitals?
- Could the proposed changes have a negative impact in relation to maternity services provision across South East London?
- How might increased travelling to A&Es out of the borough impact on the LAS response times ?
- How are LAS responding to the proposed changes to Lewisham Hospital A&E in terms of service planning?

<u>Partnership</u>

- Would there be any impact on effective discharge planning and after care if a greater number of patients are treated outside of the borough in an emergency?
- How will work be undertaken to ensure effective working is developed with a range of hospitals in relation to discharge and ongoing care?
- Will the "outstanding" safeguarding procedures and partnership working currently in place be impacted by changes to the Lewisham hospital A&E?
- Will local commissioners be able to effectively influence service design and delivery in emergency care across a number of trusts in a number of neighbouring boroughs?

Travel

- What might be the travel implications for people travelling to A&E under their own steam?
- What would be the impact on traffic and congestion on the roads with people travelling further for services and to visit relatives?

Future

- How will the potential future population increases and demographic changes influence emergency service requirements and provision across the borough?
- Has future population growth been factored into service planning for the future?
- How might the current proposed changes influence the future sustainability of healthcare services at the hospital site and in the borough?

5. London Ambulance Service proposals

5.1 On 25 April 2013 London Ambulance Service (LAS) announced it will receive an extra £7.1m this year from its commissioners to recruit 240 frontline staff to help improve levels of care to patients amidst ever increasing demand. Chief Executive Ann Radmore said: "Whilst we have been providing a good service to patients with life-threatening illnesses and injuries, increased demand has meant not everyone is getting the level of care they should from us, and many are waiting too long for our help. We know this needs to change, and that is backed up by what our patients and staff are telling us."

5.2 The additional funding will enable the service to continue to work towards having a paramedic on every emergency vehicle. This will be supported by using the additional funding to recruit more A&E support staff to introduce a model of care used in other ambulance services, where paramedics work alongside support staff on ambulances. LAS feel that this way of working will mean more patients will be treated by a paramedic, and it will increase ambulance cover locally so that patient waiting times are reduced."

5.3 LAS has developed a range of plans which it feels will enable it to operate more efficiently in the future to help manage anticipated increases in demand, and is planning to make changes to the way it responds to some 999 calls as well as introduce new working arrangements for its frontline staff. Plans include:

- reducing the number of times more than one vehicle is sent to a call when it is clinically safe to do so
- providing more clinical advice to callers over the phone when it is the most appropriate way to help them.
- Changes to staff's shift patterns and annual leave arrangements to ensure sufficient staff are working at times of highest demand and opportunities for training and development are increased.

5.4 By bringing in changes that increase capacity, LAS feel they will also be able to reduce the use of private ambulance services to support the provision of patient care. The Service will receive a further £7.7m to help maintain levels of patient care through the year while staff are recruited and the changes are introduced.

5.5 LAS have published a document outlining the plans for public consultation, the consultation formally ends on Friday 24 May 2013. The plan is attached at appendix A.

6. Accident and Emergency Services

6.1 On the 31st of January 2013 the Secretary of State for Health decided that the Accident and Emergency Department at Lewisham hospital would be reduced in size, with the most urgent cases being taken to other hospital sites across South East London. It was also decided that Lewisham Healthcare NHS Trust would take over the management of the Queen Elizabeth Hospital, which is currently part of the South London Healthcare Trust which is being dissolved. Those decisions were based on the report and recommendations of the Trust Special Administrator (TSA), Matthew Kershaw, who had been charged with developing recommendations for dealing with the failing South London Healthcare NHS Trust, based in neighbouring boroughs.

6.2 Lewisham Council has issued an application for judicial review of the decisions of the Secretary of State for Health and the Trust Special Administrator in relation to the Lewisham Hospital A&E in the High Court and has already succeeded in delaying implementation of any changes to Lewisham Hospital. The Council is asking for the court to review the recommendations of the Trust Special Administrator (TSA) affecting Lewisham Hospital and the subsequent decision to accept those recommendations by the Secretary of State for Health.

6.3 The Council has also secured an undertaking that no service changes affecting Lewisham Hospital as a result of the Secretary of State's decision will be implemented before the matter has been dealt with by the court.

6.4 On 15 May 2013, the College of Emergency Medicine published a report entitled: The drive for quality, How to achieve safe, sustainable care in our emergency departments. The report calls for fundamental change in the way emergency care systems are designed, funded and managed. Ten recommendations are made across 4 domains which, the College of Emergency Medicine fee, must be considered and adopted by national policy makers, commissioners, clinicians and Trust Boards in order to "stabilise" emergency medical services and deliver high quality care. A summary of the report is attached at appendix B.

6.5 Also on 15 May 2013, the Foundation Trust Network also issued a statement calling for changes to the organisation of and funding of emergency services. The full statement is attached at appendix C

7. Further implications

There are no legal, financial, sustainability, equalities or crime & disorder implications resulting from the implementation of the recommendation in this report, however, there will be implications arising from the changes being proposed.

Appendix

Appendix A: LAS Our plans to improve the care we provide to patients
Appendix B: College of Emergency Medicine report: The drive for quality, How to achieve safe, sustainable care in our emergency departments
Appendix C: Foundation Trust Network statement 15 May 2013

If you have any questions about this report please contact Salena Mulhere (Overview and Scrutiny Manager) on 0208 314 3380.

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London Ambulance Service NHS
NHS Trust

Our plans to improve the care we provide to patients

Dear Colleague

As a number of you have told me, it is increasingly apparent that we need to work differently to enable us to provide a safe and high-quality service to our patients in the future.

We also need to make the very best use of every penny we are given. And by working differently and more efficiently, we will be able to reduce the pressure on you at a time when demand on our Service continues to increase.

Part of doing things differently will also be about starting conversations across the whole organisation about how we engage with one another and what kind of ambulance service we want to be in the future.

This document explains some of the changes we are planning and why. We all have a part to play in making them happen, and I am keen to hear your views on how we achieve these changes in a way that sustains delivery of safe, high-quality services for patients and delivers an improved working environment for you, our staff.

I know that change can be difficult and may directly affect some of you. I want to assure you that we will do all we can to support you through this time of change.

Ann Radmore
Chief Executive

Contents

The clinical case for change

The face of London is changing, healthcare is undergoing the biggest reconfiguration that has ever been seen, and the financial challenges facing the NHS are significant. At the same time, patient expectations and demand on health services are increasing.

As an emergency and urgent care provider, the London Ambulance Service has an ever increasing role to play in helping patients and supporting the delivery of the vision for healthcare in London and the wider NHS. This includes making sure we can play our part in the delivery of high-quality and safe care in London's acute emergency and maternity services as described in the London Health Programmes' case for change[1].

Against this background, we need to change how we use our workforce to ensure that the quality of care we provide to patients continues to improve whilst delivering it in a more efficient way.

This clinical case for change describes why we need to change, what we are going to change and what the London Ambulance Service will look like in 2015 for both our patients and our workforce.

Dr Fionna Moore
Medical Director

Steve Lennox
Director of Health Promotion and Quality

[1] London Health Programmes: 'London Quality Standards - Acute Emergency and Maternity Services'. February 2013

Why now?

Our staff, patients and stakeholders have been telling us for some time that we need to change, and we really need to do things that benefit patients and improve outcomes.

In addition, the recently published Francis report into the deaths at Mid Staffordshire NHS Foundation Trust highlighted that there are many issues which are a trigger for change for all NHS services.

Our Service is facing increasing levels of demand, with 999 calls into our control room up on last year and our staff responding to four per cent more incidents overall. We have been providing a good level of service to our patients with life-threatening illnesses and injuries, despite attending 12.5 per cent more of these patients. However, few of the patients who access emergency health services have life-threatening conditions. We know these patients need a response, and we are being asked to play our part in managing patients differently.

Whenever we can, we need to address a patient's needs at the point of contact and avoid taking them unnecessarily to hospital. But some of our patients who have less serious conditions and do need an ambulance response have to wait longer for our help than they should.

On a normal day, frontline staff spend over 85 per cent of their time dealing with patients, compared with 65 per cent in other ambulance services. Essentially, this means staff are extremely busy throughout their entire shift. And we recognise that our control room staff come under immense pressure when we are busy and are holding high numbers of calls.

As a result staff are feeling the pressure, and those who work on the frontline are not getting regular breaks during shifts and have difficulty being released for training.

With demand expected to continue to increase, it is clear that change is needed if we are to maintain a safe and high-quality service for our patients and good working conditions for staff in the future.

Significant changes within the NHS in England came into effect on 1 April 2013. Key amongst those changes is the fact that our services are now commissioned directly by GPs who both want and expect that we spend the money they give us wisely to ensure the best possible outcomes for their patients.

More broadly, we see the changed system as an opportunity to engage with the wider health and social care system and, as the sole pan-London healthcare provider, to become an influential voice in shaping the future of healthcare in London.

As services are being reconfigured across London and new services are developing, for example NHS 111, we must not only work closely with our partners, but we must also ensure that as an organisation we are appropriately resourced, with staff who are trained and equipped to deal with the challenges the future may bring.

The changes we are proposing will not happen overnight and they will be challenging. But, as we start to do things differently, we will see longer term benefits for both patients and staff. For patients this will mean they receive more appropriate and timely treatment from us, leading to better outcomes for them. Staff will benefit from being less busy and will have greater opportunities to increase their clinical skills through better access to education and development within a clearly defined career structure.

We believe that the proposed changes to our clinical workforce will provide Londoners with an ambulance service which, by 2015, can respond to their needs, and which staff can be proud to work for.

By 2015:

- Every patient who rings 999 will have a response within one hour – either by telephone assessment or an ambulance attendance.
- Our rosters will enable us to match ambulance availability with 999 call demand.
- We will have established close working relationships with clinical commissioning groups to identify gaps in service and improve access to appropriate healthcare options.
- Patients will experience a seamless referral to appropriate providers, for example, NHS 111, crisis and falls teams.
- Every patient who requires a face-to-face assessment will be attended within an hour by a paramedic with enhanced assessment skills who has the right training and experienced clinical support.
- On scene senior clinical support will be provided to staff where needed.
- Staff will benefit from an embedded clinical career structure, education and regular meaningful feedback and appraisals.
- We will be less reliant on private and voluntary ambulance services as we will have recruited more staff.

Three questions

In considering whether and how we need to change the way we deliver our services in the future, we asked ourselves three questions:

- How can we change the way we deliver ambulance services to improve the quality of care and outcomes for all patients?
- How can we ensure that every patient who rings 999 receives a response in a clincally appropriate time?
- Is no change an option?

Currently not all our patients receive as timely and appropriate a response as they should; an example of this is Emily.[2]

Emily's story

Emily lives alone and is frail, elderly and vulnerable. For her, every day that she manages to maintain her independence is a day to celebrate. But today she is lying on the floor having tripped over a loose carpet. This is not the first time she has fallen. She is anxious that the authorities will assess her as vulnerable and admit her to a care home because she can no longer cope.

Emily doesn't know who to call for help. Her daughter lives some miles away and she can't reach her address book. Finally, she grabs at the telephone cord to drag the phone over and dials 999.

She asks for an ambulance, answers a set of questions, and waits. As time passes Emily notices the daylight fade. The electric fire is in the other room and she is becoming colder with every passing minute.

To Emily, it seems a terribly long time since she called 999. Initially she is able to fight off the thought she may have been forgotten, but as time passes she fears being left to die on the floor.

Truly frightened, cold and tired she dials 999 once more.

Our ambulance crews finished their busy shift 30 minutes early as they have not had a break during the day. We have

[2] All patient stories are based on real events although names and some details have been changed to protect their identities.

no resources available because calls to people with life-threatening illnesses and injuries are up six per cent.

Our clinician in our 999 control room grows increasingly concerned about Emily, aware that elderly fallers who wait more than an hour for help have a significantly worse outcome.

Eventually an ambulance crew are sent who are very caring and supportive to Emily. After a full assessment they do not find any injury or acute medical problem. They try to refer Emily to a falls team or her GP, but given the time of day they are unable to do so. Emily is, therefore, taken to hospital.

Our staff will be very familiar with Emily's story. There is a widening gap between the response time and care that we provide to our most seriously ill and injured patients, and those whose clinical need is initially assessed as less urgent.

Every day patients with no immediately life-threatening symptoms will wait too long for help, and every day patients or their relatives tell us of their experience. Every week our frontline staff raise concerns relating to delays in reaching patients, and every month we investigate one or two serious incidents where patients have waited too long for help.

Would you be happy with this response and care if Emily was your mother or grandmother?

We believe that every patient who needs an ambulance should receive one in a time frame appropriate for their condition, and no one should wait more than one hour for either an enhanced telephone assessment or an ambulance.

Responding to non life-threatening urgent calls

Some of the care we provide is excellent and amongst the best in the world. We have proven we can deliver change, for example, through working with other health partners to introduce London's trauma, cardiac and stroke networks.

We respond extremely quickly to calls that are prioritised as life-threatening or an emergency, but every patient who dials 999 and requires an ambulance should receive one in a timescale appropriate to their clinical need.

We know that some healthcare professionals believe we over triage our calls and that, if we addressed initial telephone assessment, we could use our resources more effectively. We are very aware that the patient who is ringing 999 believes they are in an emergency situation. It is our responsibility to assess their clinical need and deal with their call in the most appropriate way.

Not every 999 call needs an ambulance within eight minutes, but every patient should get a response either face-to-face or by telephone within one hour. By 2015, every patient needing a face-to-face assessment will be attended by a paramedic with enhanced assessment skills who has the right training and experienced clinical support.

Our cardiac arrest patients have the best outcomes in England. The outcomes for our less sick and seriously injured patients must be to the same high standard.

Relayed by a friend, this is the story of a cyclist who received a delayed response from us.

A cyclist's story

"I rang your service to request an ambulance for a friend of mine who had fallen off his push bike and had obviously damaged his leg. We later found out he had dislocated and fractured his ankle.

"He was in extreme pain and got very cold as he was lying on the pavement. We waited for over an hour having been told that no estimated arrival time could be given.

"In desperation, as I feared hypothermia was setting in, I flagged down a fire engine. They were of great help and support. They too rang for an ambulance and fortunately one arrived within 10 minutes.

"Once they arrived on scene the ambulance crew were excellent and professional and after treating my friend on site we were taken to hospital."

Whilst we have some of the lowest number of complaints on issues such as privacy and dignity in the whole of London, those about delayed responses now account for 40 per cent of our total complaints.

We respond to a significant number of our patients categorised as C1 or C2 within one hour (either with an ambulance or a telephone assessment), but too many of our Category C3 and C4 patients wait for over an hour and often much longer for a response.

Call categories and examples

Category A: Immediately life threatening needing an ambulance response within eight minutes – for example, a patient in cardiac arrest.

Category C1: Include diabetic patients who are confused due to a low blood sugar, requiring an ambulance response within 20 minutes.

Category C2: Traumatic injuries with no primary symptoms (for example, patients who are conscious and able to talk, and with no evidence of serious bleeding), needing an ambulance response within 30 minutes.

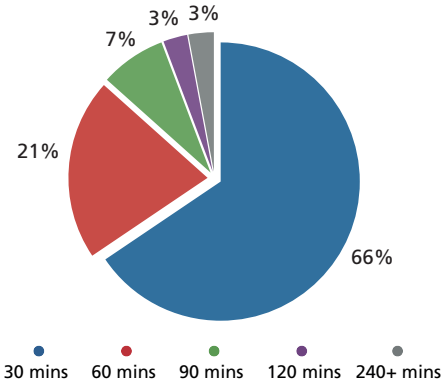
Category C3: Include some abdominal pains and headaches where the patient is fully alert, requiring an enhanced telephone assessment within 30 minutes.

Category C4: Include minor cuts, nosebleeds and back pain with no injury, needing an enhanced telephone assessment within 60 minutes.

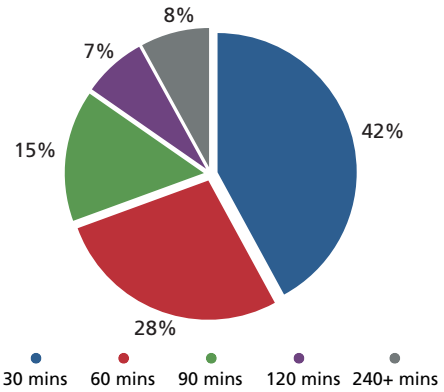
These lengthy waits can, and do, lead to patients becoming distressed and potentially more unwell. In some cases, this will also impact on their families and friends.

As patients become more anxious waiting for an ambulance, they understandably call us back. This increases the workload on our call handlers and the risk of a delay in answering a Category A call.

Category C3 response times (mins)



Category C4 response times (mins)



Last winter, some of our mental health patients waited up to six hours for a response. The distress and anxiety this causes to the patients and their carers is difficult to quantify, but the complaints we receive serve as a reminder that this is a real issue. Take Daniel's story for example.

Daniel's story

Daniel has a history of depression. He is feeling particularly vulnerable and even the routine elements of the day, such as dressing and eating, are simply too much. He feels a complete burden and utterly helpless and today he is unable to see a way out.

It is a bank holiday weekend and Daniel's usual community team are not contactable. He is unaware of how to contact a crisis team. His friends have gone away for the weekend and Daniel does not want to burden them.

Daniel becomes desperate – he does not know who to contact for help. He turns to Facebook to share his thoughts and feelings with friends.

Luckily a friend reads his online posts and contacts Daniel to persuade him to call 999 for an ambulance.

Daniel eventually calls us and he gives a vague history of feeling anxious at the point of the call – he finds it difficult to verbalise his distress. After being assessed, he is allocated a 20-minute response as our call-taker is concerned for his welfare. The lack of clarity of the problem made this call unsuitable for transfer to NHS 111. Twenty minutes pass, 30 minutes, then 40 minutes. We are still unable to identify a resource to send to Daniel. Our

clinicians within the control room try to contact him to check on him.

Concerned that Daniel doesn't answer our call, the clinicians upgrade the initial call to an emergency, requiring an eight minute response. A resource is assigned but gets cancelled to attend a cardiac arrest. We finally reach Daniel 90 minutes after his first call.

So how do you think this story ended?

There are several possible outcomes to this real life story. Daniel could have taken an overdose which, in addition to the mental distress he was suffering, may have meant he needed medical attention before a mental health assessment. But, if Daniel had not harmed himself, did he need to be taken to a busy emergency department?

By 2015 we will have established reliable ways to access alternative healthcare options that provide the most appropriate care for patients in the right place, at the right time.

By 2015:

- Every patient who rings 999 will have a response within one hour – either by telephone assessment or an ambulance attendance.
- We will have established close working relationships with clinical commissioning groups to identify gaps in service and improve access to alternative healthcare options.
- Patients will experience a seamless referral to appropriate alternative providers, for example, NHS 111, crisis or falls teams.
- Every patient who requires a face-to-face assessment will be attended by a paramedic with enhanced assessment skills who has the right training and experienced clinical support.

A skilled clinical team

If we are to deliver high-quality services to all our patients by 2015, we need to change the way we operate because we are currently not able to deliver the quality of care that everyone should receive.

It is our call handlers who hear the distress and anxiety that delays cause, as they hold 999 calls during busy periods when we do not have adequate staffing levels to meet demand.

Often, by the time an ambulance reaches a patient, they are frustrated and are less receptive to being referred to an appropriate place of care, and end up being taken to hospital.

The availability of our staff is, amongst other things, related to current annual leave and rest break arrangements, rosters which limit our ability to match 999 call demand, and the make-up of our frontline workforce. This means not every incident receives an ambulance in a clinically appropriate time frame and we have become over-reliant on overtime and contracted services to maintain safe levels of care.

To improve patient care, we need to make changes to how we use our staff. And many of the changes we are proposing have been adopted by other ambulance services.

Our commissioners are providing additional investment which will enable us to recruit more staff, but it is not just about having additional people, it is about how we ask those people to provide our services.

If we are asking our staff to work in different ways, then we need to ensure that they receive appropriate education and training, and that they have a career with the Service that meets their personal and professional aspirations.

Our staff are our key resource. For many, particularly frontline staff, joining the London Ambulance Service is about embarking on a career. And for this reason, a clinical career structure and appropriate training and supervision are essential.

It is understandable, therefore, that there is frustration amongst staff about the lack of progress with implementing a clinical career structure as exists in medicine or nursing. This has, in some cases, resulted in staff leaving to pursue other careers or work for other ambulance services where clinical leadership opportunities exist. Additionally, the lack of education and meaningful appraisals and feedback has led to a demoralised and underdeveloped workforce.

We are committed to delivering a clinical career structure as part of our modernisation programme. This will provide our crews with the opportunity

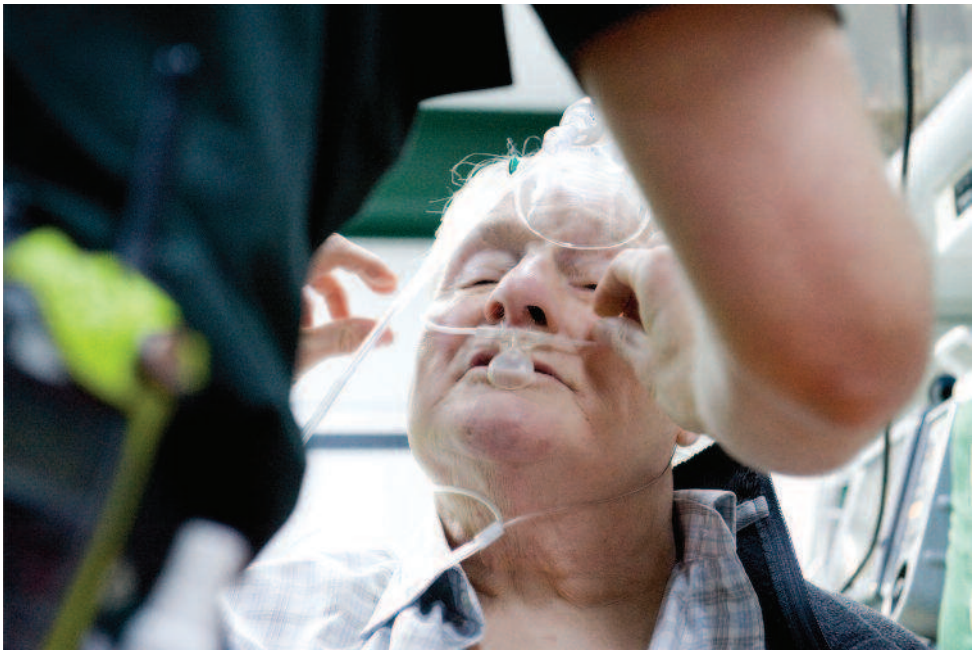
to progress to roles of clinical team leader, advanced paramedic and consultant paramedic – roles that provide clinical support and supervision remotely by telephone and on scene when needed. And we will improve education opportunities and supervision.

The additional education will ensure that paramedics are confident to work as autonomous healthcare practitioners and are recognised as such by other healthcare providers.

We have a leading clinical audit and research unit, and through their work we will continue to develop the clinical care we provide which will improve healthcare outcomes. This will include, but not be limited to, monitoring the quality of care and patient outcomes, with regular reports on stroke, cardiac arrest, heart attack and trauma, providing feedback on documentation and developing research within pre-hospital care. All our frontline staff will be encouraged and supported to undertake audit and research and play an active role in governance.

By 2015:

- On scene senior clinical support will be provided to staff where needed.
- Staff will benefit from an embedded clinical career structure, education and regular meaningful feedback and appraisals.



What will this mean for our patients in 2015?

In the future, every patient will be responded to in an appropriate time frame for their clinical condition by a registered paramedic who has received appropriate training in enhanced clinical assessment and has the right equipment to undertake their assessment. Paramedics will be supported by A&E support staff who have received additional training to work alongside them.

By ensuring a paramedic is on every ambulance we believe that outcomes will be improved and more appropriate referrals will be made.

There will be additional clinical support available at the scene as well as by telephone; this will also improve the quality of care we provide and patient outcomes.

We need to improve public understanding of how we manage 999 calls, and change the public's expectations of what service they will receive from us. We also need to move away from being seen as an emergency transport service to an organisation that provides an urgent assessment, health promotion and referral to appropriate services.

Every patient must receive the right care, at the right time, in the right place.

What will this mean for our staff in 2015?

Staff will benefit from an embedded clinical career structure, education and regular meaningful feedback and appraisals.

On scene senior clinical support will be provided to staff where needed.We will be less reliant on private and voluntary ambulance services as we will have recruited more staff.

Further details of the changes to how we will educate and use our staff are given later in this document.

So what will be different in 2015 for Emily, the cyclist and Daniel?

Emily will:

- be responded to within an hour, whatever time of day
- be assessed by a paramedic supported by A&E support staff who will have received additional training
- be referred to her GP and a falls team who will be able to adjust her care so that she can stay in her own home
- have an improved outcome without having to be taken unnecessarily to hospital
- have no risk of infection or a prolonged stay in hospital
- be able to be assessed in her own home, and supported to stay there.

The cyclist will:

- receive an ambulance within 20 minutes
- be assessed by a paramedic supported by A&E support staff who will have received additional training, and possibly additional senior clinical support
- be given pain killers before being transferred to a local trauma unit.

Daniel will:

- have an enhanced telephone assessment within 30 minutes by a registered healthcare professional who can access relevant information from his special patient notes
- be referred for a mental health assessment by his community team without needing to go to hospital, if there is no medical problem
- be taken to the local hospital which has a co-located mental health liaison team, if there is a medical problem
- have his GP informed, with his permission.

Delivering care differently

As an organisation, we need to make a number of changes which will enable us to provide better care for our patients. It is anticipated that it will take up to two years to bring in all the changes and realise the benefits from them.

The change programme will involve:

- adapting our frontline workforce
- introducing a clinical career structure
- providing more telephone clinical assessments for less serious calls
- aligning rosters with demand
- providing rest breaks
- changing annual leave arrangements
- increasing vehicle availability
- extending the use of active area cover
- responding differently to patients

Adapting our frontline workforce

We are moving towards having more care overseen by registered paramedics, bringing us in line with other healthcare professions where registered professionals, such as GPs, registered nurses and therapists, always oversee and take responsibility for care. This also supports recommendations within the recently-published Francis report into Mid Staffordshire NHS Foundation Trust.

Our qualified staff have the freedom to make decisions based on a patient's individual needs rather than prescribed protocol. In the future, we will have a model which makes best use of the additional knowledge and skills that registered paramedics bring to patient care, ensuring more patients get the right care, first time.

To achieve this, we will need to crew paramedics and A&E support staff who have received additional training together on emergency ambulances, and, in time, all our single responders will be paramedics.

As well as ensuring that a paramedic will supervise every patient who needs an ambulance response, this way of working will increase ambulance cover locally, reducing patient waiting times. These changes will also enable us to

work more efficiently because we will be able to safely reduce the number of resources we send to calls.

Existing A&E support staff will receive additional training, so that they can attend a wider range of emergency calls alongside paramedics, providing greater job satisfaction. They will be able to provide cover across the full range of shifts, making them a more integral part of the Service.

Crewing paramedics with appropriately trained A&E support staff is now a nationally accepted model of care, which has already been adopted by most other ambulance services. We will increase paramedic numbers to be able to work this way.

We have not recruited to the emergency medical technician role for some years. There are opportunities available for technicians who want to train to become a paramedic. Alternatively, if they work on the frontline, they will be able to continue working within their existing scope of practice.

What does this mean?

- We are receiving extra funding this year to increase frontline staff numbers.
- In the future our emergency ambulances will be staffed by a paramedic with a member of A&E support staff with additional training, or an emergency medical technician or an apprentice paramedic.
- A&E support staff will be given additional training to fulfil this role. They will develop their skills in emergency care including dealing with trauma-related injuries, treating wounds and fractures and looking after patients with possible spinal injuries.
- In the future, only paramedics will respond in cars, on motorbikes and on bicycles. Changing to the new workforce model will take time, however, and until paramedic numbers have increased emergency medical technicians will continue to work as single responders.
- These changes will require some staff to move from their current place of work and everyone could have to work with different colleagues.

Introducing a clinical career structure

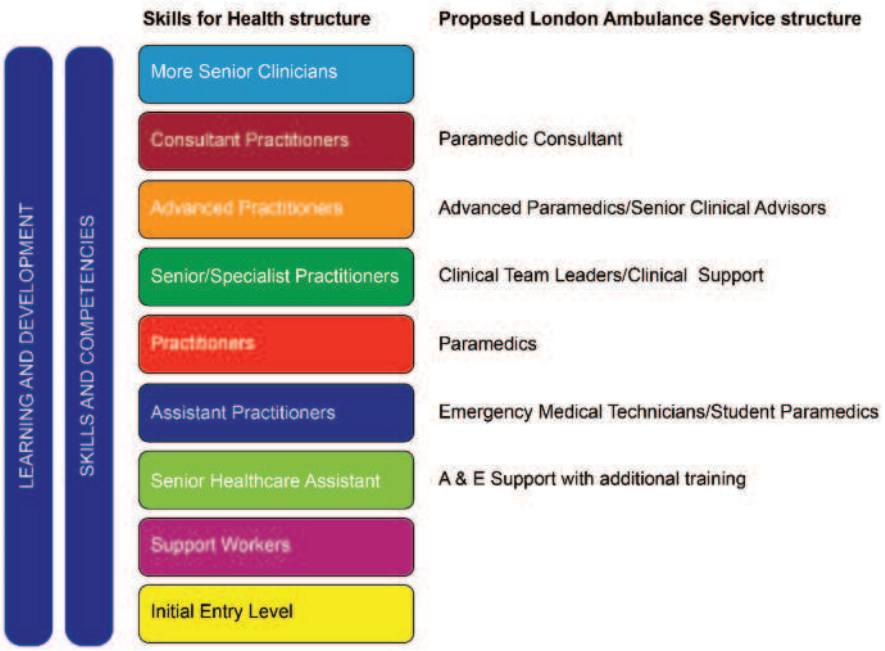
We are committed to introducing a clear clinical career structure so that our frontline staff are able to develop their clinical skills and progress their career within our Service.

Providing a range of career options will also enable us to respond better to emerging patient needs and changes in local health service provision. Our clinical career structure will support the recommendation from the Francis report for organisations to provide a leadership framework that puts patient safety, accreditation, development, common standards of competence and compliance at its heart.

Our starting point is illustrated by the diagram below which shows a range of potential ambulance roles aligned with the national clinical career structure developed by the sector skills council for health, Skills for Health.

We will work with clinical staff across the organisation to identify the best way to bring in this proposed structure.

Suggested clinical career structure



Providing more telephone clinical assessments for less serious calls

Many of the 999 calls we receive are to patients who do not have life-threatening injuries and illnesses, and who do not need an ambulance crew to attend. Instead they can be given a full clinical assessment over the phone and safely be offered advice, or redirected to other healthcare providers.

This means they get the right care first time around without unnecessary trips to hospital, and patients with more serious conditions who need an ambulance response will get care more quickly.

We have secured funding to increase staffing levels in our clinical hub – which includes the clinical support desk and clinical telephone advice teams – so that we can provide an enhanced assessment over the phone for more patients who are categorised with less serious conditions.

Staff in the clinical hub will review patients where the call is categorised as C3 and C4 and will continue to provide additional clinical oversight for other categories of calls.

To reduce waiting times for these patients, we have worked with our commissioners to agree more clinically-appropriate response times for patients dealt with by the clinical hub who are identified as needing a face-to-face assessment.

What does this mean?

- We will increase staffing levels within the clinical hub – which includes the clinical support desk and clinical telephone advice teams.
- There will be a separate consultation for staff who work in the clinical telephone advice team, starting in May 2013, about the planned changes to how we offer telephone advice in the future.

Aligning rosters with demand

Changes in demand mean that current rosters no longer provide us with sufficient frontline staff at the times that our patients really need us, particularly in the evening and at weekends.

We have hundreds of different rosters across the Service, many of which are not flexible enough to provide cover when it is needed.

Working with staff and a specialist company, we will be introducing a roster system that will align shifts with demand so that patients get a good service, no matter where they are across London and what time of the day they call us. There will need to be a greater mix of shift lengths to achieve this, though there are no plans to move to a full eight-hour shift pattern.

Importantly, training time will be protected in the future. Staff will be given an 'individual learning account', through which they will be able to book themselves on to core skills refresher training.

The new rosters will be designed with staff by the end of November 2013, and will be fully implemented by the end of March 2014, once we have recruited enough staff to cover them.

As staffing numbers increase, we will become less reliant on using private ambulance services.

What does this mean?

- We will use the detailed information about demand, obtained through a recent independent review, to identify the cover needed at each station. And working with staff and a specialist company, we will develop rosters that provide this cover using the existing jointly-agreed framework.
- Working arrangements for current relief staff will be reviewed and improved to ensure fairer distribution of work and more flexibility for this group of staff.
- These changes will require some staff to move from their current place of work and everone could have to work with different colleagues.

Providing rest breaks

Frontline staff tell us that very few of them receive a break during their busy shifts. And the existing arrangements, which restrict breaks to ambulance stations, mean that many staff who are allocated a break have it cancelled because they receive another call on the way back to their station.

Currently, staff are allowed to finish before the end of their rostered shift if they are not given a break. This means that during shift change over periods (6am to 7am and 6pm to 7pm) we don't have enough staff available to respond to calls and many patients have to wait too long for our help.

We plan to introduce new rest break arrangements by the end of June 2013. By early 2014, once we have increased staffing levels and new rosters are in place, we expect to see many more frontline staff benefiting from the break they are entitled to. This will help to ease the pressure on staff.

Importantly, the new arrangements will mean we will be able to give our patients a good service, whatever time of day it is.

What does this mean?

- Someone working a shift between six and 10 hours long will get a 30 minute break; the first 20 minutes are unpaid and uninterruptible, and the final 10 minutes are paid time and may be interrupted for the most serious calls (Red 1) where no other resource is available. Someone working a shift of 10 hours or more gets a 45-minute break. The first 30 minutes of the break is unpaid and uninterruptible; the final 15 minutes of the break is paid time and may be interrupted for Red 1 calls where no other resource is available.
- The decision to stand staff down for breaks lies with control room staff and existing software will be used to allocate the breaks.
- Rest breaks will be allocated at the location the crew becomes green and available, and within a specific window of time.
- Once on a break, staff can spend the time in whatever way they wish, and wherever they wish, provided that they are ready and available for work at the end of the unpaid period.
- In the event that no rest break is given, staff will be entitled to compensatory time for the unpaid element of their shift (20 or 30 minutes), and this should be taken within 13 weeks.
- No compensatory payments will be made.

Changing annual leave arrangements

Our annual leave arrangements for frontline staff do not give us the flexibility we require to meet demand and often leave us with insufficient cover to provide the level of service patients need from us, particularly at weekends.

Up to 15 per cent of staff at a complex are granted leave based solely on total staff numbers that should be employed at that complex. However, this does not take account of roster patterns, vacancies, or staff who are already absent through sickness, maternity leave, training etc, meaning absence levels are often much higher than they should be. Sometimes they are as high as 50 or 60 per cent, which impacts on patient care and puts additional pressure on those staff who are working.

We will introduce a system that provides us with cover when it is most needed whilst enabling staff to take their full leave allocation during the year.

Staff will find it easier to manage their leave entitlement and will have the opportunity to take all their leave, and managers will be encouraging them to do so. The amount of leave that staff carry over into their next leave year will be brought into line with support directorates and will reflect the arrangements across the wider NHS. The maximum amount of time that can be carried over will be, in exceptional circumstances, up to 37.5 hours.

What does this mean?

- A new web-based system will make it easier for staff to request and keep track of their annual leave using a secure login.
- A minimum of two weeks' notice will be expected. Requests made with less than two weeks' notice will only be considered by the on-duty management team; the resource centre will not be able to grant these requests.
- Annual leave will be allocated based on a percentage of hours produced by staff to cover all ambulance complex rosters for each day. To ensure the even spread of leave across shifts, this will be allocated by all shifts across the complex for the day.
- Any compensatory time that is accrued in lieu of rest breaks will be deducted from any request for annual leave. If a member of staff's time in lieu does not cover the shift, annual leave will be used to make up the shortfall.
- The resource centre will action leave requests within 24 hours of receipt.

Increasing vehicle availability

By having more vehicles available, we can offer a better service to patients. We need to ensure that our vehicles are more readily available and better prepared for frontline staff 24/7.

Compared to other ambulance services covering urban areas, we have high 'vehicle off road' rates. We plan to increase vehicle availability by reducing overall downtime (the number of hours that are lost because vehicles are off the road for repair, restocking, cleaning, missing equipment and staff welfare) by 0.5 per cent to 5.1 per cent by the end of June 2013. We will continue to reduce downtime each year so that by March 2018 we achieve a maximum of four per cent.

To improve levels of service to operational staff, we are setting up a dedicated unit at Bow that will be a single point of contact for managing all vehicle availability and controlling vehicle downtime.

We will be progressively reducing the age of the fleet over the next five years, which will give staff better, more reliable vehicles, and we will improve the management of our fleet. By May 2013, fleet technicians will be providing mobile workshop coverage across London 24 hours a day.

What does this mean?

- The central support unit and vehicle resource centre will work together at a new production hub to provide a single point of contact for all 'vehicle off road' matters and offer a consistent, 24-hour approach to managing the availability of vehicles.
- We started to introduce new workshop rosters in April 2013, including more unsocial hours, so that vehicles can be serviced on time, increasing reliability and reducing the risk of breakdowns.
- Mobile workshops will increasingly be used to repair vehicles away from workshop sites.
- The 'Vehicle off road' procedure (OP44) will be revised and published in May 2013 giving more general guidance on what is expected from staff and managers regarding 'vehicle off road' matters.
- Vehicle preparation teams will allocate vehicles overnight so that staff are given the most suitable vehicle for their shift.
- We will reduce the maximum age of ambulances to seven years and cars to five years, and we will implement a robust fleet replacement programme.

Extending the use of active area cover

Under the active area cover policy, staff working on ambulances, cars and motorcycles are placed in demand hotspots where the next emergency calls are highly likely to come from. This is to help reduce the length of time patients wait for a response from us. It also means staff are in the right place at the right time, and are less likely to get cancelled on the way to an incident.

We have reduced the number of cover areas, which makes it easier to manage within the control rooms. And we are continuing to use locations which enable staff to provide roaming cover in an area rather than being situated at a fixed point.

By the end of June 2013, we plan to extend the hours during which we provide active area cover. By doing so, we will ensure patients continue to be at the centre of everything we do – placing staff out in the communities they are serving. Patients will get a quicker response because staff are closer to incidents.

What does this mean?

- The active area cover period will be extended to between 6am and midnight from June this year. We will move to 24-hour cover from 1 April 2014.
- Crews will be given a location by control room staff and will be able to roam within a specific area around that location.
- Staff may use local facilities at their discretion but must remain contactable at all times.
- Crews will not be tasked to provide active area cover in the first 30 minutes of their shift. Staff not on calls will, wherever possible, be returned to station 30 minutes before the end of their shift, but remain available to attend incidents.

Responding differently to patients

Historically, we have sent a single responder as well as an ambulance crew to many calls in a bid to achieve our response time targets. This is not the best way to use our resources, it doesn't necessarily benefit our patients and it means that staff are regularly cancelled while they are on their way to a call.

We therefore plan to reduce the number of resources we send to individual incidents. We estimate that by responding differently to different categories of calls, we can reduce vehicle activations by over 400 a day, which will benefit other patients who are waiting for our help and will reduce cancellations for frontline staff.

Our proposals reflect how other ambulance services work. However, we will not bring in these changes until we have adapted our frontline workforce, as we need to ensure the staff we send to patients can deal with any clinical situation. We are therefore planning to introduce this new response model towards the end of March 2014.

What does this mean?

- We will continue to send a minimum of an ambulance crew and a single clinician in a car, on a motorbike or a bicycle to our most serious calls. Referred to as Red 1 calls, these are patients in cardiac arrest or who are unconscious and have ineffective breathing. There are around 40 of these calls a day across London.
- In future, we will no longer automatically send two resources to Red 2 calls. These patients, who include people with diabetic emergencies and seizures, need immediate on-scene care and, in many cases, hospital treatment. They will therefore be sent an ambulance crew if this is the nearest resource, without a single responder backing them up. If, however, a single responder is nearer, they will be sent, followed automatically by an ambulance crew.
- An ambulance crew will be sent to Category C1 and C2 patients if they can reach these patients within the clinically-agreed target times. If not, a single responder will be sent, backed up by an ambulance crew only if, on assessment, the patient needs to go to hospital.
- Lower category calls will be assessed by a clinician in the control room, with an ambulance crew sent only if a patient needs to be taken to hospital.

What happens next?

Tell us what you think

These changes provide a real opportunity for us to improve our service to patients as well as improve the working lives of our staff, and we would like your views on them.

More detail about the proposals can be found on the intranet – *the pulse*.

You have until Friday 24 May to let us know what you think, and you can share your thoughts in a number of ways.

Complete the feedback form
You can complete and return the feedback form opposite.

Visit *the pulse*
You can fill out a feedback form on the intranet, *the pulse*.

Email
You can email your feedback to modernisation@londonambulance.nhs.uk

Join us at a roadshow
You can join us at a roadshow where you will be able to speak to us in person about the proposals.

Monday 29 April	10am – 1pm	Charlton Athletic Football Club The Valley, Floyd Rd, SE7 8BL
Wednesday 1 May	10am – 1pm	Marriott Hotel, London Heathrow Bath Road, Hayes, UB3 5AN
	3pm – 6pm	Marriott Hotel, Waltham Abbey Old Shire Lane, Waltham Abbey, Essex, EN9 3LX
Thursday 2 May	10am – 1pm	West Ham Football Club Boleyn Ground, Green Street, E13 9AZ
	3pm – 6pm	Heathrow Renaissance Hotel, Bath Road, Hounslow TW6 2AQ
Friday 3 May	10am – 1pm	Oakleigh House 358 Bromley Common, Bromley, BR2 8HA

Speak with your local management team
You can speak with your local managers if you have any questions.

Our next steps

We will review the comments we receive and consider what changes we need to make to our plans. We will then share the outcome with you.

Have your say

Your views are important to us.
Please complete this form and send it back to us by Friday 24 May.

Q1: Is there anything else we need to consider to ensure the changes we are planning will improve patient care and the working lives of our staff?

Comments

Q2: Are there any other changes we could make which would further improve patient care and the working lives of our staff?

Comments

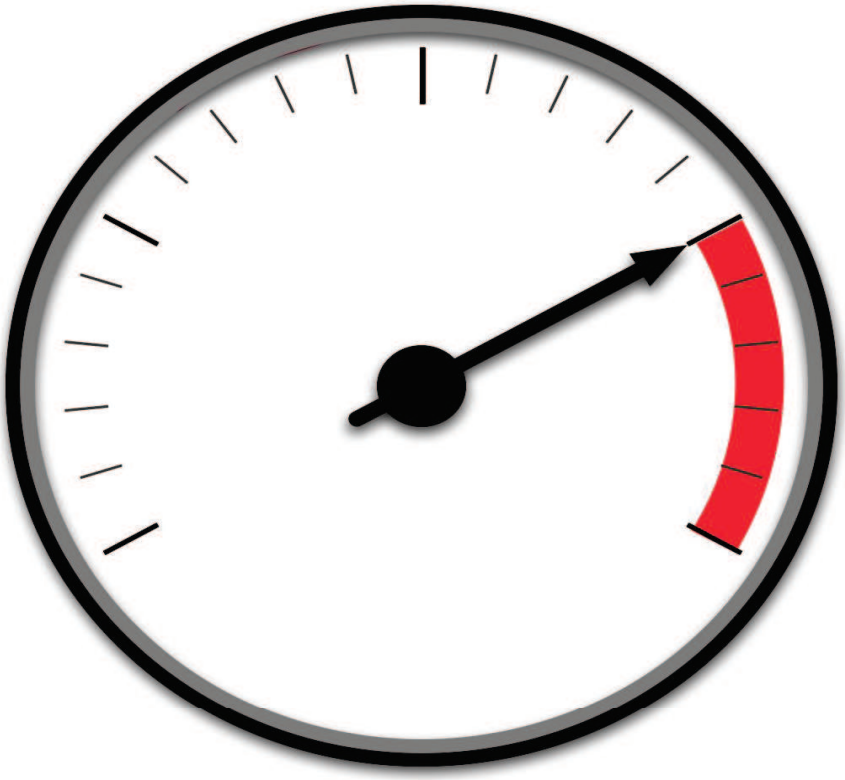
Please return this form to:
Charley Goddard, HR Manager – Employee Relations
HR Department, London Ambulance Service, 220 Waterloo Road, London, SE1 8SD

London Ambulance Service NHS Trust
220 Waterloo Road
London
SE1 8SD

The drive for quality

How to achieve safe, sustainable care in our Emergency Departments?

System benchmarks & recommendations
The College of Emergency Medicine



Summary Report

Published: May 2013

Authors:

Dr Taj Hassan, Vice President, College of Emergency Medicine

Mr Philip McMillan, Clinical and Professional Standards Manager, College of Emergency Medicine

Mr Chris Walsh, ENLIGHTENme Managing Editor, College of Emergency Medicine

Dr Ian Higginson, Co-Chair, Informatics Committee, College of Emergency Medicine

On behalf of the QED Group

Foreword

Consistent delivery of high quality emergency care remains an elusive goal for Emergency Departments (EDs) in the UK at present. This publication, the first of its kind by the College, describes the key components needed by systems as they move towards this important goal.

Much has been written about how to measure and then improve the quality of care delivered by healthcare systems. In emergency care the challenge is especially great. System benchmarking is a well described tool in the wider healthcare industry. It is used to improve consistency and drive quality improvement. The Quality in Emergency care Dashboard (QED) project surveyed 131 EDs in the UK for the financial year 2011/12. It is the largest and most comprehensive study of its kind, certainly in the UK. EDs are struggling to ensure consistent, safe care as performance deteriorates across the wider healthcare system. Workloads are increasing and there is a worsening medical workforce crisis in our EDs. The results from the QED are therefore timely.

More importantly, this report makes 10 key recommendations that we believe should be a strong focus for active discussions between commissioners, clinicians and Trust Boards as they seek to prioritise, design and deliver safe emergency care. The recommendations have some ranking and suggested timelines to help act as a focus for change, but in essence we believe they must be taken together. If properly implemented we believe they will lead to stability and consistency for the care delivered in our EDs. We will repeat this exercise in 2014 to assess and help guide relevant stakeholders on their progress. Failure to improve could have grave consequences for our patients, our staff and our ability to attract the high quality trainees of the future that are vital to drive the quality care agenda.

The College will also use this report and its recommendations to help inform the Review of Urgent and Emergency Care led by Sir Bruce Keogh, discussions with NHS England on guidance for Clinical Commissioning Groups and also to the Health Select Committee which has recently announced a review into Emergency Services and Emergency Care in May 2013.

Our commitment to highlight these issues on behalf of our Fellows and their staff is strong. More importantly, especially in the post Francis era, our commitment to our patients seeking our help in an emergency will remain unswerving.

Mike Clancy, President

Summary

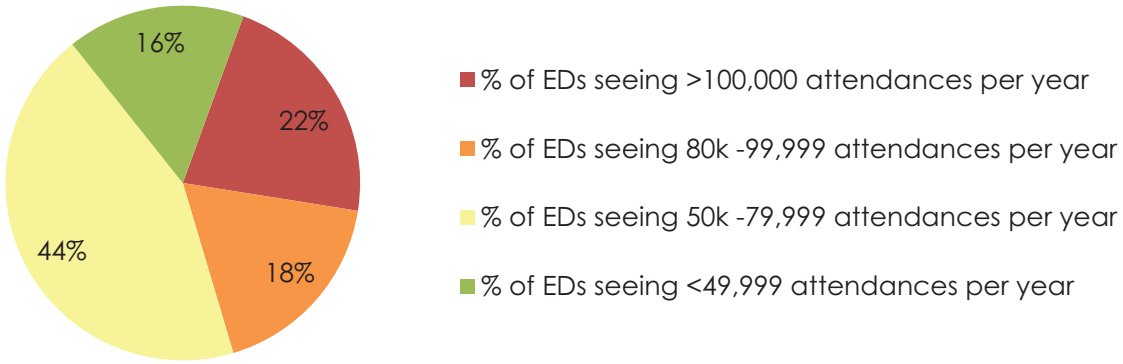
Introduction

Within the wider system, better understanding and benchmarking of what is required to commission, run and maintain the quality of care in a high performing Emergency Department (ED) is a crucial issue for the NHS[1]. This was well described in the Institute of Medicine's landmark publication: *Crossing the Quality Chasm* in 2001 and has now been translated into a framework for quality and safety for the ED by the International Federation for Emergency Medicine [2, 3]. In addition, process driven benchmarking has been identified as being a powerful tool for quality improvement[4]. The ability of EDs to provide a high quality patient experience supported by the three strands of safety, effective clinical care and consistent system performance, lies at the heart of these efforts to improve emergency care. Measurement of better outcomes for specific clinical conditions is also vital, especially for certain time critical pathologies. This is the subject of separate work by both the College and other relevant bodies[5, 6, 7].

The College of Emergency Medicine is pleased to publish its first comprehensive report on the key components of services that are being provided in the UK at present[8]. The information is derived from a detailed web-based survey completed by individual EDs in the UK. A total of 131 EDs across the UK submitted data to the QED project. This represents just over half of all EDs in the UK and nearly 60% of EDs in England – a representative dataset.

We hope that the report and its recommendations can be used by commissioners, clinicians and managers to help benchmark their systems against the best available evidence or standards set by national organisations. We have also suggested some timelines that we hope will help stakeholders focus their activities. This will identify some 'quick wins' as well as allow better linkage to national bodies (NHS England or equivalent) where central strategic support is required. We believe that timely action is essential. More importantly we want to build upon this first report by the College to refine our thinking for the future. In 2014 we will revisit the identified benchmarks and repeat the exercise, so that stakeholders in the process can measure the level of success they have achieved. Calibration of system design will be vital if we are to configure sustainable, cost effective, solutions that will drive consistent, quality improvement in the care we deliver to our patients.

Workload and demographics – The workload of the modern day ED is high with 22% of departments in the UK now seeing in excess of 100,000 patients /year. Overall, 10% of cases are triaged as category 1 or 2 and 38% of adults are category 3. Attendance rates continue to rise particularly in England. Other work suggests that this is 3-5% year on year although some systems report much higher increases especially out of hours[9]. Despite many initiatives to reduce demand over the last 10 years, none seem to have successfully created sustained change and diversion of work away from EDs.



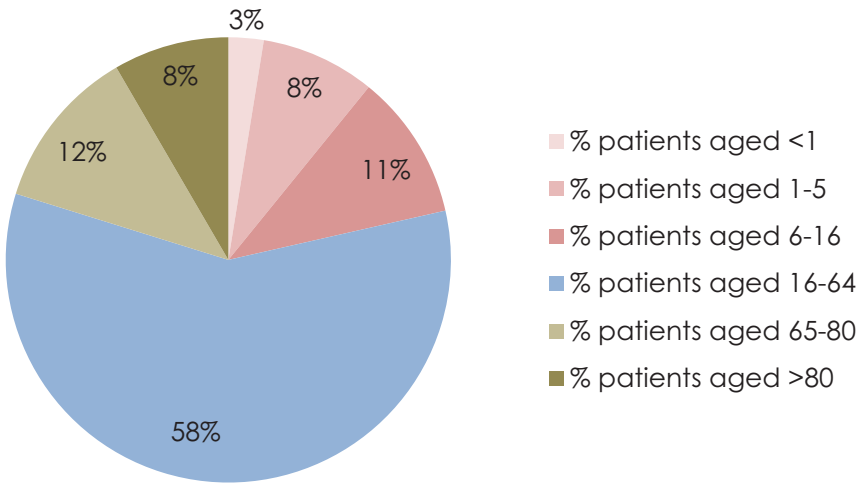
Older patients and paediatric patients form a significant proportion of the workload of the ED (20% of patients are over 65 years old and 22% of patients are under 16). Notably, 8% of patients are over the age of 80 and this number will certainly rise unless sustainable, appropriate, alternative solutions are found. A range of specific design strategies are required to manage the rising number of elderly patients who attend the ED but do not require emergency care. The role that Urgent Care Centres (UCCs) and co-located primary care services have had on ED function and activity is important and will be the subject of a more detailed report by the College later in 2013. Evidence suggests that the primary care workload is rising and that co-located primary care services could manage between 15-30% of existing ED workloads[9, 10]. In some systems it has been suggested that this could be greater, although the nature of the solution in such circumstances remains poorly defined. The best systems have optimal integration strategies between the ED and any co-located primary care service with an EM consultant as a single Director of Emergency Care. Failure to have an integrated approach recurrently leads to fragmentation of services, fragility of team working, higher levels of risk and poorer outcomes.

It is vital that commissioners and clinicians understand the workload and case mix of patients presenting to their emergency care systems. They then need to develop systems to cope with this activity. Depending upon local casemix, resourced and accessible primary care services are vital. These may be housed in UCCs. Alternatively, co-located primary care services within, or adjacent to EDs, will help to decongest departments. They will focus on certain lower priority groups of

patients, and allow optimal delivery of emergency care across the board. Whilst efforts to reduce demand will continue, this should not detract from the need to appropriately resource EDs to meet the more complex workload they are facing. Managing very busy periods of activity and surge in the ED require resilient escalation planning by the entire local healthcare system. The College has provided guidance on managing overcrowding in the ED [11].

Poorly performing care systems have flows that lead to exit block and overcrowding. These failures by systems and organisations have now been clearly proven to lead to increased mortality and morbidity for patients[12, 13, 14, 15]. Executive teams of provider organisations and commissioners have responsibilities not only to their patients but also their staff to help them work safely and sustainably when performing clinical duties in the ED at times where the wider system is performing poorly.

Age breakdown of total ED attendances (UK)



Recommendation 1: Commissioners and clinicians must work closely together as a matter of priority to better manage workload in their Emergency Departments. Clear targeted funding strategies and appropriate co-located primary care services are needed to cater for 15-30% of the present work in Emergency Departments. These will work best if Emergency Medicine Consultants as Directors of Emergency Care are given responsibility to lead on integrated care delivery, governance and training. Trust Executives must also ensure flow through the emergency care system.

TIMELINE: 1-6 months

Configuration of services - The results of the QED show that optimal configuration of services required to support a modern ED or Major Trauma Centre continues to be a challenge for commissioners, provider organisations and clinicians alike. The College has previously provided guidance on the key principles that support good reconfiguration [16]. Solutions that will ensure

safety, efficiency and clinical effectiveness must lie at the heart of all re-design. The QED data suggests that there is significant variation in how services are configured, and how some EDs are supported on site. More work is required to understand how networked solutions and integrated pathways can best support delivery of high quality care.

The design, function and role that UCCs can provide in supporting EDs continues to be a poorly researched area due often to operational imperative. The QED report reveals significant variation in UCC design and system integration. The College has also previously published guidance on unscheduled care facilities and provided a toolkit for systems wishing to develop such models [17, 18]. More recently a review by the Primary Care Foundation of a cohort of UCCs revealed a continuing variation in standards of practice and concerns about value for money [19]. The College will seek to do further collaborative work with NHS England, the Royal College of General Practitioners, and the Primary Care Foundation in this important area in order to provide recommendations on the best models of cost effective and efficient care delivery.

Recommendation 2: The College recommends adherence to key principles of good reconfiguration. Urgent Care Centre development must be part of a wider networked solution that is cost effective and efficient especially if co-located next to Emergency Departments.
TIMELINE: 3-12 months

Medical staffing in the ED - The number of Emergency Medicine (EM) Consultants in post has risen over the last five years. The average number of whole time equivalent (WTE) Consultants per ED is now 7.4, compared to 3.8 in 2007/8. Whilst this expansion is welcomed, the average number is still significantly below the College's minimum recommendation of 10 WTE Consultants per ED and up to 16 Consultants in larger departments. The College's recommended levels are designed to provide sustainable cover, with up to 16 hours EM Consultant presence per day, 7 days a week, in every department [20]. Increased EM Consultant numbers will also ensure adequate 'depth of cover' to help manage EDs during busier times and surges. Finally they will ensure better supervision of juniors and protected training time.

Consultants in EM are providing significant direct 'shop-floor' cover to help maintain safety in EDs, especially out of hours, within limited available resources. Over 77% of EDs reported that they had at least one EM Consultant present in the ED over 12 hours per weekday, but only 17% reported such presence for 16 hours. At weekends the number of departments with 'shop-floor' cover for at least 12 hours / day, falls to 30%. The College believes that EM Consultants are at the leading edge of 7 days working as espoused by the Medical Director, Sir Bruce Keogh as well as the Academy of Medical Royal Colleges within the constraints of the resources available [21,22]. It

should be noted that the intensity of working is not reflected in these numbers. Other work by the College is seeking to understand and give guidance on safe and sustainable working practices by Consultants.

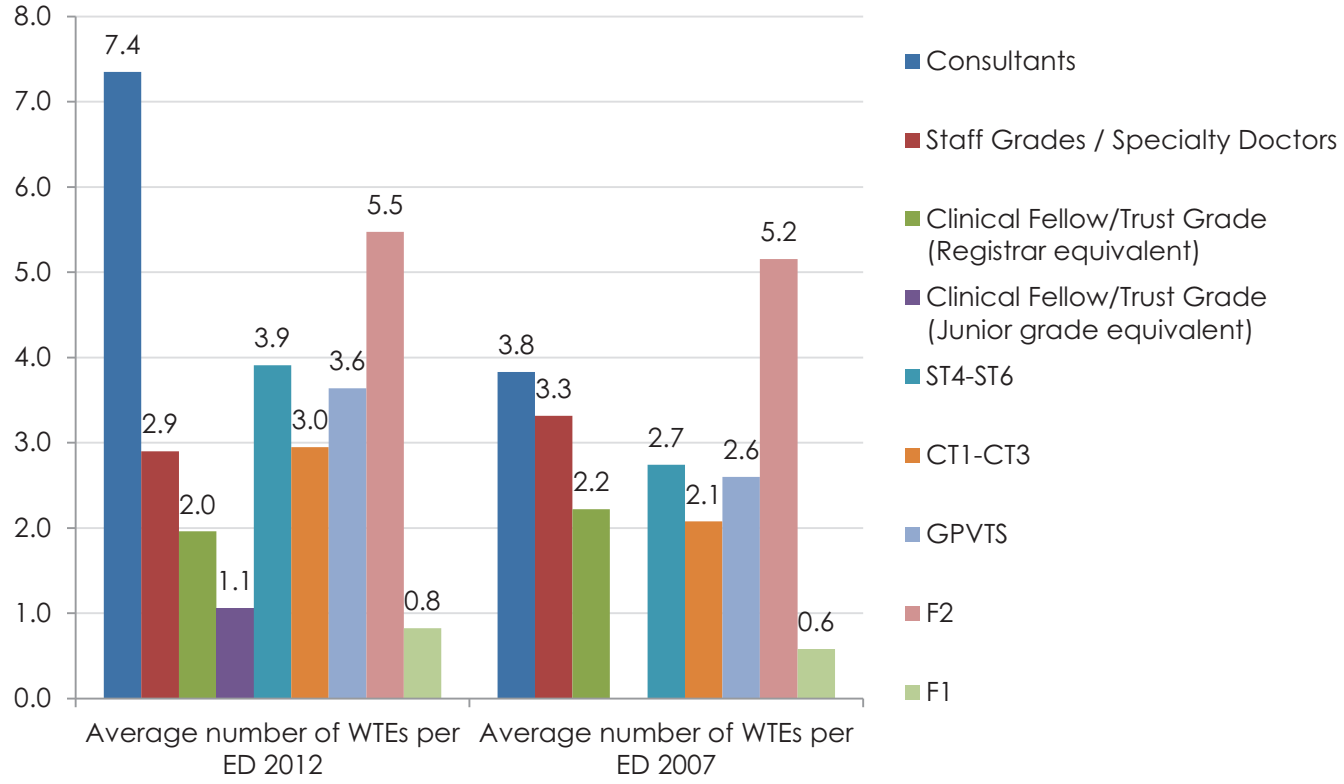
The QED has identified that 60% of EDs adhere to national College, Academy of Medical Royal Colleges and BMA guidelines on job planning: specifically the inclusion of 2.5 PAs of Supporting Professional Activity within job plans. This time is vital if EM Consultants are to lead, project manage, and deliver a host of training, quality improvement and governance activities. The College will carry out further work to explore the impact on systems where there is such variation in national recommendations.

The average number of Higher Specialist Trainees (HST4-6) posts available has risen slightly in the same 5 year time period (2007-12) but the steep fall off in recruitment into ST4-6 posts has created significant vacancy or locum rates of 29% for HST. Vacancy rates for SAS doctors have similarly deteriorated. These issues are proven to have resulted in significant clinical and financial risk for the NHS [23]. Urgent work is required to improve working and training conditions for these groups. Trends in recruitment to HST posts over the last 3 years suggests shortages in ST4-6 posts will continue for the foreseeable future if no action is taken to create sustainable working patterns that are attractive to the trainees of the future.

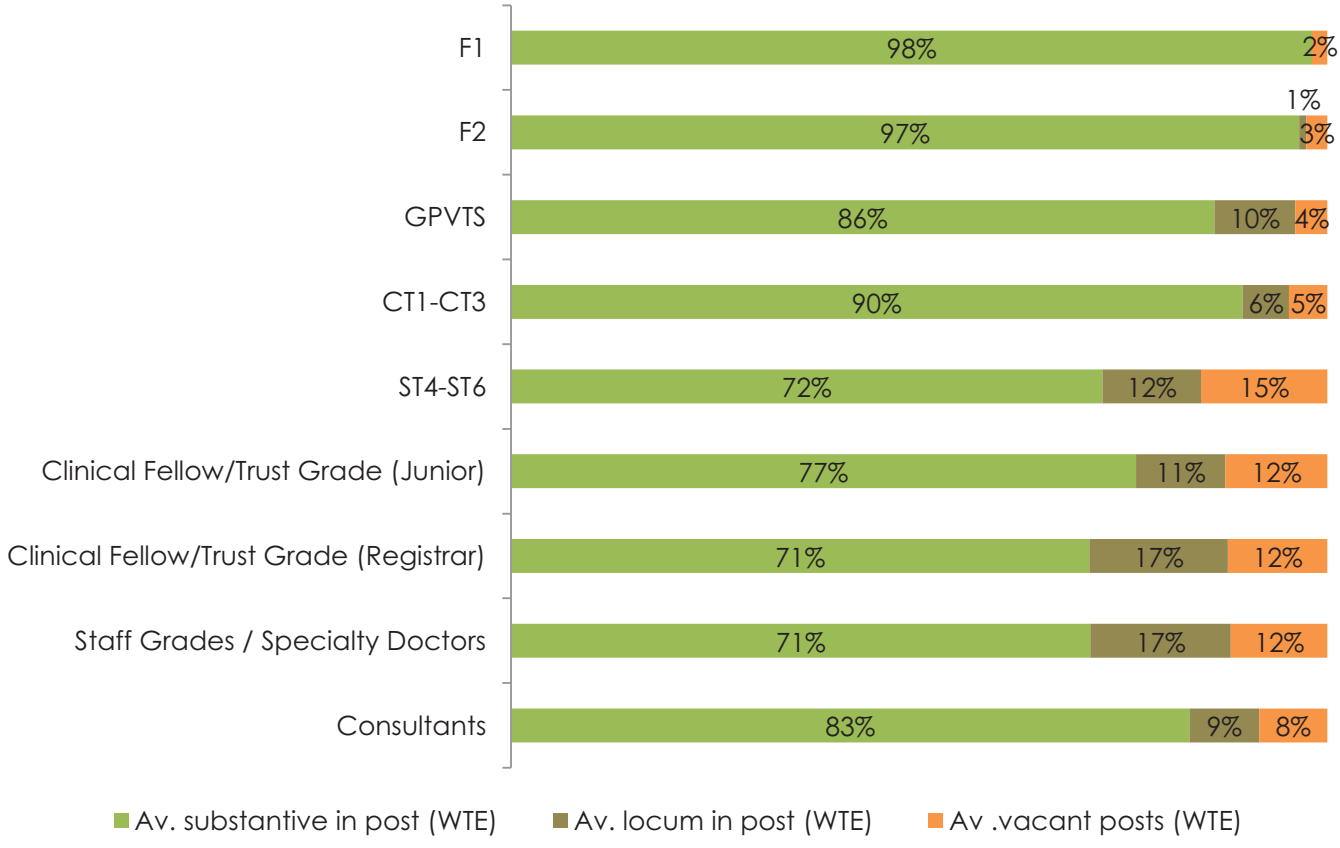
Junior grade vacancy rates are relatively low. This reflects the fact that most junior doctors are placed in EDs as part of training rotations. However, the attrition rate between core training and higher specialist training suggests that an unreasonable burden of service delivery is placed on junior staff, negatively influencing choice of specialty.

The very serious medical workforce challenges facing EDs will only be properly addressed by creating safe and sustainable working patterns that meet appropriate standards, thus allowing good training environments and attracting trainees of the future. The College has published standards on minimum Consultant staffing levels for different sized EDs. Most hospitals continue to fall short of these standards. Provider Trusts must create and show commitment to their long term vision for staffing EDs. They must support working practices for Consultants that ensure sustainability. The College will publish further guidance on safe, sustainable working practices in the spring of 2013.

Average WTE medical staff numbers (filled posts) by grade per ED - comparison 2011/12 and 2007/8



Average breakdown of substantive, locum and vacant posts 2011/12 (UK)



Recommendation 3: Trust Boards must urgently focus on, and commit to, the creation of consistent, safe and sustainable working patterns for Consultants in Emergency Medicine. Continued expansion of consultant numbers is vital. These should meet College standards. Good job planning will allow Consultants to deliver good clinical care and training consistently and also support important quality improvement activity within their Emergency Departments.

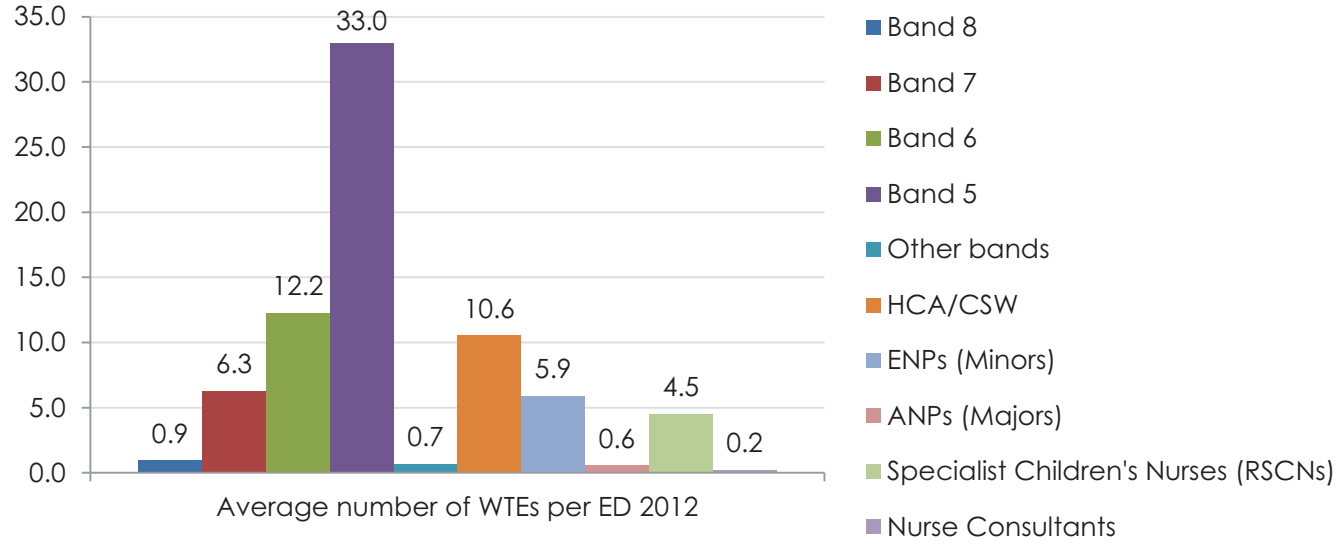
TIMELINE: 1-12 months

Nurse staffing and skillmix - The QED has provided the first comprehensive view on the levels of nursing staff working in EDs in the UK. Whilst no trend data is available, the average nursing staff numbers reveal that EDs rely heavily on Band 5 nurses, supported by Band 6 and 7s to provide 'shop-floor' leadership. The Royal College of Nursing is currently leading work to develop appropriate skillmix tools. This will support the recommendations for core ED nursing staff levels.

The role of Emergency Nurse Practitioners in seeing minor injury patients is well established. This is demonstrated by this survey. A small but slowly increasing number of EDs have Advanced Nurse (or Clinical) Practitioners (ANP or ACPs) that are able to work as part of the ED team in the majors area. It is still too early to assess the potential impact of these posts for most departments, although anecdotal evidence suggests that the greatest benefit occurs when working as a fully integrated part of the ED team. The role of Physician Assistants in some EDs is also being explored and encouraged.

Delivery of high quality care in the ED requires a strong multidisciplinary workforce with the correct skillmix. The College will continue to work closely with the Royal College of Nursing and sub specialty associations to ensure that recommended levels of nurse staffing for core ED function are attained. Provider organisations must review their nurse staffing levels to ensure standards are met and maintained. The delivery of high quality nursing is essential for effective emergency care. This requires strong nursing leadership on a shift by shift basis, as well as at Departmental level.

Average nursing staff numbers (filled posts) per ED 2011/12 (UK)



Recommendation 4: Commissioners and provider organisations should adhere to the guidance of the Royal College of Nursing with regard to nursing workforce and skillmix to maintain high quality care.

TIMELINE: 1-6 months

Clinical quality indicators of care - In 2010 new Clinical Quality Indicators (CQIs) for Urgent and Emergency care were introduced into England with the intention of driving better patient care in EDs. These related to timeliness of care, quality of care, and the patient experience. In Northern Ireland, Scotland and Wales variants of these indicators (with the main focus on the 4 hour indicator) have also been introduced. In the Republic of Ireland similar discussions have taken place.

Measuring and improving the quality of care delivered in the ED must be evidence based. The CQIs developed by the Department of Health, in conjunction with expert groups including the College of Emergency Medicine represent a suite of indicators which if applied appropriately will act as a powerful lever for improving care in the ED. The data reveals that the total time spent in the ED remains the most commonly used indicator of performance for commissioned services (87% of EDs in England). In this survey less than half of EDs reported that patient experience was being used as an indicator of care (43%) and only a third of EDs were using the Consultant sign off indicator (34%). On average only 52% of patients were treated by a doctor or practitioner within 60 minutes of arrival.

Further work is clearly required to use the existing indicators more consistently, as part of a suite focusing on quality improvement rather than an isolated system performance indicator (greater than 95% of patients spending less than 4 hours in the ED)[24]. Urgent work is required to further refine the CQIs to meet challenges in system design. Measurement and consistent improvement of a suite of indicators will require extra resources in a number of systems.

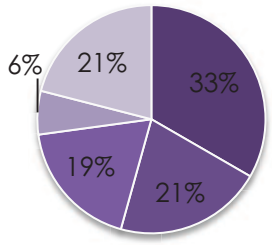
Recommendation 5: The College recommends that the Clinical Quality Indicators be applied together, as a suite, to produce a more holistic quality improvement programme.

TIMELINE: 3-12 months

Commissioning - The new commissioning framework for England was specifically surveyed. Respondents were asked to describe the ways in which commissioners and providers of emergency healthcare systems were working together to produce a joint vision to create cost effective and efficient solutions. There are useful lessons for the other devolved countries in this regard. Commissioning arrangements have progressed significantly since the QED project was undertaken. However, the findings from 2012 reveal that despite an urgent need and seeming desire by all sides, there were significant areas where the commissioning process for emergency care remained embryonic, with a lack of communication.

Respondents reported a lack of active engagement between commissioners and EM clinicians about new commissioning arrangements. 25% of EDs stated no discussion had taken place at all, whilst another 42% stated that only initial discussions had begun. Only 33% of EDs reported that EM clinicians were directly involved in discussions with their local Clinical Commissioning Groups.

The emergency care landscape for commissioners, clinicians and executive teams of provider Trusts, continues to face major challenges. Close collaborative working will produce the most cost effective and efficient solutions. This evidence suggests that there is still much to do.



- Direct discussions between EM clinicians and local CCG ongoing
- Discussing with Local Commissioning Group where there is no direct EM clinician involvement
- Continuing to negotiate with PCT and commissioning developing
- Continuing to negotiate with PCT with no commissioning development as yet
- Not involved at all in commissioning discussions but want to be involved

Recommendation 6: Commissioners, clinicians and senior managers within provider organisations should make concerted efforts to create strong network solutions. These should lead to a shared vision for their emergency systems that can be delivered in a timely fashion.

TIMELINE: 1-3 months

Safety and governance – System design that has safety and high quality integrated clinical governance is vital to all healthcare systems. Such systems are vital to allow recognition of safety issues and for calibration to occur. A general overview of governance systems in EDs was sought by the QED. Overall, 88% of departments reported having a safety lead in EM and 94% reported having a Clinical Risk Register. A total of 88% of departments reported having regular clinical governance meetings with ED staff. The actual quality of the clinical governance meetings, active linkage to their risk registers, the outputs from meetings, and the impact that they had on successful quality improvement and patient experience, was not measured. We hope this will be a major focus of future activity. The amount of time set aside within job plans for robust clinical governance and quality improvement activity was also not directly measured, though as described above only 60% of EDs met national standards in allowing adequate job planning for general 'Supporting Professional Activities'.

Only 43% of departments reported using even low fidelity simulation in the Resuscitation Room as a component of teaching, to enhance team working. The smallest sized EDs had higher than average levels of critical incidents reported. Crucially, 6% of EDs reported that a 'never event' occurred within their ED in 2011/12. This is a vital area of work and the College will continue to provide tools by which these issues can be explored and addressed in greater detail.

High quality clinical governance systems, which lead to successful change and continuous quality improvement, require dedicated resources. This will ensure that the many facets of system design,

human factors engineering, and safety can be focused upon. The College has provided clear guidance on the requirements within job planning to allow these types of activities to be performed. The College recommends 2.5 programmed activities (PAs) within a standard job plan. We will be publishing further guidance in 2013 on aspects of system design linked to active clinical governance that can help monitor and improve activity in this area.

Recommendation 7: Provider organisations should ensure that they have robust and active clinical governance systems to support safety and continuous quality improvement. Consultants must be provided with appropriate time and resources to support quality improvement.

TIMELINE: 1-6 months

Observation medicine and ambulatory emergency care – EDs with dedicated short stay observation ward areas / Clinical Decision Units (CDUs) have been proven to optimise gate keeping into the hospital bed base, provide added opportunity for safer discharge from the ED and also act as an area for ambulatory emergency care to be focused [25, 26, 27].

46% of EDs reported that they have dedicated CDUs / observation wards where patients with a range of conditions can be safely discharged following a short, intense period of investigation or a brief period of treatment and observation. Some units are more highly developed than others and a variety of different 'virtual' models also exist. The ability of the ED to provide an area with a robust gate-keeping function as well as ensuring safe discharge after a short period of observation or therapy, will become increasingly important. This is especially true where bed bases are reduced and service reconfiguration occurs.

Notably, a significant proportion of ambulatory emergency care activity is led by EM physicians in EDs. This allows the gatekeeping function to be maximised and also produce safer discharge from the ED. The College was a leader in the development of the tariff designed to encourage ambulatory emergency care (Same Day Emergency Care – SDEC tariff)[28]. We believe that with further work this tariff could be extended to certain groups of patients in the ED, and if appropriately resourced will drive provision of even more cost effective 'one stop' solutions. This will reduce diversion of patients into the main hospital bed base, which attracts greater lengths of inappropriate stay and tariff costs.

Ambulatory emergency care and observation medicine / CDUs are proven to be cost effective

and efficient strategies for certain groups of patients attending the ED. They lead to safer care. Appropriate resources are required to deliver this function.

Recommendation 8: Clinical Decision Units and ambulatory emergency care are an important component of Emergency Department function. The SDEC tariff for ambulatory emergency care should be applied to certain groups of patients in the Emergency Department to leverage change and optimise good gatekeeping of the hospital bedbase. This activity needs to be properly resourced.

TIMELINE: 3-12 months

Tariffs and Informatics systems – At the heart of an ED's ability to gauge its quality of care delivery lies its ability to measure how well it is performing. The increasing complexity of modern healthcare also relies upon connectivity to a range of other systems to enhance efficiency and effectiveness.

81% of EDs reported that their information system was either poorly integrated with or isolated from hospital and/or primary care systems. A range of difficulties were identified. Information systems that are not fit for purpose, have a lack of universal coding and are linked to inappropriate tariff arrangements have the combined potential for their EDs to be poorly reimbursed for their activity leading to wider instability in healthcare provision as has been shown elsewhere [28].

Urgent work is required to improve the informatics systems in EDs in the UK to meet international standards. These systems will be vital towards providing the infrastructure to track patients, measure trends in quality improvement, and ensuring safe cost effective care.

Recommendation 9: The College recommends that the Department of Health should urgently address and correct the tariff structures that recognise clinical activity in the Emergency Department. At present these are not fit for purpose. Trusts must also pay urgent attention to the utility and integration of their Emergency Department information systems.

TIMELINE: 3-12 months

The patient experience – This appears amongst the many recommendations of the Francis Report and is in many ways the most important of all indicators of quality [29, 30, 31]. However, the measurement tools for tracking progress continue to be poorly developed and evolve all too slowly, especially for adults. In children better progress is being made with joint work between the CEM, the RCPCH and the Picker Institute [31].

For the QED project, a range of narrative responses were received describing how hospitals are attempting to address this difficult area. This confirms the lack of standardisation. The measurement and calibration of patient experience is a vital marker of quality in EDs in the UK. Resources are required to create robust tools that will meet the needs of all patients – young, old, ill and injured, to record their patient experience and feedback ways that support systems to improve. It is not clear whether the recently introduced friends and family test will prove a robust discriminatory tool at this stage.

Recommendation 10: The College recommends that more resources are provided to create tools that will more accurately measure patient experience in the Emergency Department as a vital marker of the quality of care delivered.
TIMELINE: 1-12 months

Conclusions & future work

This report has made a number of important recommendations that require urgent action. We hope that relevant national policy makers, commissioning groups and provider organisations will now take the next steps based on these recommendations. The suggested timelines are provided to act as a guide to encourage focused activity. The College and the wider Emergency Medicine workforce will work closely with all stakeholders as required. We hope that through this approach we can effect positive change for the benefit of our patients who seek our help in an emergency.

We encourage colleagues to share these findings widely and also visit the College's ENLIGHTENme platform *Systems Design* section to share good practices at

www.enlightenme.org/em-system-design

Acknowledgements

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The College of Emergency Medicine
7-9 Bream's Buildings
London EC4A 1DT

Tel: +44(0)20 7404 1999
Fax: +44(0)20 7067 1267
www.collemergencymed.ac.uk

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FTN calls for action on A&E 15/05/2013

Commenting on the current state of accident and emergency services, Chris Hopson, Chief Executive of the Foundation Trust Network, said today:

“A&E services have been under huge pressure and although performance is now stabilising, there is a danger the system will fall over in six months’ time unless we plan effectively for next Winter.

“A&E units are facing three main problems.

“The number of people attending A&E is rising in many places and even where the increases are small, the number of frail elderly patients with complex conditions is increasing so more patients are being admitted. Hospitals are already running close to capacity in winter so small changes in the number of patients needing to be admitted creates major problems.

“The wider NHS system isn’t working effectively. Patients can’t get the GP appointments they need, many doctors out of hours’ services aren’t working in the way they should and patients simply don’t know where they should be going to get the right emergency care. So up to 30% of people in A&E shouldn’t even be there in the first place.

“The way the NHS pays hospitals for admitted A&E patients is broken. Under current rules, if a hospital admits more A&E patients than it did five years ago, they only get paid 30% of the cost of treating those patients. Two thirds of hospitals are admitting more patients than they did five years ago, some as many as 40% more. This means re-opening wards and employing more staff to cope with this extra demand. Yet hospitals only get paid 30% of these costs. Some are losing more than £5 million a year as a result, on top of the 5% savings they’re already being required to make. This can’t be right.

“The plan announced by NHS England last week is a good start but we need the Government and the NHS to clearly commit to four things now.

“First, we need to stop blaming hospitals for what is a whole system problem. The four hour A&E wait target isn’t just a measure of hospital performance, it’s a thermometer for the whole urgent and emergency care system.

“Second, whilst the plan was right to highlight the importance of each local NHS coming together to plan for next Winter, it was too vague about the resources that will be available. Hospital, ambulance and community service trusts need to plan with certainty. We need to know by end June at the latest exactly how much money will be committed from the NHS’s risk reserves to addressing what Jeremy Hunt has correctly identified as “the biggest operational problem facing the NHS”. We also need a guarantee that the NHS will use its risk reserve to allocate the funding required by each area even if that area is facing a funding shortfall.

“Third, we need a commitment that the NHS will abandon, as quickly as possible, its current approach of only paying hospitals 30% of the cost of treating some admitted A&E patients.

“Fourth, we know that the current model of urgent and emergency care is clinically and financially unsustainable. NHS England has already done good work on developing a new model. We need Jeremy Hunt to commit to completing and then implementing the results of that work as quickly as possible, even though it’s likely to involve difficult decisions in the run up to the General Election. These include re-looking at the GP contract, reconfiguring some hospital A&E Departments and investing more in community facilities”.

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Foundation Trust Network, One Birdcage Walk, London, SW1H 9JJ

Tel: 020 7304 6977 . Email: enquiries@foundationtrustnetwork.org

Registered Charity 1140900 Registered in England No 07525114

Raising standards, putting people first

Healthier Communities Select Committee

29 May 2013

Hayley Marle

Compliance Manager- Lewisham, Lambeth and Southwark

hayley.marle@cqc.org.uk

03000 61 61 61 or 07919 891 583

The purpose of this presentation is to inform the committee of :

Part one - CQC strategy 2013-16

Part two - CQC activity in Lewisham health and social care services

How we've got here - Views, comments and recommendations

- CQC public consultation Sept - Dec 2012
- Francis Report recommendations and the Government's response
- Winterbourne View Serious Case Review
- Health Select Committee report
- Review of CQC regulatory model by Kieran Walshe
- Review of CQC investigations by Deloitte
- Health and social care ratings review by the Nuffield Trust

Our purpose and role

Our purpose

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve

Our role

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care

Underpinning our approach

- Our judgements will be independent of the health and social care system
- We will always be on the side of people who use services

Five influences on quality

- Commissioners
- Professionals
- Providers
- Regulators
- People who use services

Five things we will look at

We will tackle the following five questions about services:

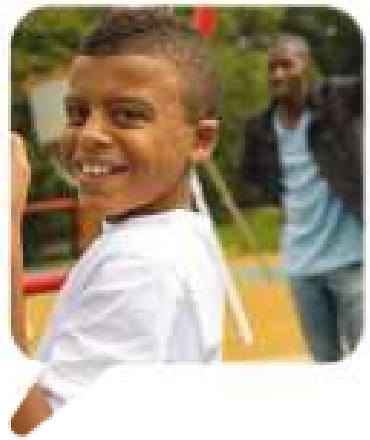
1. Are they safe?
2. Are they effective?
3. Are they caring?
4. Are they well led?
5. Are they responsive to people's needs?

Things we will do differently

- Appoint a Chief Inspector of Hospitals (recruitment process started), and a Chief Inspector of Adult Social Care and Support (advert will be out soon), and consider the appointment of a chief inspector for primary and integrated care
- Develop fundamental standards
- Specialist inspectors leading expert teams, including clinical and other experts, and experts by experience
- NHS hospitals: national teams with expertise to carry out in-depth reviews of hospitals with significant problems

Things we will do differently

- NHS hospitals: a clear programme for failing trusts that makes sure immediate action is taken to protect people and deal with failure
- Predict, identify and respond more quickly to services that are failing, or likely to fail, by using information and evidence in a more focused and open way – including people's views and experiences
- Improve understanding of how well different care services work together
- Work more closely with our partners in the health and social care system to improve the quality and safety of care



Things we will do differently

- Publish better information for the public, including ratings of services
- A more thorough test for organisations applying to provide care services, making sure named directors, managers and leaders commit to meeting standards, which is tested at registration
- Strengthen the protection of people whose rights are restricted under the Mental Health Act
- Build a high-performing organisation that is well run and well led, has an open culture that supports its staff, and is focused on delivering its purpose

What we will continue to do

- A programme of unannounced inspections and reporting across the sectors we regulate
- Inspections at any time in response to concerns
- Inspections and reviews on particular areas of care
- Regulatory and enforcement action

Next steps

- Changes for 2013/14 set out in our Business Plan
- We will deliver:
  - New fundamental standards
  - New hospital inspection methods
  - Hospital ratings
  - Begin to develop changes for other sectors
- Continued involvement of staff, providers, stakeholders and public in the development of our work
- Further consultations to be launched soon

Part two – Lewisham

Service type	Number of locations registered with CQC	Inspected between 1 April 12 and 31 March 2013
NHS (Lewisham hospital)	1	1 (100%)
Social Care	103	103 (100%)
Independent Healthcare	13	8 (62%)
Primary Dental Care	39	10 (26%)
Primary Medical Services	46	Registered as of 1 April 2013
Total	202	120/156 (77%)

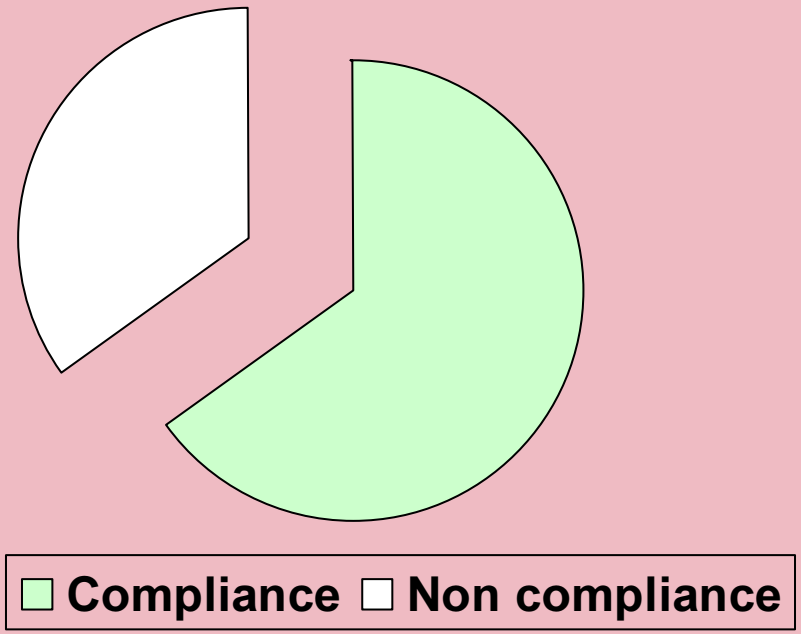
ASC broken down

Care home service without nursing	42
Domiciliary care services	34
Care home service with nursing	18
Rehabilitation services	12
Support living service	9
Extra care housing services	7
Shared lives	2
Community based services	3

NB. Locations can provide more than one type of service

What we found in social care

- 36 (35%)locations we found non compliance with one outcome or more
- 67 (65%) locations we found compliance with all five outcomes inspected



Outcomes where we more commonly find non compliance

Outcome 14 – Supporting workers

Outcome 16 – Assessing and monitoring the quality of service provision

Outcome 4 – Care and welfare of people who use the service

Outcome 21 - Records

Examples of services where we found improvements at follow ups

Housing 21 – Cedar Court Cinnamon Court

- Staffing numbers, supporting staff and cleanliness and infection control

Housing 21 –Cinnamon Court

- Respecting and involving people, care and welfare, and supporting staff

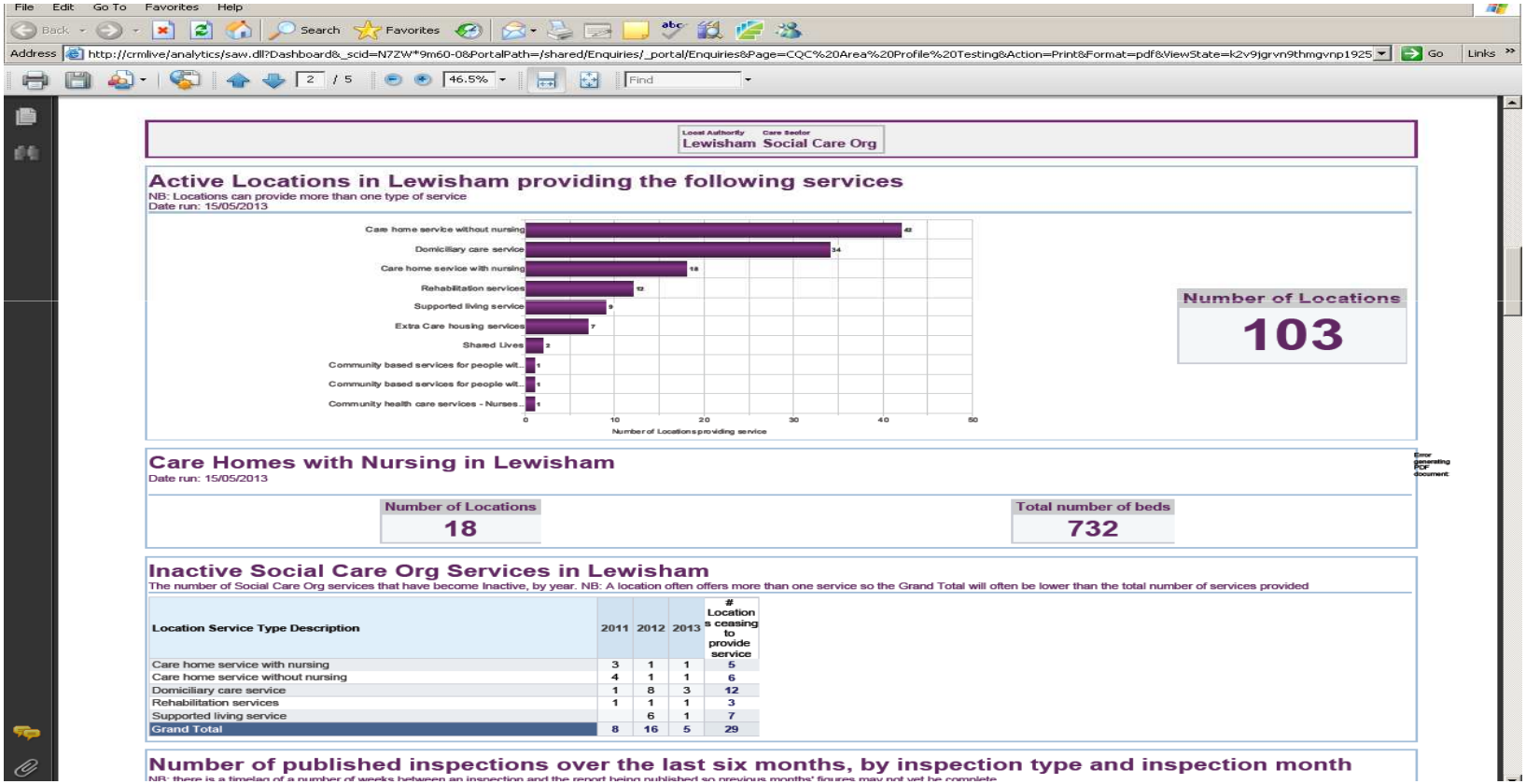
Fieldside Care Home

- Records

Services where we found good practice

- Alexander Care Centre (report published 9 May 2013). 78 beds very positive feedback from people, family, staff and other healthcare professionals. A well maintained environment
- Aster House (report published 23 April 2013) eight women with mental health problems – open and responsive manager
- Jigsaw Project (report published 8 November 2012) support in the community to 28 people with mental health problems. Stable management and people were very positive about the service

Coming soon…. Area Profiles



Lewisham Social Care Org

Active Locations in Lewisham providing the following services

NB: Locations can provide more than one type of service
Date run: 15/05/2013

Number of Locations: 103

Care Homes with Nursing in Lewisham

Date run: 15/05/2013

Number of Locations	Total number of beds
18	732

Inactive Social Care Org Services in Lewisham

The number of Social Care Org services that have become Inactive, by year. NB: A location often offers more than one service so the Grand Total will often be lower than the total number of services provided

Location Service Type Description	2011	2012	2013	# Locations ceasing to provide service
Care home service with nursing	3	1	1	5
Care home service without nursing	4	1	1	6
Domiciliary care service	1	8	3	12
Rehabilitation services	1	1	1	3
Supported living service		6	1	7
Grand Total	8	16	5	29

Number of published inspections over the last six months, by inspection type and inspection month

TRUST BOARD REPORT

Title of Report	**Care Quality Commission (CQC) Inspection Report and Action Plan**
Date of Board Meeting	**7th May 2013**
Lead Director	**Joy Ellery**
For Information, Discussion or Decision	**For Information and discussion**
Area of Core Business: Quality of Service, Care of Workforce, PPI, Partnership, Financial Balance etc	**Quality of Services**

Report Summary/Key Issues, concerns and risks:

The hospital site underwent an unannounced CQC inspection on the 8th and 11th February 2013. Five standards were inspected:
Respecting and involving people who use services, care and welfare of people who use services, co-operating with other providers, staffing and complaints.
The inspection focussed on the care and treatment provided to more vulnerable patients such as older people or those with learning disabilities. There were many positives about the inspection, particularly relating to the use of innovative integrated pathways and taking account of patients' views and experiences however, the inspectors said that the Trust needed to take action against the standards relating to respecting and involving people and the care and welfare of people who use services.
An action plan has been developed by the Deputy Director of Governance and Deputy Director of Nursing with input from all the Heads of Nursing.

Decision required by Board:

None. To note the action plan. The methods of monitoring the implementation of the plans are described.

Link to Assurance Framework/Corporate Objectives:

Links to corporate and strategic objectives around providing safe, high quality services.

Financial Implications:
None identified.

Quality Implications:

Actions taken will improve quality of services delivered.

Governance Implications (legal, clinical, equality and diversity or other):

Board Committee/Group which will oversee actions arising:

- Integrated Governance Committee

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Report on actions you plan to take to meet CQC essential standards

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RJ2
Our reference	INS1-591613532
Location name	University Hospital Lewisham
Provider name	Lewisham Healthcare NHS Trust

Regulated Activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services
	How the regulation was not being met:
	Patients were not always treated with courtesy and respect or encouraged to express their views about what was important to them in relation to their care. *(Regulation 17 (2)(a) & (c)(ii))*

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The Trust has implemented a process whereby patient feedback is sought on a continual basis across all areas. Questions relating to patients being treated with dignity and respect are always asked and our performance across the year has been continually improving with a current positivity score of 92.69 and a rate of 84.53% of respondents stating 'Yes Always' (n=978).

A question is also asked about whether or not patients feel that they were involved in decisions about their care and treatment, as much as they wanted to be. Our performance across the year has been improving and currently 64.75% of the patients responding to the questionnaire answered 'Yes definitely', 26.08% responded 'yes to some extent and 6.11% responded 'no'.

1. All wards have their monthly Patient Experience Scorecard provided by the Patient Experience Team. All Ward managers will be required to present an action plan on areas of Red at the Nursing & Midwifery Quality and Metrics Meeting.
2. Dignity and Respect are sessions which are included in all nursing induction programmes but this will be strengthened with the introduction of the 6C's which will be built into our Nursing and Midwifery Strategy which will be developed in the coming month.
3. The Matrons will perform monthly Quality Ward Rounds and will record the observations made and present these at a newly formed Nursing/ Midwifery Quality Metrics forum which will be set up to monitor and report on Nursing and Midwifery Quality Metrics. Matron Quality Ward Rounds will also be presented to the Directorate Governance Meetings.
4. All Wards will have 'Ward Contracts', which will be developed in conjunction with the Ward Team and all ward staff will be required to sign the Ward Contract. These Ward Contracts will be explicit in the expectation that all patients will be treated with Dignity and Respect and be involved in decision-making and their own care.
5. A review of Ward Dignity Champions will take place and all wards will have at least one Dignity Champion.
6. The Executive and Non-Executive Team undertake 'Executive Walkabouts', these 'Walkabouts' are observational and involve patient discussions and feedback about care. The reports from the 'Walkabouts' will be presented to the Trust Patient Experience Committee and action plans arising from the 'Walkabout' will be the responsibility of the Head of Nursing.
7. To ensure that a robust process is in place to assess the wards and departments for compliance against the essential standards of quality and safety, we will develop a new approach to our internal 'inspections'. This new approach will encompass a rigorous assessment and testing of all the evidence with which to test compliance against the full standards.
8. The Corporate Nursing Department will produce a video for all staff, to stress the importance of the important aspects of Privacy, Dignity, Communication, staff and patient handover and documentation.

9. Through our preparation and existing work on our organisational development plan for the newly merged organisation, our focus on culture will aim to embed and improve making the patient's experience, a good one.	
Who is responsible for the action?	1. Action 1 – Ward Managers 2. Action 2 – Practice Development Team 3. Action 3 – Matrons 4. Action 4 – Ward Managers & Ward Staff 5. Action 5 – Ward Managers 6. Action 6 – Heads of Nursing 7. Action 7 – Deputy Director of Nursing and Deputy Director of Governance 8. Action 8 – Deputy Director of Nursing 9. Action 9 – Human Resources department

How are you going to ensure that improvements have been made and are sustainable? What measures are you going to put in place?

1. The Trust has an existing system in place to gain patient feedback on a continual basis. The consenting patients within each area complete the questionnaire using an electronic system and all results are collated and published onto a Ward Scorecard. All wards are then required to ensure that any actions required as a result of their published results are implemented within their areas.

2. Ward scorecards will be presented by Ward managers at the newly developed Nursing and Midwifery Metrics meeting and action plans will be developed for Red areas.

3. The Matrons Quality Ward Rounds will be reported to the Nursing Quality Metrics meeting and also to the Directorate Governance meetings. Action plans arising from the Quality Ward Rounds will be monitored by the Matrons.

   All Patient Experience Feedback, scores and performance is reported through the Trust Governance Structures to the Trust Board.

4. The Executive and Non-Executive Directors also complete 'Executive Leadership Walkabouts' once a month and observe practice within ward or department areas. The observational visits to the wards also include talking to patients and gaining first hand feedback on their experience.
   The Executive Walkabouts will also form part of the Trust Patient Experience Committee reports to the Trust Board.

5. The Patient Welfare Forum also undertakes visits to the wards for observational purposes and also observes practice and obtains patient feedback. The Feedback is also reported to the Patient Experience Committee.

6. The new internal compliance inspection of assessment for the wards will cover all the aspects within the essential standards, wards will be inspected and a comprehensive report will be produced and any partial or non-compliances will require an action plan. These action plans will be monitored by the Trust Clinical Quality Committee.

Who is responsible?	1. Trust Patient Experience Team – production of monthly ward scorecards on patient experience 2. Ward managers will be responsible for the actions relating to any Amber or Red areas on their Ward Patient Experience Scorecard 3. Matrons will be responsible for the Matron's Quality Ward Round and presentation of report at Metrics and Directorate Governance Meeting 4. Patient Experience Committee will receive reports from the Executive Walkabouts 5. Patient Welfare Forum will continue to report to the Patient Experience Committee 6. The Heads of Nursing will be responsible for the monitoring of reports following the internal inspection of ward areas, along with the Trust Clinical Quality Committee
What resources (if any) are needed to implement the change(s) and are these resources available?	
The resources will be identified from within the Directorate Budgets.	
Date actions will be completed:	30th September 2013
How will not meeting this regulation until this date affect people who use the service(s)?	
The Trust had made significant improvements to date related to treating patients with dignity and respect, which has been demonstrated in our whole year results of our internal Patient Experience Questionnaire and our Friends and Family responses. However, we do recognise that there is always room for improvement and we are committed to ensure this improvement is continual. We are always seeking the feedback from patients, relatives and carers, and can be assured that over 92% of our patients are satisfied with the care they have received and the dignity and respect shown. We monitor all complaints on an ongoing basis and do have a process where action plans and improvements are made as a result of any informal or formal complaints. We aim to provide a high quality service with an excellent standard of care delivery and we will monitor this from our daily patient experience responses.	
Completed by (please print name(s) in full)	Belinda Regan

Position(s)	Deputy Director of Governance
Date	15th April 2013

Regulated Activities	Regulation
Diagnostic and screening procedures Surgical procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services
	How the regulation was not being met:
	Some patients were not protected against the risks of receiving inappropriate or unsafe care. Accurate needs assessments were not always in place, which meant that care and treatment was not always planned and delivered so as to meet patients' individual needs. *(Regulation 9 (1)(a) & (b)(i))*

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The completion of Nursing and Midwifery documentation is covered within the Nursing and Midwifery Induction Programmes. The Trust also has an E-learning package for Health Records.

The Trust has in place a monthly audit system for auditing the completion of nursing documentation which includes the Nutritional Assessment and Screening Tool and also includes all the needs assessments. It is mandatory for each ward to undertake this audit.

The results of these audits are discussed at the Trust Aspiring to Excellence meeting.

1. The Practice Development Team will continue to ensure that the importance of completing the needs assessments for patients and ensuring that this is recorded within the patient records is continually emphasised within the Trust Nursing and Midwifery Induction Programme.
2. To address the observations made by the Care Quality Commission, the Trust will establish a new group the Quality Nursing and Midwifery Metrics Group which will monitor the compliance of the monthly ward audits and will report to the Heads of Nursing and Aspiring to Excellence Group.
3. All department matrons will be required to present the reports at the Quality Nursing and Midwifery Metrics group. Action plans will be required for any partial or non-compliant areas.
4. The matrons on their Quality Ward rounds will assess the completion of the nursing and midwifery patient records as part of their observational assessment.
5. The Corporate Nursing Department will produce a video for all staff, to stress the importance of the important aspects of Privacy, Dignity, Communication, staff and patient handover and documentation.
6. The Surgical Directorate will review its core nursing assessment and care planning documentation as part of the integration planning with a view to streamlining nursing documentation.
7. As part of the establishment of the new Quality, Nursing and Midwifery Metrics meeting, the Trust will produce an annual planner for Wards to assist ward managers complete their required roles in relation to nursing and midwifery audits.
8. A Training programme in conjunction with the Dementia CQUIN and national requirements will be continued and assisted by the four main Trust Dementia Leads, the appointment of a Clinical Nurse Specialist for Dementia and a Dementia Nurse. This will assist the roll out of the Dementia pathway across all areas, the roll out of the use of Dementia Passports and the undertaking of a survey of the Carers of patients with dementia.
9. The End of Life Strategy will be finalised and approved by the End of Life Care Steering Group and work will commence on the action plan.

Who is responsible for the action?	Action 1 - The Trust Practice Development Team Action 2 – The Heads of Nursing Action 3 – Trust Matrons Action 4 – Trust Matrons Action 5 – The Deputy Director of Nursing Action 6 - Head of Nursing for Surgery Action 7 – Heads of Nursing Action 8 – Heads of Nursing Action 9 – Head of Nursing for Specialist Medicine and Trust Lead Nurse for Cancer

How are you going to ensure that improvements have been made and are sustainable? What measures are you going to put in place?

1. The Trust has an existing system in place to monitor the completion of nursing assessments on a monthly basis. This includes the Nutritional Assessment Tool A scorecard is produced which shows the completion and compliance rates for all wards. The Trust will now introduce a new system for the presentation of these reports in a newly established Quality Nursing and Midwifery Metrics forum. This forum will be run by the Senior Nurses within the Trust and all Trust Matrons and Ward managers will be required to present their data. Any partial or non-compliant areas will require an action plan which will be monitored by the group. It is anticipated that this group run on a continual monthly basis.

2. The Trust matrons will be required to report their observational findings from their Quality Ward Rounds to the Heads of Nursing meetings and the Directorate Governance meetings and action plans associated with observations will be monitored.

3. The impact of the Video production will be measured by staff feedback and the compliance audits of completed documentation.

4. The Surgical Directorate will review its documentation and through the Heads of Nursing and Surgical Governance meeting progress will be monitored and implementation plans agreed.

5. The Trust is in the process of appointing a Senior Nurse for Dementia and has submitted another proposal for a Band 7 Dementia Nurse. Training has commenced and the Trust has four Lead Trainers who have completed the National training course. A training programme will be developed for the Trust on appointment of these posts. As part of the focus on dementia for the Trust, feedback surveys from carers of patients with Dementia will be developed and rolled out within the Trust.

6. The Trust End of Life Strategy will be finalised and approved by the End of Life Care Steering Group and ratified through the Patient Experience Committee. An action plan will be part of the strategy and the Patient Experience Committee, as well as the End of Life Care Steering Group will monitor and oversee progress against the action plans.

7. To encourage patients to feel and become more involved in their care we will produce additional and appropriate patient information and will introduce a Poster Campaign with the Communications Department to be displayed on the ward – “No decision about me, without me’ ., campaign.

Who is responsible?	1. Heads of Nursing 2. Trust Matrons 3. Heads of Nursing 4. Heads of Nursing 5. Heads of Nursing 6. Head of Nursing Specialist Medicine, Patient Experience Committee 7. Heads of Nursing with the Communications department

What resources (if any) are needed to implement the change(s) and are these resources available?

1. The resources identified for the making of the video will be met by the Directorate Budget
2. The resources for the appointment of the Dementia post will be met by the Directorate budget
3. The resources required any potential introduction of new Surgical Documentation will be the subject of the Trust normal business case proposals.

Date actions will be completed:	December 2013

How will not meeting this regulation until this date affect people who use the service(s)?

The Trust has made immediate improvements since the CQC visit and the subject of the needs assessment planning and completion has been raised with all ward and senior nursing staff. Ad-hoc, spot check visits to wards have been conducted and an improvement has been seen.

The Trust is also preparing for its NHSLA level 2 assessment and audits and assessments of patient records form part of that preparation for assessment. An independent assessor has been appointed to assist the Trust with its preparation and the assessor has conducted numerous unplanned assessments of patient health records and has reported improvements.

Whilst recognising the importance of the completion of the patient needs' assessments, the Trust do believe it continues to provide safe, good quality care to its patients and carers.

Completed by (please print name(s) in full)	Belinda Regan
Position(s)	Deputy Director of Governance
Date	15th April 2013

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Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

University Hospital Lewisham

Lewisham High Street, Lewisham, London, SE13 6LH

Tel: 02083333284

Date of Inspections: 11 February 2013
08 February 2013

Date of Publication: April 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Cooperating with other providers	✓ Met this standard
Staffing	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	Lewisham Healthcare NHS Trust
Overview of the service	University Hospital Lewisham is the main hospital location of the Lewisham Healthcare NHS Trust, a medium-sized integrated acute and community trust which is the primary provider of a broad range of acute and community healthcare services for approximately 265,000 people living in the London Borough of Lewisham. University Hospital Lewisham has a 24-hour emergency department, inpatient beds, outpatient clinics, operating theatres and an integrated critical care unit.
Type of services	Acute services with overnight beds Diagnostic and/or screening service Urgent care services
Regulated activities	Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Termination of pregnancies Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 8 February 2013 and 11 February 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information we asked the provider to send to us. We reviewed information sent to us by other regulators or the Department of Health, reviewed information sent to us by other authorities, talked with other authorities and were accompanied by a specialist advisor. We used information from local Healthwatch to inform our inspection.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Our inspection team included specialist elderly care and learning disability associate inspectors.

What people told us and what we found

The main focus of our inspection was on the care and treatment provided to more vulnerable patients, for example older people, people receiving end of life care and people with dementia or learning disabilities.

The trust worked in co-operation with other partners, and was part of an innovative "developing integrated pathways across health and social care" project.

There were clear pathways and tools which were aimed at meeting the needs of vulnerable patients; however, some of the measures and tools within the pathways were not yet fully implemented or had not been audited to assess whether they were meeting patients' needs.

Some of the care records and assessments we saw did not reflect people's needs, or were incomplete or inaccurate, which meant there was a risk that not all patients experienced care, treatment and support that met their needs.

Overall, patients' views and experiences were taken into account and staff respected and promoted their privacy. However, patients' personal dignity was not always taken into account. Some patients were complimentary about the service they had received, and told

us, "staff are busy but they do have time to talk to me and they listen to me. They do a great service", "the nurses work really hard, they have lots to do" and "staff have been marvellous". However, during our inspection we saw examples of poor communication, and some patients told us that staff did not listen to them or their views.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 20 April 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✖ Action needed

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was not meeting this standard.

Overall, patients' views and experiences were taken into account and staff respected and promoted patient privacy. However, people's dignity was not always respected.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Most patients we spoke with during our inspection understood the care and treatment choices available to them and were given appropriate information and support regarding their care or treatment.

Patients knew why they were in hospital and what treatments they were receiving, although about 80% of them did not know that they had a written care plan. An inpatient with communication issues said that they were well-looked after and staff explained their care and treatment when they didn't understand.

In 2012, the Parliamentary and Health Service Ombudsman had found that a patient "was not given relevant and accurate information" about their condition on discharge. At our inspection we saw that the trust had developed a range of patient information leaflets for patients to take home, including on the risks and benefits of elective surgery and on post-natal infections, to promote patient understanding about their care and treatment.

Reasonable adjustments were offered to patients with communication difficulties. For example, people with learning disabilities (PWLD) or with dementia were encouraged to bring a supporter with them to hospital appointments. Staff we spoke with were not aware of leaflets in easy read formats, but said they could ask for these to be provided reactively. A communications passport was available for PWLD, with large print and pictures to illustrate questions. A similar passport was in development for people with dementia but was not yet available for staff use. Information could be provided in Braille, and interpreters for second language speakers or people with hearing impairments could be made available. The hospital used a symbol to indicate when a patient had specialist communication needs, such as dementia or a learning disability, to remind staff to provide extra communication support. A specific symbol indicating LD had been piloted, but was not yet in use on all hospital wards.

Signage throughout the hospital was poor, including temporary, handwritten signage and signs that did not provide good directions. Some signs were high-up and not appropriate for people with dementia or with limited mobility. We saw many people having to ask staff for directions. Staff told us that poor signage was often raised by visitors. A project to improve signage at the hospital had been completed, but due to ongoing discussions about the future use of the hospital the project recommendations were on hold.

The results of patient surveys and some information of concern we received showed that some patients or their visitors had experienced issues relating to attitude of staff and poor communication.
The trust gave us evidence which showed there were measures in place to monitor, learn from and improve the patient experience. There were specific action plans to improve patient experiences, and close working relationships with the Local Involvement Network. Recent patient feedback reports showed some improvements. We saw the results of a recent survey where 90% of patients who were asked, "How likely are you to recommend our ward to friends and family if they needed similar care or treatment?" responded that they were "likely or "very likely" to recommend the hospital.

During our inspection, most patients told us they felt well-looked after. The majority of patients, family members and visitors were complimentary about the hospital and its staff. Some people told us, "the nurses are fantastic", "I am treated really well" and "I can't fault most of the staff". However, one person said, "there were two rude nurses… but I ignored them". A family member told us, "on this ward the staff have been great but they were horrible" on another ward. An inpatient said that night nursing staff had ignored their requests for help with personal care, but that their daytime nurses were "great".

Some patients told us that they did not feel that staff listened to them or involved them in making decisions about their care. For example, a patient with learning disabilities (PWLD) said they felt well-looked after but had not been offered any choices about their care. However, most patients told us that some of their individual preferences, for example what they wanted to eat, were taken into account.

Most staff we observed provided patients with appropriate personal care and attention, spoke with patients politely and treated them with respect. Measures were in place to protect people's dignity and privacy, for example soft music was played at outpatient reception areas to mask conversations. Staff used privacy curtains when personal care was provided and during examinations and there were separate male and female bed areas. Most patients said that staff responded to call bells promptly, although some said that it was the only way they could get any attention. A patient told us, "staff are so busy I don't like to bug them…"

However, on some wards where care was provided to elderly patients we saw examples of poor or no communication. We observed that staff entered a bay, spoke to no-one and went out again. We also saw two staff having a conversation about a patient's care in front of them, without involving them in the discussion. One person told us, "I want to go home. It is so lonely here, no-one ever comes in."

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

Patients' care records and assessments did not always fully reflect their needs, or were inaccurate or incomplete, and not all measures to provide appropriate and personalised care for vulnerable patients with specific needs had been implemented. This meant that there was insufficient evidence that all patients experienced care, treatment and support that met their needs.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Most care we observed was given in a professional and timely way. The majority of patients we spoke with said their care was good and appropriate and understood their treatment. We saw examples of flexible and personalised care, such as an outpatient clinic which offered weekend appointments to ensure that people's needs were met.

However, we found there was insufficient evidence that all patients experienced care, treatment and support that met their needs. Some assessments and care records were incomplete or inaccurate, which meant care and treatment was not always planned and delivered in line with individual care plans or patient needs. The trust's nursing audits in January 2013 evidenced poor completion rates for some care documents, including that on two wards only 40% of individualised care plans for each issue identified by nursing assessments were in place.

During our inspection we observed a patient, admitted after unintentional weight loss, who waited an hour for food, having been nil by mouth all day after a cancelled procedure. Their nutritional screening was incorrectly completed, and did not document their weight loss or require staff to monitor food and fluid intakes to ensure the risk of further weight loss and poor nutrition was minimised. The trust had a system of two-hourly nursing basic checks that include positioning and pain relief for all patients. Two out of three sets of care records we looked at on one ward showed no evidence that two-hourly nursing basic checks had been done. On a third ward, there was a vulnerable patient with no appropriate plan of care.

In 2012, the trust identified a risk that it might fail to meet the national target for 98% of patients to be diagnosed, treated, discharged or admitted within four hours; it had implemented a recovery initiative and by February 2013 this risk was significantly reduced. Specialist pathways and plans, such as an overnight community palliative care nursing care service, had helped reduce hospital admissions and length of stays.

Staff carried out assessments to ensure that people's safety and welfare needs were met. For example, skin viability assessments were completed as soon as possible after admission. Staff were trained in pressure ulcer management and prevention. There were quarterly audits of pressure ulcer documentation. The audit results showed a reduced incidence of hospital acquired pressure ulcers in 2012. Pressure ulcers were reported and investigated as incidents and lessons from investigations were communicated to staff and incorporated into a monitored pressure ulcer prevention action plan.

Data collection and reporting arrangements were in place to ensure that elderly emergency patients at risk of or with dementia were identified, treated and referred to appropriate specialist services. Completion rates for ward cognition assessments had improved significantly throughout 2012.

The trust had a dementia care pathway and guidelines, elderly care specialist clinicians, and a senior clinician who led on quality improvements in dementia to ensure that people with dementia (PWD) received appropriate and personalised care. The effectiveness of care and treatments for PWD was monitored. For example, learning from an audit of prescribing for PWD was communicated to clinicians to improve future prescribing practices.

There was a named dementia champion on each elderly care ward, and staff were trained to recognise signs of dementia. However, the total number of staff who had attended dementia care training was not available, and three ward staff we spoke with were unaware of the dementia pathway. This meant there was a risk that some care and treatment for PWD might not always be planned and delivered so as to meet their specific needs.

The trust had an action plan and a clear pathway to improve access to healthcare for PWLD. Measures which had been introduced were commended by local partners as examples of good practice. Specific tools had been developed for PWLD, including a communications book, to help staff and PWLD to communicate effectively. There was a hospital passport to be completed by clinicians with the PWLD at initial medical appointments to ensure that further treatment took their needs and preferences into account. However, the tools were not yet fully implemented; some staff were not aware of the tools and had not yet attended health and wellbeing for PWLD training, and no evidence of how many passports had been completed. The trust had not yet implemented specific audits or satisfaction surveys to check that the services it provided met the needs of PWLDs.

Palliative care consultants and a local palliative care team were responsible for overall care management and pain control for people receiving EoLC. Ward staff providing the day-to-day nursing told us they were provided with EoLC training. We saw appropriate care being provided to an EoLC patient; an EoLC plan was in place and support from a palliative care link nurse. Patients with capacity were supported to make advance decisions to refuse treatment and a tool had been introduced to evaluate the wishes and needs of EoLC patients who were discharged to care in nursing homes. These EoLC tools were monitored to ensure they were used appropriately.

The trust followed national adult palliative care guidance but its EoLC strategy was still in draft form, and was not, therefore, fully implemented. A plan to replace all syringe drivers, in line with national recommendations, had been delayed as the equipment supplier was unable to provide all the required staff training until June 2013.

Cooperating with other providers ✓ Met this standard

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Reasons for our judgement

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services, because the provider worked in co-operation with others.

We were aware of some instances where patients were discharged with a lack of information or the wrong information, or where family or home situations were not taken into account. We had received information from some local care homes that discharge information was not always provided in a timely way when patients were transferred, to ensure people's safety and continuity of care. Some care home staff told us they had identified pressure ulcers which were not noted in discharge information. Our review of complaints in 2012 found that on one occasion a patient was discharged without appropriate arrangements for pain relief and with no discharge summary, and, on another occasion, the hospital acknowledged that the discharge information sent to a GP "could have been more detailed".

The trust worked with local care providers and patient representatives to improve the quality of its services. For example, there were quarterly joint providers meetings, attended by staff from care homes, inpatient and community services and local authority teams, where joint learning events and discussions about shared issues and potential solutions took place.

We saw evidence that the trust had improved the provision of information to patients, carers and GPs. Systems had been improved to ensure that sufficiently detailed information was provided to GPs. The outpatients we spoke with told us their GPs always knew about their hospital appointments and received information and test results from the hospital in a timely way.

The trust was part of the local EoLC and palliative care network. A Proactive Elderly Advance CarE (PEACE) plan had been introduced for patients at the end of their lives who were being discharged to care homes, which provided clinical advice for future medical care to support GPs and care homes to provide care in the home setting. The trust's elderly care team were responsible for completing PEACE plans and communicating them to GPs on discharge. An evaluation on PEACE plans in 2012 found that 88% of patients

with a plan were discharged for continuing healthcare. Most GPs who received the plan had found it useful in supporting the EoLC. However, 14 out of 23 discharge notes had not noted that a plan was in place, and not all GPs were aware of the plan or of its purpose. The trust had responded by improving the quality of PEACE plan completion and providing more information for GPs. A monitoring system was in place to make sure that discharge information noted that a PEACE plan was in place, to ensure that the plan of care was implemented after patients were discharged.

There were systems in place to ensure that, whenever possible, patients were discharged in a timely and appropriate way. The trust and its partners had a well-advanced "developing integrated pathways across health and social care" project, to promote people's health and wellbeing through prompt and effective interventions. During our inspection we spoke to several of the project partners and saw evidence of close working, good co-operation and communication.

A CQC review of NHS Hospital Discharges in 2012 identified no significant differences between the trust and other comparable trusts in relation to delayed discharges, delayed transfers of care or emergency readmissions. The trust's most recent monitoring of delayed discharges/transfers of care showed that most delayed discharges and transfers of care were due to shortages in non-acute NHS care. The trust and its partners had worked together to identify solutions to the delays, and a specialist team had been developed to focus on placing patients who needed high levels of nursing care. The provider may find it useful to note that while delayed discharges due to social care partners not completing assessments or putting suitable care packages in place in a timely way reduced throughout March to December 2012, these delays rose again significantly in January and February 2013.

Measures, for example daily ward rounds and meetings where discharges were discussed, and faster access for community-based care, had resulted in better than estimated dates of discharge for many planned admissions.

Most inpatients were aware of their estimated discharge dates or why their discharge was delayed. We saw evidence that patients and families were involved in discharge decisions and planning, including one-to-one meetings with hospital social workers to discuss their discharge needs and plans.

Ward staff were clear about what they needed to do in relation to making referrals for continuing health or social care, and ensuring that discharge documents and medications were in place. Each ward had either a named staff nurse or ward-based social worker who was in charge of ensuring safe and co-ordinated discharges.

Systems were in place to ensure that more complex and high-risk individuals were identified, so that coordinated responses to their care needs were developed with community partners. We saw evidence of appropriate referrals and communication between the ED and community nursing, for example referrals to tissue viability nurses where pressure sores were identified, or to dementia care specialists if patients were assessed as being at risk of dementia. The local authority's specialist LD team were involved at admission or as soon as a PWLD was identified. An A&E social worker worked alongside ED staff until 10pm, and could identify patients with specialist LD needs, alert social services and the trust's safeguarding lead, and ensure that PWLDs specific needs were identified and met.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

Our previous inspection in 2011 highlighted that staff shortages were potentially impacting on the provision of good quality care. After our inspection the trust told us that it had implemented a staffing review to ensure that there were enough qualified, skilled and experienced staff to meet people's needs.

In the 12 months before this inspection, we had received some information of concern about potential low levels of staffing and examples of poor care in outpatients and inpatients, including elderly care, assistance with eating, timely assessment, pain relief and poor communication by staff. A recent staff survey also indicated that many staff were working extra hours.

At our inspection, we found that there were enough qualified, skilled and experienced staff to meet people's needs.

During our inspection, a patient we spoke with told us, "staff are busy but they do have time to talk to me and they listen to me. They do a great service." Other comments were, "the nurses are fantastic" and "the nurses work really hard, they have lots to do". Another inpatient told us, "staff have been marvellous".

On some wards we visited there were staff vacancies and we observed that staff sometimes found it difficult to meet all patient needs. For example, one ward we visited had two nurses and a healthcare assistant (HCA) providing care for 20 patients. We saw a patient continuously ringing their call bell for five minutes before someone went to them. All three staff were providing care with other patients, and told us two agency staff had not arrived for their shift.

During our visits to the fully-occupied medical admission unit, we did not observe any patients waiting a long time for care or support. Most patients spoke well of the staff caring for them. However, out of the 60 Band 6 and Band 5 nursing staff budgeted for the unit, 10 Band 6 posts were vacant at the time of our inspection. Interviews for all 10 posts were being held during our visit, which demonstrated that the trust was attempting to fill the vacancies with permanent staff. Staff we spoke with told us that these vacancies were mainly due to high staff turnover, as the unit was demanding and busy and nurses tended to move to other wards when the opportunity arose. This meant that many of the

permanent staff were working additional hours, and that bank and agency use on the unit was high.

The provider may find it useful to note that, on both days we visited, the hospital's discharge lounge was staffed by one discharge nurse, with no other staff available in the lounge. The nurse had to collect patients' take home medications from the pharmacy, which meant the lounge was not staffed at all times.

We also visited wards where there were no staff vacancies, and the same, regular staff cared for patients. Inpatient ward staff told us that they could request additional staff if people required higher levels of care or had more challenging needs, for example if end of life care was required or a patient had a learning disability.

In outpatient clinics and A&E we observed that there were sufficient staff and a calm atmosphere. The trust had increased nursing staff in the rapid assessment and treatment unit to ensure that appropriate care was provided.

The trust risk register report dated 5 February 2013 identified two key staffing risks at the hospital, primarily related to proposed changes in the way services were delivered at the trust. We saw evidence that the trust had recruitment and retention strategies in place and was providing ongoing support and clear communications for staff to try to mitigate the risk that it would fail to recruit and retain staff.

Senior staff told us there were no frozen nursing posts, but that it was sometimes not possible to recruit suitably qualified and experienced staff.

The trust Board received quarterly reports on issues relating to staffing. The report dated 5 February 2013 showed that although overall vacancy rates at the trust had remained stable from April to December 2012, the use of bank and agency staff had increased; the trust was analysing the reasons for this in order to reduce the use of agency staff.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately. People's complaints were fully investigated and resolved, where possible, to their satisfaction.

Reasons for our judgement

People were made aware of the complaints system, which was provided in a format that met their needs. There was a written complaint policy and process, which was available on request or on the trust's website and intranet. The complaints information was available in Braille and easy-read formats on request.

An integrated complaints and patient advice and liaison service (PALs) system was in place. There were leaflets about the complaint process and PALs displayed on most inpatient ward noticeboards. However, the provider may find it useful to note that the leaflets were not visible in outpatient departments we visited. There were also electronic feedback kiosks, and we saw evidence that patients used these to comment on the services provided.

Most people we spoke with during our inspection had no complaints, but some said they were not aware of how they could comment or make a complaint. Following our visit, the trust told us it had ordered banners for display in the hospital, to help raise the awareness of patients, members of public and staff on how to make a complaint.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately, and people were given support to make a comment or complaint where they needed assistance.

Staff confirmed that if someone wanted to raise an issue or make a complaint they would direct them to PALs. We saw evidence that the PALs team supported people to make complaints, if they needed assistance. PALs could also arrange for interpreters or direct people to independent advocacy, if this was required. Patients and family members we spoke with who had accessed the PALs service said they had found it responsive and helpful.

Statistically, the trust received about the same number of complaints compared to other similar trusts. We asked for and received a summary of complaints people had made. At our inspection, the trust provided us with information which showed that it had received a total of 355 written and verbal complaints about University Hospital Lewisham between 1 April 2012 and 31 December 2012.

There was an effective complaints system available. The comments and complaints people made were generally responded to appropriately, and their complaints were fully investigated and resolved, where possible, to their satisfaction. In 2011/12, 527 written complaints were made by (or on behalf of) patients about the trust, with 52.8% of written complaints upheld.

There were systems to monitor complaints, including an electronic complaints logging system which helped to identify any trends or themes. The most frequent complaint was communication and the trust had introduced changes to address this complaint. For example they ensured all directorates and member of the public was part of the complaints committee.

Each directorate had a named senior staff member 'complaints leads', responsible for overseeing the investigation and response for each individual complaint. Action plans were in place to ensure that actions after complaints investigations were completed, with ongoing monitoring by the steering group.
The minutes of the monthly complaints steering committee (November and December 2012 and January 2013) showed that complaints leads, representatives from patient forums and PALs and other senior managers, including the Chief Executive, had attended, and discussed new and open complaints, learning and Ombudsman complaint reviews.

The minutes also showed that the trust was failing to meet its target complaints response rate of 95% of complaints responded to within 25 days. In November 2012, 69% complaints were responded to within the agreed timescale. The trust introduced measures to improve the response rates, including that one directorate had introduced a dedicated complaints co-ordinator. By December 2012 monthly complaints performance had improved, with the response rate going up from 69% to 89% responses within the agreed time.

Senior staff told us that the learning from complaints and investigations was fed back to frontline staff. However, the provider may find it useful to note that some staff we spoke said they did not get formal feedback about complaints from their managers.

We saw evidence that the trust learned from the outcomes of investigations into complaints, and implemented changes to improve the quality of the services it provided. For example, information leaflets were being provided for surgery patients after it was found that a patient had not been given appropriate and sufficient information about their surgery and aftercare.

In some cases where local resolution did not satisfy complainants, they had requested an independent review by the Parliamentary Health Service Ombudsman (PHSO). Two complaints about the trust were accepted by the Parliamentary Health Service Ombudsman (PHSO) for investigation in 2010-11; neither was upheld. In 2011/12, the PHSO received 40 complaints about the trust; one was accepted for review and was fully upheld. At this inspection, we saw action plans which provided evidence that the trust took into account learning and implemented change even when issues were still under PHSO review.

A public interest disclosure 'whistleblowing' policy was available to staff. Staff we spoke with said that if they felt their concerns were not listened to by the trust they would use the whistleblowing system. We saw evidence that one whistleblowing concern had been raised in the past 12 months and was being investigated.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: Patients were not always treated with courtesy and respect or encouraged to express their views about what was important to them in relation to their care. (Regulation 17 (2)(a) & (c)(ii))
Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Some patients were not protected against the risks of receiving inappropriate or unsafe care. Accurate needs assessments were not always in place, which meant that care and treatment was not always planned and delivered so as to meet patients' individual needs. (Regulation 9 (1)(a) & (b)(i))

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

The provider's report should be sent to us by 20 April 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk

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Healthier Communities Select Committee			
Report Title	**London Borough of Lewisham's Mental Health Adult Placement Service**		
Contributors	**Executive Director for Community Services**	**Item No**	**4**
Class	**Part 1**	**Date**	**29 May 2013**

1. Purpose

1.1 Lewisham's Mental Health Adult Placement Scheme for people with mental health problems was recently inspected by the Care Quality Commission (CQC). This report informs Members of the outcome of that inspection and the action that is being taken to address those areas which did not meet the required standard.

2. Recommendations

2.1 Members of the Healthier Communities Select Committee are asked to note the findings of the CQC inspection and the measures that have been, or are being taken, by the service to address the identified areas for improvement.

3. The Adult Placement Scheme

3.1 The Mental Health Adult Placement Scheme provides accommodation and support to people recovering from mental illness enabling them to live independently in the community. People may either live within the carer's family home or in supported lodgings where he or she will share accommodation with other service users and where support is provided by a visiting carer.

3.2 The service provides a safe, supportive and comfortable environment in which service users can adjust to living more independently in the community. Currently 28 service users are supported through the scheme: ten are placed in the homes of individual carers and 18 are supported in shared accommodation.

3.3 Adult Placement Scheme Staff are employed by the Council and for the purpose of Care Quality Commission (CQC) registration the Council is the Registered Provider. The service is managed by South London and Maudsley Trust (SLAM) under a management agreement. The carers who provide the support to service users are remunerated through the Council's Supporting People budget.

3.4 To enable service users to access the scheme, Community Mental Health Team Care Co-ordinator make a referral to SHIP (Single Homeless Intervention and Prevention Service). SHIP then liaise with the Adult Placement Scheme staff regarding the support required and necessary risk assessments.

4. The Care Quality Commission (CQC)

4.1 The Care Quality Commission (CQC) is the independent regulator of health care and adult social care services in England. Under the Health and Social Care Act 2008, providers of regulated activities are required to register with the CQC. The CQC regularly undertakes unannounced routine inspections of regulated providers and judges whether or not essential standards are being met. CQC's inspection reports are published on its website.

4.2 On 6 March, CQC conducted an unannounced routine inspection of the Mental Health Adult Placement Scheme. A copy of the inspection report is attached at Annex A. As a result of the inspection CQC found that the Scheme met three out of the five standards and identified two that required action.

5. CQC's Judgement of the Scheme

5.1 CQC found that the following three standards had been met:

- Respecting and involving people who use services
- Care and welfare of people who use services
- Safeguarding people who use services from abuse.

5.2 CQC found that the following two standards required action:

- Supporting Workers

5.3 CQC judged that the Scheme was not supporting carers to deliver care and treatment safely and to an appropriate standard through appropriate training and regular supervision (Regulation 23 (1) (a)), although CQC judged that this had a minor impact on people who use the service.

- Assessing and Monitoring the quality of service provision

5.4 CQC also judged that the Scheme did not have an effective system to protect service users against the risks of inappropriate or unsafe care by regularly assessing and monitoring the quality of services provided. (Regulation 10(1) (a)). Again CQC judged that this had a minor impact on people who use the service.

5.5 Reasons for the judgements are set out in full in the CQC inspection report.

6. Action Plan.

6.1 Where areas have been judged as requiring action, the provider is required to submit an action plan detailing how the service will address the areas for action. The action plan was submitted to CQC on 9 April and is attached at Annex B.

6.2 The action plan presented to CQC identifies a number of key activities with attached deadlines. CQC has deemed these deadlines to be acceptable.

6.3 In addition to being registered with the CQC the service is also subject to the Supporting People (SP) contract monitoring regime. Just prior to CQC's visit, Supporting People staff had undertaken a contract monitoring visit and had identified similar issues. The Scheme had been issued with a number of remedial actions and these were due for review at the end of March. The staff, managers and Supporting People commissioners will continue to monitor all the required actions very closely. Good progress has been made on the action plan to date. CQC have not yet confirmed when they intend to revisit the scheme.

7. Financial Implications

7.1 There are no financial implications arsing from this report. Any expenditure resulting from the action plan will be met from existing budgets.

8. Legal Implications

8.1 There are no legal implications arsing from this report.

Background Documents

Appendixes: CQC monitoring report (March 2013) and CQC Action Plan (April 201)

If there are any queries on this report, please contact Fiona Kirkman, Prevention and Intervention Manager on 020 8314 9626.

Appendix B

Report on actions you plan to take to meet CQC essential standards

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	1-101680840
Our reference	INS1-647556720
Location name	Lewisham Mental Health Adult Placement Scheme
Provider name	London Borough of Lewisham

Regulated Activity	Regulation
Personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting workers
	How the regulation was not being met:
	The provider was not supporting carers to deliver care and treatment safely and to an appropriate standard through appropriate training and regular supervision (Regulation 23 (1) (a))

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. Carers' meetings
Meetings with APS staff and carers have recommenced, with a meeting on 18th March. It was well attended by all but one carer. These meetings will be scheduled every 8 weeks. The agenda is collaborative and the meeting serves as a support to carers, offering a peer support element alongside the opportunity to problem solve and raise carer support needs. Outcomes from these meeting will be recorded and any action monitored.
(Timescale: with immediate effect and ongoing)

2. Comprehensive Carer Reviews
Carer reviews that are incomplete will be repeated and completed in their entirety starting with those closest to their review date , this action to be completed by APS staff.
(Timescale: by 30 June 2013)

Carer reviews that are overdue will be carried out and completed comprehensively.
(Timescale: by 30 June 2013)

The service will ensure that all Carer Reviews when due for review, are completed on time and comprehensively by APS.
(Timescale: ongoing)

3. Carers' training
Arrangements have now been made to book carers onto required training giving priority to training relating to service user safety. All carers will have a confirmed training date for these sessions.
(Timescale Completion of Training Schedule : Mid May 2013)
(Identification of Carers full training needs : July 31st 2013)
(Completion of revised training programme by all carers : October 31st 2013)

Carers' individual training needs will be reviewed, including all mandatory and non mandatory training, in particular in relation to understanding safeguarding requirements. A training plan for each carer will be produced.
(Timescale - Completion of Training Schedule : Mid May 2013)
(Identification of Carers full training needs : July 31st 2013)
(Completion of revised training programme by all carers : October 31st 2013)

4. Spot checks on carers
Spot checks on carers will recommence immediately and the service will carry out and record spot checks at all carer homes and Supported Lodgings. Any remedial action will be identified, recorded and progress monitored.
(Timescale: immediate)

5. Recruitment of staff
Recruitment is underway to recruit to the Scheme Manager Deputy posts.
(Timescale: by 31 May 2013)

6. Training for APS staff
The current administrator has completed Safeguarding Adults training on 28 March 2013 and procedures for staff will be updated immediately.
(Timescale: immediate.)

Who is responsible for the action?	Caroline Bogle –Acting Clinical Service Lead

How are you going to ensure that improvements have been made and are sustainable? What measures are you going to put in place?

The APS staff and line management will review progress on this action plan on a monthly basis to ensure that actions are on schedule and completed to timescale.

Supervision meetings with APS staff will incorporate the monitoring of progress on these actions as a standing agenda item.

Who is responsible?	Caroline Bogle –Acting Clinical Service Lead Lou Hellard – Deputy Director, SLAM

What resources (if any) are needed to implement the change(s) and are these resources available?

The recruitment of staff to cover the current temporary staff absence will enable effective progress on this action plan.

Date actions will be completed:	May 31st 2013

How will not meeting this regulation until this date affect people who use the service(s)?

Areas for improvement raised through the inspection area are all being addressed and will be completed, unless ongoing and in accordance with stated deadlines , by end July 2013. Therefore, we do not anticipate that there will be any adverse effect on service users as all key improvement actions are underway.

Additional monitoring will take place by commissioners who will seek regular progress reports.

In addition London Borough of Lewisham will commission a bespoke exercise to re-evaluate the needs of all service users by the end of July 2013.

Completed by (please print name(s) in full)	Caroline Bogle
Position(s)	Acting Clinical Service Lead SLAM Supported Accommodation
	Fiona Kirkman

Position(s)	Prevention and Inclusion Manager, LB Lewisham
Date	09.04.13

Regulated Activity	Regulation
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision
	How the regulation was not being met:
	The registered person did not have an effective system to protect service users against the risks of inappropriate or unsafe care by regularly assessing and monitoring the quality of services provided. (Regulation 10(1)(a))

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

In addition to the data and information recorded through the activity set out in our response to Regulation 23 (1) (a), managers will ensure the following action is taken to identify, assess and manage performance and risk.

1. APS and Service user meetings
A programme of service user review meetings by APS staff , without the presence of their carer, will commence immediately, to review the service users' experience of the placement. Outcomes from these will be recorded, monitored and reviewed.
(Timescale: Programme of reviews developed : Immediate)
(: All service user reviews to be completed by July 31st)

2. Support Planning and Reviews
A programme is underway to review support planning to ensure clear goals for the service user have been identified and recorded. The Wellness and Recovery Action Plan (WRAP will be incorporated in support plans and reviews.

3. Care Plans and reviews
The Care plans are developed, implemented and reviewed by Care Coordinators, and will be undertaken in partnership with the service user.
(Timescale: by 31 July 2013)

4. Service User Feedback Meetings
The service will set up a Service User Feedback meeting as soon as possible and seek users views on the required frequency of these meetings. Actions from these meeting will be produced and recorded.
(Timescale: immediate)

5. Role of commissioners in quality assurance
As part of the ongoing contract management arrangements, commissioners will work with the APS to review existing management information systems and processes. This review will consider the recording and performance management arrangements for APS, including those in place for support planning, reviews and complaints. A separate action plan, agreed with APS, will be prepared to identify any areas of improvement and monitored through the contract monitoring arrangements.
(Timescale: by 31 July 2013)

Who is responsible for the action?	Caroline Bogle –Acting Clinical Service Lead

	Lou Hellard – Deputy Director, SLAM Fiona Kirkman – Prevention and Inclusion Manager, LB Lewisham

How are you going to ensure that improvements have been made and are sustainable? What measures are you going to put in place?

The APS staff and line management will review progress on this action plan on a monthly basis to ensure that actions are on schedule and completed to timescale.

Supervision meetings with APS staff will incorporate the monitoring of progress on these actions as a standing agenda item.

Who is responsible?	Geeta Subramaniam – Head of Crime Reduction LB Lewisham Fiona Kirkman – Prevention and Inclusion Manager, LB Lewisham Caroline Bogle –Acting Clinical Service Lead Lou Hellard – Deputy Director, SLAM

The recruitment of staff to cover the current temporary staff absence will enable effective progress on this action plan.

Date actions will be completed:	31st May 2013

How will not meeting this regulation until this date affect people who use the service(s)?

Areas for improvement raised through the inspection area all being addressed and will be completed, unless ongoing, by end July 2013. Therefore, we do not anticipate that there will be any adverse effect on service users as all key improvement actions are underway.

Additional monitoring will take place by commissioners who will seek regular progress reports.

Completed by (please print name(s) in full)	Caroline Bogle/Fiona Kirkman
Position(s)	Acting Clinical Service Lead SLAM Supported Accommodation Inclusion and Prevention Manager – LB Lewisham
Date	09.04.13

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Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Lewisham Mental Health Adult Placement Scheme

Social Services Department, 3rd Floor Ladywell Unit, Lewisham Hospital, Lewisham High Street, London, SE13 6LW

Tel: 02083333000

Date of Inspection: 06 March 2013

Date of Publication: March 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Supporting workers	✗ Action needed
Assessing and monitoring the quality of service provision	✗ Action needed

Details about this location

Registered Provider	London Borough of Lewisham
Registered Manager	Ms. Margaret Redman
Overview of the service	The London Borough of Lewisham Mental Health Adult Placement Scheme provides community placements for Lewisham Borough residents with, or recovering from, mental ill health. Placements are provided either in supported lodgings or within a family home. The scheme can offer placements for a maximum of 28 people.
Type of service	Shared Lives
Regulated activity	Personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 6 March 2013, talked with people who use the service and talked with carers and / or family members. We talked with staff, reviewed information we asked the provider to send to us and reviewed information sent to us by commissioners of services.

What people told us and what we found

People who used the service told us that the care and support they received was good. They said that they felt that their rights were respected, and that carers respected their privacy and dignity. One person said 'I am always treated with respect".

We found that people received safe and appropriate care, and that the care planning records were up to date.

People using the service told us that they felt safe in their placements. Carers understood their role in safeguarding people who use the service. .

Carers were assessed and approved by the scheme. There were a number of mandatory training courses that they were expected to attend. However, records showed that the majority of the scheme's carers were waiting to attend relevant courses.

We found that the service had a number of systems in place to monitor the quality of the care provided. However, it could not demonstrate that it had taken action when issues were found. We were unable to examine a number of records, including those relating individual reviews carried out with people using the service and the complaints log, as their whereabouts could not be determined.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 12 April 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

People expressed their views and were involved in making decisions about their care and treatment.

We looked at five electronic support plans. These were presented in a way that the people who used the service were able to understand. People told us they were involved in their care planning and they felt they were listened to.

People's diversity, values and human rights were respected. All carers had to sign a service agreement. Part of this included the expectation that they valued each person using the service as a full citizen with rights, responsibilities and the entitlement to be consulted about their care. People using the service told us they felt their rights were respected, and that carers respected their privacy and dignity. One person said 'I am always treated with respect".

There was a policy in place regarding matching people requiring a service to carers. This took into account the person's cultural and religious needs as well as more general ones. For example, plans of care showed that people were supported to attend a religious service of their choice.

People who used the service were given an introductory handbook. This set out the aims and objectives of the scheme, and what people could expect from it.

People were supported in promoting their independence. People's independence levels and how to maintain and/or enhance them were included in the five support plans we looked at. Community involvement was included in plans of care. Independence and community involvement were an important part of the purpose of the scheme. One person told us "I have achieved remarkable things, the carers don't hold me back. They encourage me to go out and do things ". Another person said "this has been a lifeline. I get a lot of support and have been able to progress personally".

The scheme had details of a local advocacy group if any of the people using the service wanted to make use of this service.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

People's needs were assessed and care was planned and delivered in line with their individual care plan.

People who used the service were assessed prior to being provided with the service. Wherever possible, people contributed to the assessment, and from the information gathered a plan of care was drawn up. This was then used to match the person to an appropriate care worker.

Input into care planning was provided through a number of sources. The scheme produced a support plan for each person, drawn up with the involvement of the person. Additionally, a care coordinator drew up a number of plans, including a mental health plan, a crisis management plan and a physical health plan. Care coordinators did not work directly for the scheme but were employed by a local NHS trust and worked in conjunction with the scheme to care for the specific mental health needs of people using the service.

The five support plans of care we looked at contained all the relevant information to enable the carers to deliver the agreed amount of care in the way that people preferred. Each plan had been reviewed within the last seven months.

Care and treatment was planned and delivered in a way that ensured people's safety and welfare. People told us that they were very happy with their care workers. They described carers as "good as gold", "supportive "and "amazing". One person told us "they don't look at me as though I am mentally ill". Another said," I am very happy in my home, my care worker is great".

Where appropriate there were crisis plans in place to deal with any emergencies relating to people using the service. Carers were provided with a range of training in areas such as first aid and health and safety. There was an emergency procedure in place for office based staff to refer to if required.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Training records showed that all carers had received trained in the safeguarding of vulnerable adults. The scheme provided training approximately every three years The provider may find it useful to note that, although carers we spoke with demonstrated an understanding of the protection of vulnerable adults, we did not find evidence of an assessment of the need of individual workers for refresher training in safeguarding.

The member of staff administering the service on a temporary basis had not undergone safeguarding training. The clinical service lead manager told us that the administrator had been given specific guidance if any safeguarding concerns arose. As a result of this inspection they told us they were making arrangements for training in the following week.

Carers we spoke with described how they would deal with a safeguarding concern. They were provided with written information on how to contact safeguarding organisations, should it become necessary.

Staff were provided with safeguarding and whistleblowing procedures. However, the provider may find it useful to note that the safeguarding procedure, although revised in 2012, still referred to the Care Quality Commission's regulatory predecessor.

Staff and carers were also provided with guidance relating to the use of physical restraint. This stated that individual guidelines would be put into place where necessary, and also that carers and staff would receive relevant training, advice and support in working practices that would make the use of restraint a last resort. The provider may find it useful to note that the records did not indicate that any training relevant to this had been provided. We were told that there had not been any episodes of restraint.

People who used the service told us that they were given information about what abuse was and how to deal with it. They told us they felt safe in their placements. They said that they knew how to complain, but had not had reason to do so.

Supporting workers ✖ Action needed

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was not meeting this standard.

Carers were not supported to deliver care and treatment safely and to an appropriate standard.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Carers were not supported to deliver care and treatment safely and to an appropriate standard as the majority were waiting for places on a number of training courses. Regular carer meetings had not been taking place.

Training records showed that some carers had completed training in areas such as the mental capacity act, needs and risk assessment, equality and diversity and medication management. However, there were a large number of gaps in the training provided. All the carers were waiting for places on service user participation and empowerment course, and a support planning course. More than half of the carers were waiting for places on a number of other courses such as complaints, fire safety, food safety and first aid. This lack of training meant that people using the service were at risk of receiving inappropriate care.

Information provided to carers stated that they would receive regular visits from a manager from the scheme, and that also regular carer meetings would be held. We were unable to find evidence that either of these were taking place, although carers said they had received phone calls from the clinical service lead manager in the absence of the scheme manager, to ask if everything was satisfactory. We were told by the clinical service lead manager that the meetings would be resumed shortly, and invitations to one had just been sent. Carers told us that the support from the scheme had decreased recently in the absence of the scheme manager

The scheme had two permanent staff posts. At the time of this inspection visit the manager was absent from work and the second post was vacant. This meant we were unable to discuss with senior staff the support, supervision and training that was provided to care staff. The clinical service lead manager,who was overseeing the scheme in the absence of the manager, informed us that the scheme manager received supervision on a regular basis.

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

The provider did not have an effective system to regularly assess and monitor the quality of service that people received. The absence of the scheme manager had impacted upon the level of monitoring being carried out.

The scheme's guide for people using the service stated that each person would receive at least an annual review, separate from the review of the support plan that was carried out with the carer. We were unable to find any records that these reviews had taken place.

We saw evidence that the support plans for people using the service had been reviewed within the last year, however we could not establish that the goals set at these reviews were followed up. This meant that the scheme could not establish that people using the service were achieving their goals, such as gaining new independent living skills; or maintaining their independence.

The scheme had a complaints procedure in place. People using the service told us that they thought they had been given a complaints leaflet when they first joined the scheme. None of the people we spoke with had made any complaints. We were unable to review how many complaints had been made in the last year, or how they were dealt with as the log could not be produced.

People who used the service were asked for their views about the care and treatment provided. Questionnaires were sent to them from the scheme, the most recent having been sent in July 2012. The scheme had held periodic meetings for people using the service, at which they could give feedback and express their views. The provider may find it useful to note that these had lapsed, and we were unable to find minutes for any meetings during 2012. The clinical service lead manager told us that the scheme planned to restart these shortly.

The scheme carried out reviews of each of their carers. These were due to take place annually however several were overdue as a result of the absence of the scheme manager. We looked at two carer reviews. One had been only partially completed. A number of key areas relating to the individual care of the people using the service, and a health and safety assessment of the premises had been left blank. This meant that the scheme could not determine the quality of the care being provided by its carers; or be satisfied that the accommodation people were living in was safe and suitable for purpose.

We were told that the scheme carried out spot checks of carers. The reports of these checks could not be provided. Carers told us that spot checks used to be carried out, but that since the scheme staff numbers had dropped to only the manager these had not been continued.

Carers told us that they had had regular group meetings with the scheme manager. These had not taken place over the past year. They described how useful they had found them, and that they looked forward to them recommencing.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Personal care	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: The provider was not supporting carers to deliver care and treatment safely and to an appropriate standard through appropriate training and regular supervision (Regulation 23 (1) (a))
Regulated activity	Regulation
Personal care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The registered person did not have an effective system to protect service users against the risks of inappropriate or unsafe care by regularly assessing and monitoring the quality of services provided. (Regulation 10(1)(a))

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 12 April 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

This section is primarily information for the provider

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk

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South London and Maudsley NHS
NHS Foundation Trust

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Quality Account 2012/2013

Part 1

Introduction

The purpose of the quality report is to enable the Trust to be transparent and accountable for the quality of the services we provide. Quality accounts have taken on new impetus this year with new structures for commissioning coming into force across the NHS, and following the Francis report into the failure of quality governance at Mid Staffordshire FT which resulted in catastrophic consequences for patients, their families and carers, events which NHS organisations are determined not to see happen again. The annual quality account gives us an excellent opportunity to promote the importance of quality: as users of the service experience it, by setting priorities for the coming year and highlighting achievements over the past year.

2012/13 proved to be a tough year in terms of managing the demand for our acute beds, and there have also been a number of serious incidents which we have investigated thoroughly, and learned important lessons from. On a more positive note we launched a number of new services in 2012/13, including; the Croydon Triage ward, and home treatment service for older adults. See summary of achievement - page 3

This year we once again welcome the engagement and input of our partners and stakeholders in the development of our quality account. The comments and response from all stakeholders will be included in section five of the account. We are grateful for the contribution made by our Foundation Trust's Council of Governors to this report, through its quality sub group which has met throughout the year.

We know that 2013/14 will be a challenging year for all NHS services but we also know that our commitment to quality will enable us to improve the efficiency and effectiveness of our services, and continue to provide users of our services with a positive and therapeutic experience. This quality report reflects our ambition to deliver continuous quality improvement in all our services. To our best knowledge the information presented in this report is accurate. We hope you will find it informative and stimulating.

Chief Executive Officer Date

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A summary of successes and developments in 2012/2013

- Our Croydon Adult Acute Triage in-patient service at the Bethlem Royal Hospital was opened in December 2012. This unit will provide assessment for adult patients from the borough of Croydon.
- We became one of only two Department of Health national demonstration sites for IAPT-SMI. IAPT-SMI is Improving Access to Psychological Therapies (IAPT) for people with severe mental illness (SMI). For psychosis, the aim is to demonstrate improved access to cognitive behavioural therapy and family interventions.
- We have implemented a streamlined acute medicine referral pathway for inpatients at the Maudsley site with Kings, working with the Medicine Clinical Academic Group of Kings College Hospital. This means that Maudsley in-patients with physical health problems, who need to be seen by Kings College Hospital physicians, are seen much quicker.
- Our children's ward at the Bethlem Royal Hospital, Acorn Lodge has evaluated the effectiveness of routinely admitting children in an emergency. The service is the first children's mental health in-patient unit in the country to routinely provide this vital service.
- We have established during 2012 children's and young persons IAPT (Improving Access to Psychological Therapies) services in Southwark and Lambeth. This service provides Cognitive Behavioural Therapy (CBT), and parenting to young people and their families. This initiative is now being rolled out in Croydon.
- We have successfully moved to a new model of one integrated Psychological Therapies services service in each of our four principal boroughs. Each service has a single point of access, and a framework for medical, psychological and social needs addressed in an integrated approach.
- Our Psychiatric Liaison Service based at St Thomas' Hospital was accredited with excellence for Psychiatric Liaison Accreditation Network, Royal College of Psychiatrists standards (PLAN).
- We have piloted a home treatment service for older adults in Southwark and Lambeth ensuring people are treated in least restrictive environment; close to home.
- Our older adult services have participated in two national patient safety initiatives - Harm Free Care on Hayworth Ward at the Ladywell Unit in Lewisham, and the Patient Safety thermometer in all inpatient and continuing care areas.
- We have developed a well being and Namaste initiative in our continuing care homes, which provides an innovative model of care for patients with advanced dementia.
- Our clinical audit team won the top prize of the gold clinical audit award in the annual Healthcare Quality Improvement Partnership (HQIP) national clinical audit awards 2013, for their work on the care of patients receiving rapid tranquillisation.
- We gained more national recognition at the Health Service Journal Patient Safety Awards 2012 - winners in the category of Patient Safety in Mental Health for the project, with work on the early detection of the physically deteriorating patient across all services.

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…..and what we can do better.

- Violence and aggression remains a threat to the safety of patients and staff on our in-patient units. While we have succeeded in reducing the overall numbers of violence, other indicators show that there is clearly more to do. In 2013/14 we will be doing more to help patients feel safer.

- Our patient survey results show clearly that many patients are unable to access the support and advice they need to quickly when in a crisis or emergency. We will be taking steps to improve access to good quality advice and support.

- People with mental illness are more likely to suffer from serious diseases such as diabetes and coronary artery disease. We will be taking steps to improve the routine screening of inpatients and those prescribed anti-psychotic medication.

- For many people, the concept of recovery is about staying in control of their life despite experiencing a mental health problem. Professionals in the mental health sector often refer to the 'recovery model' to describe this way of thinking. Putting recovery into action means focusing care on supporting recovery and building the resilience of people with mental health problems, not just on treating or managing their symptoms. Recovery planning is key to ensuring progress towards recovery. Currently the number of patients with good quality recovery plans which have been developed with the help of staff are in the minority. The Trust will in 2013/14 be focussing on supporting patients to develop their recovery plans.

- Helping to stop people smoking is a national health priority. The Trust is moving to having a totally smoke free environment for patients and staff. In order to achieve this we are improving the availability of advice and support available to patient who smoke, both in the community and when admitted to hospital.

All these have been translated into quality priorities for 2013/14. See pages 6,7,& 8.

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PART 2. Looking Forward

Our quality priorities for 2013/2014

Over the past year we have listened to feedback from service users, their families and carers, our staff, as well as commissioners and regulators. This process of gathering feedback has included:

- Listening to complaints and compliments from patients and their families and carers
- Listening to service users and carers at Trust Wide and borough based events
- Receiving reports on our services from the Care Quality Commission – CQC, following inspections of our services
- Listening to the views of commissioners at contract quality and serious incident monitoring and management meetings
- Listening to the views of the Health Overview and Scrutiny Committees of Lambeth, Southwark, Lewisham and Croydon
- Listening to the view of the Local Involvement Networks - LINks (Healthwatch) from each of our four main boroughs
- Reviewing audit results, research findings, service reviews and assessments and service user surveys
- Continuing discussions with a quality working group of the Members Council which has looked at quality issues over the year
- Facilitating discussions and reviews between the Board of Directors and the Council of Governors
- Discussions and presentations at Senior Leaders events within the Trust
- We have also reviewed national guidance and service quality themes and issues which are emerging nationally

In addition we have been mindful of the work that we have done so far to improve the quality of our services and our desire to build upon what has been done so far.

In consulting and agreeing on our quality priorities for next year we have taking into account a number of national frameworks and guidance, and local priorities on quality including:

- The Commissioning for Quality and Innovation framework [CQUIN]
- Quality schedules in our contracts with Clinical Commissioning Groups
- The national Mental Health Strategy – 'No Health Without Mental Health'
- The Trust Equalities Strategy
- The Francis Report into the failing at Mid Staffordshire NHT FT
- The National Outcomes frameworks for:
  - Adult & Social Care
  - Child Health
  - Public Health

The priorities for 2013/2014 which are set out below have been arranged under the three broad headings which put together provide the national definition of quality in NHS services: patient safety, clinical effectiveness, and patient experience.

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Our Quality Priorities for 2013/14

		Quality Priority	Measure	Target	How we will achieve this?
Patient Safety	1	Violence and aggression on in-patient wards continues to be our biggest obstacle to ensuring that all patients benefit from a safe and therapeutic stay in hospital. Our quality priority this year is to work to increase the number of **patients who feel safer** when in our hospitals. This priority continues from previous years.	We will measure this by asking the question in our patient surveys; "Do you feel safe?"	At least 90% of patients will response positively to this question. In 2012/13 overall 80% responded positively to this question.	By supporting all in-patient services to adopt a package of measures which are designed to reduce violence and aggression and improve communication between staff and patients. We call it our 'care delivery system'.
	2	All patients should have an individual crisis plan which they can refer to for **accessing support in a crisis**. Our priority for this year is to increase the number service users with crisis plans. This is a new priority for 2013/14	We will measure this by asking the question in our community patient surveys "Have you been offered a crisis plan for emergency mental health situations?"	60% of patients will respond positively to this question In 12/13 the average Trust wide was 51%	A key component of the new Support and Recovery Care plan is the Crisis Plan. Implementation of the Recovery model and training to clinical teams will ensure the crisis plan is developed jointly with service users and that they receive a copy.
	3	More people with schizophrenia will develop cardio vascular disease and metabolic conditions (such as diabetes) than the general population. Our quality priority this year is to **improve our screening for early detection of long term physical health conditions** in order that interventions can be made to reduce the risk of these diseases. This builds on quality priorities from previous years	CQUIN measure - screening on admission for glucose levels, lipids, blood pressure, weight. Other tests for metabolic disease for patients prescribed anti-psychotic medication	60% of patient admitted in Q2, rising to 75% Q3 and 4. Previous service performance has not been measured.	Working with SLaM clinical staff and GPs to improve clinical protocols. Feeding back performance to clinical staff. Staff education on recognising and treating diabetes.

NOT FOR CONSULTATION

Clinical Effectiveness	4	All Trusts sites will eventually become totally smoke free, this target recognises the damage done by smoking tobacco. Our quality priority is designed to support our smoke free strategy. This year all patients who are ready to quit will be identified, supported, and **offered nicotine replacement therapy NRT or smoking cessation counselling.** This is a new quality priority for 2013/14	We will measure this by, a] the number of patients whose smoking status has been assessed, b] the number offered intervention, c] the number of staff trained to level 1	85% of all patients will have their smoking status recorded. 60% will be offered brief smoking ceasation intervention. (inpatient >6 days) 60% staff to do e-learning SC package [46% in 12/13]	Implementation of SLAM Smoke Free Strategy. Delivery of smoking cessation level 1 training to staff working at SLAM
	5	Included in our inpatient surveys for 2013/14 will be the question "Would you recommend this service to your family and friends". This is known nationally as the **family and friends test**. We will be using the results of the surveys to compare our services and make improvements to the experience that our patients have of our hospitals. This is a new quality priority for 2013/14	We will measure the response to this by surveys in each inpatient unit.	As this is a new measure we will set a target for the year end, when we have reviewed quarter 1 scores.	We will use surveys to ask patients this question. Achieve of the improvement target will be made by more local actions taken in response to patient feedback generally.
	6	Our clinical teams collect a lot of data about patients when they come into the service when they leave the service. Some of this data is used to tell us whether the service was successful in treating patients. In the past few teams have had the benefit of considering this information and comparing it with other teams in order to improve the treatment outcomes for patients. Our quality priority this year is to **facilitate a team review of outcome data** with all teams annually. This quality priority continues from 2012/13	We will measure this by the number of teams who have an annual review of team clinical outcomes data [HoNOS].	50% of all clinical teams. In 2012/13, 65 teams had a review of their outcomes data	The SLAM Outcomes Team and Outcomes Lead within each CAG will facilitate feedback to teams on outcome data.

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Patient Experience	7	For many patients, the path to recovery is about identifying life goals and support mechanisms necessary to achieve those goals. Good quality, recovery and support care plans can be essential to achieving those goals and achievement plans. Our quality priority this year is to **support patients to develop their support and recovery care plans**. This is a new quality priority for 2013/14	CQUIN measure- number of community CPA patients in adult mental health, with a completed Support and Recovery care plan.	CQUIN - Target for year to be agreed from Q1 baseline	Pilot is currently underway for delivering brief team based training on the use of the new Support and Recovery Care Plan. Following evaluation of the pilot, the plan is to commission further training to roll out to AMH teams.
	8	One of our quality priorities for this year is to **improve our standard of customer service** which patients, their families and carers experience. This supports the principle of a 'culture of compassion' as recommended in the Francis Report. In 2013/14, we will focus on reducing the number of complaints about staff attitude. This is a new quality priority for 2013/14	We will measure this by the number of complaints in the category of staff attitude and behaviour as a proportion of the total complaints received.	Percentage of complaints regarding staff attitude to be under 20% of the total complaints in all categories. [Average 30%, in previous 5 years]	Customer service training. 5 SLAM Commitments RCN Leadership Program Appraisal/Re-validation Privacy & Dignity policy implementation Values publicity.
	9	This year we will be holding focus groups with patients in hospital about the quality of service they receive. We will be **producing clear quality improvement plans as a result of these conversations**. These conversations will be facilitated patient focus groups on inpatient units. The aim is to gain comprehensive service user opinion of the quality of inpatient services along the following quality dimensions: - Safety - Dignity and respect - Environment - Treatment interventions - Equity and equality This is a new quality priority for 2013/14	CQUIN measure – Local Service User Focus Group Findings at Q1 and evaluation of improvement at Q3. Implementation plans produced by SLaM at Q2 and Q4.	CQUIN measure – Local Service User Focus Group Findings at Q1 and evaluation of improvement at Q3. Implementation plans produced by SLaM at Q2 and Q4. Payment will be for delivery against the action plan and delivery of improved patient satisfaction	Each borough will identify a user focus group within the voluntary sector or from within SLaM which is able to undertake this exercise. Service User Consultants to work with inpatient teams to identify the top 10 concerns/issues with the ward or their patient experience. Then the ward management/PPI lead/link worker and patient group to agree an action plan.

PART 2. STATEMENTS OF ASSURANCE FROM THE BOARD

Review of services

During 2012/13 the South London and Maudsley NHS Foundation Trust provided a broad spectrum of mental health and addictions services. At the end of the year there were 238 clinical teams providing in-patient, out-patient, community and liaison services [which are based in our partner acute Trust hospitals; Guy's and St Thomas', King's College Hospital, Lewisham University Hospital and Croydon University Hospital]. These services are structured into seven Clinical Academic Groups. The Trust Board has reviewed all the data available to them on the quality of care in all these services.

The income generated by the NHS services reviewed in 2012/13, represents 100% of the total income generated by the provision of NHS services by SLaM for 2012/13.

Approximately 29% of the Trust's activity relates to services provided outside the four core borough contracts of Lambeth, Southwark, Lewisham and Croydon. This includes R&D funding, local authority funding, junior doctors training, and income from other commissioning PCTs, and specialist services national commissioning agencies.

Participation in National Quality Improvement Programmes

National quality accreditation schemes, and national clinical audit programmes are important for a number of reasons. They provide a way of comparing our services and practice with other Trusts across the country, they provide assurances that our services are meeting the highest standards set by the professional bodies, and they also provides a framework for quality improvement for participating services.

During 2012/13, seven national clinical audits and two national confidential enquiries covered NHS services that the South London and Maudsley NHS Foundation Trust provides.

During that period SLaM participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the SLaM was eligible to participate in during 2012/13 are listed below:

- The national audit of psychological therapies for anxiety and depression
- The six national, Prescribing Observatory for Mental Health - POMH-UK audits:
  - Prescribing of anti-dementia drugs
  - Prescribing antipsychotic medication for people with dementia
  - Assessment of the side effects of anti-psychotics
  - Monitoring of patients prescribed Lithium
  - High dose/polypharmacy antipsychotic prescribing
  - Prescribing in personality disorder
- The national confidential enquiry into suicide and homicide by people with mental illness
- The national confidential inquiry into maternal and child deaths

The national clinical audits and national confidential enquiries that the SLAM participated in, for which data collection was completed during 2012/13, are tabled below alongside the number of cases submitted to each audit or enquiry.

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Participation in the Prescribing Observatory (POMH-UK) managed by the Royal College of Psychiatrist's Centre for Quality Improvement

TOPIC	Participation by trust		National participation	
	Number of teams	Number of patients	Number of teams	Number of patients
Prescribing high-dose and combination antipsychotics: acute/PICU, rehabilitation/complex needs, and forensic psychiatric services	37	434	722	9537
Prescribing for people with a personality disorder	48	91	437	2600
Screening for metabolic side effects of antipsychotic drugs	21	226	372	6078
Prescribing antipsychotic medication for people with dementia	20	434	482	12790

The Royal College of Psychiatrists National Audit on Schizophrenia fed-back Trust level results to SLAM in June 2012 and the results were discussed and action planned at the Psychosis CAG Care Pathways Executive. The action plan was updated again early 2013 to consider the findings and recommendations from the national audit report published in December 2012.

The summary feedback in the Trust level report demonstrated that SLaM performed in the middle range on most of the key standards. In common with other trusts, SLAM scores on the physical health indicators was the weakest area of performance (i.e. under 50% compliance). Physical health is therefore a huge priority for SLaM and much work is underway to ensure better physical health in our service users. A broad approach is taken to this, incorporating access to routine populations screening, lifestyle interventions, appropriate long-term condition management where indicated and access to acute medical care. A CQUIN target in 13/14 has also been negotiated with the CCGs as a further incentive to improve performance in this area.

About two thirds of people with psychosis smoke, a much higher proportion than in the general population. A smoking policy has been introduced in SLaM to address this and a conference is planned on May 9th 2013 in collaboration with local Primary care, public health and respiratory physicians to agree the best ways to reduce smoking rates in people with psychosis.

- Findings of the national psychotherapy audit have informed the redesign of psychological services across the Trust
- Results of medication prescribing audits were fed back to all prescribers, with reminders of prescribing guidelines.

The reports of 32 local Trust wide clinical audits were reviewed by our Quality Governance Committee in 2012/13 and a number of actions have been taken to improve the quality of health care provided, including:

- **Supervised Confinement (SC) -** new policy ratified in 2012 and a SC working party established; half-day SC awareness/action planning event, chaired by the Medical Director, was held in November; service user rights in SC laminated sheet sent to wards with SC rooms for display; new SC registers in place on wards with SC rooms for logging activity and observation.
- **Safeguarding Adults** - funding has been ring-fenced for new full-time Trust wide Safeguarding Adults Lead post in 2013/14.
- **Enhanced Observation -** A sub group of the practice council 'Nursing at Night' is developing an agreed set of practice standards. The Observation and Engagement policy will be updated in Spring 2013, to include more precise standards of night time observations.
- **Patient Information** – In 2012, a quarterly patient information bulletin was circulated to teams. These incorporated newly published patient information leaflets, details on how to order leaflets and information on standards of information giving. A laminated poster which highlights what information patients are entitled to receive has been distributed to wards to display.
- **Smoking Cessation** – In 2012, a smoking cessation, Level 1 e-learning training package for mental health services has been written by SLAM/IOP staff and enabled for all non-medical clinical staff. This achieved 46% uptake in 2012/13.

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The Trust has participated in a number of non-audit national quality improvement programmes.

Participation in National Quality Improvement Projects (non-audit) managed by the Royal College of Psychiatrist's Centre for Quality Improvement

CCQI PROGRAMME	Participation by trust	National participation
Service accreditation programmes		
ECT clinics	2 ECT clinics	93 ECT clinics
Working age adult wards	13 wards	165 wards
Psychiatric intensive care units	0 PICUs	34 PICUs
Older people mental health wards	3 wards	57 wards
Inpatient learning disability units	1 unit	36 units
Inpatient rehabilitation units	1 unit	36 units
Memory services	1 services	61 services
Psychiatric liaison teams	1 team	43 teams
Service quality improvement networks		
Inpatient child and adolescent units	2 units	91 units
Child and adolescent community MH teams	1 team	45 teams
Therapeutic communities	2 communities	83 communities
Low secure forensic mental health services	1 service	66 services
Medium secure forensic mental health services	2 services	64 services
Perinatal mental health inpatient units	2 units	15 units

Green = participation. Red = no participation

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the South London and Maudsley NHS Foundation Trust (SLaM) for the reporting period, 1 April 2012 - 31 March 2013, that were recruited during that period to participate in research approved by a research ethics committee was 4658.

This level of participation in clinical research demonstrates SLaM's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. SLaM and its closest academic partner, the Institute of Psychiatry (King's College London) (IoP), are committed to working together to promote mental wellbeing and to establish the best possible treatment and care for people with mental illness and their family members. The total value of research grants held by the IoP at 31 March 2013 was £196 million. In a pioneering global collaboration between King's College London, SLaM, King's College Hospital and Guy's & St Thomas' Hospital NHS Foundation Trusts, 'King's Health Partners' was formally accredited in March 2009 as one of the UK's first five Academic Health Sciences Centres (AHSCs). King's Health Partners has the core aim of aligning clinical services, research and training much more closely for direct patient benefits for a large and diverse population.

During the reporting year, SLaM was involved in conducting 211 clinical research studies, 78 of which were adopted onto the National Institute of Health Research (NIHR) Portfolio. SLaM is fully compliant with and is using national research systems (IRAS and CSP) to manage these studies in proportion to risk. All of our NIHR Portfolio studies have been conducted under NIHR topic specific networks, the majority of studies being under the Mental Health Research Network. Contracts for our commercially-sponsored studies have been negotiated and managed by the King's Health Partners Clinical Trials Office using the national model clinical trials agreement (mCTA).

The Joint R&D office of SLaM and the Institute of Psychiatry, KCL, is now part of NIHR Research Support Services, a national framework for local health research management that aims to standardise good practice within the NHS. As part of this, SLaM has issued its R&D Operational Capability Statement (at http://www.kcl.ac.uk/iop/research/office/R-and-D-assets/Assets-Spreadsheets-and-PDF/R-and-D-SLaM-Operational-Capability-Statement-2012-2013.pdf), which has been reviewed and agreed by the Trust Board of Directors. The R&D Office uses the national NIHR HR Good Practice Resource Pack. The R&D Office has issued 133 honorary contract or letters of access based on the Research Passport during the reporting period.

In the 2012 calendar year 1471 publications resulted from our involvement in ethically approved research in partnership with the Institute of Psychiatry, helping to improve patient outcomes and experience across the NHS.

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Goals agreed with commissioners – use of the CQUIN payment framework

A proportion of Trust income in 2012/13 was conditional on achieving quality improvement and innovations (CQUIN) targets agreed between SLaM and commissioning PCTs through the Commissioning for Quality and Innovation (CQUIN) framework. Further details of the agreed goals for 2012/13 and for 2013/14 are available on request from Julia Gannon, Head of Contracting.

Overall the Trust achieved 79% of goals agreed with commissioners under the CQUIN element of contracts. That equates to £5m out of a potential £6.3m of CQUIN incentive payments.

Registration with the Care Quality Commission – CQC

South London and Maudsley NHS Foundation Trust is required to register with the Care Quality Commission. The CQC is the health care regulator responsible for making sure that all services meet the standards set by the Government. Our current registration status is 'registered, no conditions'. The CQC has not taken enforcement action against the Trust during 2012/13.

We are subject to regular unannounced inspections by the CQC. These take the form of either full inspections of the essential standards of quality and safety, or inspections of arrangements for detaining people under the Mental Health Act. We welcome these inspections as it helps us to make improvements to our services. Concerns are acted on immediately with actions plans submitted to the CQC within the required timeframe.

During 2012/13 the CQC have conducted full essential standards inspections at:

- Bethlem Royal Hospital - July 2012 (seven different wards)
- HMP Thameside, (services managed under the registered location of Lambeth Hospital) - January 2013
- Woodlands Continuing Care Home for Older People (Lambeth) on March 2013 (three wards)
- Bethlem Royal Hospital (four wards at River House) February 2013

The following table summaries findings of CQC inspectors. Ticks are where services were found to be compliant with standards, crosses where services were not compliant with standards. Where our services were not compliant, CQC inspectors found that this non-compliance had a minor impact on people who use the service.

CQC Standard	HMP Thameside Inspected March 2013	Bethlem Royal Hospital Inspected July 2012	River House Inspected Feb 2013	Woodlands Continuing Care Home Inspected March 2013
Treating people with respect and involving them in their care	✓	✓	✓	✓
Providing care, treatment and support that meets people's needs	✓	✓	✓	✓
Caring for people safely and protecting them from harm	✓	✓	✗	✗
Standards of staffing	✓	✓	✓	✗
Quality and suitability of management	✓	✓	✓	✗

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Non compliance: River House

CQC Standard	Inspectors findings	What action we have taken
Caring for people safely and protecting them from harm.	Inspectors found: printed information for patients to be lacking, the standard of décor poor, scruffy furniture, ligature point risks, and some areas not as clean as expected.	Leaflets and poster replenished, areas painted, new furniture ordered, all curtain fittings inspected for ligature risks, and found to be ligature safe. Cleaning regime reviewed and cleanliness audits increased.

Non compliance: Woodlands

CQC Standard	Inspectors findings	Action we have taken
Caring for people safely and protecting them from harm.	On the day of inspection some areas of the ward were unclean, and some areas of the ward required maintenance – loose skirting board and bathroom furniture, loose plasterwork, and some mould in the bathroom.	The areas have been deep cleaned and new cleaning schedules instituted. Daily cleanliness inspections are been conducted. All maintenance issues with fixture fittings and fabrics have been rectified .
Standards of staffing	On the day of the inspection staff training records were found to be not up to date, and some staff had not attended refresher training. Appraisal and supervision records were not up to date.	Training records have been updated. All staff with outstanding training and refresher training have been booked on to do training, deadlines for e-training have been set. All appraisals are scheduled to be complete by the end of June 2013
Quality and suitability of management	On the day of the inspection temporary staffs were not able to access some health care records, some care plans were not up to date.	Staffs have been briefed on the 'standards for health records keeping' policy, copies have been circulated to staff. Care and recovery plans for all patients are being reviewed and rewritten. Care plans will be audited by senior nursing staff.

All areas of non-compliance are subject to quality improvement action plans which have been submitted to the CQC. These will be vigorously managed through to completion by the Trust, and the CQC will conduct follow-up inspections in 2013/14 at Woodlands and River House.

Full inspection reports for all these inspections can be found on the CQC website.

Monitor

Monitor is the independent NHS Foundation Trust regulator. Monitor is responsible for ensuring that the Trust is well managed, and that it meets required national targets and standards. As at 2nd April 2013 our Monitor Governance risk rating was green [on a scale of red, amber and green, where green is good].

The Health and Safety Executive (HSE)

The HSE has issued no prohibition or improvement notices to the Trust during 2012/13.

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Information governance

Information governance is about ensuring that the information we hold is accurate, complete, up-to-date, reliable, and handled securely & confidentially. The Information Governance (IG) Toolkit is an annual national self-assessment process overseen by the Department of Health. The Toolkit provides assurance in relation to the Trust's compliance with the information governance standards in six key areas covering information governance management, confidentiality and data protection, clinical information, corporate information, secondary uses and information security. The Trust submitted its final assessment for the year on 28 March 2013.
The South London and Maudsley NHS Foundation's Information Governance assessment overall score for the 2012-13 financial year was **91%,** and was graded **green**. The Trust has outlined an IG action plan to maintain and improve compliance on the Toolkit standards.

Data quality

Good quality information is fundamental to the successful operation of the Trust. It underpins important decisions relating to how care is provided at an operation, management and strategic level. For example the GP code is essential to enable the transfer of clinical information about the patient from the Trust to the patient's GP. Information drives performance management within the Trust and is an essential requirement of both clinical and corporate governance. Standards for these data quality priorities are in included in the Trust's information governance (data quality) policy.

The Trust is constantly striving to improve the quality of its data. External publications of SLaM performance are presented each month to the Chief Executive's performance management review (CEO PMR). Local analysis is provided ahead of national deadlines enabling action if needed. Data Quality reports are available on the Trust reporting systems and these provide details of patients with data quality issues. It is the responsibility of the clinical services to improve their data quality. This is further strengthened by the Performance Team sessions held monthly with each CAG in advance of the CEO - PMR. The Clinical Systems Support Team provides routine data quality improvement tasks such as NHS Batch Tracing, reducing patient duplicates, and ward reminder alerts for diagnosis at discharge. Data quality training and support is offered to all Trust staff and clinical teams.

The Trust submitted records during 2012/13 for inclusion in the Hospital Episode Statistics and Minimum dataset (HES data). These are included in the latest published data. The percentage of records in the published data which includes the patient's ethnicity, GP code, NHS number, diagnosis and postcode was as follows:

Data Item	SLaM 2009/10	SLaM 2010/11	SLaM 2011/12	SLAM 2012/13	London MH Trusts Average	NHS National Average
Ethnicity	93	95	99.8	**100**	98.7	98.2
GP Code	97	97	100	**100**	100	99.9
NHS Number	98	98	98.2	**98.5**	98.6	99.0
Diagnosis	85	96	94.8	**96**	90.3	98.5
Post Code	98	99	100	**100**	99.6	99.9

Table 1. Data completion rates for five core items %

Clinical coding error rate

The South London and Maudsley NHS Foundation Trust was not subject to payment by results clinical coding audit by the Audit Commission during the 2012/2013 financial year.

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National indicators 2012/2013

The Trust is required to report against a list of published indicators which link to existing commitments and national priorities within the periodic review 2011/2012. They include:

CQC Indicators	SLaM 2009/10	SLaM 2010/11	SLaM 2011/12	SLaM 2012/13	National Average 12/13	National Target
Access to crisis resolution	97%	98%	98.4%	99.4%	98.2%	90%
CPA – 7 day follow-up	96%	93%	96.3%	96.8%	97.4%	95%
Delayed discharges/transfers	4.3%	4.2%	2.9%	3.4%	N/A	7.5%

Table 2. Performance against Mental Health Service National Indicators

Definitions
Access to Crisis Resolution Home Treatment (Home Treatment Team)
Home treatment teams provide intensive support for people in mental health crisis, in their own home. Home Treatment is designed to prevent hospital admissions and give support to families and carers. The numerator here is the percentage of admissions to the Trust's acute wards that were assessed by the crisis resolution home treatment teams prior to admission.

Care Programme Approach (CPA) 7 day follow-up
Follow up within seven days of discharge from hospital has been demonstrated to be an effective way of reducing the overall rate of death by suicide in the UK. Patients on the care programme approach (CPA) who are discharged from a spell of inpatient care should be seen within seven days.

Delayed Discharges
The number of non-acute patients, age 18 and over, whose transfer of care or (discharge from hospital) was delayed. Delayed transfers of care attributable to social care are excluded.

New national indicators for the Quality Account

Number of Staff recommending the Trust

The national staff survey results on the question of whether staff would recommend the Trust as a place to work or receive treatment is a new mandatory indicator for inclusion in the quality account. In the 2012 survey slightly more staff responded positively to this question than in the 2011 survey, and the Trust did marginally better that the average score for mental health/learning disability Trusts - below.

Service Users Experience of Health and Social Care Staff

The other national quality indicator for 2012/13 is the national patient survey results on the question of how users of services found the health and social care staff of the Trust. Results are below and show that overall the Trusts scores were in the mid range when compared to other similar Trusts.

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Survey of people who use community mental health services 2012
South London and Maudsley NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2011 scores for this NHS trust	Change from 2011
Health and Social Care Workers							
S1	Section score	8.5	8.2	9.1			
Q4	Did this person listen carefully to you?	8.7	8.2	9.3	212	8.7	
Q5	Did this person take your views into account?	8.4	7.9	9.0	185	8.4	
Q6	Did you have trust and confidence in this person?	8.1	7.6	9.0	210	8.4	
Q7	Did this person treat you with respect and dignity?	9.1	8.8	9.7	212	9.1	
Q8	Were you given enough time to discuss your condition and treatment?	8.1	7.7	8.7	209	8.2	

Incidents and harm to Patients

The third national quality indicator for 2012/13 is the number of reported incident where severe harm or death was reported. These are incidents reported by the Trust to the National Reporting and Learning System NRLS. Full reports can be found here http://www.nrls.npsa.nhs.uk/

Total number of Incidents reported by the Trust	7079	
Rate of incidents per 1,000 bed days	22.1	*
Number of incidents where severe harm or death was reported	111	
Percentage of severe harm or death incidents (to total number reported	1.5%	**

Notes:
Data is for 12 month period 2012/13, month 12 data was not available at time of writing and has been calculated as a average of the previous 11 months.
*This compares with a median of 23.8 for all mental health organisations [April-Sept 2012]
**This compares with a mean rate of 1.6% for all mental health organisations

There were no 'Never Events' [DH, 2010] reported by the Trust in 2012/13. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

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Part 3 - Review of quality performance

3.1 Review of progress made against last years priorities

Our 2012/2013 quality priorities were selected after consultations with stake holders and staff from our services. The following summarises progress made against each priority over the year.

Priority One - Reducing the level of violence in our in-patient wards

Violence and aggression in our in-patient services continues to remain a significant obstacle to ensuring that all patients benefit from having a safe and therapeutic experience of in-patient care. For 2012/13 we said we would embed simple, research proven interventions into the routine practice of the ward.

Target — We said that in 2012/13 we would reduce the incidence of serious violence incidents by 12.5%.

Measure — We monitored incidents which were reported as well as the number of injuries reported to the Health and Safety Executive as a result of violence under the RIDDOR regulations.

Headline — **The number of incident of violence in our services fell by 8%, compared to the pervious year, our target was 12.5%.** See Chart 1.
However there has been an increase in reported incidents in our Medium Secure Units and adolescent mental health services (CAMHs) in-patient services over the year. See table 3.
Measures design to reduce violence and aggression continue to be introduced across our in-patient services.
RIDDORs [Injuries reported to the Health and Safety Executive as a result of violence reported to the HSE] have fluctuated over the year, and remain high in Psychosis and Behavioural and Development services. See table 4.

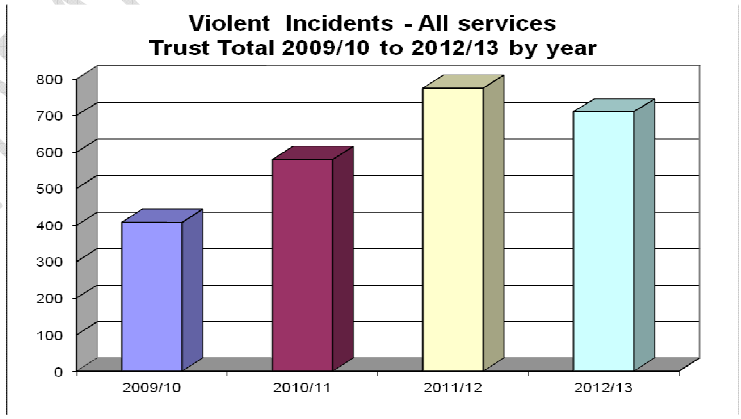

Chart 1 . All incidents of actual violence (in all services) by year – last four years, showing fall from 2011/12

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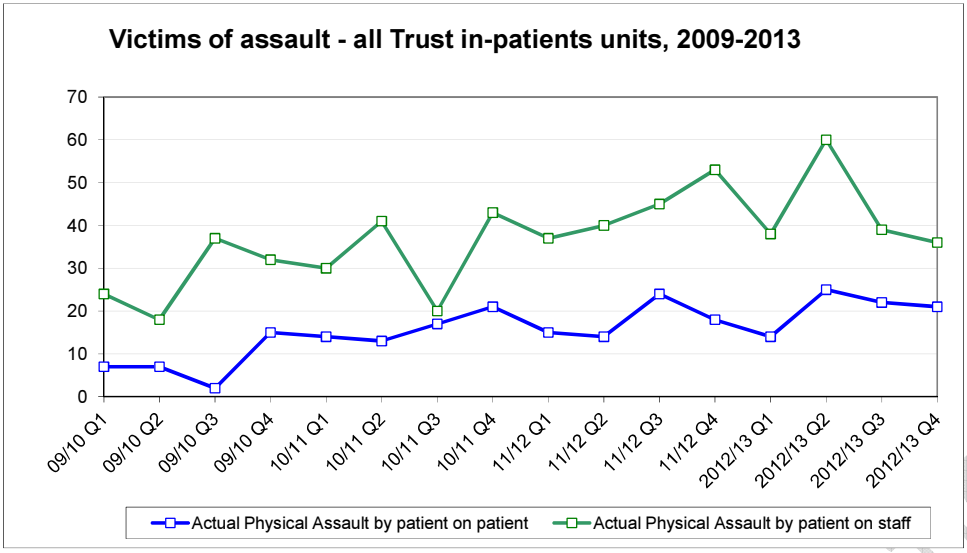

Chart 2. Showing reported incident of violence directed at staff, (green line), and patients(blue line).

Reported incident data over four years clearly shows an upward trend in the numbers of both staff and patients who are victims of assault over the past four years. Recent data however shows a marginal improvement, which is encouraging given the background context of increasing activity and admissions in acute services.

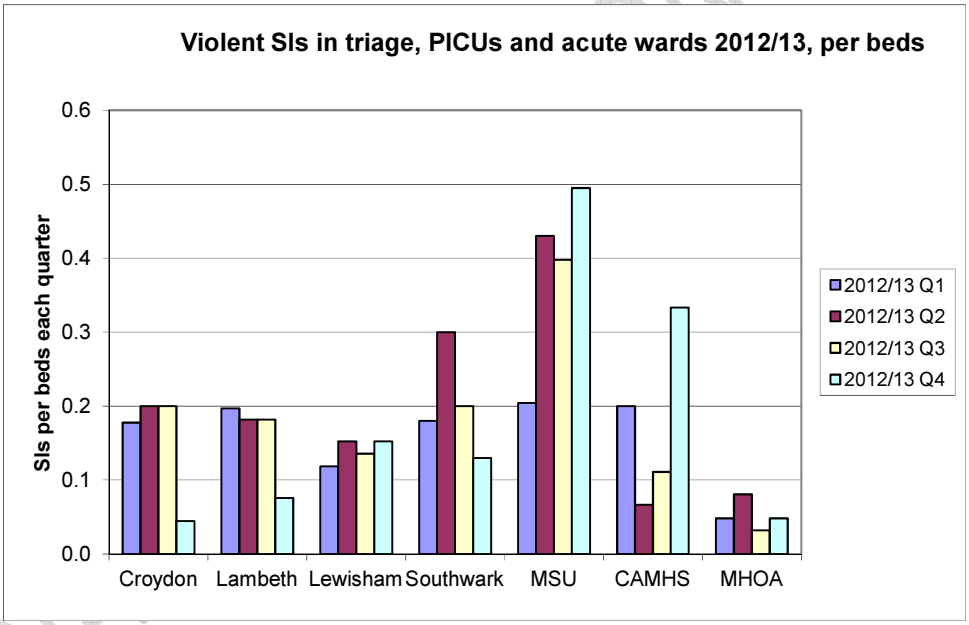

Chart 3. Rate of reported violence per bed by quarter 2012/13 – for; adult brough services (Croydon, Lambeth, Lewisham and Southwark) which include triage and acute adult wards, Medium Secure Units (MSU), adolescent (CAMHS) in-patient units and Older Adults in-patient units (MHOA).

The increases in reported incidents in medium secure units, adolescent units, and triage units are the result of many factors. While incidents reported from adolescent units have tended not to result in injury, those in medium secure units have. See table 4 overpage – RIDDORS – injuries reported to the HSE. Acute adult mental health (Psychosis) services, triage units, and forensic in-patient services remain the hot spots for violence and aggression in our services.

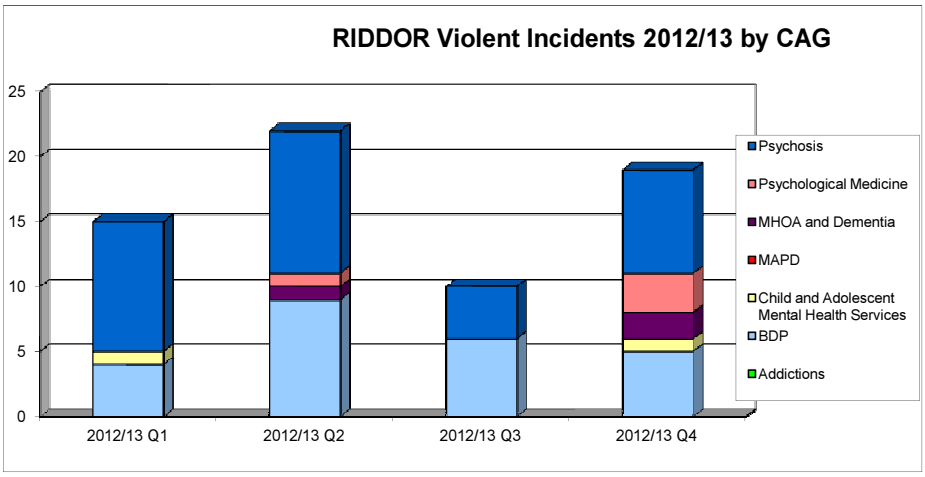

Chart 4 . Injuries reported to the HSE as a result of violence and agression by quarter 2012/13 – for each Clinical Academic Group

Throughout the coming year we will continue to embed our violence reduction clinical toolkit, which is evidence based and designed to reduce risk; it is also collaborative, requiring participation from the patients, families and carers and the clinical team.

The toolkit includes simple research proven interventions, such as; the introduction of a violence prediction tool, introducing the 'zoning' system. Services are also beginning to work with higher risk patients to develop advanced statements of preferred and effective interventions to reduce and manage their violence and aggressive behaviour. The use of debriefing is also being promoted by the PSTS training team, to increase the opportunities that patients and staff have to learn from incidents after they happen.

We now have this toolkit completely embedded within four wards which have all shown marked improvement in levels of violence and improved patient experience and staff satisfaction. Many other ward teams are taking up elements of the toolkit, and we expect to embed it in all in-patient services within the next two years.

Priority Two - Helping patients in our hospitals feel safer

We recognise that for patients in our hospitals, it is crucial to their wellbeing and recovery that they feel safe at all times. In addition to the work to reduce violence outlined above, we have been developing our safe and therapeutic services training [PSTS] for staff. This now includes training in the impact of staff attitude and environmental factors, such as noise and heat. Nursing staff are supervised and appraised on their practical application of PSTS skills and techniques. Clinical staff are also trained in how to respond to the problem of bullying and harassment in relation to safeguarding vulnerable patients.

Target	We said that in 2012/13 we would improve responses to the patient survey question 'do you/did you feel safe?' by 10%. Measure We said that we would ensure that the question 'do you/did you feel safe?' is included in all in-house patient satisfaction surveys for in-patients.
Headline	**The percentage of patients surveyed who said they felt safe on our wards has fallen to 80% compared to last year 86%**, although the number of patients surveyed this year was considerably higher, at over 2500. This group included a higher proportion of patients who had been discharged from hospital. The number of patient who said they could approach staff to help them feel safe remains steady at 87%.

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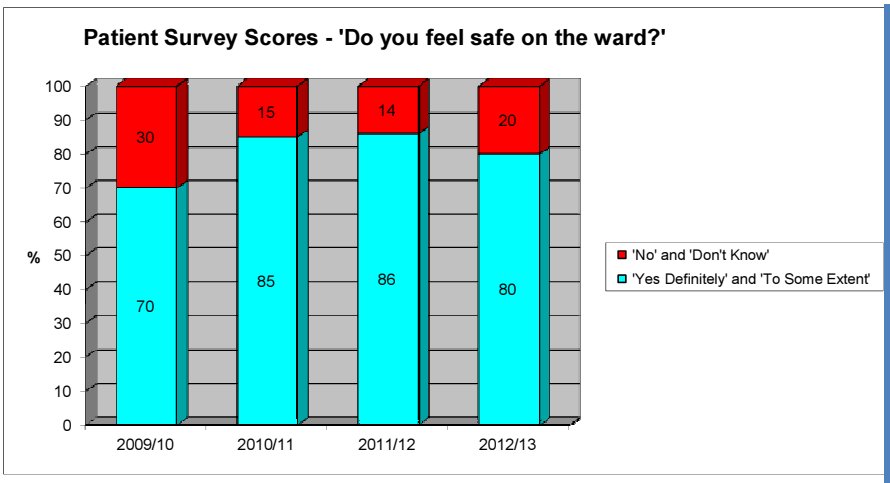

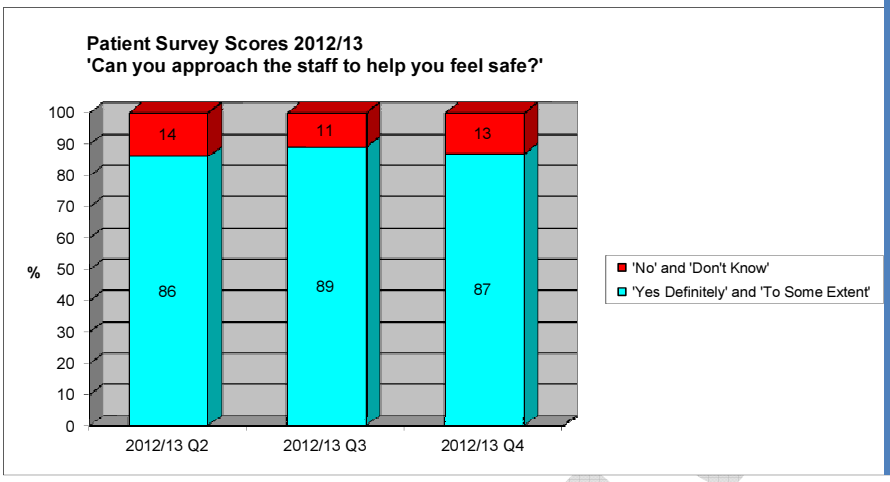

The percentage of patients surveyed who said they feel safe on our wards has fallen to 80% compared to last year 86%.
The number of patients surveyed this year was considerably higher, at over 2500, and included more patients who had been discharged from hospital.
The number of patient who said they could approach staff to help them feel safe fell to 87% from 89%.

Priority 3 - To be in the top 20% of MH trusts in the National Patient survey

Although our in-house patient surveys are becoming more comprehensive every year, we recognise the annual National Patient Survey as being the most reliable source of comparable feedback we have from our patients. The annual survey gives as a measure of how well patients think we are doing over a range of important issues, such as information on treatments, whether our staff listen to patients, and whether patients feel they can trust our staff.

Target	To be in the top 20% of Trusts of our type [inner city, mental health], in the National Patient Survey results.
Measure	League table of UK Inner City Mental Health Trusts
Headlines	The methodology behind the analysis of the national patient survey results changed in 2012, so that it is more difficult to make comparisons with other Trust, however **overall our analysis is that we made the top 20% of all mental health Trusts who took part in the national survey**.

In terms of the average scores per section, SLAM was in the amber (same as other Trusts) for 7/9 sections. In one section, talking therapies – 'did you find the talking therapy you received in last 12 months helpful?' we were in the green (better than other trusts) and for one section/question – 'have NHS mental health services involved a member of your family or someone else close to you, as much as you would like?' SLaM was in the red (worse than other Trusts).

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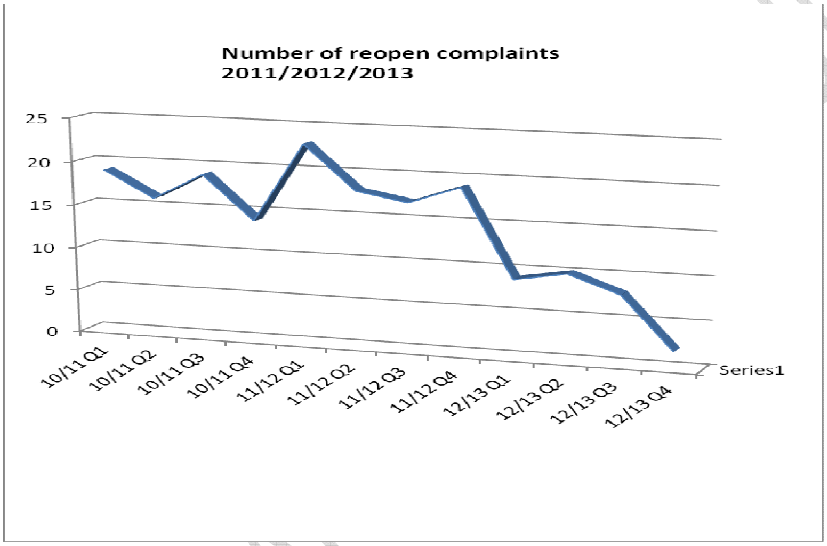
Priority 4 - Improving the quality of responses to patient's complaints

If patients, families and carers are not satisfied with the way their complaint is dealt with by the service, they have the option of putting their complaint in writing, in which case it will be dealt through the formal Trust complaints process. A measure of the success of this process and the consequential satisfaction of complainants is whether complaints are reopened or escalated.

Target To reduce the number of formal complaints which are reopened by the complainant, by 10%.
To reduce the number of complaints which are referred by the complainant to the Parliamentary Health Service Ombudsman - PHSO.

Measure Number of formal complaints reopened or escalated.

Headlines **The overall trend for reopened complaints is downwards. Raw data shows that it has fallen by considerably more than 10%, this may change as more complainant reopen their complaints in the future. The number of complaints escalated to the ombudsman is falling.**



The number of formal complaints reopened has decreased over the last three quarters, although the numbers for the last two quarters Q3 and Q4 are likely to increase as more notifications are received for complaints initially opened in those two quarters.

Chart 3. Formal Complaints Reopened

Complainants who are not satisfied with the response they receive to their complaint have the option of escalating the complaints to the Parliamentary Health Service Ombudsman. All complaints response letters from the Trust provide this information. The four year trend below shows that fewer people are escalating their complaints in this way.

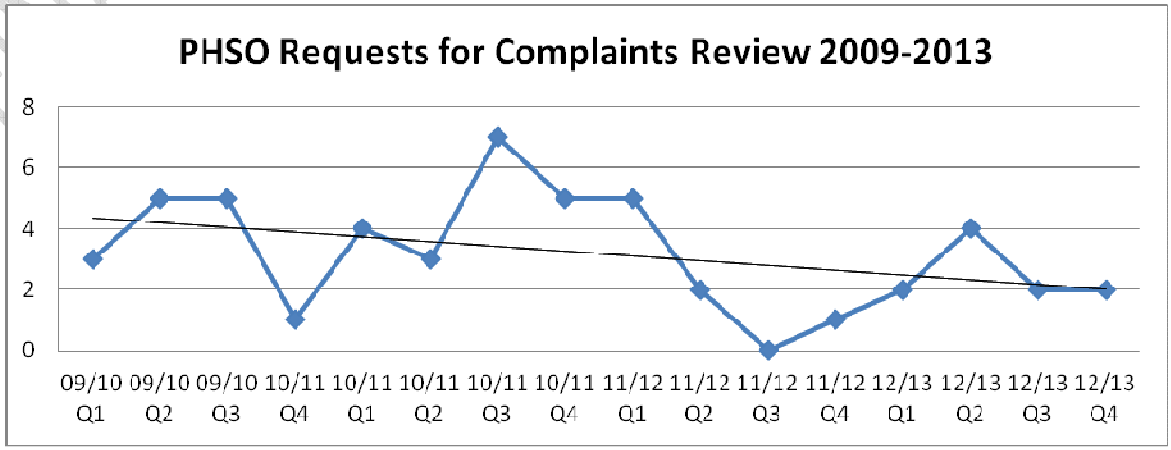


Chart 4. Complaints referred to the PHSO – last three years

Priority Five - Measuring clinical effectiveness

All our clinical services use clinical outcome tools which measure the wellness and functioning of patients across a range of indicators, for example; coping with social situations, and symptoms of illness. While these tools vary according to the type of service they are designed for, the objective is to use them to measure progress or deterioration in a patient's overall presentation. The way to gain an overall impression of clinical outcome is to compare outcome scores taken at the beginning of an episode of care (or entry to a service), with score at a later date preferably at the end of a treatment episode. Two such scores are known as a paired score.

Target	We said that in 2012/13 we would collect a paired outcome score for 75% of all eligible patients in each service pathway.
Measure	We said that they will be measured by completed scores taken from our health records system.

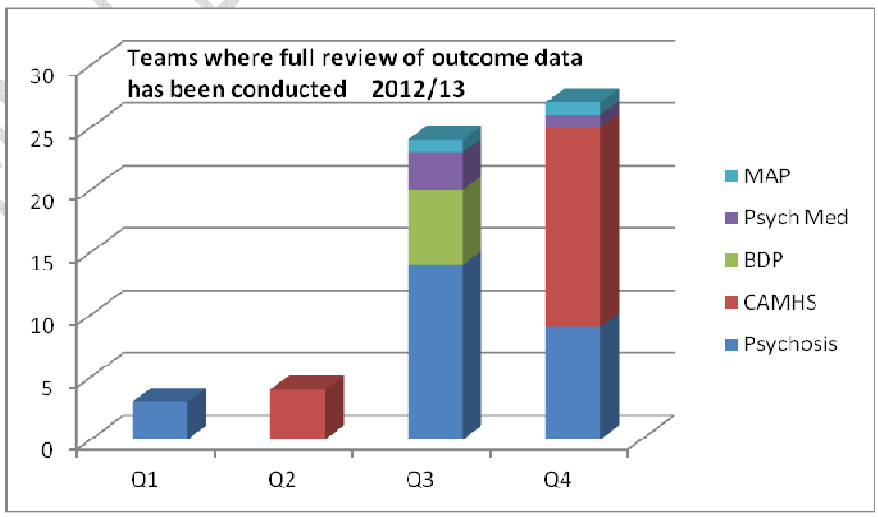
Headline Data unavailable at 10/05

Priority Six - Reviewing clinical outcomes scores to improve outcomes

The collection of clinical outcome data gives our clinical teams a great opportunity to look at their data and compare it with other similar services to see if improvements in outcomes for patients can be made.

Target	We said that all clinical teams will review their outcome data at least annually
Measure	We said that we would measure this by the proportion of teams collecting outcomes data which have had a dedicated session examining their outcomes and context data, including comparison with similar teams in the Trust, each year.

Headlines **65 teams had the opportunity to review their outcome scores data in 2012/13. The pace of conducting these reviews has picked up as the year has progressed, and we are now confident going into 2013/14 that this year most of our teams will benefit from a review.**



Number of clinical teams who had the benefit of a full review of their clinical outcome data in 2012/13.

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Priority Seven - Improving waiting times

Waiting times for assessment and treatment from our services vary greatly according to the local demand, demand fluctuations and the capacity of service commissioned. We said that we would for all services specify the wait time target and put into place plans for achieving those target times.

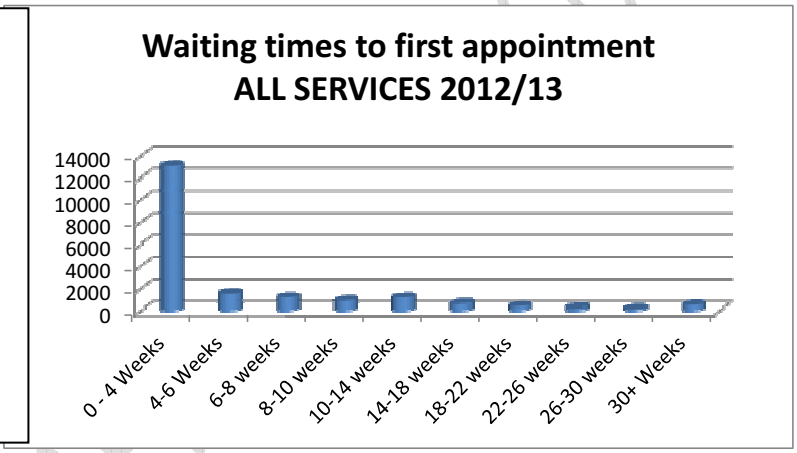
Target To set waiting time targets for all pathways.
Measure Date of referral received to date of first appointment

Headlines **The Trust has made significant progress over the year in both measuring waiting times in all services areas. Many patients have benefited from the focus on tackling waiting times in services such as psychological treatment services, and CAMHS Southwark services. Waiting lists in these two areas have fallen significantly over the year due to targeted work to increase the number of available appointments.**

The vast majority of patients referred to the Trust are seen on the same day when presenting as an acute emergency or within days when referred by a GP.

Chart 6. Shows the distribution of waiting times aggregated for all Trust services, for all patients seen for first appointments.

A total of 20,000 patients were seen, 93% were seen within 18 weeks.



Services with significant and consistently long wait times are:

- Croydon IPTT Services where there are long wait times for patients with complex presentations. This provision was recently included in a Joint Strategic Needs Assessment of services for people with depression led by commissioners in Croydon.
- Croydon CAMHS services were there has been new investment toward the end of the year which has had a positive impact on waiting lists.

Priority Eight - Improving our response to requests from GPs

As care pathways and structural changes to services bring primary and secondary care services closer together, the flow of clinical information between them will become a vital component of safe and seamless care. Our ability to provide GPs with information, support and advice quickly and succinctly will become a key measure of the quality and responsiveness of our services.

TARGET To establish minimum standards for responding to requests for support and advice from General Practitioners.

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MEASURE Call back time from request receipt to call back from Care Co-ordinator or Consultant.

Headline **48 hours is the targets for responding to requests from GPs. GP Liaison is improving, and being largely driven in Borough services by the CQUIN targets. In quarter four (Jan- April), 98% (120/122) of calls to consultant psychiatrists or the duty desk were answered within 48 hours.**

Q1 2012/2013	Number of calls from GPs for advice	% responded to within 48 hours	Q2 2012/2013	Number of calls from GPs for advice	% responded to within 48 hours
Lambeth	84	50%	Lambeth	67	100%
Southwark	54	100%	Southwark	21	100%
Lewisham	18	100%	Lewisham	43	100%
Croydon	12	100%	Croydon	19	100%
Q3 2012/2013	Number of calls from GPs for advice	% responded to within 48 hours	Q4 2012/2013	Number of calls from GPs for advice	% responded to within 48 hours
Lambeth	12	91%	Lambeth	17	90%
Southwark	53	100%	Southwark	56	100%
Lewisham	22	100%	Lewisham	46	100%
Croydon	9	100%	Croydon	3	100%

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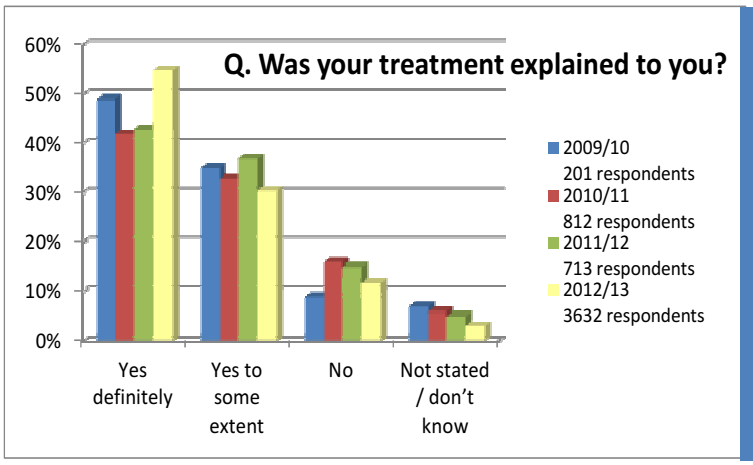
Other Indicators we use to measure quality

Improving Patient Experience

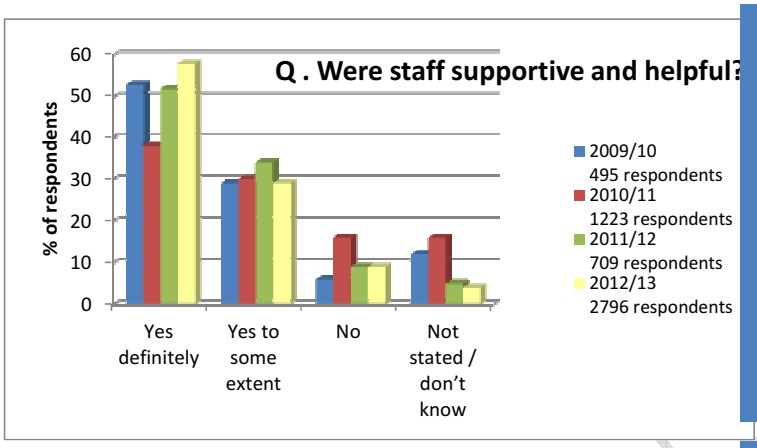
The experience and satisfaction of patients their families and carers is central to our approach to quality measurement and quality improvement. Over the past four years the numbers of surveys conducted and different ways in which the views of patients are sought has improved considerably. In 2012/13 over four thousand patients were invited to complete surveys on the services they received. For the purposes of this report, as in previous years we are presenting the overall results to the following care survey questions.

1. Was your treatment explained to you?
2. Were the staff supportive and helpful?
3. Was the environment and furnishing up to the standard you would expect?
4. Did you trust the staff?
5. Did the staff listen to you?

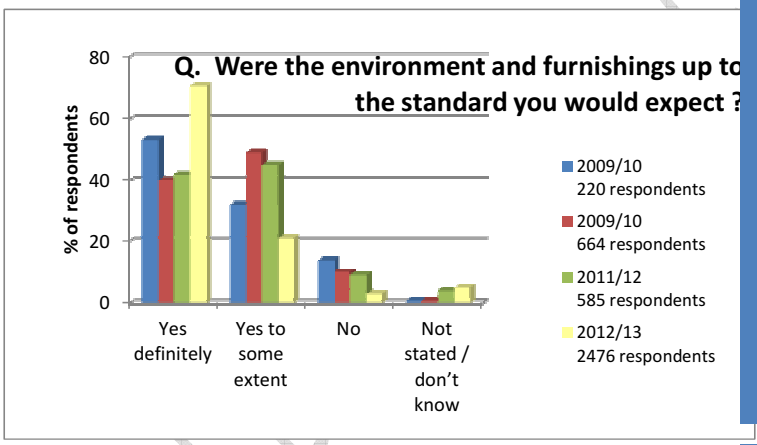
The following tables summarise results from our in-house surveys to these five core questions. Note that in 2012/13 many more patients were surveyed out of hospital, in day care, clinics, outpatients and community settings.



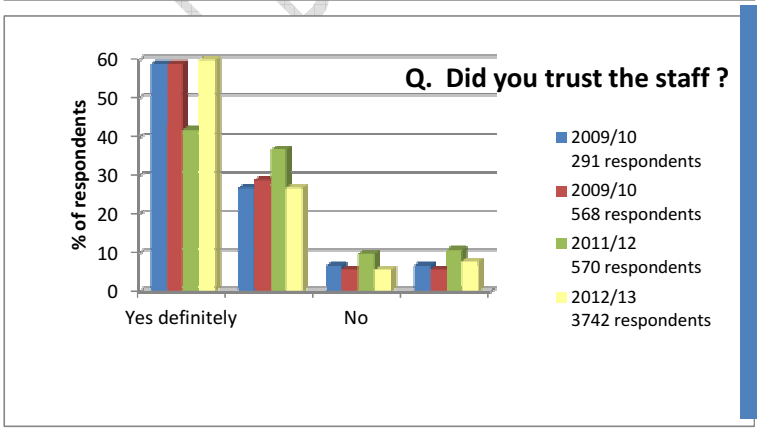
Our survey data shows that generally patients were more satisfied that their treatment was explained to them, than in the previous two years.
In the 2012 national patient survey many more patients were happy that their medication had been explained to them, compared to the 2011



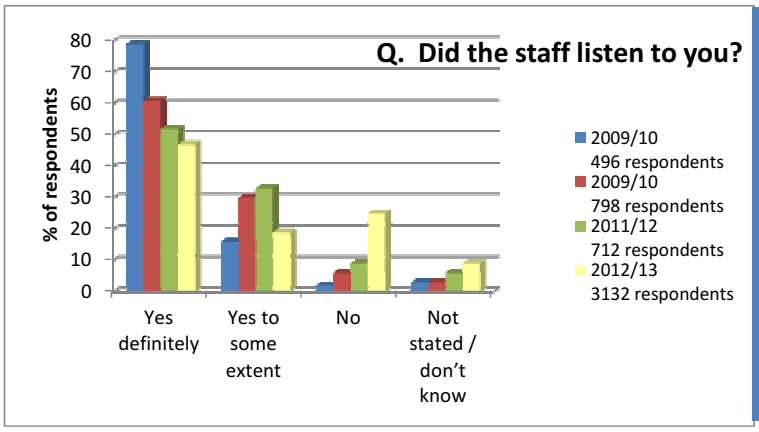
Our in-house surveys show that responses to this question showed a marginal improvement in 2012/13, with more patients saying that staff were 'definitely' supportive and helpful.



Generally patients responded very positively to this question in 2012/13, with many more 'definitely' responses.



Results from both the national patient survey and our in-house surveys show a marginal fall (compared to the year before) in the number of patients who felt that they trusted the staff who were involved in their care.



National patient survey results on this question have been consistent, however our in-house surveys this year, show that fewer patients felt that staff listened to them.

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National Patient Survey 2012 – Community Mental Health

This survey was conducted at the start of 2012. 219 questionnaires were returned by users of SLaM services. Key results were:

Where we scored better than before:

- Did you find your talking therapies helpful?
- Were the purposes of medication explained?

Where we scored worse than before:

- Were you told about the possible side effects of medication?
- Were your views taken into account when deciding what was in your care plan?

The results of the 2012 survey have been carefully considered by the Patient Experience Group. A number of plans and objectives around Patient Experience will be implemented throughout 2013/14 some of these are highlighted below:

- The development of action group to respond to the recommendations highlighted within the Francis Report
- The implementation of the 'Friends and Family Test' (FFT) across all of SLaM's inpatient wards. The FFT is only mandatory throughout the Acute hospitals but SLaM believe that the FFT will enable us to further improve patient experience. This is a quality priority for next year.
- The re-development of the qualitative feature of patient experience information through the telling of patient stories, and establishing focus groups, and service improvements with patient and staff collaboration.
- To develop both strong working relationships with our external partners including local Healthwatch organisations, Health Overview & Scrutiny Committees, Clinical Commissioning Groups and third sector agencies.

SLaM services and people from Black and Ethnic Minority groups.

Throughout 2012/13 SLAM held quarterly meetings with the four borough LINks groups from Croydon, Lambeth, Lewisham and Southwark to explore issues relating to the Quality Account and concerns raised about the over-representation of patients from Black and Minority Ethnic (BME) communities in mental health services. At a four-borough LINKs meeting on 19th November 2012 these issues and statistics were explored in detail. The meeting agenda included a summary of the research which shows an elevated incidence of schizophrenia in African and Caribbean populations living in England (Fearon, 2006) and a question and answer session with Dr. Shubulade Smith, author of the chapter of the Schizophrenia Commission's

report 'The Abandoned Illness' (November 2012) – Mental Health and Minority Ethnic Groups (pages 48-51). One of the key messages from Dr. Smith was that getting help early is crucial to good outcomes and the Commission's report recommendations reflect this 'early intervention services which provide treatment in non-stigmatising settings need to be extended'.

Ethnicity distribution of inpatient and community caseloads

	Inpatient			Community			Total	
	n	% column	% row	n	% column	% row	n	% column
White	370	50.8	1.8%	19722	61.9	98.2%	20092	61.6
BME	359	49.2	2.9%	12144	38.1	97.1%	12503	38.4
Not stated	8		0.2%	3296		99.8%	3304	
Total	737	100%	2.1%	35162	100%	97.9%	35899	100

The composition of the total SLAM caseload broadly reflects the general population ethnic distribution in the local boroughs at the 2011 census. The community caseload has a slightly higher over-representation of White patients (62%) compared with the general population (55%). Conversely, the inpatient population has a slightly higher representation of patients from a BME group (49.2%) than the general population in SLAM boroughs (45%).
In terms of the total SLAM caseload, the most common diagnosis is schizophrenia – accounting for nearly one fifth (18%) of the diagnoses on the SLAM caseload. Schizophrenia, schizotypal and delusional disorders are also the only conditions for where there is a higher proportion of BME patients (62.5%) than White patients (37.5%) with this diagnosis. For all other diagnoses there was a slight under-representation of BME patients (i.e. under 45% BME patients).

Inpatients, ethnicity and diagnosis

In terms of the diagnostic distribution among the SLAM inpatient population, schizophrenia, schizotypal and delusional disorders account for nearly half of the inpatient diagnoses (45.4%).

Of inpatients with a diagnosis of schizophrenia, there is a high representation of BME patients (71%) compared to White patients (29.0%). See table below.

	White			BME			Total	
	n	% column	% row	n	% column	% row	n	% column
F20-29 - Schizophrenia, schizotypal and delusional disorders	96	25.9	29.0	235	65.5	71.0	331	45.4
Other diagnosis	274	74.1	68.8	124	34.5	31.2	398	54.6
Total	370	100	50.8	359	100	49.2	729	100

Access to Talking Therapies for BME patient with schizophrenia

	Ethnic Group	Proportion of service users received CBT	%
Patients receiving CBT for Psychosis	BME	268/2247	11.9%
	White	145/1240	11.7%

Proportion of service users on the care programme approach CPA with a schizophrenia spectrum diagnosis who have received CBT for Psychosis in the last year

The table above shows that the proportion of service users who have received CBT for psychosis is very similar for BME (11.9%) and White (11.7%) ethnic groups.
Our outcome data indicates that psychological interventions are equally successful with people from BME communities as white people. However, there are some audit indications that drop-out

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rates are higher in BME groups and we are working to address this through improving the cultural competencies of our psychological therapies workforce.

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Lewisham Healthcare NHS

NHS Trust

Draft 1.1 (Version 30)

QUALITY ACCOUNT 2012-2013

Document Version Control

Draft	Version	Date	Amended By	Comment/Amendment
1.1	20	26th April 2013	Glen Davidson	Inserted A&E survey results and added narrative asking Fay Blackwood for further information (page 50)
1.1	21	30th April 2013	Sarah Goreham	Inserted Document Version Control table (page 2)
1.1	23		Janette Haworth	
1.1	24	9th May 2013	Keziah Bowers	CQUIN 13/14 table amended Emergency Readmissions (section 2.1.2) amended Latest SHMI data added
1.1	25	9th May 2013	Belinda Regan	Insertion of Infection Control additions Addition of Francis report Priorities
1.1	26	10th May 2013	Belinda Regan	Insertion of additional Clinical Effectiveness priority information
1.1	27	14th May 2013	Keziah Bowers	Further editing to section 2.1.2 on emergency readmissions with feedback from Jo Peck and Liz Aitken
1.1	28	14th May 2013	Belinda Regan	Addition of Staff Survey data and narrative Addition of Patient Safety Information Addition of C. Difficile published data
1.1	29	15th May 2013	Ayesha Omar	Table 1 updated for Colectomy Length of Stay (LoS excluding outlier included in the table)
1.1	29	15th May 2013	Ayesha Omar	Table 2 updated for Colectomy Length of Stay (LoS excluding outlier included in the table)
1.1	29	15th May 2013	Ayesha Omar	Addition of Length of Stay narrative for Colectomy and Knee replacement procedures.
1.1	30	16th May 2013	Belinda Regan	Addition of Infection Control amendments

Contents

GLOSSARY:

A&E	Accident and Emergency
A2E	Aspiring to Excellence
AIDS	Acquired Immunodeficiency Syndrome
AVPU	Alert, Voice, Pain, Unresponsive score
C & YP	Children and Young People
CAD	Coronary Artery Disease
CAGG	Clinical Audit and Guidelines Group
CAP	Clinical Audit Programme
CCG	Clinical Commissioning Group
CCI	Charlson Co-morbidity Index
CCU	Coronary Care Unit
CHKS	Independent provider of healthcare intelligence, benchmarking and quality improvement services
CLRN	Comprehensive Local Research Network
CNST	Clinical Negligence Scheme for Trusts
COPD	Chronic Obstructive Pulmonary Disease
CPA	Clinical Pathology Accreditation
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CT	Computerised Tomography
DoH	Department of Health
DoL	Deprivation of Liberty
EoLC	End of Life Care
ERAS	Enhanced Recovery After Surgery
ERP	Enhanced Recovery Programme
GP	General Practitioner
GRE	Glycopeptide Resistant Enterococci
HDU	High Dependency Unit
HES	Hospital Episode Statistics
HIV	Human Immunodeficiency Virus
HPA	Health Protection Agency
HRG	Healthcare Resource Group
HSMR	Hospital Standardised Mortality Ratio
HV	Health Visitor
IG	Information Governance
ITU	Intensive Therapy Unit
IVIG	Intravenous Immunoglobulin
KO41	NHS Complaints System
LHNT	Lewisham Healthcare NHS Trust
LINks	Local Involvement Networks
MAU	Minor Assessment Unit

MEWS	Modified Early Warning Score
MIND	Mental Health Charity
MMR	Measles, Mumps and Rubella
MRSA	Methicillin-resistant *Staphylococcus aureus*
MSSA	Methicillin-Sensitive *Staphylococcus aureus*
NCDAH	National Care of the Dying Audit-Hospitals
NHS	National Health Service
NHSLA	National Health Service Litigation Authority
NICE	National Institute for Health and Clinical Excellence
NPSA	National Patient Safety Agency
ONS	Office for National Statistics
OSC	Overview and Scrutiny Committee
OWL	Outcomes with Learning
PALS	Patient Advice and Liaison Service
PAR	Patient at Risk
PbR	Payment by Results
PCT	Primary Care Trust
PDN	Practice Development Nurse
PEAT	Patient Environment Action Team
PEWS	Paediatric Early Warning Score
PMETB	Postgraduate Medical Education and Training Board
PROMS	Patient Reported Outcome Measures
PWF	Patient Welfare Forum
QIPP	Quality, Innovation, Productivity and Prevention
QRP	Quality Risk Profile
RA	Rheumatoid Arthritis
RALI	Risk Adjusted Length of Stay
RAMI	Risk Adjusted Mortality Index
RATU	Rapid Assessment Treatment Unit
RCA	Root Cause Analysis
RHA	Review Health Assessment
RIO	Community Electronic Patient Record
SBAR	Situation, Background, Assessment and Recommendation
SHMI	Summary Hospital Mortality Indicator
SINAP	Stroke Improvement National Audit Programme
SUS	Secondary Uses Service
TNM	Tumour, Node, Metastasis Cancer Staging System
TVN	Tissue Viability Nurse
UK	United Kingdom
VTE	Venous Thromboembolism
WHO	World Health Organisation

PART 1

1. Statement of Quality from the Chief Executive

Welcome to the 2012-13 Quality Account for Lewisham Healthcare NHS Trust. I hope you find the report a useful guide to our performance over the last year and our priorities going forward as we continue to work towards a new organisation and working with local people and other local organisations to improve healthcare in Lewisham and Greenwich.

This is Lewisham Healthcare NHS Trust's third year and following the successful integration of Lewisham community services in 2010, the trust is preparing for further integration of services with the proposed merger of Queen Elizabeth Hospital, Woolwich.

Coming together as one organisation will give us the opportunity to work in partnership to develop and improve patient pathways for local people and meet ever increasing NHS challenges.

This third year has seen the benefits of integration really beginning to make a difference with the successful achievement of all of our performance targets, the development of new services and the provision of care being much closer home.

As part of the quality improvement programme, the last three years has seen major upgrades to the hospital site.

April 2012 saw the opening of our new Emergency Department. The purpose built new Emergency Department is co-located with our new Urgent Care Centre and includes the children's emergency facilities. It has larger, better equipped resuscitation services, and we have modern individual treatment bays to ensure all patients and carers are treated with dignity and privacy."

A new reception area for the hospital has also been completed, which has improved access to the hospital, and also includes a new quiet room for all visitors.

During 2013 the Trust has upgraded its clinical environment with the refurbishment of the Neonatal Intensive Care Unit, the development of state–of-the-art theatre operating facilities and the recent commencement of work to refurbish the maternity labour ward.

Our performance once again this year has been good, with the Trust being named as one of the Top 40 Hospitals for the fifth year running by CHKS, one of the UK's leading independent providers of health intelligence. CHKS assess our services by looking at a range of measures including hospital acquired infections, patient reported outcomes and experiences, our mortality rates and staff survey. We are particularly proud of our record of low mortality rates, low rates of MRSA and of Clostridium difficile and our improved performance in both patient and staff surveys.

In line with our focus on quality, we introduced our Quality Improvement Strategy during 2012, which provided the framework for our quality improvement programme for 2012-2013. Quality Improvement Roadshows were held across the Trust during 2012 to promote our strategy for continual improvements.

During 2012 we saw a new departure for the NHS and the reforms to the NHS planned for 2013 will radically change the landscape in which we operate.
The NHS Trust Development Authority came into being in 2012 with a single ambition: to support NHS Trusts to deliver high quality, sustainable services in the communities they serve.

The NHS reforms come on the back of the most sustained period of improvement the NHS has seen in recent memory but also at a time when challenges that lie ahead are greater than those faced for many years.

The publication of the Mid Staffordshire Public Inquiry Report in 2013 provides a salutary reminder that while meeting the ever increasing challenges, we have to be relentlessly focussed on ensuring that the quality of care we provide meets the very highest standards we would expect for own care and that of our families.

As a truly integrated provider, the community to hospital care pathway will enable us to drive through improvements in preventing ill health, providing personalised care that is effective and safe and results in a good experience for our service users. The priorities for the Trust going forward in 2013-2014 will aim to deliver continuous improvement in patient care over the next year.

Our priorities for 2013-14 focus on further embedding the work we have started through implementing our quality improvement strategy, with the addition of new priorities that we feel will focus on the learning gained from the outcomes of the Mid Staffordshire Public Inquiry and that will bring benefit to our local population.

The priorities for the forthcoming year are focussed and based around the NHS Outcomes Framework, the National Quality Board priorities, local partnership and clinical commissioning group priorities as well as those priorities linked to patient and user feedback.

We will continue to develop the new organisation within the quality and governance framework for an aspiring Foundation Trust and will continue to work with our membership and Shadow Governors to bring a service user perspective to all we do, whether in designing new services or monitoring the quality of those we already provide. As always, we will strive to provide the very best care that our local community deserves.

I hope that you find the information contained in this Quality Account of interest and we will be producing a shorter, easier to read version shortly. The full document will also be available on our web site: www.lewisham.nhs.uk.

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

Signed:

Tim Higginson
Chief Executive

Part 2

2.1 PRIORITIES FOR IMPROVEMENT

The foundation for high standards of health care are set out in the rights and pledges of the NHS Constitution, the expectations and priorities in the Mandate from the Government to the NHS Commissioning Board and the measures set out in the NHS Outcomes Framework 2013/14.

Following the success in achieving significant improvements and outcomes from last year's Trust priorities, this year the Trust will focus on developing and embedding the culture for quality improvement across a newly merged organisation. The Trust's Quality Improvement Strategy sets out the vision and direction for the Trust over the coming three years and although this will be reviewed and updated to reflect a newly merged organisation based on two acute hospital sites and community services, the vision for quality improvement will remain the same.

The vision of our Quality Improvement aims to provide the best possible healthcare in the hospital and community for the population of Lewisham and Greenwich and other local people, working independently and with partners. As well as promoting good health in local communities and being a centre of excellence for educating healthcare professionals, we will be innovative in service design, development and evaluation.

As defined within our strategy the term quality will be focused in three parts:

- Patient Safety
- Effectiveness of Care (Clinical Effectiveness)
- Patient Experience

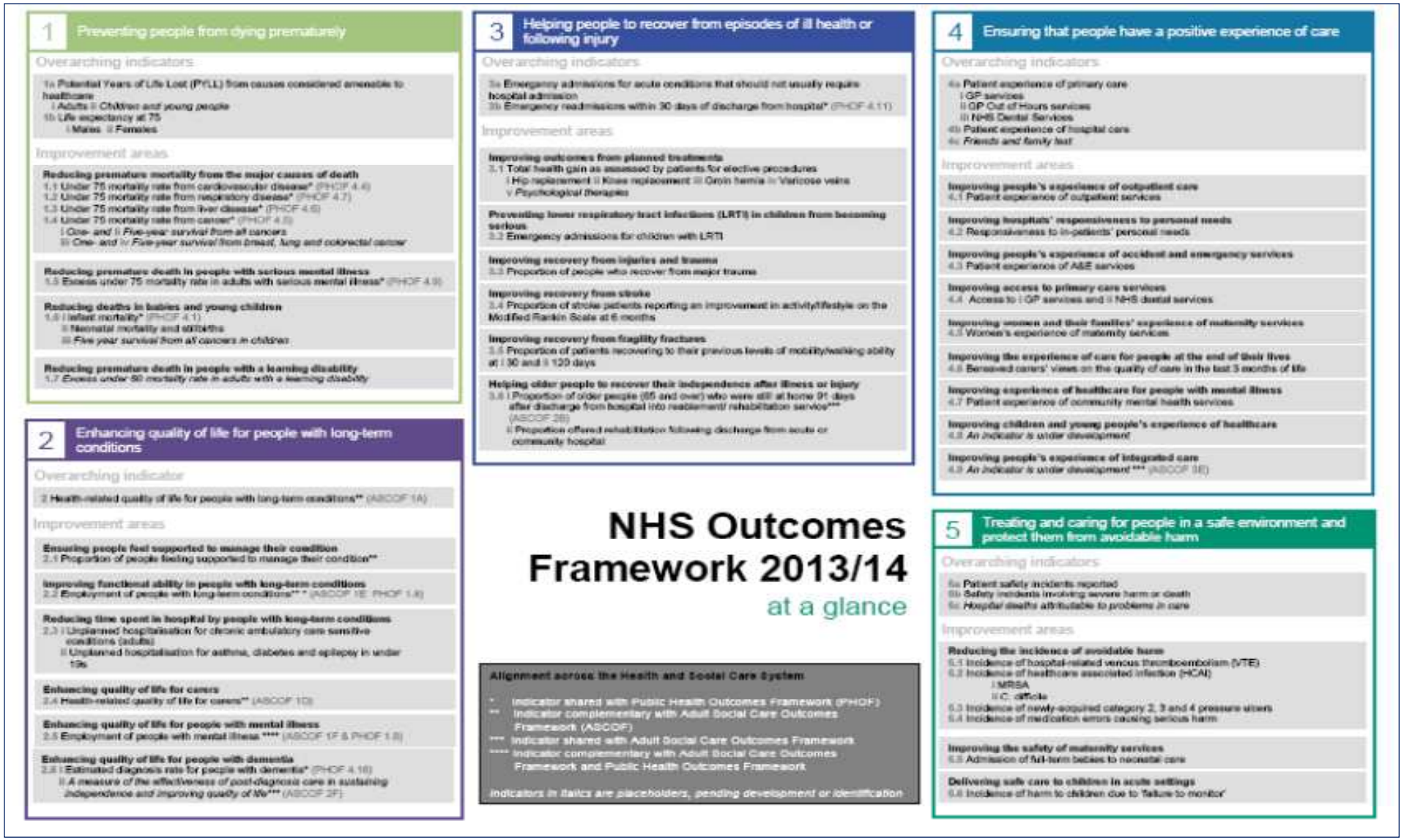
this provides for the foundation on which our priorities for improvement will be built over the coming years.

Through our Quality Improvement Strategy and from the learning gained from the Mid Staffordshire Public Inquiry and recommendations, we will introduce new priorities and will continue to use The NHS Outcomes Framework 2014/13 as the basis for setting, measuring and reporting on agreed priorities.

The NHS Outcomes Framework 2012/13 reflects the vision set out in the White Paper *Equity and Excellence – Liberating the NHS*, strengthening the focus of driving quality improvement and outcome measurement throughout the NHS by encouraging a change in culture and behaviours, including a stronger focus on tackling health inequalities.

It is structured around five domains, which set the high-level national outcomes which the NHS is aiming to improve. This year the Trust has set its priorities around each of these five Domains, see Figure 1.

Figure 1. The NHS Outcomes Framework 2013/14 at a Glance



Overview

Following the successful achievements in quality improvement last year, the Trust after wide discussion has decided on the following priorities for 2013-14:

Patient Safety Priorities

Summary

1. Patient Safety Incidents Reported
2. Reducing the incidence of avoidable harm
3. Safety walkarounds
4. Improving the safety of maternity services
5. Delivering safe care to children in acute settings

Clinical Effectiveness Priorities

Summary

1. Reducing premature mortality and increased survival rates from breast, lung and colorectal cancer
2. Reducing mortality rates amenable to healthcare
3. Improving outcomes and total health gain as assessed by patients for planned treatments
4. Improving diagnosis, treatment and quality of life for people with Dementia

Patient Experience

Summary

1. Implementation of the Department of Health Friends and Family Test
2. Improving maternity services
3. Improving children's and young people's experience of healthcare
4. Improving the way we manage and learn from complaints

Learning from the Mid Staffordshire Public Inquiry (Francis Report)

Summary

1. Promoting a culture of openness, transparency and candour
2. Promoting a culture of 'Putting patients first' with care and compassion

Patient Safety – Domain 5

In addition and to complement the existing work within the Trust's Patient Safety programme, the Trust will focus on the following priorities:

2.1.1(i) Priority 1 – Patient Safety Incidents reported

The Trust continues to encourage staff to report all adverse events or 'near misses' using the electronic incident report system which all staff can access. These include incidents involving clinical care and systems supporting the delivery of care, and are known as patient safety incidents. Anonymised patient safety incidents are then sent from the Trust's incident reporting electronic database to the NHS National Reporting and Learning System (NRLS). These are uploaded on most working days to ensure that the reporting to NRLS is undertaken in a timely manner.

Organisations that report more incidents usually have a better and more effective safety culture. Many patient safety commentators hold that an organisation cannot learn and try to improve if it is not aware of what the problems are in the first place.

Within the Trust, Directorates receive automatic monthly reports from the incident reporting database setting out a brief description of all incidents reported within their area, and bar charts which group the main type of incident related for example to medication, implementation of care, consent, confidentiality, treatment or procedure.

Each Directorate delivers a patient safety report to the Patient Safety Committee on a quarterly basis setting out an analysis of those incidents and any actions taken and planned to reduce risk in the future.

The number of reported patient safety incidents overall, and any where severe harm or death has occurred as a result, is reported to the Patient Safety Committee each month. Any incident resulting in severe harm or death is investigated as a Serious Incident and reported externally to a national NHS database (StEIS). The delivery of a satisfactory investigation report is monitored by the Clinical Commissioning Group who took over this function on 1 April 2013 from NHS London (the former Strategic Health Authority). The Trust Board already receives a list of any new Serious Incidents declared on a monthly basis, however during 2013 – 14 this report will be expanded to include the rate of patient safety incidents per 100 admissions resulting in severe harm and death.

The outcome measures will be:

1. Reporting of overall numbers of Patient Safety Incidents
2. Reporting of the rate of patient safety incidents per 100 admissions
3. Reporting of Never Events
4. Reporting of rate and percentage of reported incidents which result in severe harm or death
5. Reporting of all hospital deaths attributable to problems in care

2.1.1 (ii) Priority 2 - Reducing the incidence of avoidable harm

The Trust's Patient Safety Committee oversees the work undertaken in many areas to reduce the incidence of avoidable harm to patients in the care of the Trust whether being cared for in the community or in hospital. Figures relating to the following areas are reported monthly or quarterly within a Patient Safety Scorecard which is reviewed each month at the Patient Safety Committee.

Venous Thromboembolism (VTE)
It is known that nationally there is a significant number of patient deaths every year from venous thrombo-embolism (blood clots); some of these deaths are now considered avoidable if appropriate care is reliably given. The Trust aims to reduce to zero avoidable deaths from VTE. We aim to do this by ensuring that all patients admitted to hospital have a risk assessment for VTE performed as part of the admission process, and that this is repeated within 24 hours of admission and at any time there is a change in the patient's clinical condition. Should a patient develop a VTE there should be a root cause analysis of the care given with the aim of identifying any gaps or problems to enable staff to learn and reduce risk for future patients. These measures will be audited on a regular basis.

Healthcare Associated Infection (HCAI)
Some infections are potentially life threatening or life changing. Patients must be protected from acquiring infections as a result of receiving healthcare. The Trust has an Infection Prevention and Control team which includes a team of specialist nurses and microbiologists who work closely with staff in associated disciplines including pharmacy (to ensure that if they are needed we use the correct antibiotics in the most advantageous way to combat infection, and to reduce the likelihood of bacteria becoming resistant), cleaning services to ensure that our environment is kept as clean as possible, and biomedical scientists who identify different organisms which need treatment. They also provide mandatory education and updates to ensure that staff understand and carry out handwashing and decontamination correctly and consistently, The Trust has strict levels of tolerance for incidents of MRSA bacteraemia and C Difficile which reduce year by year. Root cause analysis is used as a tool to investigate any HCAI events to help reduce the likelihood of healthcare associated infection in future. The Trust Board receives regular updates on any incidences of healthcare associated infection.

Pressure Ulcers (bedsores)
These are areas of skin or underlying tissue that become damaged because pressure reduces the blood supply to these areas. Pressure ulcers are usually caused when someone sits or lies in the same position without moving for long periods, however they can develop in just a few hours. If care is not taken pressure ulcers can lead to more serious skin problems, becoming painful, infected or causing blood poisoning or bone infection. In serious cases the underlying muscle or bone may be destroyed and in extreme cases it can become life threatening.
As people are surviving longer, they may be less mobile or live for longer with chronic illnesses such as diabetes that may predispose them to the development of pressure ulcers. It is therefore crucial that patients are protected from the development of pressure ulcers as far as possible. Prevention methods may include pressure relieving equipment such as chair cushions and bed mattresses, and importantly helping people to reposition themselves frequently or turning them to relieve pressure if they are less mobile or bed bound.
The Trust has a Pressure Ulcer working party that reports to the Aspiring to Excellence programme and which concentrates solely on reducing the numbers of avoidable pressure ulcers both within the hospital and where the patient is being visited by community services.

Patient Falls
Frail or older people tend to be more susceptible to falling and this can lead to significant harm such as a fractured hip or head injury, and in extreme cases may shorten a person's life or lengthen the time it takes to recover to better health. The Trust therefore aims to reduce the number of patient falls overall and to minimise the harm suffered should a fall not be prevented in

the first place. The Trust employs a clinical nurse specialist in the prevention and management of falls. Various methods have been employed over the years including the purchase of 47 very low beds to reduce the impact of falling out of bed where bed rails are unsuitable for a patient. Signs by a patient's bed that indicate that they have been assessed as being at increased risk of falling so that nursing staff can provide assistance appropriately.

Recognition of the Deteriorating Patient
The chance of recovery is increased where deterioration in a patient's condition is identified early and the situation escalated to appropriate healthcare professionals. A reduction in cardiac arrests in the general ward areas would indicate that early warning systems are likely to be being used effectively. The Trust will therefore monitor the number of out of ICU cardiac arrests (where no Do Not Resuscitate Order is in force) and aim to reduce this to zero.

Safe Surgery – compliance with the WHO Surgical Safety Checklist
All areas where invasive procedures or operations are carried out are required to use this checklist prior to the operation beginning. Such simple checklists have been shown to improve the reliability of tasks being carried out within healthcare and to reduce harm to patients. The Directorate of Surgery will carry out regular observational audits during 2013 - 14 to measure the effectiveness of the implementation of the checklist within theatres. We wish to avoid this checklist being seen simply as 'tick boxes' but to ensure it is being used and valued by all healthcare practitioners as a valuable harm reduction tool.

Inquests
On rare occasions care management problems come to light as part of Her Majesty's Coroner's inquest investigation that have not previously been identified by the Trust. Such events will result in feedback to the relevant Directorate for comment and the development of an action plan to reduce the risk of recurrence. Any such action plans will be monitored by the Trust's Outcomes With Learning (OWL) Group which is chaired by the Executive Director of Operations and Nursing.
At the end of an inquest HM Coroner has the power to make recommendations to a public organisation should s/he feel that a system remains that could lead to another death and this is called a 'Rule 43 Recommendation'. Any such Rule 43 Recommendation will be subject to a response from the Chief Executive within 56 days and any actions to improve safety arising from this process are reviewed at the OWL Group. The receipt of a Rule 43 Recommendation from the Coroner is also reported on the Trust's Patient Safety Scorecard.

The outcome measures will be:

1. Increase in the percentage of patients risk assessed for Venous Thromboembolism VTE
2. Incidence in hospital associated [VTE] and percentage of root cause analysis in these cases
3. Incidence of Healthcare Associated infection –
    - MRSA bacteraemia hospital attributable cases
    - MRSA – emergency admissions screening
    - MRSA – elective admissions screening
    - Rate of C Difficile cases per 100,000 bed days (age 2 and above)
4. Incidence of newly acquired category 2, 3, and 4 pressure ulcers
5. Incidence of medication errors causing serious harm
    - Omitted medicines
6. Number of patient falls resulting in harm (by level of harm)
7. Identification of the Deteriorating Patient
    - Out of ICU cardiac arrests
8. Safe Surgery
    - Compliance with the WHO Surgical Safety checklist (observational audit)
9. Inquests

- Any inquests where care management problems are identified as contributory to patient deaths (where the care management problem has not previously been investigated as a Serious Incident)
- Any Rule 43 recommendations from the Coroner

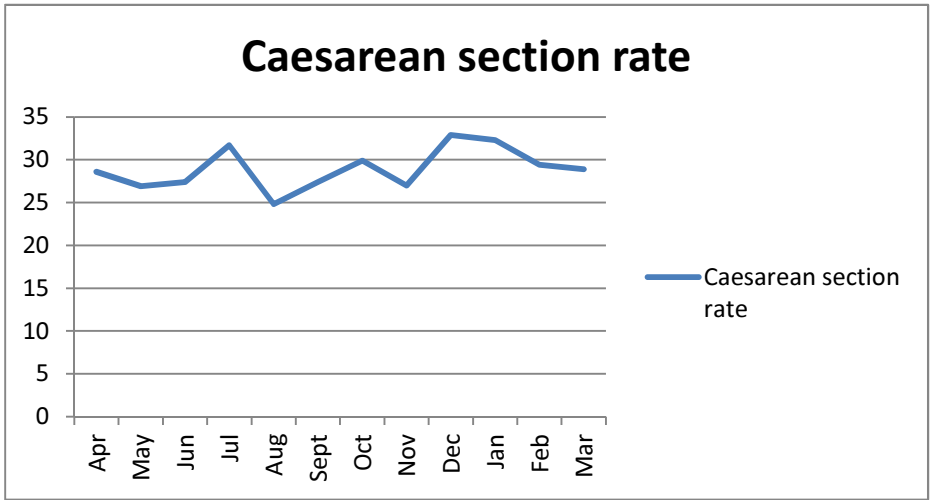
2.1.1 (iii) Priority 3 - Improving the safety of maternity services

Maternity Unit staff aim to provide the best possible care for women and babies during pregnancy, birth and in the immediate neonatal period. To this end the Maternity Service has been working hard through the past year towards achievement of Level 2 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Standards during 2013 - 14. During June 2013, two assessors will spend two days in the Maternity Unit and examine policies to check that they support good practice, and paper work evidence of compliance with the standards. They will also review current clinical notes to check whether there is robust evidence that the policies are being carried out in practice and they will also speak with front line midwives and obstetricians to check their knowledge.

Should any adverse event occur the Directorate of Women and Sexual Health has robust governance procedures in place to ensure that any significant patient safety incident is reviewed by a senior obstetrician and midwife. Any themes or trends are identified which allows actions to be taken to improve safety in the future. These are reviewed at weekly meetings.

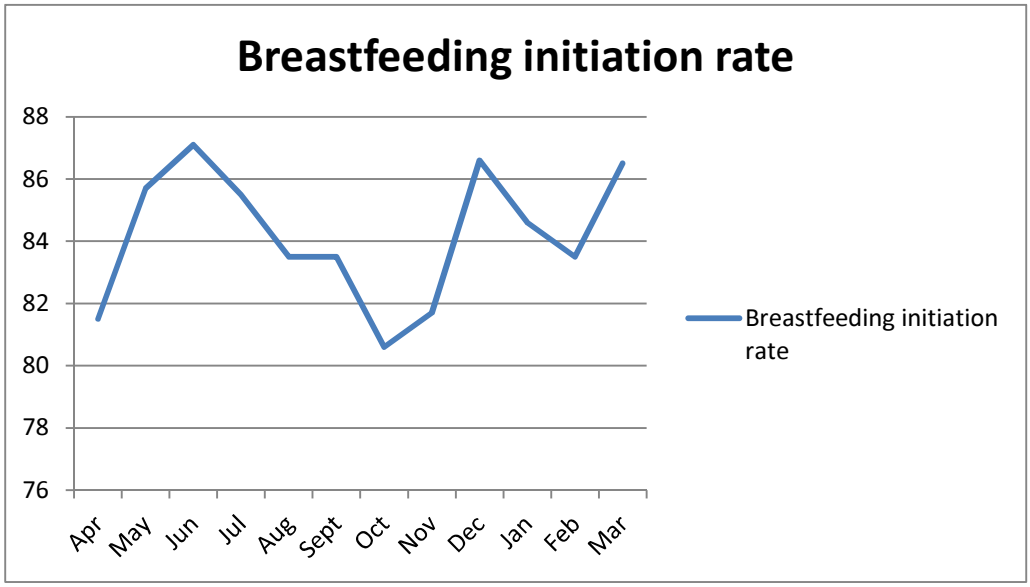
The Maternity Unit maintains a 'Maternity Dashboard' which is reviewed every month at the Directorate Governance and Risk meeting and is sent quarterly to the Trust's Patient Safety Committee. This helps senior staff to monitor the quality of care being given within the unit via trends in areas including the rate of Caesarean sections and normal vaginal births, perineal tears, unexpected adverse outcomes such as stillbirth, and the number of unexpected admissions of full term babies to the Neonatal Intensive Care Unit.

Caesarean Section Rate
During 2012 – 13 the Maternity Unit had the following rates of Caesarean sections, the overall rate being 28.9%.



An action plan is in place to help reduce the rate to under 26% throughout the coming year, and this is being monitored both internally and by the local commissioners of care.

Initiation of Breastfeeding
Increasing the number of breastfed babies is a national public health priority and the rates of women who choose to breastfeed their baby initially is captured on the Maternity Dashboard on a monthly basis. The rates are consistently higher within London than the rest of England and this is also demonstrated in Lewisham Healthcare NHS Trust where the rates have stayed firmly in the 80 – 90% bracket throughout 2012 – 13, whereas for the rest of England the rate is around 74%.



During the year 2012 – 13, from a total of 4,122 births at Lewisham Healthcare NHS Trust, six women required blood transfusions during or after childbirth, and there was one hysterectomy which was required to save a woman's life after severe blood loss could not be stopped by any other method; both she and her babies made a good recovery.

Similar monitoring will continue throughout the coming year in 2013 – 14 with the aim of reducing the rate of Caesarean sections and any adverse outcomes of maternity care. Lewisham Healthcare NHS Trust will also aim to reduce the numbers of mother who continue to smoke during their pregnancy through improved referral to smoking cessation counselling, and continue to increase the numbers of women who chose to breast feed their babies.

The outcome measures will be:

1. Admission of full terms babies to neonatal care
2. Rate of Caesarean sections (as a percentage of all births within the maternity unit)
3. Breast feeding initiation
4. Smoking at the time of delivery
5. Stillbirths per 1,000 births
6. 3rd and 4th degree tears
7. Hours of consultant presence on labour ward

2.1.1 (iv) Priority 4 - Delivering safe care to children in acute settings

A child's clinical condition can sometimes deteriorate suddenly and unexpectedly if they are ill. The Children's Directorate has introduced an observation chart which uses the Paediatric Early Warning Score (PEWS) to assist nurses to recognise as early as possible, sometimes from subtle changes, when a child's condition may be worsening and prompts them to call a doctor at the earliest signs of a concern.

During 2013 – 14 the Trust will continue to educate staff in the recognition of the deteriorating child, and appropriate escalation. The Trust's Resuscitation Officer is informed of all instances of cardiac arrest or peri-arrest situations throughout the hospital and is a member of the Trust's Patient Safety Committee. Any incidences of children suffering harm due to failure to monitor will be reported monthly on the Patient Safety Scorecard and reviewed at the Patient Safety Committee.

The outcome measures will be:

1. Incidence of harm to children due to failure to monitor

2.1.1 (v) Priority 5 - Safety Walkarounds

As part of the implementation of the national Patient Safety Initiative the Trust introduced Safety Walkrounds during 2010 and have continued them ever since. The Safety Walkround involves a pre-arranged visit to a clinical area by Executive and Non-Executive Directors accompanied by the Patient Safety Manager and a structured discussion with as many local staff of any grade or discipline as can be free at the time. Five Safety Walkrounds were undertaken during 2012 – 13 to Labour Ward, the Emergency Department, Laurel ward (specialises in haematology), Jenner Health Centre in SE 23, and Oak ward (Care of the Elderly).

The purpose of the Safety Walkround is to allow the Directors to see for themselves what goes on within wards and departments, and an opportunity to interact with and gain a firsthand account from front line staff. Staff are asked about and have a chance to comment on positive issues and also to highlight any concerns with the most senior members of the Trust. Where possible the Directors also speak with current patients and gain their views of the care they have been given in that ward or department.

Afterwards, a report of the Safety Walkround is compiled and agreed with the participants before being submitted to the Patient Safety Committee. It includes a nominated person to take any actions arising from issues highlighted during the Walkround, and the report is also sent to the Integrated Governance Committee, a subcommittee of the Trust Board.
The Safety Walkrounds have been well received and the Trust aims to continue them during 2013 – 14.

The outcome measures will be:

1 The number of safety walkarounds to the wards and departments by Executive and Non-executive Directors
2. The number of changes made to improve the quality of services resulting from Safety Walkrounds

2.1.2 Clinical Effectiveness – Domains 1, 2 and 3

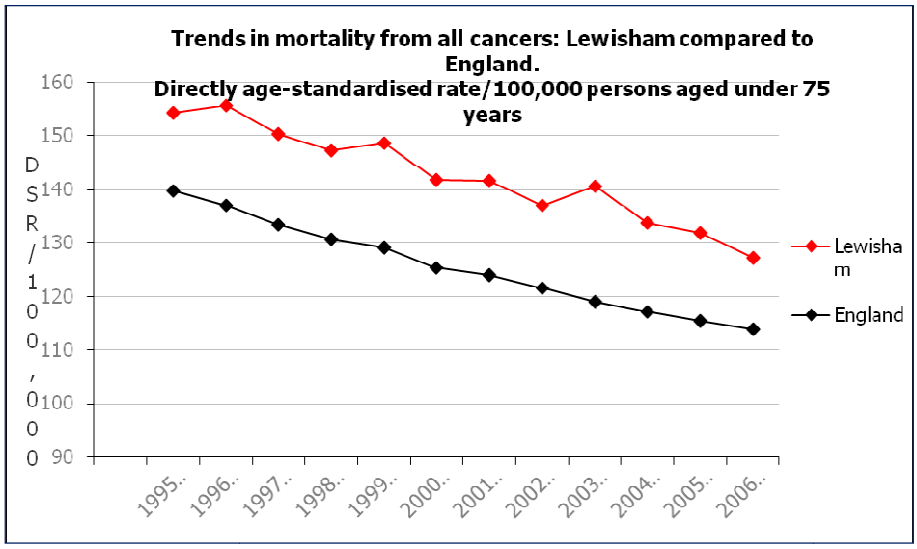
2.1.2 (i) Priority 1 – Reducing premature mortality and increased survival rates from breast, lung and colorectal cancer

Lewisham is in the bottom 20% of areas nationally for deprivation, life expectancy, and premature deaths from cancer and cardiovascular disease.
Mortality from cancer accounts for 19% of the male life expectancy gap and 13% of the female life expectancy gap between Lewisham and England.
Although there is a clear downward trend in premature mortality from cancer in Lewisham, the relative gap between Lewisham and England has increased from 9.35 in 1995-97 to 11.6% in 2006-08.
The largest number of cancer deaths are from Lung cancer in Lewisham followed by Breast, Colon and Prostate cancer.
Working together with Lewisham's Strategic Partnership, there is a need to understand the excess cancer mortality in both men and women aged 65+ in Lewisham compared to England and also a need to consider what are the most effective interventions to promote awareness of cancer symptoms and the benefits of screening to the diverse populations in Lewisham.

Approximately 900 people are diagnosed with cancer every year in Lewisham, although this number varies each year. From a recent public health analysis of cancer incidence in Lewisham, we have a clear indication of the areas which require a particular focus.

- 75% of cancers occur in people aged over 60 years
- Breast, lung, colorectal and prostate cancers account for half (49.2%) of cancer in Lewisham
- Lung cancer is now the second most common cancer in men (prostate being the most common cancer)
- Lung cancer accounts for 17% of cancer cases but 22% of deaths. Lung cancer mortality has been consistently higher in Lewisham than in London or in England and Wales, in both sexes
- Bowel cancer incidence in Lewisham is generally lower than nationally, but mortality is higher, especially among males. Bowel cancer mortality is higher in Lewisham in females than in London or nationally.

The graph below shows the trend of rates of early death from cancer in people under 75 in Lewisham compared with those for England.



Continuing the work undertaken last year to increase the early detection of and interventional treatments for patients with cancer, this year the Trust will focus on further improving the early detection and prevention of cancer.

The national screening campaign for bowel and lung cancers last year saw a positive impact on the numbers of patients requesting screening. This year, the Trust will extend the age range for bowel cancer screening to 75 years in line with the Cancer Reform Strategy.

The stage of a cancer is a description of the extent the cancer has spread. The stage often takes into account the size of a tumour, how deeply it has penetrated, whether it has invaded adjacent organs, how many lymph nodes it has metastasized to (if any), and whether it has spread to distant organs. Staging of cancer is the most important predictor of survival, and cancer treatment is primarily determined by staging.
Using the internationally recognised cancer staging system [TNM staging system], throughout 2013/13 the Trust continued to improve the completeness of cancer staging for Lung, Bowel, Breast and Upper Gastrointestinal tumours and achieved 70% of cancer staging across these tumour groups.

This year the Trust will extend cancer staging across all main tumour groups.

The outcome measures will be:

1. Increase in number of patients being screened for Bowel and Lung Cancer
2. Extension of age range for screening to 75 years
3. Improved Cancer staging for all cancers clinically diagnosed at Lewisham Healthcare NHS Trust

2.1.2 (ii) Priority 2 – Reducing mortality rates amenable to healthcare

Following the publication of the NHS Outcomes Framework 2013/14, the National Quality Board dashboard indicators and also as a direct response to the findings of the Mid Staffordshire Public Inquiry, the Trust has committed to strengthen its processes and systems for the review of mortality rates amenable to healthcare.

Mortality from causes considered amenable to health care is an outcome which is linked to the quality of health care provided by a health system. It is based on the principal that deaths from certain causes and at certain ages should not occur in the presence of timely and effective health care.

The NHS Outcomes Framework uses the definition of 'the number of deaths from causes considered amenable to healthcare multiplied by age-specific life expectancy for the relevant age-group and gender' and also includes a list of 'causes considered amenable to healthcare'.

For 2013/14 the National Commissioning Board has launched its National Quality Dashboard which will report on the national figures for 'mortality amenable to healthcare'. The dashboard will report on individual trust level mortality figures as well as reporting on regional and national level comparisons. This will enable Trusts to benchmark against local peers as well as regional and national benchmarks.

The Trust already has a system in place for reviewing mortality using the Summary Hospital-level Mortality Indicator, however, in light of the findings of the Francis Public Inquiry, this will be strengthened to reflect the proposed new organisation, its structure and services provided.

In addition to this, the Trust will develop a priority to establish a review process for the mortality rates amenable to healthcare, using the national statistics as a benchmark.

During 2013/14 the Trust will focus on the following areas:

- Deaths within 30 days of emergency admission to hospital: fractured proximal femur

  (Rationale - Fractured proximal femur can accelerate death. Variations in death rates for fractured proximal femur between 'like' populations suggest that some of these deaths are potentially avoidable).

- Deaths within 30 days of a hospital procedure: surgery (non-elective admissions)

  (Rationale - The national confidential enquiries into deaths after surgery (NCEPOD) have, over many years, consistently shown that some deaths are associated with shortcomings in health care).

The outcome measures will be:

1. Establishment of new process for Trust and specialty review of Summary Hospital-level Mortality Indicator
2. Introduction of National Quality Dashboard into Trust level reporting for Mortality Amenable to healthcare
3. Establishment of review process for identified areas of mortality review as above

2.1.2 (iii) Priority 3 - Improving outcomes and total health gain as assessed by patients for planned treatments [PROMS]

Patient Reported Outcome Measures (PROMs) have been collected nationally since April 2009 as a means of gathering information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves. For planned surgical procedures, this involves collecting data on the patient's perception of the following:

- their mobility
- the ability for them to care for themselves
- their ability to perform usual activities
- their pain and discomfort
- their level of anxiety/depression.

This 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.

During 2012/13 the Trust set PROMS as one of its priorities (a full review of the work undertaken in 2012/13 can be see seen in chapter 3).

Throughout the work undertaken, several key challenges arose:

- Appropriateness of questions for the Trust patient population – e.g. EQ-5D (Diabetes & Cardiac not cured by TKR)
- Should we have exclusions – Varicose Vein surgery (laser)
- Were denominator figures correct – relies on Trust coding
- Consultant Concerns - feedback does not match that of actual feedback in follow-up clinic

As a result of this work and with the availability of patient level data, the Trust has commenced the process of reviewing all patient notes of those patients were an improvement in healthgain was not seen.

For 2013/14 the Trust will continue with this work and will seek to establish the rationale behind the patient level data with the inclusions of patients.

The outcome measures will be:

1. Improvement in PROMS scores (healthgain) for the Trust for the identified procedures
2. Improvement in patient satisfaction scores for surgical patients
3. Learning from reviews of patient level data

2.1.2 (iv) Priority 4 - Dementia - Improving the diagnosis, treatment and quality of life in a long term condition (Domain 2 of NHS Outcomes Framework)

There are around 800,000 people with dementia in the UK, and by 2040, the number of people affected is expected to double.

During 2012, the Trust committed to improving the standards of care and pathway management for patients with Dementia which resulted in the establishment of screening, risk assessments, referral for specialist diagnosis and the development of a Dementia Passport.

Also during 2012 the Department of Health launched its new nursing strategy for Dementia, '*Making a difference to Dementia'*.

The '*Making a Difference to Dementia*' vision recognises the unique and specialist contribution of all nurses and their teams who are involved in the care of someone with dementia at different stages along their care pathway.

It also recognises that there is a need to ensure people with dementia have the best, compassionate care and support from all nurses and their teams. All nurses can make a contribution across the dementia pathway, irrespective of provider. This support starts right from keeping well, awareness raising and reducing social stigma, through to early identification, diagnosis, maintaining health and wellbeing and finally end of life care and bereavement support for carers and their families.

Expanding upon the work and achievements during 2012, the Trust will aim to focus it's work on embedding the practices for screening of patients, risk assessment of patients and referral pathways for patients with Dementia, as well as focussing on the training and development of staff and also the care for carers of people with Dementia.

The outcome measures will be:

1. Increased number of patients being screened for dementia
2. Increased numbers of patients being risk assessed for dementia
3. Increased numbers of patients being referred for specialist diagnosis
4. Increased use of locally developed 'Dementia Passport' for patients across health and social care
5. Education and training of staff with Dementia Training Programme
6. Carer experience and satisfaction

2.1.3 Patient Experience

2.1.3 (i) Priority 1 - Implementation of the Department of Health Friends and Family Test

In May 2012, David Cameron announced the inception of the Friends and Family Test. This test was to become the means by which members of the public could express their views about the services that they received, and also support people to make informed choices about accessing healthcare services. In November 2012, the Department of Health published guidelines for healthcare providers on the implementation of the Friends and Family Test. Under these guidelines the following question was to be offered to every person who was discharged home from adult inpatient facilities, and form A&E:

"Would you recommend our ward/A&E to friends or family if they needed similar care or treatment?."

Org:	RJ2	Lewisham Healthcare NHS Trust	NHS Friends and Family Test
Period:	February_2013		Accident & Emergency (Types 1 & 2)

Number of responses received via each mode of collection							
SMS/ Text/ Smartphone app	Electronic tablet/ kiosk at point of discharge	Paper/ Postcard given at point of discharge	Paper survey, sent to the patients home	Telephone survey once patient is home	Online survey once patient is home	Other	
0	0	773	0	0	0	0	773

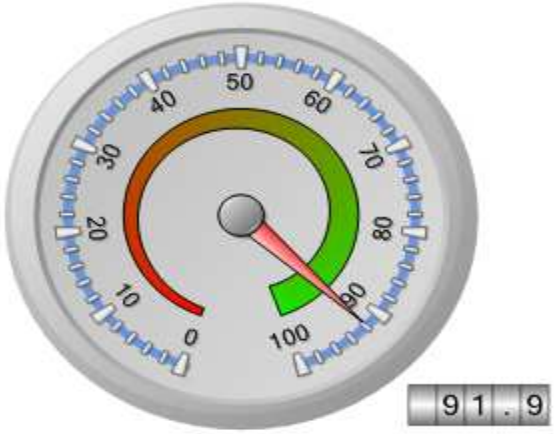
Hospital Site Details		Total responses in each category for A&E Department								
Hospital Site Details		Total responses in each category for A&E Department						Total Number of people eligible to respond	Total number of responses for each A&E department	Response rate for each A&E department
Site code	Hospital Site name	1 - Extremely Likely	2 - Likely	3 - Neither likely or unlikely	4 - Unlikely	5 - Extremely unlikely	6 - Don't Know			
RJ224	University Hospital Lewisham - RJ224	645	112	6	4	4	2	5067	773	15.3%
	Total	645	112	6	4	4	2	5067	773	15.3%

This test is mandatory from 1st April 2013. Lewisham Healthcare NHS Trust has been offering this question to people who use our adult inpatients wards and A&E since October 2012. The Trust has been providing Friends and Family Test reports to the Department of Health since January 2013 and has been achieving the target response rate of 15%.

In 2013/14 Lewisham Healthcare plans to increase the implementation of the Friends and Family Test by increasing uptake and increasing the range of services that are offering the question to patients.

We plan to increase uptake of the test to 20% by March 2014.
We plan to implement the test in Maternity Services and in one other service by March 2014.

Lewisham Healthcare NHS Trust Friends and Family results from 17th Oct 2012 and 31st March 2013	Number of questionnaires submitted between 17th Oct 2012 and 31st March 2013
91.9%	**5578**



Response	Count	Percent
Extremely likely	3839	73.59%
Likely	1066	20.43%
Neither likely nor unlikely	146	2.80%
Unlikely	53	1.02%
Extremely unlikely	46	0.88%
Don't know	67	1.28%

The outcomes measures will be:

1. Implementation of the test in Maternity Services and one other service by March 2014
2. Increase uptake of the Test in adult inpatient wards and our A&E to 20% by March 2014

2.1.3 (ii) Priority 2 - To improve Maternity Services

During 2012/13, Lewisham Healthcare Maternity Services continued to implement a range of measures designed to improve our Maternity Services. Feedback from women who have used our services show us that these measures have been largely successful in making Lewisham a hospital that women would recommend to others who were going to give birth.

In 2013/14 we want to continue to embed those improvements, and to do even more to make our Maternity Department a gold standard service. We want to ensure that:

1. Women have 1 to 1 care in labour and don't feel they have been left alone
2. Women who have problems during their pregnancy get to know the antenatal ward midwives by rotating them to day assessment to provide better continuity of midwifery care
3. Women who need extra support in labour have the same comforting birth environment in the delivery suite, as they enjoy in the birth centre.

To this end we have begun refurbishment of the Labour Ward. The refurbishments are planned to improve the comfort of women who arrive on the ward, to help them feel cared for from the moment that they walk through the door and offer more facilities for waterbirths. There will be improved privacy for women who suffer still births by relocating the dedicated birthing room to a quieter part of the delivery suite.

We have also reviewed the patient flows through day assessment and tightened the criteria for attendance at these clinics so that they are targeted to provide care in the most effective way. We plan to change working practice in the antenatal clinic rooms so that the space is maximised and used to greatest effect. This will include a change in layout to produce a suite of consulting rooms on one side of the clinic, and a midwifery led area on the other side. We also plan to extend the reception opening times to make the clinic opening times friendlier to working people.

We have plans to increase breastfeeding support and advice through the use of volunteers who provide much valued peer support. This will be based in the breastfeeding room on our postnatal ward.

We also plan to do more to measure women's experience of our services. We have already undertaken an extensive survey of women who gave birth in Lewisham and are reviewing the results with the intention of taking action for improvement. By October 2013 we will have implemented the National Friends and Family Test in Maternity Services so that every new mother is offered the opportunity to let us know how she felt about her experience. We plan to introduce parent panels to improve service user engagement and to test the improvements that we have planned.

The outcomes measures will be:

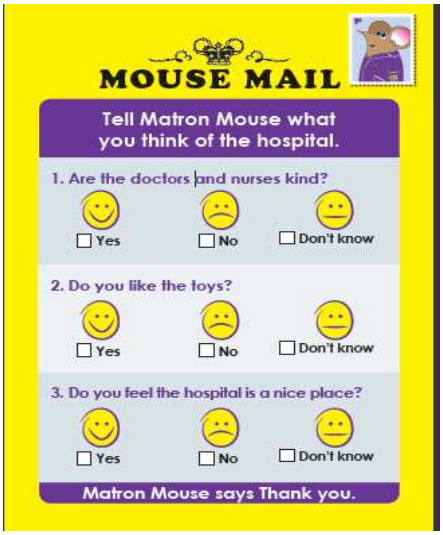
1. Completion of the refurbishment of the Labour Ward
2. Improvement in the National Midwifery Survey results 2013

2.1.3 (iii) Priority 3 - Helping children and young people to express their views about our services

Lewisham Healthcare NHS Trust has an excellent track record of providing high quality, responsive children and young peoples' health services. For example, in 2012 we received a rating of 'excellent' in an Ofsted inspection of our services. Lewisham Healthcare has partly achieved this by listening to service users and demonstrating that we are responsive to their needs.

In 2013/14 we plan to develop a more structured and wide ranging service user engagement plan so that the development of all of our services has input from children, young people and parents.

We already have a survey programme in place enabling children who visit our emergency department, our Woodlands Day Care Unit and parents who visit our neonatal ward, to have their say. For example, in the Children's ED we ask young people to 'send a message to Matron Mouse'.



We want to expand that survey programme so that children who are inpatients, and children and parents who access our community services are able to tell us what we should change about our services.

The outcome measures will be:

1. We will have feedback from children and young people who use all our hospital services
2. We will have feedback from people who use our community services
3. We will be able to show what we have done tom improve services based on that feedback

2.1.3 (iv) Priority 4 - Improving the way in which we manage complaints

The recently published Francis Report of the enquiry into the failings of the Mid Staffordshire NHS Foundation Trust contains 290 recommendations. Among these are a range of recommendations from Chapter 3 of the report as to how NHS Trusts should manage and ensure a proactive approach to learning from complaints.

This includes, for example:

- constantly promoting to the public their desire to receive and learn from comments and complaints; constant encouragement should be given to patients and other service users, individually and collectively, to share their comments and criticisms with the organisation
- the publication of complaints in the interests of transparency
- ensuring that the methods of registering a comment or complaint must be readily accessible and easily understood. Multiple gateways need to be provided to patients, both during their treatment and after its conclusion, although all such methods should trigger a uniform process, generally led by the provider trust

Lewisham Healthcare NHS Trust has set up a working group to address its response to the report recommendation, which includes all chapters.

The Trust Complaints Committee will oversee the development and implementation of its complaints action plan in response to those recommendations and will ensure that those recommendations from Chapter 3 of the report are fully implemented.

The Outcome measures will be

1. The development of an action plan which will include the recommendations from the report
2. The implementation of the action plan – progress reviewed by a sub-committee of

2.1.4 Learning from the Mid Staffordshire Public Inquiry

The Inquiry has made 290 recommendations designed to change culture and ensure 'patients not numbers come first' by creating a common patient centred culture across the NHS. Francis says no single one of the recommendations is on its own the solution to the many concerns identified.

The essential aims of what has been suggested are to:

- Foster a common culture shared by all in the service of putting the patient first.
- Develop a set of fundamental standards, easily understood and accepted by patients, the public and healthcare staff, the breach of which should not be tolerated.
- Provide professionally endorsed and evidence-based means of compliance with these fundamental standards which can be understood and adopted by the staff that have to provide the service.
- Ensure openness, transparency and candour throughout the system about matters of concern;
- Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards.
- Make all those who provide care for patients – individuals and organisations – properly accountable for what they do and to ensure that the public is protected from those not fit to provide such a service.
- Provide for a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field.
- Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do.
- Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public, and all other stakeholders in the system.

The recommendations cover a variety of organisations such as DH, Commissioners, CQC, Monitor and Professional regulators.

The key themes and related messages for the Trust at this stage are:

- Putting the patient first
- Governance, compliance and assurance
- Fundamental standards of behaviour
- Responsibility for, and effectiveness of, healthcare standards (e.g. information in our quality accounts and reporting of inquests to the CQC)
- Effective complaints handling
- Medical training and education
- Openness, transparency and candour
- Nursing and workforce
- Caring for the elderly
- Information handling
- Coroners and inquests

The Trust has already set up an action working group who are undertaking a comprehensive gap analysis and self-assessment against the recommendations in order to determine which recommendations are relevant to the Trust and will develop an action plan which will monitored by the Trust's Clinical Quality Committee, going forward, as part of the overall integrated governance work plan for 2013-2015.

2.1.4 (i) Priority 1 - Promoting a culture of transparency, openness and candour

Chapters 21 and 22 of the Mid Staffordshire focus on the Values and Standards within the NHS and also Openness, transparency and candour.

Of the many recommendations laid out in the Francis report, it recommended that the core values expressed in the NHS Constitution should be given priority of place and the overriding value should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos.
All NHS staff should be required to enter into an express commitment to abide by the NHS values and the Constitution, both of which should be incorporated into the contracts of employment.

Being Open within Clinical Services

For the forthcoming year the Trust will continue to promote an open and transparent culture within its clinical services in accordance with an obligation of candour as highlighted by the Francis Report into the standards of care at Mid Staffordshire NHS Trust.

Should a patient safety incident happen and a patient come to harm the expectation in accordance with the Trust's Being Open Policy is that an apology will be given that the incident occurred, a discussion held with the patient by a senior clinician to see if there is anything that can be put right as soon as possible and to listen to the patient or their family's perspective on events, an investigation carried out and the patient and / or their relative offered feedback on the findings. Any actions planned to reduce the risk of the same thing happening again would be fed into the Directorate's governance processes and subject to review by the Trust's Outcomes With Learning Group.

Values and Standards and Duty of Candour

A number of recommendations were set out within the Francis Report relating to 'Values and Standards (Chapter 21) and Openness, Transparency and Candour' (Chapter 22).

The recommendations included the following:

- "The core values expressed in the NHS Constitution should be given priority of place and the overriding value should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos.

- "All NHS staff should be required to enter into an express commitment to abide by the NHS values and the Constitution, both of which should be incorporated into the contracts of employment.

- "All organisations should review their contracts of employment, policies and guidance to ensure that, where relevant, they expressly include and are consistent with the duty of openness, transparency and candour

Lewisham Healthcare NHS Trust accepts the recommendations that the overriding value should be to ensure that our patients take priority. As we prepare for a new, merged organisation, our own Trust values will focus on putting our patients first.

Through the work of the Organisational Development and Clinical Teams we will ensure that the recommendations of fostering a culture of openness, transparency and candour are embedded as the foundations for our new organisation.

We continue to review and embed our values based behaviours framework to cover all staff and we will ensure that all of our staff will be fully aware and understand their responsibilities as part of the new updated NHS Constitution. We will review and update where appropriate our recruitment process and contracts of employment and any staff employed by us as a contractor will be expected to abide by the same requirements.

We will also ensure all of our policies and contract of employment abide by the duty of candour, openness and transparency. This will also be reflected within induction and education & training activity.

The Outcome measures will be

1. Evidence in all Serious Incident reports where a patient has been harmed during healthcare, of a Being Open discussion with the patient / their relatives.
2. Development of new set of Values, Standards and Behaviour Framework for new organisation.
3. Development of new contracts of employment with explicit statements of candour.
4. Updated Induction programmes

2.1.4 (ii) Priority 2 - Promoting a culture of 'Putting patients first' with care and compassion

The publication of the Francis report in 2013 has drawn attention back to the basics of care, ensuring that patients are treated with dignity and respect, are adequately fed and hydrated and ensuring that we give every patient the best possible care that they deserve. The Trust constantly measures patient experience and quality through a rolling programme of feedback surveys and audit. These tools and feedback from recent inspections by the Care Quality Commission show us that while we get it right much of the time, there is room for improvement, and consistency is the key.
Patient feedback is sought on a continual basis across all areas. Questions relating to patients being treated with dignity and respect are always asked and our performance across the year has been continually improving with a current positivity score of 92.69 and a rate of 84.53% of respondents stating 'Yes Always' (n=978).

A question is also asked about whether or not patients feel that they were involved in decisions about their care and treatment, as much as they wanted to be. Our performance across the year has been improving and currently 64.75% of the patients responding to the questionnaire answered 'Yes definitely', 26.08% responded 'yes to some extent and 6.11% responded 'no'.

We are aiming not just for consistency in practice, but in behavior so that all staff are delivering to the same high professional standards.

To help us to do this, Lewisham will include the Chief Nursing Officer's (CNO) 6 C's of nursing: 'Care, Compassion, Competence, Communication, Courage and Commitment' from the Commissioning Board's strategy 'Compassion in Practice: Nursing, Midwifery and Care Staff Our Vision and Strategy' in the Lewisham Healthcare NHS Trust nursing strategy for 2013/14. The CNO's vision includes change delivered by front line staff, leadership at every level, training and development reflecting the 6 Cs, a change in culture, collaborative working, good communication and support for staff.

Work is already underway and during the 2013/14 we will continue this work by ensuring the following:

- All wards have their monthly Patient Experience Scorecard provided by the Patient Experience Team. All Ward managers will be required to present an action plan on areas of Red at the Nursing & Midwifery Quality and Metrics Meeting.
- Dignity and Respect sessions (which are included in all nursing induction programmes) will be strengthened with the introduction of the 6C's which will be built into our Nursing and Midwifery Strategy
- The Matrons will perform monthly Quality Ward Rounds and will record the observations made and present these at a newly formed Nursing/ Midwifery Quality Metrics forum which will be set up to monitor and report on Nursing and Midwifery Quality Metrics. Matron Quality Ward Rounds will also be presented to the Directorate Governance Meetings.
- All Wards will have 'Ward Contracts', which will be developed in conjunction with the Ward Team and all ward staff will be required to sign the Ward Contract. These Ward Contracts will be explicit in the expectation that all patients will be treated with Dignity and Respect and be involved in decision-making and their own care.
- A review of Ward Dignity Champions will take place and all wards will have at least one Dignity Champion.
- The Executive and Non-Executive Team undertake 'Executive Walkabouts', these 'Walkabouts' are observational and involve patient discussions and feedback about care. The reports from the 'Walkabouts' will be presented to the Trust Patient

Experience Committee and action plans arising from the 'Walkabout' will be the responsibility of the Head of Nursing.

- To ensure that a robust process is in place to assess the wards and departments for compliance against the essential standards of quality and safety, we will develop a new approach to our internal 'inspections'. This new approach will encompass a rigorous assessment and testing of all the evidence with which to test compliance against the full standards.
- The Corporate Nursing Department will produce a video for all staff, to stress the importance of the important aspects of Privacy, Dignity, Communication, staff and patient handover and documentation.
- Through our preparation and existing work on our organisational development plan for the newly merged organisation, our focus on culture will aim to embed and improve making the patient's experience, a good one.

The Outcome measures will be:

1. Delivery and implementation of the Nursing and Midwifery Strategy priorities above listed above

2.2 STATEMENTS RELATING TO QUALITY OF NHS SERVICES PROVIDED

The purpose of this section is to provide evidence of services provided by Lewisham Healthcare NHS Trust.

The full list of services provided is provided in Appendix 1 and is the Statement of Purpose as required for registration by the Care Quality Commission.

Surgery	Women and Sexual Health	Children and Young People	Acute and Elderly Medicine	Specialist Medicine
Adult Surgical Wards	Alexis Clinic	Children's Community Nursing Team	Acute Adult Medical wards	Adult Outpatient Services
Anaesthesia	Gynaecology OPD	Children's Day Care ward	Adult Emergency Department / Urgent Care Centre	Appointments Team, and Choose & Book
Critical Care	Gynaecological Surgery	Children's Emergency Department	Adult Therapies	Cancer Services
Critical Care Outreach	Maternity & Midwifery	Children's Inpatient Ward	Community Matrons	Cardiac Physiology
Clinical Site Management	Obstetrics	Children's OPD	Discharge Lounge	Community Head and Neck Team (CHANT)
Clinical Technicians	Women's Health OPD	Children's Specialist Nurses	District Nursing including Continence Nurse	Dietetics and Nutrition
HIP Team	Sexual and Reproductive Health / HIV	Community Children's Team	Elderly Care wards including Mulberry and Clinical Assessment Service	Foot Health and Orthotics
Preadmissions/ENT OPD		Family Nurse Partnership Team	Falls	Home Enteral Nutrition (HEN team
Pain Service		Health Visiting Team	Intermediate Care	Musculoskeletal Services (MSK)
Surgical Specialties		Immunisation Team	Pharmacy	Orthotics Service
Surgical Specialist Nurses and plaster technician		NICU	Safeguarding Vulnerable Adults	Specialist Medicine Teams
Synergy Contract Management		School Age Nursing Service	Stroke Service (Beech and community pathway)	Specialist Nursing Teams
Theatres and Endoscopy		Special Needs Nursing Team		Palliative Care
Tissue Viability		Safeguarding Children and Young People		Pathology
		Therapies (Children)		Phlebotomy
				Radiology
				Speech and Language Therapies
				Speciality Medicine
				Specialist Nursing Teams

Overview

Review of Services

The services provided by Lewisham Healthcare NHS Trust during 2011-12 are listed in the main document below. The data was collated through a variety of programmes. In the following section information is provided about important quality measures and outcomes for these services.

Once again this year, the Trust was one of CHKS's Top 40 hospitals for the fourth year running demonstrating high performance against a range of key indicators assessed by this independent organisation.

Summary of Quality Indicators Reviewed

Patient Safety Indicator 1 Treating and caring for people in a safe environment and protecting them from harm	The percentage of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism during 2013/13
Patient Safety Indicator 2 Treating and caring for people in a safe environment and protecting them from harm	The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during 2012/13
Patient Safety Indicator 3 Treating and caring for people in a safe environment and protecting them from harm	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 2012/13
Clinical Effectiveness Indicator 1 Preventing People from dying prematurely Enhancing quality of life for people with long terms conditions	The value and banding of the Summary Hospital-Level Mortality indicator [SHMI] for 2012/13 The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for 202/13
Clinical Effectiveness Indicator 2 Helping people to recover from episodes of ill health or following injury	The Trust's Patient Reported Outcomes Measures [PROMS] for 2012/13 for: (i) Groin hernia surgery (ii) Varicose Vein Surgery (iii) Hip replacement (iv) Knee replacement

Clinical Effectiveness Indicator 3 Helping people to recover from episodes of ill health or following injury	Percentage of patients aged: (i) 0-14 (ii) 15 or over Readmitted to hospital within 28 days of being discharged from hospital for 2012/13
Patient Experience Indicator 1 Ensuring People have a positive experience of care	The Trust's responsiveness to the personal needs of its patients during 2012/13
Patient Experience Indicator 2 Ensuring People have a positive experience of care	The percentage of staff employed by the Trust who would recommend the Trust as a provider of care to their family and friends

2.2.1 Patient Safety

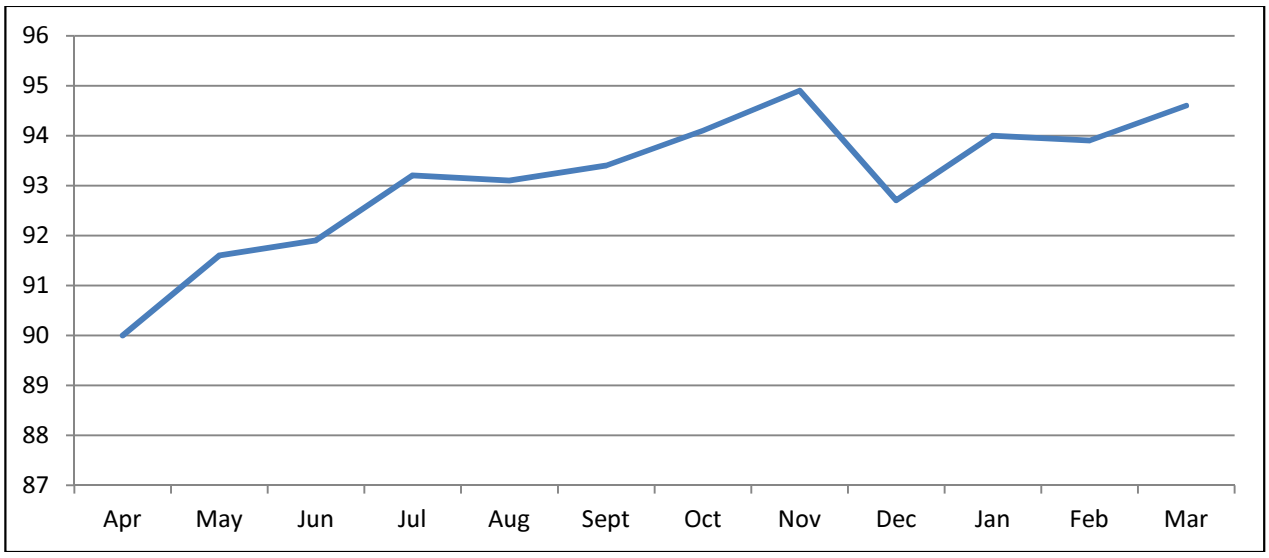
2.2.1 (i) Patient Safety Indicator 1 – The percentage of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism during 2012/13

1 - Risk assessment and prophylaxis of patients for venous thromboembolism (VTE)

An important measure to help reduce the incidence of VTE in hospital patients is the assessment of the risk of each individual patient, therefore it is expected that a VTE risk assessment is carried out for all hospital in-patients on admission, after 24 hours and / or at any subsequent change in a patient's clinical condition .

VTE risk assessment was audited throughout 2012- 13 and showed an increasing compliance in assessment at patient admission to hospital.

Chart showing percentage of inpatients who were risk assessed for VTE on admission to hospital during 2012 - 13



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

The Trust has already taken the following actions to improve the number of VTE risk assessments including:

- a 'screen saver' has been published on all Trust computers to inform staff of the VTE risk assessment requirements;
- a medical consultant talks to all new junior doctors on their induction programme to ensure that they are informed about VTE risk assessment requirements;
- audit results are fed back to front line staff and monitored every month at the Patient Safety Committee.

The biggest change introduced during early 2013 was that a VTE risk assessment was added to the adult in-patient Prescription Chart. The chart was totally revised during 2012 – 13, and it is

hoped that this will provide a more easily seen prompt to clinicians to carry out further risk assessments when indicated. Auditing of performance will continue.

The VTE Risk Assessment tool (below) was incorporated into the Adult Drug Chart during 2012 – 13

Julian Beeton to insert graphic

Performance with regard to repetition of VTE assessment 24 hours after admission to hospital or at a change in the patient's condition was less good and therefore Lewisham Healthcare NHS Trust will concentrate on improving these elements during 2013 – 14 by continuing to increase awareness amongst junior doctors, nurses and pharmacy staff.

Appropriate prophylaxis (preventative measures such as compression stockings and / or low molecular weight heparin injections) was audited throughout the year and this also requires improvement so raising awareness and auditing will be continued throughout the next year to ensure an improvement in the quality of care.

Can we insert audit results here?

[Present in table format, the figures for at least the last two reporting periods]

Lewisham Healthcare NHS Trust intends to take /has taken the following actions to improve this percentage/proportion/score/rate/number, and so the quality of its services by [insert descriptions of actions]

2.2.1 (ii) Patient Safety Indicator 2 – The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during 2012/13

During 2012 – 13 performance in the prevention of healthcare associated infections continued to improve with only one case of MRSA bacteraemia, and 8 cases of C. difficile. The number of C difficile cases was below the tolerance level set for the Trust by the Department of Health (17 allowed) and shows a decrease in numbers from previous years.

Whilst recognising the new reporting requirements for the purpose of Quality Accounts as set out in the amendments to the 2010 regulations; unfortunately national data is not available on the rate of c. difficile reported per 100, 000 bed days.

The mandatory surveillance reporting is via the Health Protection Agency [HPA] who collect and publish the data on monthly 'counts' as opposed to rate per 100,000 bed days. Once per year in July, the HPA publish the data as a rate per 100.000 bed days. This data is and will not be available for the publication of the Trust Quality Accounts and therefore, the data has been expressed in counts.

The data below demonstrates the mandatory reporting made to the HPA through 2012 – 2013 and also shows data from peer organisations:

Figure 1 demonstrates data Monthly counts of *C. difficile* infection by Acute Trust for patients aged 2 years and over - Trust Apportioned only*

Figure 1 Monthly counts of *C. difficile* infection by Acute Trust for patients aged 2 years and over - Trust Apportioned only* April 2012-March 2013

Title:	Monthly counts of *C. difficile* infection by Acute Trust for patients aged 2 years and over - Trust Apportioned only*														
Reporting Period:	April 2012 to March 2013														
No. of months:	12														
Publication dat	01 May 2013														
Trust Code	**Trust Type**	**Region**	**Trust Name**	**April 2012**	**May 2012**	**June 2012**	**July 2012**	**August 2012**	**September 2012**	**October 2012**	**November 2012**	**December 2012**	**January 2013**	**February 2013**	**March 2013**	**TOTALS**
R1H	--	London	Barts Health	7	10	5	8	14	9	3	9	3	8	7	5	88
RJ6	--	London	Croydon Health Services	2	1	3	1	6	3	2	1	1	5	2	3	30
RJ1	FT	London	Guy's & St. Thomas'	4	5	8	5	5	4	6	1	4	4	1	1	48
RQX	FT	London	Homerton University Hospital	0	1	2	0	1	0	3	3	1	1	1	0	13
RJZ	FT	London	King's College Hospital	1	8	2	7	8	7	6	5	1	2	4	3	64
RJ2	--	London	Lewisham Healthcare	0	0	1	0	2	1	2	0	1	1	0	0	8
RAP	--	London	North Middlesex University Hospital	3	3	1	2	2	1	2	1	1	1	3	2	22
RYQ	--	London	South London Healthcare	6	5	4	5	4	4	7	2	1	8	8	4	58
*Trust apportioned - specimen taken in an acute trust 4 or more days post admission - see caveats page for more details																

Source data HPA website (accessed 14th May 2013) http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1254510678961

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

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

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

- continuing to undertake antimicrobial and other ward rounds with the Consultant microbiologists and clinical teams
- Using up to date streamlined antimicrobial prescribing guidelines with monitoring of performance against these
- Maintaining a strong and visible presence at ward level by the Infection Prevention and Control Team who monitor compliance with the Saving Lives C. difficile care bundle
- Continuing the multidisciplinary weekly C. difficile review group which allows for the review of care and progress of any patients with C. difficile
- Undertaking root cause analysis on all Trust attributable C. difficile cases to allow any learning for practice to be understood and shared
- Continuing to undertake joint audit work with the facilities staff to ensure that ongoing standards of cleanliness are maintained.

During 2013 - 14 we will continue to maintain this excellent performance and seek to reduce the incidence of MRSA bacteraemias to 0; in addition we will work hard to reduce further the total number of patients suffering from hospital associated C difficile.

2.2.1 (iil) Patient Safety Indicator 3 – The number and rate of patient safety incidents reported within the Trust and the number and percentage of such patient safety incidents that resulted in severe harm or death for 2012/13

At the time of writing this report, the latest national data published represented the April 2012 – September 2012 reporting period.

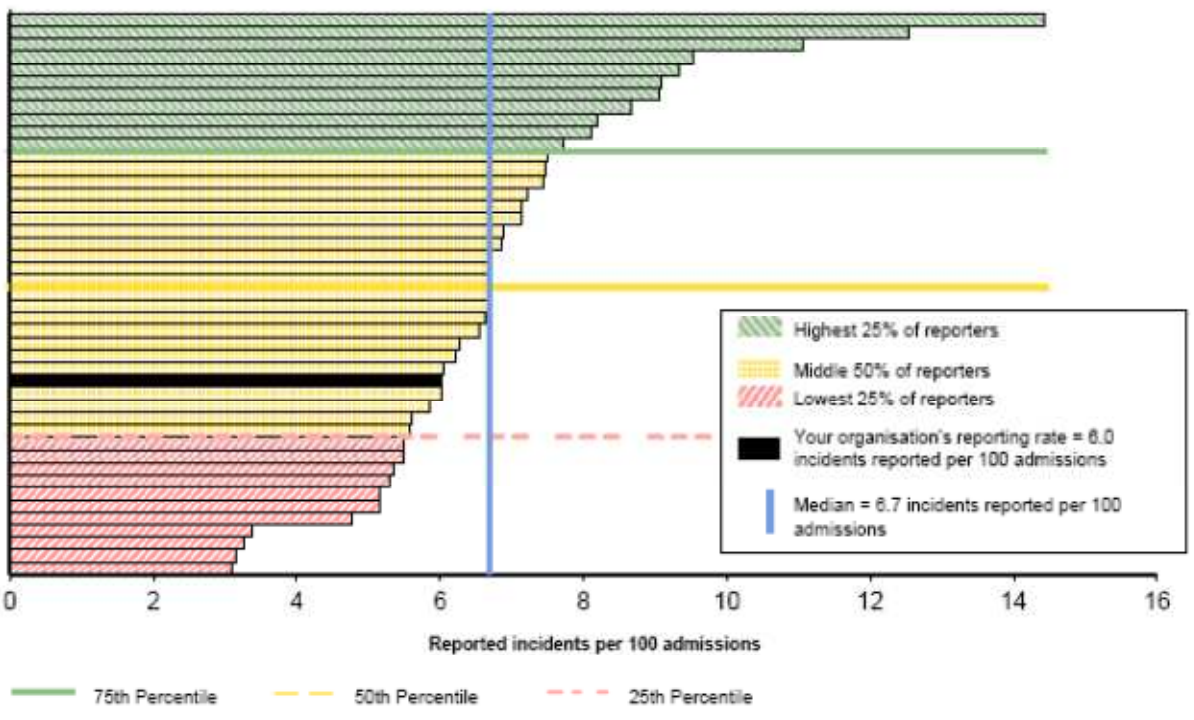
Lewisham Healthcare NHS Trust considers that this data is as described for the following reasons:

The timeliness of reporting to the National Reporting and Learning System (NRLS) has continued during the past year and has improved. We reported to the NRLS system in every month during this six month period. Fifty percent of our incidents were submitted more than 3 days after the incident occurred, whereas the average amongst peer Trusts was fifty percent submitted more than 30 days after the incident occurred. It is important to report serious safety risks promptly both locally and to the NRLS so that lessons can be learnt and action taken to prevent harm to others.

Table 1 Organisation Patient Safety Incident Report - April 2012 to September 2012

The comparative reporting rate summary shown below provides an overview of incidents reported by your organisation to the National Reporting and Learning System (NRLS) between 1 April 2012 and 30 September 2012. 1,743 incidents were reported during this period.

Figure 1: Comparative reporting rate, per 100 admissions, for 45 medium acute organisations.



The Trust was again within the middle 50% of reporters in terms of actively encouraging reporting of incidents, though our rate had slipped downwards from a rate of 7.7 incidents per 100 admissions to 6.0 incidents per 100 admissions.

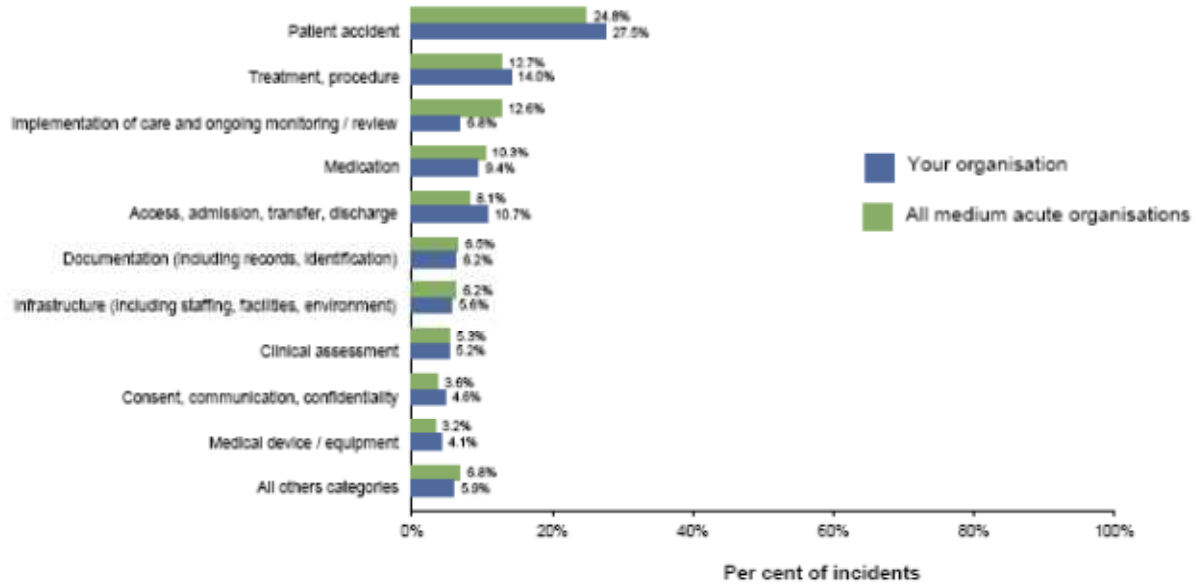
Lewisham Healthcare NHS Trust intends to take the following actions to improve this percentage/proportion/score/rate/number:

We cannot learn and improve if we do not know what the problems are, so during the year 2013 – 14 we will be working harder to encourage staff to continue reporting adverse events, and continuing to promote a patient safety culture which aims to support staff to learn and work together towards achieving zero avoidable harm for patients. The Patient Safety Manager continues to talk to all staff on Trust induction and promote the need to report all types of incidents. The Risk Team will aim to produce additional newsletters to inform staff how safety can and has been improved through the reporting and investigation of patient safety incidents.

Figure 1 Type of incident reported April 2012 – September 2012

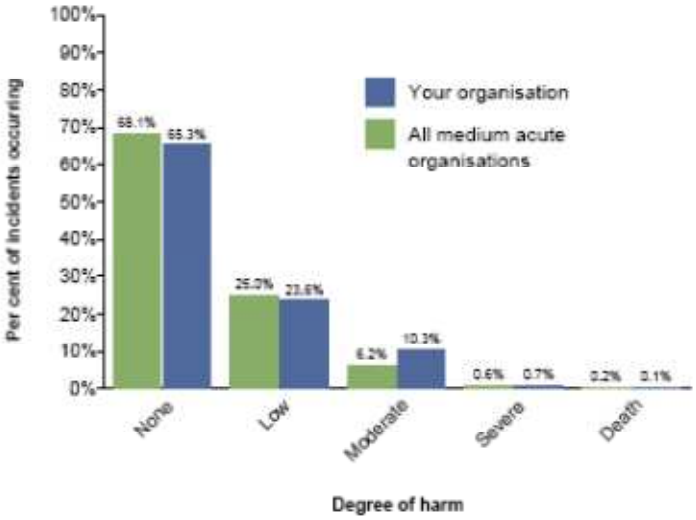
What type of incidents are reported in your organisation?

Figure 2: Top 10 incident types



If your reporting profile looks different from similar organisations, this could reflect differences in reporting culture, the type of services provided or patients cared for. It could also be pointing you to high risk areas. The response system is more important than the reporting system.

Figure 3: Incidents reported by degree of harm for medium acute organisations



Your figures:	None	Low	Moderate	Severe	Death
	1,139	411	180	12	1

Do you understand harm?

Nationally, 67 per cent of incidents are reported as no harm, and just under 1 per cent as severe harm or death.

However, not all organisations apply the national coding of degree of harm in a consistent way, which can make comparison of harm profiles of organisations difficult.

Organisations should record actual harm to patients rather than potential degree of harm.

The NRLS report shows that the Trust is reporting similar types and rates of incidents as its peer group Trusts (such as falls, medication errors, implementation of care, medical equipment issues and so on).

The levels of harm incurred by such incidents are also consistent with other peer group Trusts.

The one death attributable to an avoidable patient safety incident represents a rate of 0.1% of incidents occurring at our Trust. The average for all medium acute peer group Trusts in London is 0.2%.

Local Data compiled at the end of March 2013 shows that Lewisham Healthcare NHS Trust investigated 89 Serious Incidents (SIs) during the year 2012 – 13. Grade 3 or 4 pressure ulcers, which developed whilst patients were under the care of either community or hospital staff, were the subject of 53 of these SIs.

Not all incidents declared as an SI involved harm to a patient, some resulted in minor or no harm, or were near misses (where harm almost reached a patient but was prevented for some reason just before it could cause a problem). However all these incidents were considered to be worthy of an in depth investigation with root cause analysis in order to identify where learning could help to reduce the risk of harm to future patients, or met criteria prescribed by the strategic health authority requiring such a level of investigation.

	Number	**Rate per 100 admissions***	**Rate per 100,000 population****
Total number of patient safety incidents reported to NRLS between 1 April 2012 and 31 March 2013	3563	6.48	1295
Patient safety incidents resulting in serious harm	21	0.038	7.636
Patient safety incidents resulting in or materially contributing to a death	3	0.0054	1.09

***The number of admissions to University Hospital Lewisham during the year 2012 – 13 = 55,000 (source: LHT Information Department)**

****The latest figure for the population of the London Borough of Lewisham = 275,000 at end March 2011 (source: Office of National Statistics website)**

2.2.2 Clinical Effectiveness

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

The Summary Hospital-level Mortality Indicator (SHMI) is a mortality indicator which was initiated by the Department of Health as a means of standardising how mortality rates are monitored and reported nationally. The SHMI is the ratio between the actual number of patients who die following a treatment at the Trust and the number that would be expected to die on the basis of average National figures in England, given the characteristics of the patients treated there. The SHMI score includes deaths that have occurred outside of the hospital within 30 days of discharge as well as deaths within the hospital.

The data used to produce the SHMI is generated from data the Trust submits to the Secondary Uses Services (SUS) which is linked with data from the Office for National Statistics (ONS) death registrations to enable capturing of deaths which occur outside of hospitals.[1]

SHMI has been reported nationally since October 2011 and is published by the NHS Information Centre on a quarterly basis using a rolling 12 month data period[2]. Each trust is given a SHMI value and a banding. The baseline SHMI value is 1. A trust would only get a SHMI value of 1 if the number of patients who die following treatment there was exactly the same as the number expected using the SHMI methodology. The scoring is also divided into three bands:

Banding 1 – Where the trust's mortality rate is 'higher than expected'
Banding 2 – Where the trust's mortality rate is 'as expected'
Banding 3 – Where the trust's mortality rate is 'lower than expected'

The NHS Information Centre highlights that the SHMI requires careful interpretation, and should not be taken in isolation as a headline figure of Trust performance. It is best treated as a 'smoke alarm'. It is an indication of whether individual trusts are conforming to the national baseline of hospital-related mortality and it should be used in conjunction with a wider range of quality indicators. For example, in addition to SHMI, Lewisham Healthcare NHS Trust also monitors mortality rates through the Risk Adjusted Mortality Index (RAMI). This mortality index allows the Trust to monitor mortality rates within individual directorates and specialties and to drill right to down to specific cases which might need to be reviewed. The RAMI and the SHMI scores are reported to the Trust Board.

Table 1 shows the score and the banding that has been assigned to Lewisham Healthcare NHS Trust and its peers which have been published to date. The table also highlights the Trusts with the best and worst performance nationally for each reporting period. To date the Trust has achieved banding 2 - 'as expected', in all of its SHMI scores. This is on a par with its selected peer group.

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

The Lewisham Healthcare NHS Trust's SHMI rating has consistently fallen within the 'as expected' range due to the regular monitoring of mortality rates within the Trust. For example, the Trust's SHMI data is previewed and signed off by the Medical Director prior to the National quarterly publication. In addition to this, the Trust carries out its own additional regular mortality monitoring

[1] Definitions used here are the Health and Social Care Information Centre, SHMI Executive Summary document, available at: https://indicators.ic.nhs.uk/download/SHMI/April_2012/Specification/FUNNEL_PLOTS.pdf

[2] National SHMI scores are available on the NHS Information Centre website: https://indicators.ic.nhs.uk/webview/index.jsp?v=2&catalog=http%3A%2F%2F172.16.9.26%3A80%2Fobj%2FfCatalog%2FCatalog21&submode=catalog&mode=documentation&top=yes)

using the Risk Adjusted Mortality Index (RAMI). The Trust's RAMI scores are reported on a monthly basis to the Trust Board

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

Making certain that the 'as expected' SHMI banding achieved by the Trust is sustained and through ensuring that any RAMI scores which are higher than expected are reviewed by looking at the patient's coded information. This coded information holds details of what diagnoses, co-morbidities and procedures the patient had whilst admitted at the Trust. If necessary a case note review is carried out to ensure that the patient did receive the best quality care possible.

Table 1: Lewisham Healthcare NHS Trust Summary Hospital-level Mortality Indicator (SHMI)

Summary Hospital-level Mortality Indicator (SHMI)	Apr 10 - Mar 11 (published October 2011)		Jul 10 - Jun 11 (published January 2012)		Oct 10 - Sep 11 (published April 2012)		Jan 11 - Dec 11 (published July 2012)		April 11 - Mar 12 (published October 2012)		Jul 11 - Jun 12 (published January 2013)		Oct 12 – Sep 12 (published April 2013)	
Provider name	Value	Banding	Value	Banding	Value	Banding	Value	Banding	Value	Banding	Value	Banding	Value	Banding
THE WHITTINGTON HOSPITAL NHS TRUST	0.67	3	0.68	3	0.67	3	0.69	3	0.71	3	0.71	3	0.71	3
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	0.72	3	0.71	3	0.71	3	0.72	3	0.72	3	0.71	3	0.68	3
BARTS HEALTH NHS TRUST*	0.69	3	0.69	3	0.68	3	0.80	3	0.83	3	0.84	3	0.83	3
CROYDON HEALTH SERVICES NHS TRUST	1.05	2	1.03	2	1.02	2	1.01	2	1.00	2	0.96	2	0.96	2
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	0.91	2	0.89	2	0.89	2	0.90	2	0.89	2	0.87	3	0.83	3
HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	0.95	2	0.98	2	0.98	2	0.97	2	0.98	2	0.98	2	0.93	2
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	0.92	2	0.92	2	0.90	2	0.91	2	0.94	2	0.90	2	0.93	2
LEWISHAM HEALTHCARE NHS TRUST	0.95	2	0.96	2	0.99	2	0.98	2	0.96	2	0.92	2	0.90	2
NEWHAM UNIVERSITY HOSPITAL NHS TRUST*	0.80	3	0.79	3	0.80	3								
SOUTH LONDON HEALTHCARE NHS TRUST	0.90	2	0.91	2	0.92	2	0.95	2	0.99	2	1.02	2	1.03	2
WEST MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	0.88	2	0.89	2	0.93	2	0.93	2	0.98	2	1.01	2	0.98	2
WHIPPS CROSS UNIVERSITY HOSPITAL NHS TRUST*	0.92	2	0.90	2	0.89	2								
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	1.17	1	1.20	1	1.22	1	1.25	1	1.25	1	1.26	1	1.21	1
GEORGE ELIOT HOSPITAL NHS TRUST	1.21	1	1.21	1	1.23	1	1.23	1	1.16	1	1.12	2	1.10	2

Note: Values shaded in purple are the highest and lowest performing Trust's nationally for that reporting period

* Whipps Cross University Hospital Trust and Newham University Hospital Trust merged with Barts Hospital to form Barts Health NHS Trust

When the NHS Information publishes the National SHMI scorings on a quarterly basis, it also publishes a number of contextual indicators including the percentage of patients who have died at each Trust who were receiving palliative care. The method used to calculate Trusts SHMI score currently makes no adjustments for palliative care patients. This means that any Trusts which have a high number of palliative care patients may appear to have a higher number of deaths than expected using the SHMI scoring system. For example, a trust which has an onsite hospice or palliative care unit would have a higher number of deaths than other trusts.

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

Following concerns raised by some hospital trusts that they are unfairly penalised under the current methodology for offering specialist inpatient palliative care or hospice services, an investigation was conducted to review whether making an adjustment to the SHMI calculation for such service provision was practical and to what extent it would produce differing results from the current methodology.[3] The review concluded that it is currently not possible to clearly identify those organisations with specialist inpatient palliative care provision.

Also, those trusts which do provide palliative care provision currently take different approaches to how the patient's palliative care is coded (documented).

The percentage of Lewisham Healthcare NHS Trust's patients with palliative care coded at either diagnosis or specialty level for the trust is shown in Table 2 below. The table also highlights the Trusts with the highest and lowest percentages nationally of palliative care patients treated each reporting period.

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

- Lewisham Healthcare NHS Trust has a specialist palliative care team. This is reflected in the data as on average 22% of the Trust's patients are coded as palliative care patients. This is significantly more than those Trusts highlighted below which have been reported nationally as coding less than 1% of patients as receiving palliative care.

- The two Trusts (also shown in the table below) which have been reported nationally as having the highest percentage of palliative patients both treat large numbers of palliative care patients which is most likely why their mortality figures are significantly higher.

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

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

[3] See the NHS Information Centre article entitled '*The Use of Palliative Care Coding in the Summary Hospital-level Mortality Indicator*' and available at http://www.ic.nhs.uk/CHttpHandler.ashx?id=11150&p=0 (accessed 26th March 2013).

Table 2: Lewisham Healthcare NHS Trust Percentage of Patient Deaths with Palliative Care coded at either diagnosis or specialty level

SHMI Contextual Indicator: Percentage of Patient Deaths with Palliative Care coded at either diagnosis or specialty level	Apr 10 - Mar 11 (published October 2011)	Jul 10 - Jun 11 (published January 2012)	Oct 10 - Sep 11 (published April 2012)	Jan 11 - Dec 11 (published July 2012)	April 11 - Mar 12 (published October 2012)	Jul 11 - Jun 12 (published January 2013)	Oct 12 – Sep 12 (published April 2013)
Provider Name	%	%	%	%	%	%	%
AINTREE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	37.8%	40.1%	41.6%	41.7%	44.1%	42.9%	41.9%
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	29.9%	33.3%	37.5%	41.3%	44.2%	46.3%	43.3%
BARTS HEALTH NHS TRUST*	5.2%	5.3%	4.3%	20.3%	20.3%	19.7%	20.2%
CROYDON HEALTH SERVICES NHS TRUST	13.4%	12.8%	12.3%	12.0%	13.1%	14.5%	18.0%
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	37.4%	37.5%	37.8%	38.9%	40.7%	41.0%	40.3%
HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	5.1%	2.7%	5.1%	6.5%	14.0%	18.4%	19.4%
LEWISHAM HEALTHCARE NHS TRUST	19.1%	21.9%	23.8%	25.4%	23.9%	19.6%	18.5%
NEWHAM UNIVERSITY HOSPITAL NHS TRUST*	38.9%	39.6%	38.9%				
SOUTH LONDON HEALTHCARE NHS TRUST	26.5%	27.4%	28.3%	28.2%	28.4%	28.6%	28.9%
WEST MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	14.9%	16.2%	16.0%	16.3%	16.8%	17.1%	14.0%
WHIPPS CROSS UNIVERSITY HOSPITAL NHS TRUST*	30.2%	28.6%	26.9%				
EAST CHESHIRE NHS TRUST	2.0%	4.4%	7.1%				
ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	3.2%	0.4%	0.5%				
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	6.6%	2.2%	0.9%	0.0%	0.0%	0.7%	7.9%
ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	8.1%	1.6%	0.4%	0.4%	0.2%	0.3%	0.3%

Note: Values shaded in purple are the highest and lowest performing Trust's nationally for that reporting period* Whipps Cross University Hospital Trust and Newham University Hospital Trust merged with Barts Hospital to form Barts Health NHS Trust.

2.2.2 Clinical Effectiveness

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

One of the Trust's priorities for the year 2012-13 was to improve outcome scores for patients undergoing groin hernia, varicose vein surgery and hip and knee replacement procedures. A recognised means of gathering data on patient outcomes is through the use of Patient Reported Outcome Measures (PROMs). This data has been collected nationally since April 2009 as a means of collating information on the effectiveness of care delivered to NHS patients as perceived by patients themselves.

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

Throughout 2012-13 Lewisham Healthcare NHS Trust has been monitoring the adjusted average health gain for patients based on the PROMs data. The improved adjusted average health gain score for the patients was taken as a direct measure of the improvement in patients' outcomes and vice versa. In particular, since autumn 2012, patient identifiable data has been made available to the Trust in relation to the PROMS questionnaires. This has facilitated the identifying and reviewing of cases where patients reported a less than satisfactory outcome following surgery.

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Figure 1 - Lewisham Healthcare NHS Trust PROMS performance April 2011 – March 2012

PROMs - Key Facts

April 2011 to March 2012 (published 14th February 2013)

Outline

This spreadsheet should be used in conjunction with the PROMs publication.

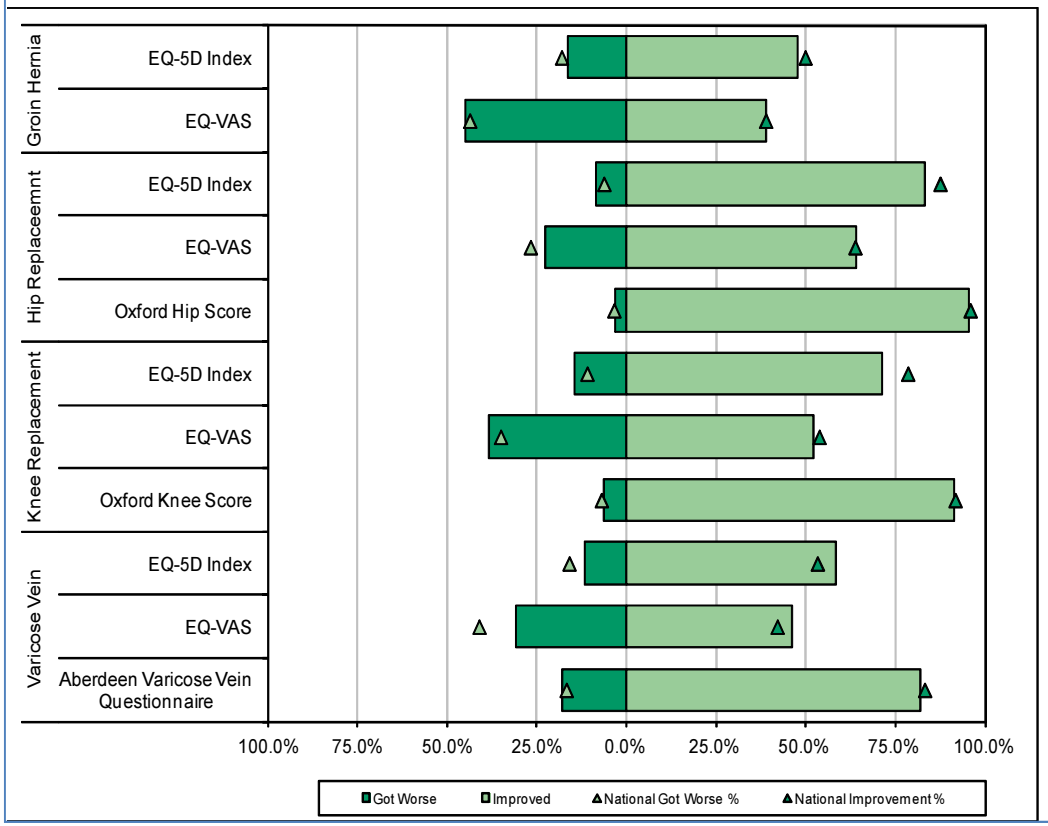
The 'Key Facts' sheet provides the ability to select the 'Key Facts' for one organisation at a national , SHA of responsibility, PCT of responsibility or provider level.

Organisation Level	Provider
Organisation	Lewisham Healthcare NHS Trust

Participation rate – 71.1% (National 73.7%) – based on pre-op

Response Rate - 68.4% (National 79.8%) – based on returned post-op Questionnaires

Percentage of patients that have improved for each procedure and scoring mechanism (unadjusted)



Percentage improving		Measure		
		EQ-5D Index	EQ-VAS	Condition Specific
Procedure	Groin Hernia	47.7%	38.8%	N/A
	Hip Replacement	83.1%	64.2%	95.4%
	Knee Replacement	71.2%	52.0%	91.5%
	Varicose Vein	58.5%	46.2%	82.0%

Number improving		Measure		
		EQ-5D Index	EQ-VAS	Condition Specific
Procedure	Groin Hernia	62	50	N/A
	Hip Replacement	49	34	62
	Knee Replacement	79	53	118
	Varicose Vein	55	42	82

Percentage getting worse		Measure		
		EQ-5D Index	EQ-VAS	Condition Specific
Procedure	Groin Hernia	16.2%	45.0%	N/A
	Hip Replacement	8.5%	22.6%	3.1%
	Knee Replacement	14.4%	38.2%	6.2%
	Varicose Vein	11.7%	30.8%	18.0%

Number getting worse		Measure		
		EQ-5D Index	EQ-VAS	Condition Specific
Procedure	Groin Hernia	21	58	N/A
	Hip Replacement	5	12	2
	Knee Replacement	16	39	8
	Varicose Vein	11	28	18

Figure 2 – Lewisham Healthcare NHS Trust Unadjusted Scores April 2011 – March 2012

PROMS QUESTIONNAIRE	LEWISHAM SCORES	NATIONAL SCORES
EQ-5D Index (a combination of five key criteria concerning general health)		
Groin	47.7% respondents recorded increase	49.8%
Hip	83.1% respondents recorded increase	87.4%
Knee	71.2% respondents recorded increase	78.4%
Varicose Vein	58.5% respondents recorded increase	53.2%
EQ-VAS (current state of the patients general health marked on a visual analogue scale)		
Groin	38.8% respondents recorded increase	38.8%
Hip	64.2% respondents recorded increase	63.7%
Knee	52.0% respondents recorded increase	53.7%
Varicose Vein	46.2% respondents recorded increase	42.%
Condition Specific Measures		
Hip Replacement - joint related improvements following operation as measured by response to a series of questions about their condition (Oxford Hip Score)	95.4 % of hip replacement respondents improvements	95.8%
Knee Replacement - joint related improvements following operation as measured by response to a series of questions about their condition (Oxford Knee Score)	91.5%	91.6%
Varicose Vein - varicose vein related improvements following operation as measured by response to a series of questions about their condition (Aberdeen Varicose Vein Questionnaire) (83.1% nationally).	82%	83%

Throughout 2012 and 2013 and with the introduction of patient level data, the Trust reviewed the patient level data and has undertaken an analysis of its PROMS data with regard to knee replacement surgery.

Table 1 provides information about the number of Questionnaires completed before and after the knee replacement procedures within the Trust. **Table 2** provides a breakdown of the change in patients' condition in terms of improvement, deterioration or no change following the knee replacement surgery. The data covers the period from April 2011 – September 2012.

***PROMS Analysis April 2011 - September 2012:**

Table 1

Total No. of Knee Replacements	No. of completed Questionnaire 1	No. of completed Questionnaire 2
154	153	50

Table 2

Number of patients that reported improvement:	36/50	72%
Number of patients that stayed the same	4/50	8%
Number of patients that showed deterioration	6/50	12%
Blanks (Questionnaires not fully completed or invalid data entry)	4/50	8%

***PLEASE NOTE:** these figures having collated from the patient identifiable PROMS report. Please note that this time period does not reflect the date of the procedure as carried out in the Trust. The dates reflect the when PROMS received the questionnaire 2.

Based on the above information, a review was carried out by the Surgery Directorate to investigate the reasons behind deterioration in patients following surgery. In the review of the six cases where patients were reporting a deterioration, with the examination of the clinical notes and letters to GP's, 4 out of 6 patients had a documented improvement in both range of motion and pain levels. One patient was unhappy with the type of surgery performed and wished to proceed to a full knee replacement against the consultant's advice. A further patient was non compliant with the post operative exercise regime which is known to impact recovery of range of motion.

The following tables show Lewisham Healthcare NHS Trust's performance in terms of its PROMS participation rate as well as adjusted average health gain in comparison to a selection of its peers (i.e. a range of other Trusts of a similar demographic) for the years 2011-12 and 2012-13. Please note that due to their small number, the Trust's figures for the adjusted average health gain for 2012-13 has been suppressed and replaced with an '*' (asterisk) to protect patient confidentiality. Due to the lack of availability of the adjusted average health gain for the Trust and its peers, no reasonable conclusions could be drawn or comparisons made.

The Lewisham Healthcare NHS Trust considers that this data is as described for the following reasons.

- The Trust has identified that its participation rate for the year 2012-13 has reduced in comparison to the last year. A similar trend could be observed across the Trust's peer group and also at a national level where a significant dip in the participation rate is noticed. The Trusts scoring highest in terms of participation rate has been highlighted in green in the PROMS participation table.
- From the National benchmarking dataset, there are approximately 20 Trusts with a participation rate of 0%.

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

- The Trust is committed to improving its participation rate for PROMs by ensuring that all eligible patients are invited to fill in the PROMs questionnaire. The Trust intends to achieve this through the following means:
    - A closer scrutiny of the existing systems and processes for identifying and inviting patients eligible for participation in PROMs.
    - Working towards developing improved systems and processes for identifying and inviting patients eligible for participation in PROMs and establishing means to allow continuous monitoring of these systems.

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Table 3 - Varicose Veins provisional PROMS scores April 2011 - March 2012 and April 2012 – September 2012 (published 14th February 2013)

VARICOSE VEINS	April 2011 – March 2012					April 2012 – September 2012				
Organisation Name	**Modelled Records**	**Average Questionnaire 1 (pre-op) Score**	**Average Questionnaire 2 (post-op) Score**	**Health gain (Questionnaire 2 average – Questionnaire 1 average)**	**Adjusted average health gain**	**Modelled Records**	**Average Questionnaire 1 (pre-op) Score**	**Average Questionnaire 2 (post-op) Score**	**Health gain (Questionnaire 2 average – Questionnaire 1 average)**	**Adjusted average health gain**
National	6,612	0.755	0.849	0.094	0.094	1586	0.745	0.838	0.093	0.093
London Strategic Health Authority	798	0.716	0.805	0.088	0.077	163	0.723	0.797	0.074	0.079
Lewisham Healthcare NHS Trust	91	0.704	0.804	0.101	0.097	16	0.644	0.784	0.140	*[4]
Guy's and St Thomas' NHS Foundation Trust	74	0.772	0.829	0.057	0.086	7	0.854	0.844	-0.010	*
King's College Hospital NHS Foundation Trust	55	0.730	0.830	0.100	0.095	12	0.734	0.862	0.128	*
South London Healthcare NHS Trust	*29*	*0.810*	*0.925*	*0.116*	*	*	*	*	*	*
Whipps Cross University Hospital NHS Trust	*9*	*0.739*	*0.943*	*0.204*	*	No data	No data	No data	No data	No data
Croydon Health Services NHS Trust	*11*	*0.762*	*0.853*	*0.090*	*	*	*	*	*	*
Homerton University Hospital NHS Foundation Trust	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
Newham University Hospital NHS Trust	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
West Middlesex University Hospital NHS Trust	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
Barts Health NHS Trust	*	*	*	*	*	6	0.740	0.767	0.027	*
Barts and The London NHS Trust	93	0.625	0.719	0.094	0.047	No data	No data	No data	No data	No data

Please note that Whipps Cross University Hospital Trust, Newham University Hospital Trust and Barts and The London NHS Trust have now merged to form Barts Health NHS Trust.

[4] Please note that due to their small number, the Trust's figures for the adjusted average health gain for 2012-13 has been suppressed and replaced with an '*' (asterisk) to protect patient confidentiality

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Table 4 - Groin Hernia provisional PROMS scores April 2011 - March 2012 and April 2012 – September 2012 (published 14th February 2013)

GROIN HERNIA	April 2011 – March 2012					April 2012 – September 2012				
Organisation Name	Modelled Records	Average Questionnaire 1 (pre-op) Score	Average Questionnaire 2 (post-op) Score	Health gain (Questionnaire 2 average – Questionnaire 1 average)	Adjusted average health gain	Modelled Records	Average Questionnaire 1 (pre-op) Score	Average Questionnaire 2 (post-op) Score	Health gain (Questionnaire 2 average – Questionnaire 1 average)	Adjusted average health gain
National	22211	0.788	0.874	0.087	0.087	1586	0.745	0.838	0.093	0.093
London Strategic Health Authority	1776	0.790	0.862	0.072	0.081	163	0.723	0.797	0.074	0.079
Lewisham Healthcare NHS Trust	120	0.783	0.864	0.082	0.085	16	0.644	0.784	0.140	*[5]
Guy's and St Thomas' NHS Foundation Trust	84	0.836	0.889	0.053	0.082	7	0.854	0.844	-0.010	*
King's College Hospital NHS Foundation Trust	50	0.814	0.871	0.057	0.067	12	0.734	0.862	0.128	*
South London Healthcare NHS Trust	245	0.783	0.870	0.087	0.090	*	*	*	*	*
Whipps Cross University Hospital NHS Trust	65	0.795	0.810	0.014	0.030	No data	No data	No data	No data	No data
Croydon Health Services NHS Trust	35	0.813	0.868	0.055	0.062	*	*	*	*	*
Homerton University Hospital NHS Foundation Trust	32	0.836	0.915	0.079	0.143	No data	No data	No data	No data	No data
Newham University Hospital NHS Trust	42	0.748	0.809	0.061	0.084	No data	No data	No data	No data	No data
West Middlesex University Hospital NHS Trust	68	0.725	0.856	0.131	0.076	No data	No data	No data	No data	No data
Barts Health NHS Trust	No data	No data	No data	No data	No data	6	0.740	0.767	0.027	*
Barts and The London NHS Trust	39	0.781	0.862	0.081	0.108	No data	No data	No data	No data	No data

Please note that Whipps Cross University Hospital Trust, Newham University Hospital Trust and Barts and The London NHS Trust have now merged to form Barts Health NHS Trust

[5] Please note that due to their small number, the Trust's figures for the adjusted average health gain for 2012-13 has been suppressed and replaced with an '*' (asterisk) to protect patient confidentiality

Table 5 - Hip Replacement provisional PROMS scores April 2011 - March 2012 April 2012 – September 2012 (published 14th February 2013)

HIP REPLACEMENT	April 2011 – March 2012					April 2012 – September 2012				
Organisation Name	**Modelled Records**	**Average Questionnaire 1 (pre-op) Score**	**Average Questionnaire 2 (post-op) Score**	**Health gain (Questionnaire 2 average – Questionnaire 1 average)**	**Adjusted average Health gain**	**Modelled Records**	**Average Questionnaire 1 (pre-op) Score**	**Average Questionnaire 2 (post-op) Score**	**Health gain (Questionnaire 2 average – Questionnaire 1 average)**	**Adjusted average health gain**
National	35,423	0.351	0.767	0.416	0.416	1586	0.745	0.838	0.093	0.093
London Strategic Health Authority	2,463	0.353	0.747	0.394	0.399	163	0.723	0.797	0.074	0.079
Lewisham Healthcare NHS Trust	53	0.391	0.776	0.385	0.435	16	0.644	0.784	0.140	*[6]
Guy's and St Thomas' NHS Foundation Trust	139	0.426	0.755	0.329	0.411	7	0.854	0.844	-0.010	*
King's College Hospital NHS Foundation Trust	79	0.355	0.787	0.432	0.451	12	0.734	0.862	0.128	*
South London Healthcare NHS Trust	279	0.322	0.754	0.432	0.400	*	*	*	*	*
Whipps Cross University Hospital NHS Trust	58	0.226	0.732	0.506	0.432	No data	No data	No data	No data	No data
Croydon Health Services NHS Trust	No data	No data	No data	No data	No data	*	*	*	*	*
Homerton University Hospital NHS Foundation Trust	*22*	*0.221*	*0.667*	*0.446*	*	No data	No data	No data	No data	No data
Newham University Hospital NHS Trust	36	0.268	0.645	0.377	0.363	No data	No data	No data	No data	No data
West Middlesex University Hospital NHS Trust	31	0.400	0.736	0.335	0.368	No data	No data	No data	No data	No data
Barts Health NHS Trust	No data	No data	No data	No data	No data	6	0.740	0.767	0.027	*
Barts and The London NHS Trust	64	0.328	0.660	0.332	0.383	No data	No data	No data	No data	No data

Please note that Whipps Cross University Hospital Trust, Newham University Hospital Trust and Barts and The London NHS Trust have now merged to form Barts Health NHS Trust

[6] Please note that due to their small number, the Trust's figures for the adjusted average health gain for 2012-13 has been suppressed and replaced with an '*' (asterisk) to protect patient confidentiality

Table 6 - Knee Replacement provisional PROMS scores April 2011 - March 2012 April 2012 – September 2012 (published 14th February 2013)

KNEE REPLACEMENT	April 2011 – March 2012				April 2012 – September 2012					
Organisation Name	Modelled Records	Average Questionnaire 1 (pre-op) Score	Average Questionnaire 2 (post-op) Score	Health gain (Questionnaire 2 average – Questionnaire 1 average)	Adjusted average health gain	Modelled Records	Average Questionnaire 1 (pre-op) Score	Average Questionnaire 2 (post-op) Score	Health gain (Questionnaire 2 average – Questionnaire 1 average)	Adjusted average health gain
National	37,337	0.403	0.705	0.302	0.302	1586	0.745	0.838	0.093	0.093
London Strategic Health Authority	2,930	0.379	0.650	0.271	0.267	163	0.723	0.797	0.074	0.079
Lewisham Healthcare NHS Trust	109	0.383	0.649	0.265	0.287	16	0.644	0.784	0.140	*[7]
Guy's and St Thomas' NHS Foundation Trust	148	0.365	0.610	0.245	0.248	7	0.854	0.844	-0.010	*
King's College Hospital NHS Foundation Trust	76	0.375	0.654	0.280	0.297	12	0.734	0.862	0.128	*
South London Healthcare NHS Trust	326	0.386	0.645	0.259	0.243	*	*	*	*	*
Whipps Cross University Hospital NHS Trust	110	0.363	0.629	0.265	0.268	No data	No data	No data	No data	No data
Croydon Health Services NHS Trust	No data	No data	No data	No data	No data	*	*	*	*	*
Homerton University Hospital NHS Foundation Trust	40	0.323	0.520	0.197	0.180	No data	No data	No data	No data	No data
Newham University Hospital NHS Trust	56	0.287	0.533	0.246	0.255	No data	No data	No data	No data	No data
West Middlesex University Hospital NHS Trust	42	0.267	0.706	0.440	0.345	No data	No data	No data	No data	No data
Barts Health NHS Trust	No data	No data	No data	No data	No data	6	0.740	0.767	0.027	*
Barts and The London NHS Trust	88	0.322	0.556	0.234	0.213	No data	No data	No data	No data	No data

Please note that Whipps Cross University Hospital Trust, Newham University Hospital Trust and Barts and The London NHS Trust have now merged to form Barts Health NHS Trust

[7] Please note that due to their small number, the Trust's figures for the adjusted average health gain for 2012-13 has been suppressed and replaced with an '*' (asterisk) to protect patient confidentiality

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Table 7 – PROMS pre and post –operative questionnaire issue and response rates April 2011 to March 2012 (provisional published 14th February 2013

	All Procedures					All Procedures			
Provider Name	Total eligible episodes	Q1s completed	Participation rate	Q1s linked	Linkage rate	Q2s sent to date	Issue rate	Q2s returned to date	Raw response rate
ENGLAND	247,702	184,786	74.6%	144,091	78.0%	174,328	94.3%	130,592	74.9%
PARK HILL HOSPITAL	40	510	1275.0%	431	84.5%	460	90.2%	384	83.5%
WORCESTERSHIRE PCT	Data not available	Data not available	Data not available	Data not available	Data not available	9	100.0%	9	100.0%
BMI - BISHOPS WOOD	68	6	8.8%	*	*	6	100.0%	6	100.0%
BARTS HEALTH NHS TRUST	27	*	*	*	*	*	*	*	*
WEST MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	517	299	57.8%	227	75.9%	275	92.0%	177	64.4%
WHIPPS CROSS UNIVERSITY HOSPITAL NHS TRUST	812	610	75.1%	432	70.8%	519	85.1%	305	58.8%
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	1,605	879	54.8%	743	84.5%	852	96.9%	579	68.0%
LEWISHAM HEALTHCARE NHS TRUST	953	678	71.1%	593	87.5%	645	95.1%	441	68.4%
CROYDON HEALTH SERVICES NHS TRUST	398	86	21.6%	85	98.8%	86	100.0%	48	55.8%
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	825	601	72.8%	455	75.7%	572	95.2%	358	62.6%
NEWHAM UNIVERSITY HOSPITAL NHS TRUST	408	347	85.0%	261	75.2%	331	95.4%	192	58.0%
BARTS AND THE LONDON NHS TRUST	957	622	65.0%	518	83.3%	598	96.1%	354	59.2%
HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	420	174	41.4%	130	74.7%	164	94.3%	111	67.7%
SOUTH LONDON HEALTHCARE NHS TRUST	2,419	1,630	67.4%	1,240	76.1%	1,514	92.9%	1,102	72.8%

Please note that Whipps Cross University Hospital Trust, Newham University Hospital Trust and Barts and The London NHS Trust have now merged to form Barts Health NHS Trust

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Table 8 - PROMS post-operative questionnaire issue and response rates April 2012 to September 2012, provisional (published 14 February 2013)

Provider Name	Total eligible episodes	Q1s completed	Participation rate	Q1s linked	Linkage rate	Q2s sent to date	Issue rate	Q2s returned to date	Raw response rate
ENGLAND	118,368	85,965	72.6%	62,949	73.2%	31,687	36.9%	10,534	33.2%
PARK HILL HOSPITAL	13	294	2261.5%	236	80.3%	100	34.0%	21	21.0%
BMI - THE MANOR HOSPITAL	13	24	184.6%	12	50.0%	7	29.2%	6	85.7%
BARTS HEALTH NHS TRUST	970	562	57.9%	386	68.7%	163	29.0%	42	25.8%
WEST MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	240	170	70.8%	122	71.8%	79	46.5%	24	30.4%
WHIPPS CROSS UNIVERSITY HOSPITAL NHS TRUST	0	30	0.0%	11	36.7%	6	20.0%	*	*
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	856	375	43.8%	314	83.7%	184	49.1%	46	25.0%
LEWISHAM HEALTHCARE NHS TRUST	439	197	44.9%	164	83.2%	94	47.7%	30	31.9%
CROYDON HEALTH SERVICES NHS TRUST	166	27	16.3%	25	92.6%	14	51.9%	7	50.0%
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	440	159	36.1%	123	77.4%	99	62.3%	40	40.4%
NEWHAM UNIVERSITY HOSPITAL NHS TRUST	0	9	0.0%	*	*	*	*	*	*
BARTS AND THE LONDON NHS TRUST	0	15	0.0%	14	93.3%	10	66.7%	*	*
HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	208	135	64.9%	74	54.8%	47	34.8%	*	*
SOUTH LONDON HEALTHCARE NHS TRUST	1,048	780	74.4%	559	71.7%	240	30.8%	72	30.0%

Please note that Whipps Cross University Hospital Trust, Newham University Hospital Trust and Barts and The London NHS Trust have now merged to form Barts Health NHS Trust

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2.1.2 Clinical Effectiveness

2.1.2 (iv) Clinical Effectiveness Indicator 3 – Reduction in emergency readmissions within 28 days of discharge from hospital (Domain 3 of the NHS Outcomes Framework)

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

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

In April 2012 the Trust participated in an audit which engaged with GPs, Consultants, Social Care, local commissioners and other relevant staff to determine what percentage of readmissions were avoidable. The outcomes showed that a very low number of readmissions were considered avoidable – only 2 out of 56 readmissions reviewed, i.e. 3.6%. A number of local schemes are being carried out with a focus on reducing avoidable readmissions.

28 Day Readmissions

In the 2011-2012 Quality Account, it was highlighted that as part of the Trust's Quality Improvement Strategy, the avoidance and reduction in emergency readmissions within 28 days of discharge from hospital would be a priority for 2012-2013.

The National 28 Day Readmission data is not yet available for 2011/12 or 2012/13. The next dataset is due to be published in December 2013. However using the Trust's own figures, the 28 day emergency readmission rate for Lewisham Healthcare NHS Trust is shown in the tables below. It has been calculated by dividing the total number of patients readmitted within 28 days of discharge by the total number of hospital discharges. The list of peers against which we are comparing ourselves is also shown below.

Table 1 - Readmissions – the number of patients who are readmitted as an emergency within 28 days of discharge from the Trust

2011-12		Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
Readmissions (28 days)	Trust	9.3%	8.8%	8.0%	9.2%	9.6%	8.7%	7.2%	8.5%	8.2%	8.5%	7.2%	8.3 %
	Peer	8.3%	8.2%	8.2%	7.8%	8.1%	8.1%	8.1%	7.8%	8.4%	7.6%	7.8%	7.0 %
	No.	390	409	376	428	436	396	335	412	376	404	340	421

2012-13		Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Readmissions (28 days)	Trust	8.6%	8.0%	7.9%	8.1%	6.1%	6.1%	6.9%	8.2%	8.2%	8.9%		
	Peer	7.3%	7.1%	7.4%	7.3%	7.2%	7.3%	7.1%	7.1%	7.9%	6.2%		
	No.	371	419	357	401	278	280	344	397	363	435		

Please note: These figures are extracted from a live system. As data is continually updated, figures are subject to change.

Peer Group * Please note that during 2012-2013, Whipps Cross University Hospital Trust and Newham University Hospital Trust merged with Barts Hospital to form Barts Health NHS Trust	
Croydon Health Services NHS Trust	Newham University Hospital NHS Trust*
Guy's & St. Thomas' Foundation Trust	South London Healthcare NHS Trust
Homerton University Hospital NHS Foundation Trust	The West Middlesex University Hospital
King's College Hospital NHS Foundation Trust	Whipps Cross University Hospital NHS Trust*
Barts Health NHS Trust	

The data shows that there has been a reduction in 28 Day readmission rates in 2012-13. For example, when compared to 2011, the three months of August, September and October 2012 all have a readmission rate of less than 7%, whereas the same three months the previous year was 7.2% at best and at worst peaking at 9.6%. The tables also show that from April – December 2012, there has been a reduction for each month when directly compared to the same month in 2011-12. This is a noteworthy achievement and the Trust will continue to work towards maintaining this reduction in emergency readmissions.

One means of reducing emergency readmissions is through ensuring there are appropriate pathways in place in the community to deliver alternatives to emergency hospital admission. An example of this is the COPD (Chronic Obstructive Pulmonary Disease) pathway. The Respiratory Nursing service, together with the Community Matrons, is now able to respond within the community to meet the needs of this group of patients and therefore avoid acute admissions. For example, GPs can contact the nursing team so that the patient can be assessed in their own home and given additional support and care if required. Further, if the patient does come to the Emergency Department, where possible they are assessed by a specialist nurse and treated within the Emergency Department so that the patient does not need to be admitted to hospital unnecessarily.

Another example of how emergency admissions are being avoided is within the Acute Oncology Service which supports cancer patients through their cancer pathway. The team has been using an assessment tool which can be used when chemotherapy patients contact them over the phone and report they are feeling unwell. The assessment is carried out on the phone and depending on the score the patient is advised as to what they should do next. The team have carried out training within the Emergency Department on how to provide best care to oncology patients without an unnecessary admission. The Emergency Department admissions are also reviewed each morning to check whether any oncology patients have been admitted overnight.

For older patients arriving at the Emergency Department and the Rapid Assessment Treatment Unit (RATU), there is an ongoing initiative to ensure that an early review is carried out where possible by a multidisciplinary team and a consultant to prevent the patient needing to be admitted to hospital and to allow the patient to go home with either increased rehab or care.

30 Day Emergency Department Readmissions

Lewisham Healthcare NHS Trust has improved the support for patients who are treated in the hospital's emergency department and thus reduced the need for follow-up emergency care.

Compared to 2011-12 year, there has been a significant reduction in the number of patients who need to re-visit the Emergency Department 30 days after receiving treatment there.

This has been achieved by the community and hospital healthcare professionals working closely together under one organisation following the integration of the University

Hospital Lewisham and Lewisham Community Health Services into Lewisham Healthcare NHS Trust.

Since Lewisham Healthcare NHS Trust was formed, a major area of focus has been ensuring that patients get the right follow-up care after they have been unwell and therefore keeping people healthy, independent and out of hospital. Working towards better integration of community and acute services ensures that patients with long term conditions have the support they need to manage their health within the community setting and avoiding an unnecessary hospital. This is better for the patient and saves tax payers' money by freeing up hospital beds.

Less than 10% of people who have been seen in the Emergency Department now need to visit the Department again within 30 days. The table below displays the quarterly data for 2011-12 and 2012-13.

Table 2: Lewisham Healthcare NHS Trust Emergency Department's Rates for 30 Day Emergency Readmissions in 2011-12 and 2012-13

Period	Readmission %
Quarter 1 2011/12	15.3%
Quarter 2 2011/12	14.5%
Quarter 3 2011/12	14.0%
Quarter 4 2011/12	10.2%
Total 2011/12	**14.1%**
Quarter 1 2012/13	9.2%
Quarter 2 2012/13	9.1%
Quarter 3 2012/13	8.7%
Quarter 4 2012/13	Data not yet available

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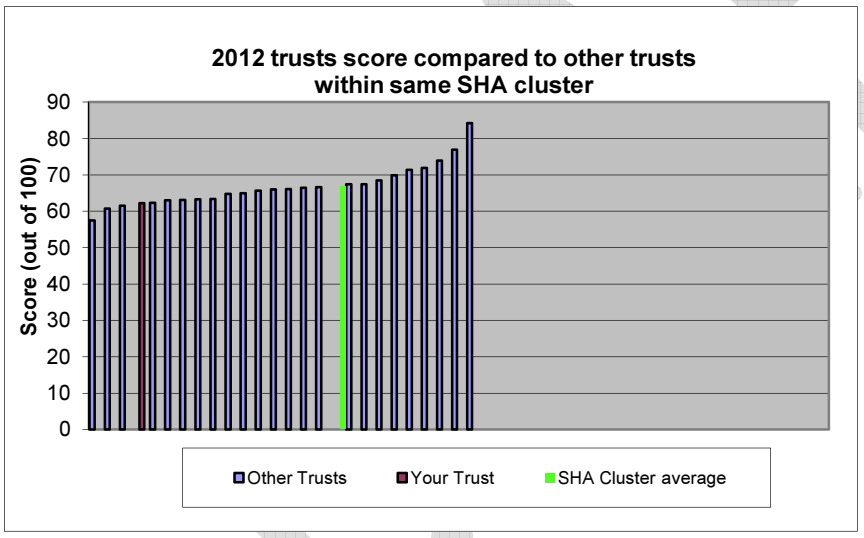
2.2.3 Patient Experience

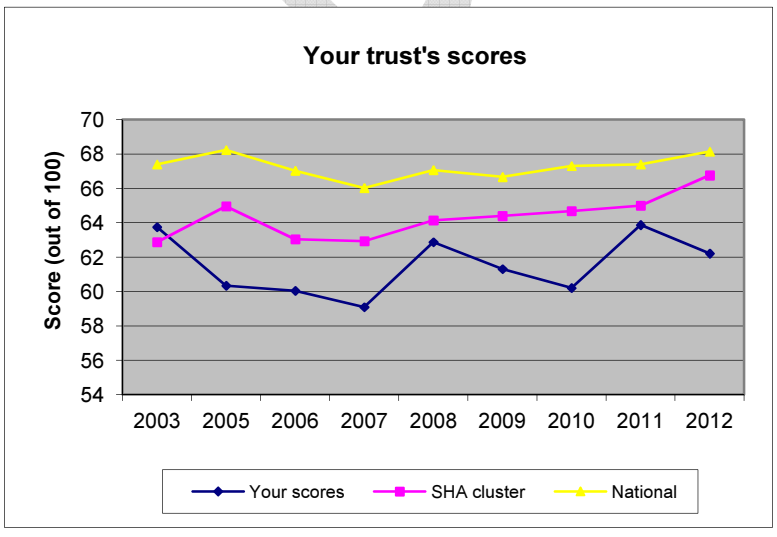
2.2.3 (i) Patient Experience Indicator 1- The Trust's responsiveness to the personal needs of the patients

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

The National Inpatient Survey results were published in April 2013. While these results show that we still have much to do to maintain and improve the standards of our services, Lewisham was pleased to be in the top 20% of Trusts for aspects of our surgical care. In particular people felt that our team explained their treatment in a way that they could understand. In relation to most other aspects of care we were as good as most other hospitals in England, and we were pleased to see that in aspects of basic care, our scores had improved since 2011. For example, people felt that they had more confidence and trust in our nurses in 2012. This is a tribute to how hard our nurses have worked during a difficult period of change and uncertainty for the Trust.

With regard to the specific measures in the relevant national CQUIN, Lewisham has shown overall improvement in the last 5 years, reflecting the overall picture in the sector. Lewisham has performed slightly better than other sector Trusts including South London Healthcare NHS Trust



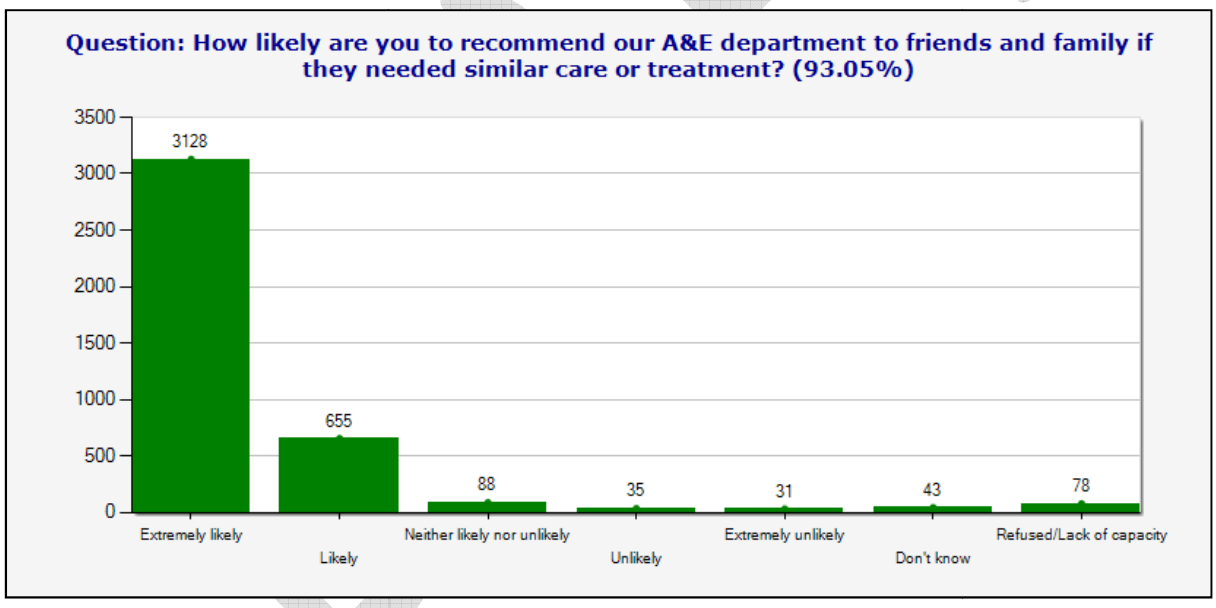


The Lewisham Healthcare NHS Trust intends to take / has taken the following actions to improve this rate and so the quality of its services by:

Making improvements in specific areas. In particular, we need to focus on the experience people have of discharge from hospital, the length of time that they wait, and the information that they are given to take home.

Our National A&E Survey results were also published in 2012. Although these results were a little disappointing they the fact that the survey was conducted during the period when the A&E and Urgent Care Departments were under refurbishment. Surveys that we have undertaken since the department moved into its new premises have shown a much improved picture. Neverthless, we have developed a comprehensive action plan, including the implementation of new systems to improve patient flows, the recruitment of staff to manage this, and the implementation of training for staff to improve communication of test results for example.

The most up-to-date information that Lewisham Healthcare NHS Trust has to tell us what people think of our A&E and adult inpatient services, is the results of our on-going Friends and Family Test. Lewisham Healthcare has been offering this test to patients since October 2012. Hundreds of people have used the opportunity to feed back their experiences, and over 90% tell us that they would be extremely likely or likely to recommend our services to friends or family.



2.2.3 (ii) Patient Experience Indicator 2 – The percentage of staff employed by the Trust who would recommend the Trust as a provider of care to their family and friends

Following amendments which were made to the National Health Service (Quality Accounts) Regulations 2010, changes to the reporting requirements for Quality Accounts was published in March 2013. The Regulations have been amended to: take into account changes to the care system from April 2013, following the introduction of the Health and Social Care Act 2012.

Of the amendments made, publication of the percentage, scores and numbers of staff employed by the Trust who would recommend the Trust as a provider of care to their family and friends was made mandatory.

The annual staff survey is used to understand staff experience and perceptions. The survey is undertaken by all NHS organisations enabling comparisons between similar trusts and to compare the experiences of staff in a particular trust with the national picture. The results provide the opportunity to improve local working conditions for staff which ultimately improve patient care. The outcomes from the annual survey are available to external organisations such as CQC and Monitor who may use it as an additional measurement of our performance.

An overall staff engagement score is made up of 3 key findings. The Trust has scored 3.82, this is an increase from the previous year's 3.63 score. The national average is 3.69 placing us in the highest (best) 20% compared to other similar organisations.

In relation to the NHS Constitution 'Pledges' to staff, Pledge 4 - '**To engage staff in decisions that affect them and the services they provide, and empower them to put forward ways to deliver better and safer services'** has two additional themes within the 2012 survey, 'staff satisfaction and equality and diversity'.

Within these themes, are six associated key findings, 4 of these are in the best 20%. Out of those 4, there are 2 key findings which have significantly improved.

- Staff recommendation of the trust as a place to work or receive treatment
- Having equality and diversity training in the last 12 months

Figure 1 below demonstrates the percentage rates in responses to the staff survey questions for the questions relating to staff employed by the Trust who would recommend the Trust as a provider of care to their family and friends.

The results demonstrate the top performers and our peer organisations, as well as those Trusts who scored the lowest.

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Figure 1. The percentage of staff employed by the Trust who would recommend the Trust as a provider of care to their family and friends

Data is Unweighted		Q12										
National NHS Staff Survey 2012		To what extent do these statements reflect your view of your organisation as a whole?										
This sheet contains questions relating to: immediate managers, senior managers, and staff views of the organisation.		c) I would recommend my organisation as a place to work						d) If a friend or relative needed treatment I would be happy w standard of care provided by this organisation				
Note: In order to the preserve anonymity of individual staff, where there were fewer than 11 responses to a question responses are not displayed		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Base (number of respondents)	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
		%	%	%	%	%		%	%	%	%	%
	ALL ACUTE TRUSTS	--	**5**	**11**	**28**	**41**	**15**	**63,143**	**3**	**8**	**24**	**47**	**18**
	ACUTE TRUSTS	--	**5**	**11**	**29**	**41**	**14**	**56,502**	**3**	**9**	**26**	**46**	**15**
RF4	Barking, Havering And Redbridge University Hospitals NHS Trust	Q36	11	15	33	36	5	324	7	16	30	40	7
R1H	Barts Health NHS Trust	Q36	6	11	30	40	13	323	4	10	32	42	12
RJ6	Croydon Health Services NHS Trust	Q36	6	13	36	36	9	402	8	18	33	32	9
RJ1	Guy's and St Thomas' NHS Foundation Trust	Q36	2	4	21	40	34	345	1	3	14	47	35
RQX	Homerton University Hospital NHS Foundation Trust	Q36	3	4	16	46	31	377	1	4	20	47	28
RJZ	King's College Hospital NHS Foundation Trust	Q36	2	7	14	46	31	396	2	3	16	48	31
RR8	Leeds Teaching Hospitals NHS Trust	Q32	11	18	36	28	8	380	5	17	31	39	8
RJ2	Lewisham Healthcare NHS Trust	Q36	2	7	20	50	21	260	3	7	25	50	16
RXF	Mid Yorkshire Hospitals NHS Trust	Q32	13	25	30	26	6	389	9	19	31	34	8
RNL	North Cumbria University Hospitals NHS Trust	Q31	13	24	36	23	3	420	11	20	33	31	5
RYQ	South London Healthcare NHS Trust	Q36	10	24	32	25	8	308	6	16	31	36	11
RRV	University College London Hospitals NHS Foundation Trust	Q36	2	8	19	43	28	386	1	4	12	49	34
RFW	West Middlesex University Hospital NHS Trust	Q36	4	13	29	41	13	314	4	11	25	47	13

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Figure 2 demonstrates the summary scores of the key finding question related to Staff recommendation of the trust as a place to work or receive treatment across our peer organisations, those with the top and bottom scores.

Data is Unweighted

National NHS Staff Survey 2012

: contains scores for 28 Key Findings - 'summary scores' for groups of individual

Note: In order to the preserve anonymity of individual staff, where there were fewer than 11 responses to a question responses are not displayed

			Key Finding 24. Staff recommendation of the trust as a place to work or receive treatment 12a, 12c, 12d	
			Score	Base
	ALL ACUTE TRUSTS	**--**	**3.62**	**63,195**
	ACUTE TRUSTS	**--**	**3.57**	**56,550**
RF4	Barking, Havering And Redbridge University Hospitals NHS Trust	Q36	3.28	326
R1H	Barts Health NHS Trust	Q36	3.52	323
RJ6	Croydon Health Services NHS Trust	Q36	3.35	401
RJ1	Guy's and St Thomas' NHS Foundation Trust	Q36	4.07	347
RQX	Homerton University Hospital NHS Foundation Trust	Q36	4.03	377
RJZ	King's College Hospital NHS Foundation Trust	Q36	4.04	396
RR8	Leeds Teaching Hospitals NHS Trust	Q32	3.16	382
RJ2	Lewisham Healthcare NHS Trust	Q36	3.78	260
RXF	Mid Yorkshire Hospitals NHS Trust	Q32	3.01	390
RNL	North Cumbria University Hospitals NHS Trust	Q31	2.90	419
REF	Royal Cornwall Hospitals NHS Trust	Q39	3.08	393
RYQ	South London Healthcare NHS Trust	Q36	3.20	307
RRV	University College London Hospitals NHS Foundation Trust	Q36	4.01	386
RFW	West Middlesex University Hospital NHS Trust	Q36	3.52	316

KEY	
	National Scores
	Top performing Scores /Trusts
	Lewisham Healthcare NHS Trust
	Botton performing Scores/Trusts

Figure 3. Demonstrates the results of Lewisham Healthcare NHS Trust, its peers, the upper quartile performing Trusts and lower quartile performing Trusts for question 12d – 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'.

Data is Unweighted

National NHS Staff Survey 2012 - acute & acute specialist trusts only

Code	% to strongly agree / agree with the Q12d. 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'	SCORE	QUARTILE
Column1	Column2	Column3	Column4
RNL	North Cumbria University Hospitals NHS Trust	35.337	1st
RWD	United Lincolnshire Hospitals NHS Trust	40.464	1st
RJ6	Croydon Health Services NHS Trust	40.898	1st
RYQ	South London Healthcare NHS Trust	47.231	1st
RF4	Barking, Havering And Redbridge University Hospitals NHS Trust	47.385	1st
R1H	Barts Health NHS Trust	54.321	1st
RFW	West Middlesex University Hospital NHS Trust	60.510	2nd
RKE	The Whittington Hospital NHS Trust	65.306	3rd
RJ2	Lewisham Healthcare NHS Trust	65.385	3rd
RQX	Homerton University Hospital NHS Foundation Trust	74.801	4th
RJZ	King's College Hospital NHS Foundation Trust	79.592	4th
RJ1	Guy's and St Thomas' NHS Foundation Trust	82.133	4th

Quartile	
Lower Quartile (25th)	55.3395021
Median Quartile (50th)	63.255814
Upper Quartile (75th)	72.2598768

Average score for each quartile	
Average score for 1st quartile - 49.982	49.982
Average score for 2nd quartile - 58.913	58.913
Average score for 3rd quartile - 67.440	67.44
Average score for 4th quartile - 81.856	81.856

Trusts in the 4th quartile are the top performers

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

Fay we need to put in why we think we have improved throughout the year with these results

The Lewisham Healthcare NHS Trust intends to take / has taken the following actions to improve this rate and so the quality of its services by: what are we going to continue to do to keep on improving on these scores

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2.3 Participation in Clinical Audit

Overview

Participation in Clinical Audits

The Lewisham Healthcare NHS Trust is committed to continually improving the healthcare we provide to service users. Clinical Audit is a crucial part of the Trusts strategy to improve the healthcare we provide.

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

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

National Audit and Confidential Enquiries Programme

During April 2012 to March 2013, 40 National Clinical Audits and 8 National Confidential Enquiries covered NHS services that Lewisham Healthcare NHS Trust provides. During that period Lewisham Healthcare NHS Trust participated in 100% (40/40) National Clinical Audits and 100% (8/8) National Confidential Enquiries of the National Clinical Audits and National Confidential Enquiries which it was identified as eligible to participate in.

The table below shows the National Audits and National Confidential Enquires which the Trust were eligible to participate in and the submission rate.

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Table 1 - Trust participation submission rate for all eligible National Audits and National Confidential Enquires for 2012/13

Audit Title		Eligible	Participated	Reporting Period	% Submission Rate
No	**National Clinical Audits**				
1	Acute Myocardial Infarction & Other ACS (MINAP)	Yes	Yes	1st April 2012 – 31st May 2013	71 cases In progress
	Acute Myocardial Infarction & Other ACS (MINAP Validation Study)	Yes	Yes	2nd January 2013 - 28th February 2013	100%
2	Acute Stroke - Organisational (SSNAP)	Yes	Yes	1st April 2012 – 31st May 2013	100%
	Acute Stroke – Patient Data (SSNAP)	Yes	Yes	1st December 2012 - 1st December 2013	100%
3	Adult Asthma (British Thoracic Society)	Yes	Yes	1st September 2012 – 31st December 2012	100%
4	Adult Community Acquired Pneumonia (British Thoracic Society)	Yes	Yes	1st December 2012 – 31st May 2013	In progress
5	Adult Critical Care (ICNARC CMPD)	Yes	Yes	1st April 2012 – 31st March 2013	100%
6	Blood Sample Labelling (National Comparative Audit of Blood Transfusion)	Yes	Yes	1st April 2012 - 31st March 2013	100%
7	Bowel Cancer (National Bowel Cancer Audit)	Yes	Yes	1st August 2010 – 31st July 2011	73%
8	Bronchiectasis (British Thoracic Society)	Yes	Yes	1st October 2012 – 31st January 2013	100%
9	Cardiac Arrest (National Cardiac Arrest Audit)	Yes	Yes	1st April 2012 – 31st March 2013	100%
10	Cardiac Arrhythmia (Cardiac Rhythm Management Audit)	Yes	Yes	1st April 2012 – 31st May 2013	In progress 100% to date
11	Carotid Interventions (Carotid Intervention Audit)	Yes	Yes	1st October 2011 – 31st December 2012	100%
12	Childhood Epilepsy 12 (RCPH National Childhood Epilepsy Audit)	Yes	Yes	1st January 2013 – 31st	In progress

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				January 2014	
13	Diabetes (National Adult Diabetes Audit)	Yes	Yes	20th August 2012 – 18th January 2013	100%
14	Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	Yes	15th June 2012 – 31st October 2012	100%
15	Emergency Use of Oxygen (British Thoracic Society)	Yes	Yes	15th August 2012 – 1st November 2012	100%
16	Fever in Children (College of Emergency Medicine)	Yes	Yes	1st August 2012 – 30th November 2012	100%
17	Fractured Neck of Femur (College of Emergency Medicine)	Yes	Yes	1st August 2012 – 30th November 2012	100%
18	Heart Failure (Heart Failure Audit)	Yes	Yes	1st April 2012 – 31st May 2013	In progress
19	Hip Fracture (National Hip Fracture Database)	Yes	Yes	1st April 2012 - 31st March 2013	100% (TBC by HES)
20	Hip, Knee and Ankle Replacements (National Joint Registry)	Yes	Yes	1st April 2012 - 31st March 2013	278 operations (awaiting coding figure)
21	Lung Cancer (National Lung Cancer Audit)	Yes	Yes	1st January 2011 - 31st December 2011	93%
22	National Audit of Dementia (NAD)	Yes	Yes	16th April 2012 – 19th October 2012	100%
23	Neonatal Intensive & Special Care NNAP	Yes	Yes	1st January 2012 – 31st December 2012	100%
24	Non-Invasive Ventilation-Adults (British Thoracic Society)	Yes	Yes	1st February 2013 – 31st May 2013	In progress
25	Oesophago-Gastric Cancer (National O-G Cancer Audit)	Yes	Yes	1st July 2012 – 30th July 2012	100% Organisational
				1st April 2011 - 1st October 2012	24 cases Awaiting final confirmation
26	Paediatric Asthma (British Thoracic Society)	Yes	Yes	1st November 2012 – 30th	100%

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				November 2012	
27	Paediatric Pneumonia (British Thoracic Society)	Yes	Yes	1st November 2012 – 5th April 2013	100%
28	Parkinson's Disease (National Parkinson's Audit)	Yes	Yes	1st August 2012 – 11th January 2013	100%
29	Potential Donor Audit (NHS Blood and Transplant)	Yes	Yes	1st April 2012 – 31st March 2013	100%
30	Renal Colic (College of Emergency Medicine)	Yes	Yes	1st August 2012 – 30th November 2012	100%
31	Severe Trauma (Trauma Audit & Research Network)	Yes	Yes	1st January 2012 – 31st December 2012	55% (to Feb 2013)
32	Ulcerative Colitis & Crohn's Disease (UK IBD Audit)	Yes	Yes	1st January 2013 – 31st March 2014	In progress
	National Confidential Enquiries				
1	Child Health (CHR-UK)	Yes	Yes	30th June 2012 – 31st March 2013	100%
2	Elective Surgery (National PROMs Programme)	Yes	Yes	1st April 2012 – 31st March 2013	44.9% All procedures (to Sept 2012)
3	Mothers and Babies Reducing Risk Through Audit and Confidential Enquiries (MBRRACE)	Yes	Yes	1st April 2012 - 31st March 2013	100%
4	National Review of Asthma Deaths (NRAD)	Yes	Yes	1st February 2012 – 31st January 2013	100%
5	NCEPOD – Alcohol Related Liver Disease (ARLD)	Yes	Yes	2nd November 2012 – 18th January 2013	100%
6	NCEPOD – Bariatric Surgery Study (BS)	Org. Q Only	Yes	2nd January 2012 – 31st March 2012	100%
7	NCEPOD – Cardiac Arrest Procedures Study (CAP)	Yes	Yes	1st February 2011 – 10th October 2011	100%
8	NCEPOD – Subarachnoid Haemorrhage (SAH)	Yes	Yes	1st February 2012 – 23rd March 2013	100%

The National Clinical Audits and National Confidential Enquiries that Lewisham Healthcare NHS Trust was eligible to

participate in during April 2012 to March 2013
The National Clinical Audits and National Confidential Enquiries that Lewisham Healthcare NHS Trust participated in, and for which data collection was completed during April 2012 to March 2013, are listed alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 2 0 National Clinical Audits and National Confidential Enquiries Included in the National Clinical Audit and Patient Outcome Programme (NCAPOP) List published by the Department of Health

Table 3 - Additional National Clinical Audits that Lewisham Healthcare NHS Trust Participated in during 2012-2013

Additional National Clinical Audits					
No	**Audit Title**	**Eligible**	**Participated**	**Reporting Period**	**% Submission Rate**
1	Acute Kidney Injury Audit	Yes	Yes	1st August 2012 - 15th March 2013	100%
2	Cardiac Rehabilitation	Yes	Yes	1st April 2012 - 31st March 2013	In progress
3	Consultant Sign Off in the Emergency Department	Yes	Yes	14th February 2013 - 29th March 2013	100%
4	COPD Discharge	Yes	Yes	1st April 2012 - 6th August 2012	100%
5	Intermediate Care	Yes	Yes	15th January 2012 - 4th May 2012	100%
6	Accidental Awareness During Analgesia in the UK (NAP5 - AAGA)	Yes	Yes	1st June 2012 - 15th June 2013	In progress
7	Diabetes - Inpatient Audit	Yes	Yes	17th September 2012 – 28th September 2012	100%
8	Intensive Care Over Nations (ICON)	Yes	Yes	8th May 2012 - 31st July 2012	100%

Reviewing Reports of National Clinical Audits

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

The reports of National Clinical Audits and Confidential Enquiries were reviewed by Lewisham Healthcare NHS Trust in January 2012 to December 2012 and the actions that Lewisham Healthcare NHS Trust will be taking to improve quality are detailed in Table 4.

Table 4 – Actions taken resulting from the Trust review of National Audit and National Confidential Enquiry Reports

National Clinical Audit / Confidential Enquiry	Actions Taken
National NHS Kidney Care - Acute Kidney Injury (AKI) Audit	As a result of participating in this audit the Trust has set up an electronic algorithm to detect patients who may have, or be at risk of developing AKI 3. The algorithm detects patients with an increased creatinine level. It compares the level with those taken in the last 12 months and any result with a greater than 3 fold increase is then flagged up to alert staff that this patient may have, or be at risk of developing an Acute Kidney Injury. Following the success of the initial algorithm further work is underway to develop the alert system, including sending e-mail prompts to the Outreach team identifying patients who may be eligible for review to rule out AKI. An initial AKI management care bundle and local guidelines have also been developed to guide staff in the appropriate treatment of patients with AKI. These continue to be promoted across the Trust and further audits to ascertain compliance against the bundle will be carried out in the coming year.
National Hip Fracture Database (NHFD)	Joint ward rounds with the Elderly Care team and ICU Consultant now take place to review all fractured neck of femur patient's pre operatively. This has lead to better outcomes for patients.
Stroke Programme (SSNAP)	As a result of the SINAP and organisational stroke audits, the stroke unit at Lewisham Healthcare NHS Trust has introduced changes to the stroke discharge pathway in order to improve length of stay, and thereby facilitate timely and prompt transfer of patients from hyperacute stroke units. The physiotherapy department has introduced a weekend service in order to ensure that appropriate patients are both assessed and given therapy on the unit if required.
NCEPOD – Cardiac Arrest Study	In response to the recommendations made by this enquiry, the Trust has introduced a Deteriorating Patient Policy and revised the treatment escalation of care plans in use. An audit is underway to look at previous resuscitation attempt rates and a local goal will be set following this to reduce the number of cardiac arrests in the Trust that lead to Cardiopulmonary Resuscitation (CPR).

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

The Clinical Directors within each directorate across the Trust are ultimately responsible for ensuring that all aspects of the quality agenda which encompass the services provided under their direction are closely monitored through participation in Clinical Audit.

The Clinical Directors delegate responsibility to Clinical Audit Leads at speciality level within their Directorate to ensure that all audits included in the annual Clinical Audit Programme are registered, completed, and reported within the year, and that any recommendations and actions resulting from audit are implemented and monitored.

It is the responsibility of the Directorate Governance and Risk Leads, and Clinical Audit Leads to represent their area at the Trusts Clinical Audit and Guidelines Group (CAGG). The primary purpose of the CAGG is to provide assurance to the Trust Board via the Clinical Quality Committee that Clinical Audit, Clinical Quality and Clinical Effectiveness activity across the Trust is being undertaken effectively and within the prescribed timeframes.

The sharing of learning and evidence based practice is promoted by the CAGG. The Clinical Audit Leads are given the opportunity to present an audit they have undertaken in the past 12 months at a CAGG meeting during the course of the year to encourage the wider sharing of learning with other specialties across the Trust. Staff are also given the opportunity to showcase examples of excellence in Clinical Audit at an annual Clinical Quality and Research Day which is open to all staff, patients, carers and the local population.

The reports of 171 local audits were reviewed by the Trust between April 2012 to March 2013 and examples of changes to practice are displayed in the table 4 below. A full list of the local audits reviewed is attached in Appendix 3

Table 4 – Changes to practice resulting from Clinical Audit

Audit Title	Directorate	Audit Standard	Audit Result	Actions Triggered
Babies Born Before Arrival (BBA) Audit	Women's & Sexual Health	Identify what factors contribute to BBA, with the aim to reduce the incidence where possible	The predominant cause of Babies Born Before arrival appeared to be precipate labour (less than an hour) or a slow onset of labour with sudden and rapid progress to established labour. 65% of women audited did not telephone the maternity service for advice about when to come in or to alert staff their labour had started. One women reported difficulty getting through to the ward for advice.	Dedicated phone in only telephone lines were installed to ensure that if women do try and call in for advice, lines are not blocked by operational calls. Dedicated line for emergency cases from London Ambulance Service A midwife with homebirth experience will now attend mothers whose Babies are Born Before Arrival, and where Mother and Baby are well, they can then safely stay home and avoid hospital admission. A review of the information given to mothers about when and how to access care in labour is being undertaken.
Implementation of new	Acute & Elderly	Standardise the	A pilot of new	Increase the number of

Nasogastric (NG) feeding documentation	Medicine	Trust's documentation and compliance with national NPSA guidelines to ensure the safe feeding of patients via NG tubes.	documentation was carried out on two medical wards. NG tube standardised documentation and practice has increased overall compliance from 36% to 91% in accordance with NPSA guidelines	wards using the standardised documentation Continue MDT training regarding NG tube placement Re-audit all wards using documentation in 2013 to assess implementation and continued use of the standardised documentation
Audit of Rheumatology Advice Line Service	Specialist Medicine	The National Institute for Health and Clinical Excellence (NICE) guideline CG 79 recommends that people with Rheumatoid Arthritis (RA) should have access to a named member of the multidisciplinary team who is responsible for coordinating their care, and have the knowhow to access this specialist care rapidly in the event of a flare up of their condition in between routine appointments. To support this recommendation the Rheumatology department at Lewisham Healthcare NHS Trust set up a dedicated telephone and e-mail advice line to provide support to patients. This audit looked at the number of contacts received by the service over a one month period, assessed how much time was spent dealing with patients, and how many contacts led to further referral for rapid clinic review.	During the one month period audited, 94 calls/e-mails were received by the advice line. 72% of calls came directly from patients, with the remaining 28% of contacts being made by carers, GPs and Community or District Nurses. 81% of patient contacts were from adult patients with inflammatory arthritis, reflecting the workload of the specialist nurses. 95% of calls/e-mails were dealt with at the time of contact. 5 patients were given a rapid review appointment with the nurse specialist - all patients required additional treatment when reviewed so were therefore seen appropriately.	The audit demonstrated that the Rheumatology advice line service is an effective way for patients, carers and healthcare professionals to contact the department for specialist advice in line with NICE guidance recommendations. The service will continue and will be re-audited in a year's time to further assess it's success.
3 Hour post-operative Adenoidectomy recovery Audit	Surgery	A 3 hour recovery protocol is utilised in dedicated paediatric units who undertake adenoidectomy procedure. Lewisham Healthcare NHS Trust piloted a move from a 6 hour recovery period to the 3 hour period in line with other paediatric units. This audit established the impact on	93% of patients were successfully discharged within the new 3 hour recovery period. Initial feedback showed that there was also a positive benefit of 3 hour discharge with regards to bed management, and would allow better management of clinical resources (i.e. impact on inpatient beds).	The Trust will adopt the 3 hour post-operative recovery protocol for all Adenoidectomy procedures. Further audits to establish patient and staff satisfaction and continued benefit of revised protocol are planned.

		morbidity, associated complications and clinical effectiveness following this change in practice		
Accuracy of Prescribing on Children's Inpatient Ward Audit & Re-Audit	Children & Young People	In response to a recent study which showed that 13% of inpatient prescriptions in paediatric wards in London contained errors, the Royal College of Paediatric and Child Health (RCPCH) introduced a prescribing exam for new starters to paediatrics. This audit and re-audit looked at prescribing practice to see if the new training has impacted on practice.	The initial audit in April 2012 showed good compliance with signature and dating of prescriptions, and documentation of patient weight. It also showed good compliance with the writing out in full of those medications with nonstandard units of measurement Areas of poor compliance were medications which required a dose calculation written out, fluid prescription and the recording of valid period for certain medications (i.e. how long antibiotics should be given)	Following the initial audit an awareness campaign was instituted in paediatrics using posters, e-mails and dissemination of results amongst junior doctors to improve the accuracy of prescribing. Further training was also provided to new doctors. The re-audit in August 2012 demonstrated a 46% reduction in the number of errors per drug chart. There were improvements in almost all areas but the documentation of micrograms was still not always written out in full. Further education of doctors rotating into paediatrics and continued awareness of accurate prescribing will continue.

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2.4 Participation in Research

Overview

The Lewisham Hospital NHS Trust is committed to providing healthcare services that is evidence-based. The Trust's research portfolio continues to expand, with an increase in the number of research studies opened and in the number of patients recruited into the study. The Trust aims to continue to focus on studies that are of good quality and are relevant to the needs of the population it serves. This has been done by working collaboratively with the Comprehensive Local Research network (CLRN).

During 2012-13 the Trust conducted 88 research studies (an increase from 75 in 2011-12). Currently on Lewisham's research portfolio of studies there are 306 patients that were recruited to participate in research studies approved by a research ethics committee, an increase to the total of 245 patients recruited in 2011-12.

The Trust also holds an annual Research and Clinical Effectiveness Day, in order to showcase the high level of research work and clinical audit being carried out. The aim of this programme is to highlight important research activities going on in the Trust and also serve as a platform to promote collaboration and partnership across the Trust. All those involved in research or clinical effectiveness are invited to produce posters on their work which are on display for all Trust staff to view. This very successful event celebrates all the work going on in the Trust and is used to share new findings and best practice.

Illustrative Model Statement

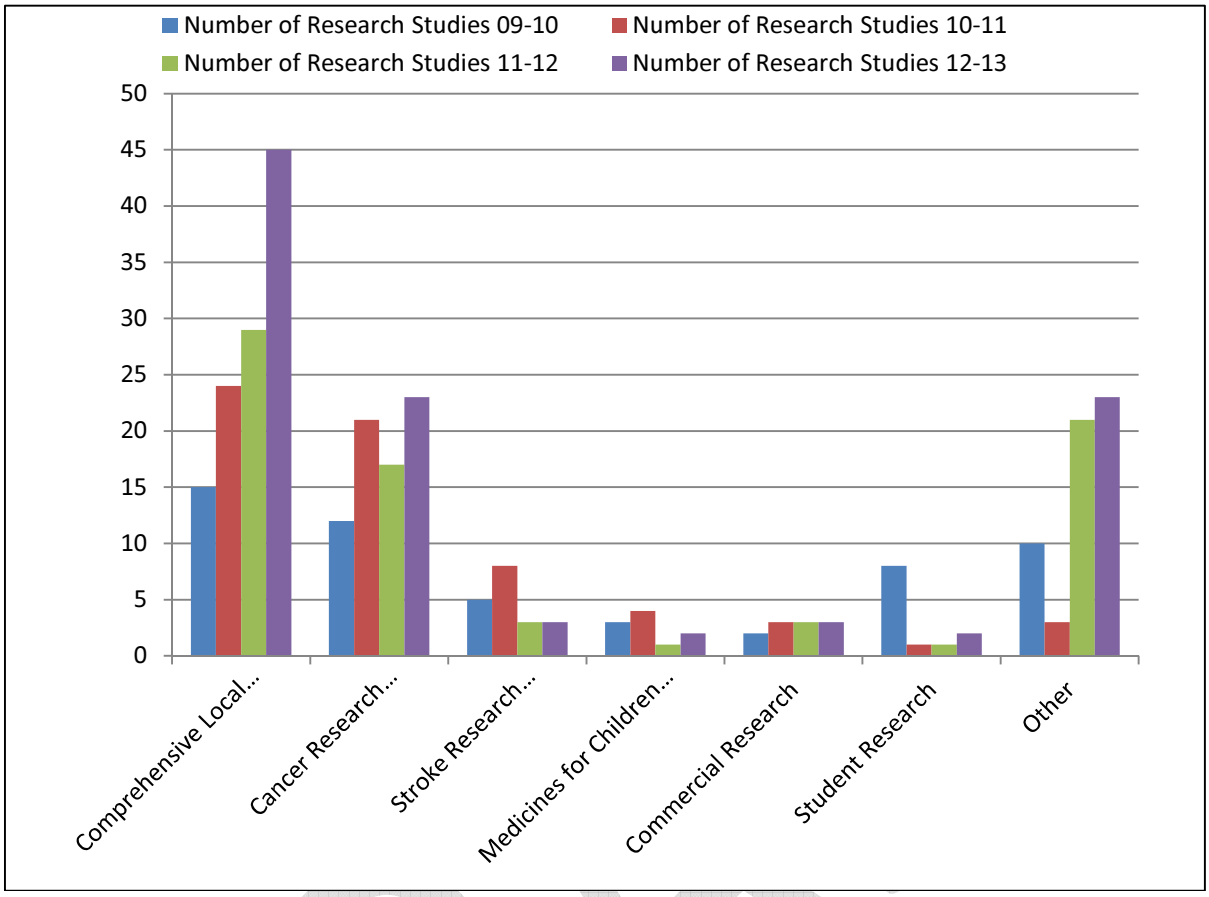
"The number of patients receiving NHS services provided or sub-contracted by Lewisham Healthcare NHS Trust in 2012-13 that were recruited during that period to participate in research approved by a research ethics committee was 306."

Participation in Clinical Research

The Lewisham Hospital 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.
The Trust works with a number of research networks including the Cancer Research Network, The Stroke Research Network and Medicines for Children Research Network. Lewisham Healthcare also works with the London South Comprehensive Local Research Network whose remit includes the Trust's research in rheumatology, paediatrics, age and aging, neurology, critical care, dermatology, respiratory medicine, and recently Hepatology, Gastroenterology, Women's Health, Cardiology, Diabetes, Epilepsy and HIV. In addition to these different types of research, the Trust has also hosts Commercial research, student research forming part of higher degrees, and the continuation of a small number of "other" research including investigator led projects.

During 2012-13 there have been 88 research projects that have been active within the Trust compared to 75 in 2011-12, 64 in 2010-11 and 55 in 2009-10. These have spanned a number of different specialties (see figure below).

Lewisham Healthcare Research Portfolio



In the last year, Lewisham Healthcare has continued to work closely with the South East London Cancer Research Network to provide access to cancer research locally. This allows patients to be offered the opportunity to participate in research nearer to their home.
In 2010-11, 75 patients were recruited to cancer research, and a further 15 patients were recruited in 2011-2012, an additional 13 patients recruited in 2012-13 making it a total of 103 patients recruited; compared to 3 during 2009-10. This resulted from an increase in research nursing support, greater resources in pharmacy and more consultants agreeing to act as research leads thus allowing an expansion of the research portfolio for cancer. Lewisham Healthcare Trust has been featured for key recruiting success to cancer trials in 2012- 2013; it is highly anticipated that this growth and success to recruiting to clinical trials will continue.

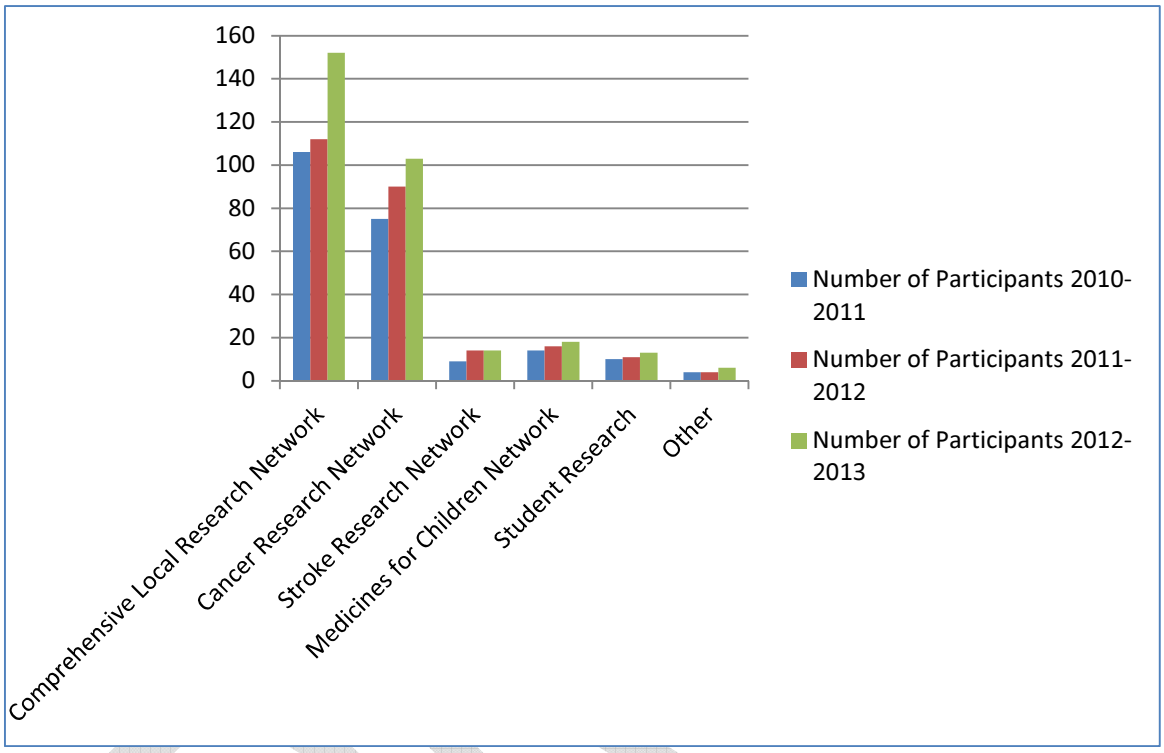
Close working relationships with other research networks including the South East Stroke Research Network and the Medicines for Children Research Network have also resulted in increased patient recruitment and clinical trials being set up in these areas.

Many of the Consultants at Lewisham Healthcare NHS Trust have become involved in Specialty Groups set up by the South London Comprehensive Local Research Network. These new research groups are a means of bringing together specialists from a particular speciality working in trusts across South London in order that research may be carried out collaboratively across a number of healthcare sites and made more accessible to patients. Lewisham Healthcare NHS Trust Consultants act as lead or joint lead for Nervous System Disorders and Musculoskeletal Specialty Groups. There is also representation from Trust Consultants on a number of other specialty groups including Dermatology, Paediatrics, Age and Aging, Respiratory Medicine and Critical Care. A Research Nurse Forum is in place to provide peer support for staff working on research within the Trust and resources have been channelled into departments to enable

continuation and expansion of the important work that is being undertaken. This highlights the dedication of Trust staff to 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.

Recruitment to research that has been approved by a NHS Research Ethics Committee has increased to 306 in 2012-13, 247participants in 2011-12 compared with 238 participants recruited in 2010-11.

Number of Participants recruited to Clinical Trials



Going forward, it is expected the continued growth of the research portfolio within the Trust will maintain momentum so that research remains an important and integral part of the services we provide at Lewisham Healthcare NHS Trust, setting the benchmark for best practice, which resulted in Lewisham Healthcare Trust Research & Development Department recognised by the NIHR for demonstrating best practice for Patient and Public Involvement in the in 2013.

2.5 Goals agreed with Commissioners (CQUINs)

A proportion of Lewisham Healthcare NHS Trust income in 2012-2013 was conditional on achieving quality improvement and innovation goals agreed between Lewisham Healthcare NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

The CQUIN framework was introduced in April 2009 as a national framework for locally agreed quality improvement schemes. It enables commissioners to reward excellence by linking an amount of English healthcare providers' income to the achievement of local quality improvement goals. The framework aims to create a culture of continuous quality improvement, with stretching goals agreed in contracts on an annual basis.

Further details of the agreed goals for 2012-13 and for the following 12 month period are available electronically at [provide a weblink]

The Trust achieved xxx% of its 13 CQUIN goals for April 2012 – March 2013.

The full programme of CQUINs for 2012-13 and the outcomes achieved are listed in **Table 1** below. All of the CQUIN indicators were designed to drive forward quality improvement for patients across a range of Trust services. As last year, the topics were set to reflect national and local priorities. The Trust participated in the 4 National CQUINs which were mandatory for all Trusts to complete. There were also 6 locally agreed CQUINs and 3 specialist CQUINs. A few examples of are outlined below.

In line with the national VTE (Venous Thromboembolism prevention programme, the Trust maintained the systems established under the 2011-12 national VTE CQUIN, for conducting risk assessments for all adult inpatients followed by appropriate prophylaxis as necessary. During 2012-13, the Trust has continued to meet the high standards set by the Department of Health and has ensured that at least 90% of adult inpatients are assessed for VTE.

One of the Trust's local CQUIN priorities was to increase the recording of patients' smoking status to ensure that if a patient was a smoker, they were offered brief advice on the benefits of quitting and informed of the support available to assist with quitting. Where a patient wished to quit, they were then referred to the Trust's Stop Smoking Service. A new online training package was launched for staff to learn more about how to offer brief advice to patients, and an electronic referral system was also established. This comprehensive approach to supporting patients in stopping smoking has led to a significant increase in stop smoking referrals and quits. The data shown in the table 2 below highlights the increase in figures in 2012-13 in comparison with 2011-12.

Table 2 – Smoking Cessation performance April 2011 – March 2013

	April 2011 – March 2012	**April 2012 – March 2013**
Number of referrals to Stop Smoking Service	157	651
Number of Quits	18	108

Please note that these figures do not include referrals and quits from maternity services. The maternity service automatically refers all women who smoke to the Stop Smoking Service.

Lewisham Healthcare NHS Trust is an integrated Trust that covers both acute and community services. Therefore two of the local 2012-13 CQUINs were community-based. These were in

relation to improving the care and coordination of services provided to patients reaching the end of their life and improving paediatric appointment scheduling. Each CQUIN had a number of milestones which needed to be achieved by the Trust. For instance, the CQUIN around End of Life Care included providing appropriate training to community nurses so that where appropriate, they can verify a patient's death, rather than the patient's family having to wait for a doctor to complete this process.

There were three Specialist CQUINs which related to quality improvement in the Trust's HIV service, the Neonatal Intensive Care Unit and in the processes for collecting quality data relating to five clinical specialties (Haemophilia, Neonatal Intensive Care Unit, HIV, Cystic Fibrosis, and Intravenous Immunoglobulin (IVIG)). This data is being collected nationally and will be used to benchmark and compare Trust's across England and to set quality targets for 2013-14.

The Lewisham Healthcare NHS Trust has performed well against its 2012-13 CQUIN goals and its ongoing commitment to using the CQUIN programme to improve quality and introduce innovation will be reflected in the 2013-14 CQUIN scheme (see Table 3 for the proposed 2013-14 CQUINs).

Table 3: Lewisham Healthcare NHS Trust 2012-13 CQUIN scheme and the percentage achieved against the payment available

No.	Name of Goal	Description of Goal	Payment Available[8]	% Achieved
National CQUINs				
1	Venous Thromboembolism (VTE)	% Adult inpatients to be VTE Risk Assessed on admission using the national tool.	£154,549	100%
		% Adult inpatients assessed as at risk of VTE to receive appropriate prophylaxis.	£154,549	100%
2	In-patient Experience	Focus on improving outcomes of 5 questions from annual national patient survey. Questions were based around "responsiveness to personal needs of patients".	£154,549	20%
		Focus on improving outcomes of 5 questions from monthly local patient survey. Questions were based around "responsiveness to personal needs of patients".	£154,549	100%
3	NHS Safety Thermometer - Data collection & reporting	Improve the collection of data in relation to pressure ulcers, falls, urinary tract infections in those with a catheter and VTE	£471,538	100%
4	Dementia	Improving awareness and diagnosis of dementia using risk assessment in an acute care setting. Achievement based on targets for screening, risk assessments and referrals.	£369,432	100%
Local CQUINs				
5	Cancer staging	Increasing the recording and reporting of cancer staging	£334,163	100%
6	COPD Discharge Bundle	Implementation of the COPD discharge care bundle	£417,704	100%
7	End of Life Care (EOLC)[9]	Improving care and coordination of services to EOLC patients in acute and community services in	£464,115	100%

[8] These are estimated figures based on the expected value of the 2012/13 Trust contracts.
[9] Community based CQUIN

No.	Name of Goal	Description of Goal	Payment Available[8]	% Achieved
		relation to: - Identification and registration - Communication - Implementation of the Liverpool Care Pathway - Verification of Deaths		
8	Stop Smoking	Increasing - Recording of smoking status - Training and delivery of brief interventions - Number of referrals and quits	£417,704	100%
9	Maternity - CNST Level 2	Action plan to achieve CNST Level 2	£1,400,700	100%
10	Paediatric appointment scheduling9	Improving paediatric appointment scheduling	£177, 292	50%
Specialist CQUINs				
11	HIV	To better meet the primary health care needs of HIV patients in relation to: - Patients registered and disclosed to GP - Communication with GPs about the care of HIV patients - Increase in % of HIV patients receiving drugs via home delivery - Assess implementation and impact of the HIV QIPP plan	£69,276	TBC
12	Neonatal Intensive Care	Neonatal Provision of care in relation to: - Reduction in Length of Stay - Reduction in the number of avoidable admissions	£34,638	100%
13	Specialist Quality Dashboards	Implementation of Specialist Clinical Dashboards for Haemophilia, Neonatal Intensive Care Unit, HIV, Cystic Fibrosis, Intravenous Immunoglobulin (IVIG)	£14,845	100%
Total for CQUIN Scheme			**£4,78,603**	

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Table 4: Lewisham Healthcare NHS Trust proposed CQUINs for 2013-14

Proposed CQUINs for 2013-14 (subject to changes)	
Name of Goal	**Description of Goal**
Pre-Qualification Criteria	
3 million lives	Set a trajectory for increasing planned use of telehealth / telecare technologies
Intra-operative fluid management (IOFM)	Demonstrate that trajectories are in place which are consistent with National Technology Assessment Centre (NTAC) guidance
International & Commercial Activity	Demonstrate that clear plans are in place to exploit the value of commercial intellectual property – either standalone or in collaboration with Academic Health Science Network

Proposed CQUINs for 2013-14 (subject to changes)	
Name of Goal	**Description of Goal**
Digital First	Establish a trajectory for improvement to reduce inappropriate face-to-face contact
Carers for people with Dementia	Demonstrate that plans have been put in place to ensure that carers are signposted to relevant advice and receive relevant information to help and support them
National CQUINs	
VTE	• Ensuring Risk Assessments are completed for all relevant adult inpatients • Conducting Root Cause Analysis on confirmed cases of pulmonary embolism or deep vein thrombosis
Friends & Family	A survey of patients to ask whether they would recommend our services to friends and family.
NHS Safety Thermometer	Conduct a monthly snapshot audit to collect data in relation to pressure ulcers, falls, urinary tract infections in those with a catheter and VTE. This will be both in hospital and across a number of the community nursing services.
Dementia	• Case Finding i.e. improve the number of patients being identified as potentially having dementia • Clinical Leadership – ensuring sufficient clinical leadership and appropriate training of staff in dementia • Supporting Carers – ensuring carers of people with dementia feel adequately supported.
Local CQUINs	
Maternity	• 1:1 care for women in established labour • Supernumerary Shift Co-ordinator • Newborn Screening
Stop Smoking Service	Roll out Nicotine Replacement Therapy to all hospital wards
Alcohol	Assessment, Brief Interventional Advice and referral to Alcohol Liaison Services
Children & Young People's Services	Community Paediatric Services Outcome Measures Community Diagnostic population registry
Cancer	To be confirmed but likely to be around cancer staging
Specialist CQUINs	
HIV	• Increase the proportion of patients who have disclosed to their GP • Ensure at least annual communication with GPs about the care of HIV patients where the patient has agreed to disclose to their GP • Increase number of patients receiving medication via home delivery • Substitute / switch from branded ARVs to generics
Neonatal Intensive Care	• Improved access to breast milk in preterm infants • Timely administration of total parenteral nutrition (TPN) in preterm infants
Quality Dashboards	Collect quality data relating to five clinical specialties (Haemophilia, Neonatal Intensive Care Unit, HIV, Cystic Fibrosis, and Intravenous Immunoglobulin (IVIG)).

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2.6 What others say about the provider

Care Quality Commission (CQC) registration status

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

Lewisham Healthcare NHS Trust is subject to periodic reviews by the Care Quality Commission (CQC) and the last review was on the 8th and 11th February 2013 at Lewisham Healthcare NHS Trust.

The CQC visited the Trust on the 8th and 11th February 2013 for the purpose of an unannounced inspection. The report was published on 9th April 2013 and the CQC judgement concluded that the Trust had failed to meet two of the essential standards.

The CQC judged the Trust to have failed on two standards and considered there to be 'minor impact' on the people who use the services.

The standards which were not considered to have been met were:

- Standards of treating people with respect and involving them in their care.
- Standards of providing care, treatment and support that meets people's needs.

The Trust has developed a comprehensive action plan which has been submitted to the CQC. The progress of the implementation of the action plan will be monitored through the Trust's Clinical Quality Committee.

The full report can be viewed via the following link:

http://www.cqc.org.uk/sites/default/files/media/reports/RJ2_Lewisham_Healthcare_NHS_Trust_RJ224_University_Hospital_Lewisham_20130409.pdf

The Care Quality Commission has not taken enforcement action against Lewisham Healthcare NHS Trust during 2012/13.

Monitoring performance

Lewisham Healthcare NHS Trust has an established process for the continual review of compliance against each of the relevant CQC Outcomes for the essential standards of quality and safety.

Each outcome has an Executive and Operational Lead to ensure the continual update of evidence to demonstrate compliance is ongoing. The Clinical Effectiveness department is responsible for working with both the Executive and Operational Leads and collating all the evidence for each outcomes by means of a completing a Provider Compliance Assessment (PCA)

The PCA focuses on outcomes for the 16 key essential standards most directly related to the quality and safety of care. These are set out in part 4 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Provider Compliance Assessment is completed for each outcome and is composed of a series of prompts from which the organisation can use to collect evidence to demonstrate compliance.

The PCA's are reviewed formally with the Executive and Operational leads every six months and any existing evidence is updated with additional evidence gathered where possible.

Following the completion/updating of the PCA, a RAG rating on current compliance is given to the outcome by the Executive and Operational Leads.

Care Quality Commission Quality Risk Profile

As part of the Care Quality Commission's monitoring of the Trust against the essential standards of quality and safety, they conduct monthly reviews on a wide range of information held centrally about each registered provider.
To undertake this review, the CQC uses the Quality Risk Profile (QRP) which is a tool used by them to gather data/information about an organisation, to compare this information against national benchmarks.
The data gathered serves many useful purposes in that it helps the CQC to monitor the compliance of the organisation against National Standards for Quality and Safety and alert the CQC to areas of high risk, which they may then choose to review by way of inspection.

The Quality Risk Profile (QRP) enables CQC to assess where risks lie and prompt front line regulatory activity, such as an inspection. It supports the Trust to make robust judgments about the quality of services. It is used alongside the CQC's guidance about compliance, including the judgment framework, and additional information known to inspectors.

In order to ensure that the Trust maintains its compliance with National Standards; and to ensure that it responds in a timely manner to any risk highlighted by the CQC and that it is proactively managing them, the QRP is reviewed monthly by the Clinical Effectiveness department and also the service clinical area leads. The source data used by CQC is reviewed and action plans are developed by the service area and monitored on a regular basis through the Directorate Governance and Risk meetings.

All published risk profile areas have designated leads and all areas identified have associated work streams, work programmes and action plans. The monthly QRP, new risk rated profile indicators and associated service area action plans and progress are reported monthly to the Trust Integrated Governance Committee, which is a sub-committee of the Trust Board.

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2.7 Periodic Reviews by CQC

Review of Compliance – March 2013

The Care Quality Commission did an unannounced inspection to the Trust on the 8th and 11th February 2013.. They observed how patients were being cared for; they talked to people who use our services, they talked to staff and checked the Trust records and looked at records of people who use the services.

The Care Quality Commission reviewed the following Outcomes:

- Outcome 1: Respecting and involving people who use services.
- Outcome 4: Care and Welfare of people who use services
- Outcome 6: Cooperating with other providers
- Outcome 13: Staffing
- Outcome 16: Complaints

The report was published on 9th April 2013 and the CQC judgement concluded that the Trust had failed to meet two of the essential standards.

The CQC judged the Trust to have failed on two standards and considered there to be 'minor impact' on the people who use the services.

The standards which were not considered to have been met were:

1. Standards of treating people with respect and involving them in their care.
2. Standards of providing care, treatment and support that meets people's needs.

The Trust has developed a comprehensive action plan which has been submitted to the CQC. The progress of the implementation of the action plan will be monitored through the Trust's Clinical Quality Committee.

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2.8 Special Reviews by CQC

Lewisham Healthcare NHS Trust has participated one special review conducted by the Care Quality Commission in relation to the following area during 2012/13.

Termination of Pregnancy services, June 2012

The Care Quality Commission carried out a review as part of a targeted inspection programme to all provider services that provide the regulated activity of termination of pregnancy. The CQC found that fourteen NHS abortion clinics had broken the rules by allowing doctors to pre-sign forms authorising a termination. They also found irregularities at some clinics.

Lewisham Healthcare NHS Trust was found to be compliant.

The focus of the visit was to assess the use of the forms that are used to certify the grounds under which a termination of pregnancy may lawfully take place. The government asked for over 300 private and NHS clinics to be inspected over concerns doctors were signing forms before a woman had been seen.

The inspectors looked at a random sample of medical records for eight people who had undergone a termination of pregnancy at the Trust. The records dated from January – March 2012. In each case, they looked at the completed certificate and the other records for that person.

The records showed that the doctors completed certified, and dated the relevant form following their individual assessment of each person.

They found that for each of the records, doctors' certifications were being accurately and appropriately maintained.

The Care Quality Commission did not elicit feedback from people who used the service as part of this review.

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External Agency Reviews of Assessments, Inspections and Accreditations within the Trust during April 2012 – March 2013

Introduction

Every NHS Trust is subject to review and scrutiny by several External Agencies in the form of planned or ad hoc visits, inspections and accreditations. External reviews may encompass the whole organisation, the management or a particular service area.

There are a number of external agencies that may undertake reviews. Increasingly these agencies share and cross-refer information about the organisation as a way of assessing performance, carrying out local and national benchmarking, and also developing a quality risk profile on the organisation. The external reviews are also part of the Trust's internal control mechanism in that they provide assurance to the Board who use external reviews as a measurement of how the Trust is performing.

It is therefore essential to ensure that consistently accurate and reliable information is submitted as part of these reviews, and that the burden of collating evidence for the Trust is minimised. This will be achieved through the clear lines of accountability and responsibility allocated in relation to each of the external agency reviews.

Lewisham Healthcare NHS Trust

Lewisham Healthcare NHS Trust has had the following external assessors', accreditations and inspections during the period from April 2012 - March 2013. The recommendations for each of these assessments have been positive and constructive for the Trust. Where a recommendation is made an action plan is completed by the relevant service or directorate team. All action plans are then presented at the relevant governance and risk meeting within the Directorates and or at the relevant subcommittee to the Integrated Governance Committee. The Integrated Governance Committee reports directly to the Trust Board.

The table below lists all the external assessments that were carried out across the organisation with recommendations and action plans with progress to date.

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Table 1: Schedule of External Agency Reviews up to 31st March 2013

Title of External Review (visit / accreditation / inspection / assessment / standard, etc)	Date of review	Report received	Current Level of compliance	Recommendations	Progress to Date
South East London Cancer Peer Review The National Cancer Peer Review Programme (NCPRP) – assessment against nationally agreed "quality measures".	April 2012	Yes	Compliance is by individual tumour sites.	No recommendations.	Not Applicable
Medicines Healthcare and Regulatory Agency (MHRA) – Blood Transfusion	April 2012	Yes	Compliant	No recommendations.	Not Applicable
South East London Bowel Cancer Screening Centre Quality Assurance (QA) Visit	April 2012	Yes	Good	85 recommendations with key issues, being addressed across both sites Kings College Hospital and Lewisham Healthcare NHS Trust	This work is being developed across both organisations with a full action plan. This is being monitored by the Trust Clinical Quality Committee.
NHS Information Centre for Health and Social Care - Patient Environment Action Teams (PEAT) inspection	May 2012	Yes	Good	No recommendations	Not Applicable
Clinical Pathology Accreditation (UK) Limited – Main Visit Assessment (Clinical Biochemistry, Histology, Microbiology, Cytology)	May 2012	Yes	Compliant	No recommendations	Not Applicable.
Care Quality Commission - Termination of Pregnancy (Women and Sexual Health, Maternity Services)	June 2012	Yes	Good	No recommendations	Not Applicable.
National Industrial Fuel Efficiency Service (NIFES) Consulting Group.	June 2012	Yes	Good	The procedures for evacuation of buildings, training attendance to be recorded for all sites in the Centre Fire Log.	An action plan is in place to support the recommendations and is being monitored by the Trust Patient Safety Committee.

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Title of External Review (visit / accreditation / inspection / assessment / standard, etc)	Date of review	Report received	Current Level of compliance	Recommendations	Progress to Date
NHS London – London local Supervising Authority Annual Audit Report, Monitoring the Standards of Supervision & midwifery Practice.	July 2012	Yes	Good	Supervisor of Midwives to review caseloads, strengthen the interface of the team whilst raising the profile.	A full action plan has been developed and progress against the action plan is monitored by the Directorate Governance and Risk Meeting and the Trust Clinical Quality Committee.
NHS London Health Programmes. NHS South East London PCT Cluster Report. Quality and Safety programme: Audit of Acute hospitals. Services. (Adult and paediatric and Maternity services)	July - September 2012	Yes	Good	The London quality standards are based on existing national standards to deliver consistently safe and high quality services.	This work has been developing across Directorates and is monitored through the Directorate Governance and Risk meetings.
West Midlands Quality Review Service – Health Services caring for adults with haemoglobin disorders	September 2012	Yes	Accreditation	There are a number of recommendations for the Team.	An action plan is in place and ongoing across the Directorate and is monitored through the Directorate and Risk, Patient Safety Committee meetings.
NHS East & South East England Specialist Pharmacy Services	November 2012	Yes	Compliant	One moderate and One minor deficiencies that require action within 6-12 months.	This work has been developing within the Directorate and is monitored through the Drugs and Therapeutics Committee meeting.
NHS Cancer Screening Programme – London Quality Assurance Reference Centre - Peer Review – Hospital Based Programme Coordination, Cervical Cytopathology, Histopathology and Colposcopy	November 2012	Yes	Good	9 red recommendations and 13 yellow recommendations are highlighted in the report.	A full action plan and working party is in place. The recommendations are being monitored through the Directorate and Risk meetings and the Trust

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Title of External Review (visit / accreditation / inspection / assessment / standard, etc)	Date of review	Report received	Current Level of compliance	Recommendations	Progress to Date
					Clinical Quality Committee.
NHS South London Cardiac and Stroke Network – LCVP Arrhythmia Services	December 2012	Yes	Good	No recommendations	Not Applicable
NHS South London Cardiovascular and Stroke Network – Stroke Unit Assessment	December 2012	Yes	Good	No recommendations	Not Applicable
Care Quality Commission – Review of Compliance	February 2013	Awaiting		Delay in report being published from Care Quality Commission	
KPMG – Information Governance. Internal Audit 2012 -13	March 2013	Yes	Requires Improvement	Two low priority recommendations and one medium priority to improve the efficiency and/or effectiveness of the evidence in place to support the Trust self assessment.	The Information Governance Manager is working to achieve this recommendation and is monitored by the Trust Integrated Governance Committee who reports to the Trust Board.

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2.9 Data Quality

Overview

Data Quality

Good information is fundamental to the successful delivery of healthcare services. It is essential for both clinical and management decisions. The Secondary Uses Services (SUS) is delivered nationally by the NHS Information Centre. It is a service which collates and stores electronic healthcare data. It is designed to provide anonymous patient-based data that enables a range of reporting and analyses to support the NHS in the delivery of healthcare services. For example, it allows monitoring of equity of access and provision.

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

The Trust measures many different aspects of Data Quality – from the presence of a GP and NHS Number recorded within a patient record, to the detail and depth within the clinical coding associated with an admission.

In a number of areas, the Trust compares data quality against those of peer Trusts. Below is a table and a chart showing Trust against Peer for some data quality areas as reported in the CHKS application that is used by the Trust to benchmark against other Trust. (Acute activity and data only).

Data Quality Report against Peers – updated to December 2012 **(2011/12 refreshed)**

CHKS Data Quality Report (Signpost tool)

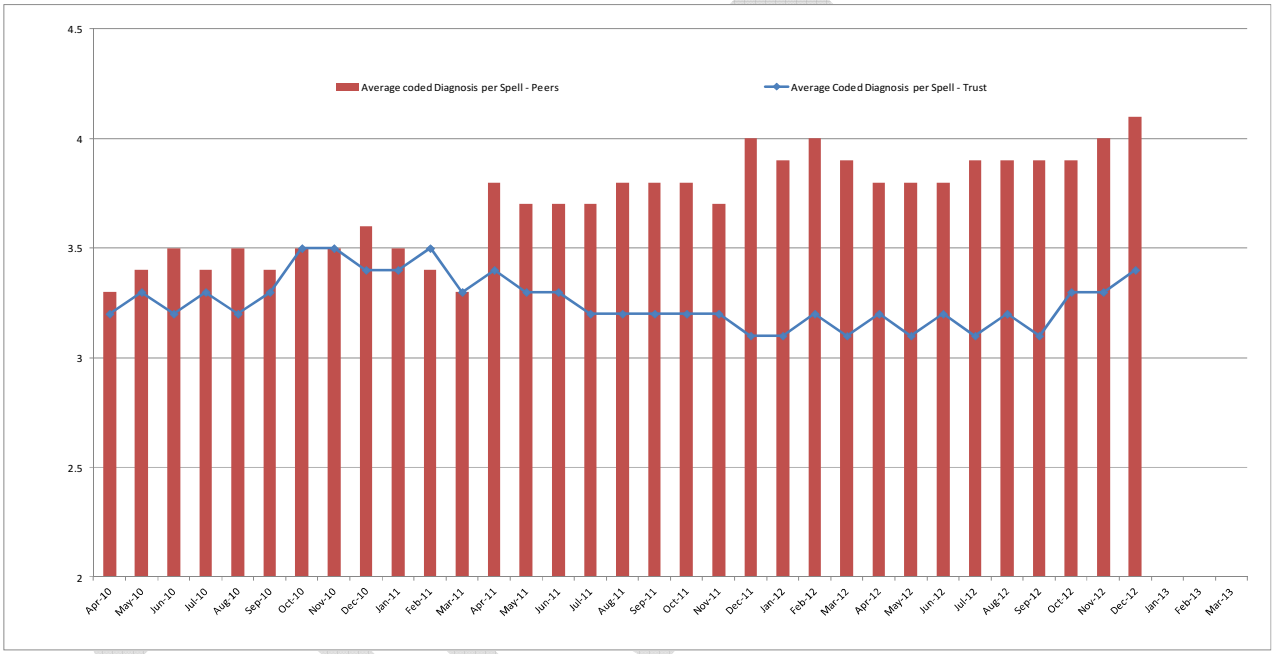
Month	Unacceptable primary diagnosis		Diagnosis non-specific		Sign and symptom as a primary diagnosis		Average Diagnosis per coded episode		Trust DQ Score		Trust DQ Score (HRG V4)	
	Trust	Peer	Trust	Peer	Trust	Peer	Trust	Peer	Trust	Peer	Trust	Peer
2012/13-YTD M9	**0.01%**	**0.07%**	**15.51%**	**18.25%**	**8.52%**	**10.4%**	**3.2**	**3.9**	**95.5**	**95.4**	**96.4**	**95.1**
2011/12	**0.15%**	**0.15%**	**13.33%**	**15.37%**	**9.00%**	**10.72%**	**3.2**	**3.8**	**96.5**	**95.6**	**96.5**	**94.6**
2010/11	0.11%	0.15%	13.19%	15.46%	8.22%	10.45%	3.4	3.6	94.1	92.9	94.1	92.4
2010	0.16%	0.17%	13.74%	15.59%	8.22%	10.09%	3.3	3.4	93.8	92.8	93.8	92.6

Data quality is taken very seriously by the Trust as it can impact on the quality of patient care provided to patients. During 2012/13 we developed further the Data Quality information available for review. The Trust's Data Quality scorecard shows performance against key targets, is used to identify areas for improvement and is discussed in various forums, (including the Integrated Governance Committee). The scorecard, which contains over 90 measures, is updated on a monthly basis, and key Data Quality metrics are included on the Trust Board scorecard.

A review of the Trust's depth of clinical coding (i.e. a reflection of the complexity of their conditions) for admitted patients showed that the Trusts depth was below that of Peer Trusts; a subsequent external review found that the Trust was NOT 'missing' a significant amount of co-morbidities, based on the % of patients that are grouped to a "with complications" HRG as compared to Peers. Whilst the difference in depth of coding is stark in the chart below, the external review and the recent Audit Commission led Coding Audit have not led the Trust to conclude that co-morbidities are being routinely omitted from the coding record.

The depth of coding feeds into the Hospital Standardised Mortality Ratio calculations via the Charlson co-morbidity index [CCI].The Charlson co-morbidity index (CCI) predicts the risk of death over a one-year period for a patient who may have co-morbid conditions, such as heart disease, AIDS or cancer (covering a total of 22 conditions). Each condition is assigned a score of one, two, three or six, depending on the associated risk of dying. The scores are then added together and given a total score which predicts mortality.

Average Number of Diagnosis per coded episode



This chart shows the depth of coding, in terms of Diagnoses recorded against a single episode of care.

As part of our continual review of data quality and our ongoing work with improving the quality of data, the Trust selects key performance indicators which are reviewed by external auditors. In addition to this, the Trusts data Quality Team carries out audits of patient data and data collection procedure, looking at the way staff are collecting data – whether they check the patients address and GP details at each visit for example, as well as ensuring that the data reflects what happened – that a patient attended the specific clinic appointment or not for example. The internal audits are received by the Data Quality Group and action plans developed to help drive improvement.

NHS Number and General Medical practice Code Validity

The Trust submits data to the Secondary Uses Service (SUS) to support the commissioning and billing process and is also included in the Hospital Episode Statistics. The Trust monitors the data quality of the SUS data, and the percentage of records in the published data:

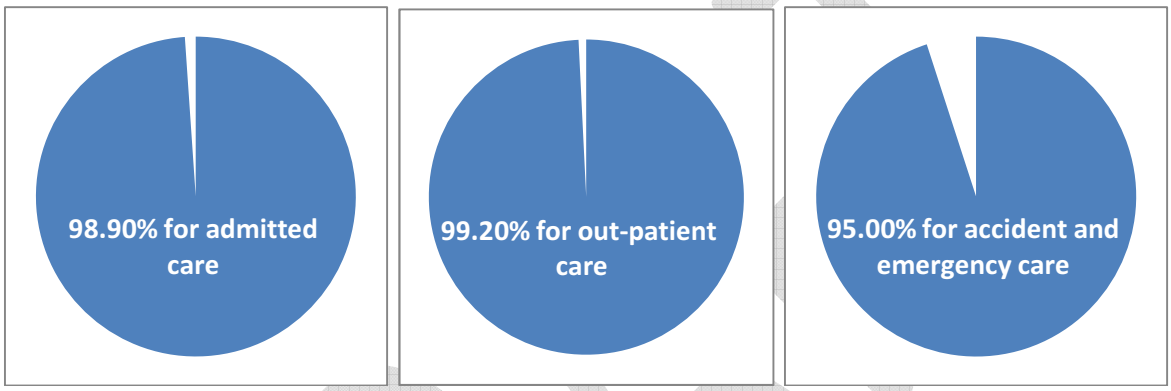
a) which included the patient's valid NHS number was:

98.90% for admitted care;

99.20% for out-patient care; and

95.00% for accident and emergency care.

Valid NHS number in records

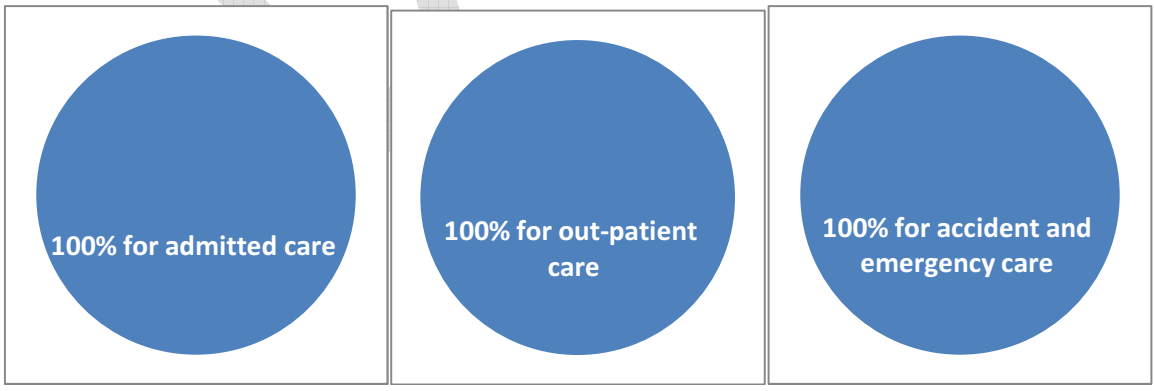


a) Which included the patient's valid General Medical Practice Code was:

100% for admitted patient care;

100% for out-patient care; and

100% for accident and emergency care.



2.10 Information Governance Toolkit

Overview

Information Quality and Records Management

Information Governance (IG) is the way by which the NHS handles all organisational information – in particular the personal and sensitive information of patients and employees. It allows organisations and individuals to ensure that personal information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care.

The Information Governance Toolkit published by the Department of Health provides the standards against which healthcare services are required to measure their Information Governance performance. This year (March 2013) the Trust achieved an overall score of 80%.

"Lewisham Healthcare NHS Trust's Information Governance Assessment Report overall score for 2012-13 was 80%."

The main Information Governance objectives in the 2012 – 13 were:

- To reinforce the importance of confidentiality, data protection and information security by enhancing the tailored mandatory Information Governance training programme.
- To strengthen the Clinical Information Assurance and Secondary Use Assurance areas of the Information Governance Toolkit
- To further strengthen the Trust's Information Risk Programme, Asset and System Management which supports the long term resources required to lead on the Information Governance agenda.
- To support the Trust in implementing new information systems by ensuring their compliance to Information Governance standards, governmental guidelines and industry best practice.
- Ensuring that all our staff received Information Governance training.
- Ensuring that lessons learnt from incidents/serious incidents are clearly communicated and incorporated into daily work.

Information Governance Toolkit

The Information Governance Toolkit submission for the Trust for 2012/13 was scored at 80% compliance, showing an improvement of 6%. The table below shows the comparison against the version 9 (2011-12) submission:

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Table 1 – Comparison of Information Governance Toolkit submission 2012 – 2013

Initiative	V9 March 2012	V10 March 2013
Information Governance Management	86%	66%
Confidentiality and Data Protection Assurance	74%	81%
Information Security Assurance	68%	80%
Clinical Information Assurance	80%	93%
Secondary Use Assurance	70%	83%
Corporate Information Assurance	77%	77%
Overall total	74%	80%

A result of 80% shows a steady improvement especially around the Information Security, Clinical Information and Secondary Use Assurance areas. Work completed during the year ensured that personal data is handled in accordance with best practice providing efficient and safe care to patients within the hospital as well as the community setting.

A better awareness and compliance with the Information Governance (IG) principles was achieved through the delivery of a bespoke Information Governance Training Programme which is tailored to the needs of different staff groups across clinical and administrative areas.

Key aspects of the toolkit covering the Statement of Compliance for the secure N3 connection were audited by the internal auditor, KPMG, prior to the final submission on 31st March 2013. This audit concluded that the overall design and operation of key information governance controls are appropriate and the recommendations made were only required to improve on best possible practice.

Alterations to the provision of care within Southeast London will affect the Trust and require changes to its Information Governance arrangements.

We achieved a lower score in Information Governance Management this year because we decided to postpone the IG review of our existing contracts. This was done light of the upcoming merger with the Queen Elizabeth Hospital in Greenwich.

The IG review of all our contracts will be a priority of the work undertaken as part of the integration. The Trust will be compliant with all Information Governance standards thereafter.

2.11 Clinical Coding

Overview

Payment By Results

Payment by Results (PbR) is the method by which Lewisham Healthcare receives payment for patients seen and treated within the Acute setting. Each patient's condition, what treatment they received, how they were treated and how long they were in hospital for is used to allocate each patient to a nationally agreed category. The categories, which are called Healthcare Resource Groups (HRGs), have a national tariff which is used to determine the amount that the Trust is reimbursed for patient care. The HRGs are based on the Clinical Coding recorded against each episode of care, it is important that the coding is accurate so that the Trust is not over or under paid. In addition to this, the coded data forms part of the patients clinical record and is used to help identify where improvements in service can be made. The data is also submitted nationally to the Secondary Use Service (SUS) , who collect national data to allow them to look at trends and patterns across the NHS as a whole

The Trust had its Admitted Patient Care Clinical Coding audited as part of a national audit programme in 2012/13. The audit was based on 200 Finished Consultant Episodes from quarter 1 2012/13.

This audit looked at areas selected by Commissioners (South London Commissioning Support Unit) and as such the areas cannot be directly compared to those from previous years or to those seen in the wider NHS as the areas are not the same and hence it would not be a fair comparison.

The areas chosen for audit– General Medicine short stay emergency spells and Obstetrics, non-delivery, produced different results and have generated different action points for the Trust.
The table below shows the audit outcomes, showing errors identified and the £ net value of errors to Commissioners.

	General Medicine – Short Stay Eme		Obstetrics Non Delivery	
	Volume	%	Volume	%
Spells tested	100		100	
Spells where £ changed	6	6%	11	11%
Net change (Provider over / under charge)	£762	0.9%	-£178	-0.4%
Spells where HRG changed	6	6%	11	11%
Primary diagnosis incorrect	8	8%	12	12%
Secondary diagnosis incorrect	27	11.1%	10	29.4%
Primary procedures incorrect	3	12%	2	200%
Secondary procedures incorrect	3	12%	0	0%
Errors = coder error – all spells	18	38.%	2	8.3%
Errors = coder error – spell changing £	5	41.7%	1	6.7%
Errors = co morbidities	14	29.8%	2	8.3%
Errors – co-morbidities, spell changing £	3	25%	0	0%
Errors = Other	1	2.1%	1	4.2%
Errors = Other, spell changing £	1	8.3%	1	6.7%
Errors = Source Documentation	14	29.8%	19	79.2%
Errors = Source doc, spell changing £	3	25%	13	86.7%

As the table shows, there was a higher level of errors within the Obstetrics Non Delivery FCEs than in the General Medicine FCEs.
In the case of Obstetrics non delivery, the main error cause was documentation error – where the clinical information the different in source documentation used for coding purposes (EDS, Ante Natal pro-forma and the case notes) contradicts.

The action plan developed by the Trust highlights on-going work with Midwifery staff, working with them to improve the data accuracy and quality, explaining to them the way what is written down is used by the clinical coders to reflect the patient care provided to patients.

In addition to this the audit identified an issue with the Admission Method recorded against a significant number of FCEs. The Trust had already identified this issue but had been asked by Commissioners not to amend the records until the annual refresh of data when the Trust is able to resubmit the whole year 2012/13 data to the Secondary Users Service (SUS) without impacting on the PbR payment process.

There were a smaller number of errors with the General Medicine Short Stay audit, with 4 of the 6 errors being due to the coders not coding correctly the information within the source coding documentation. The main action point in this area is the need to work with the coding staff on how they should extract information from the source documentation to ensure that coding errors are minimised.

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Part 3

3.0 REVIEW OF QUALITY PERFORMANCE in 2012/13

3.1.1 Patient Safety

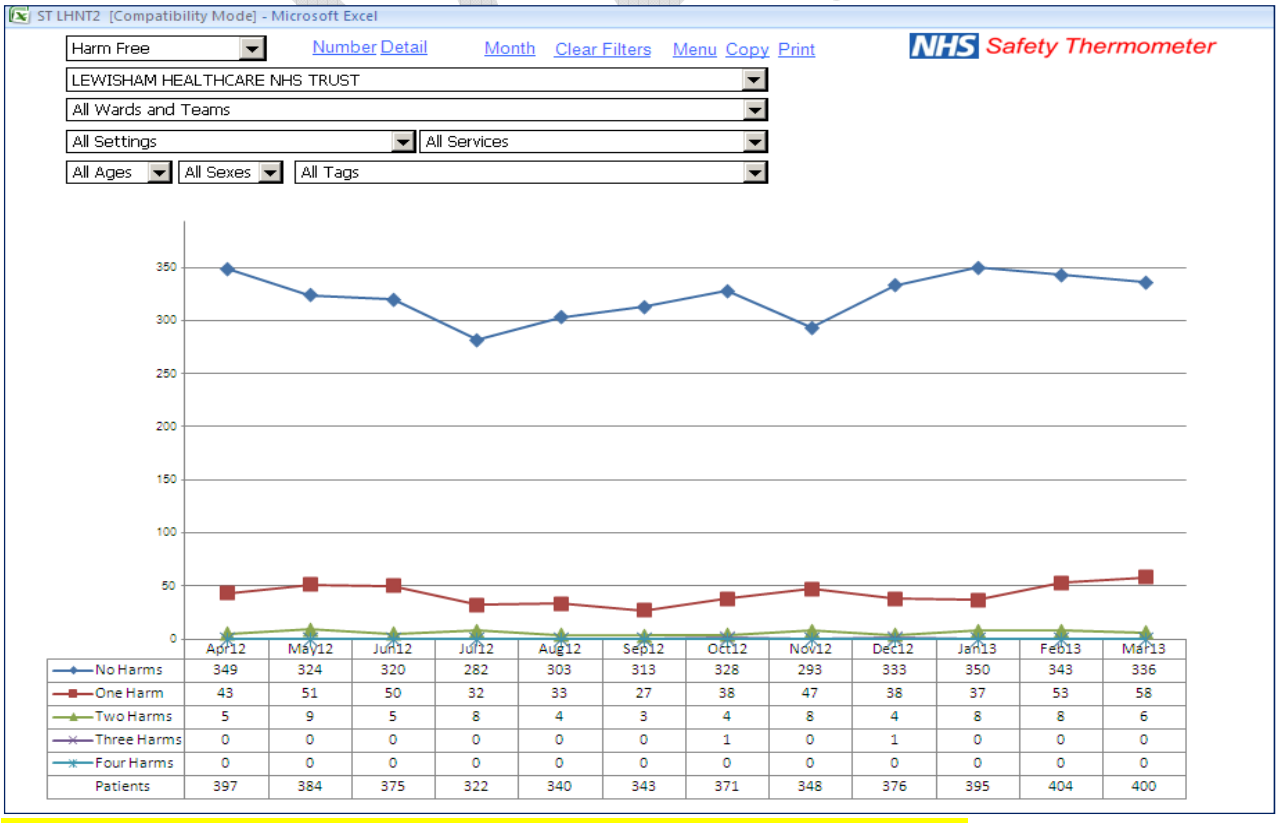
1.1.1. (i) Priority 1 – Implementation of the NSH Safety Thermometer to monitor and measure 'harm free care'

The NHS Thermometer was developed and piloted in 2011/12 by NHS front line teams as part of the Department of Health [DoH] Energising for Excellence and QIPP Safer Care programme (Safety Express). In 2012 the tool was rolled out across NHS England.

The NHS Thermometer measures four high volume patient safety issues. At Lewisham Healthcare NHS Trust we have also introduced additional indicators and flags into the national tool to identify those patients who are considered vulnerable and those patients with high levels of acuity and dependency and those identified as being on the End of Life Care [EoLC] pathway.

The NHS Thermometer also forms part of the Nursing and Midwifery Quality Metrics work programme as well as forming part of the Patient Safety Programme.

During 2012 the Trust successfully rolled out the use of the Thermometer across 100% of all ward areas, including the Emergency and Maternity departments.
Each month the data is collected by the ward teams and presented at the Senior Nurses and Midwives meeting with a review of the harm free care and results of the audit.



	Apr12	May12	Jun12	Jul12	Aug12	Sep12	Oct12	Nov12	Dec12	Jan13	Feb13	Mar13
No Harms	349	324	320	282	303	313	328	293	333	350	343	336
One Harm	43	51	50	32	33	27	38	47	38	37	53	58
Two Harms	5	9	5	8	4	3	4	8	4	8	8	6
Three Harms	0	0	0	0	0	0	1	0	1	0	0	0
Four Harms	0	0	0	0	0	0	0	0	0	0	0	0
Patients	397	384	375	322	340	343	371	348	376	395	404	400

Add in NHS Safety Thermometer Outcomes Table and report analysis

3.1.1. (ii) Priority 2 - Evidence of reduction in severe harm or death caused or contributed to by safety incidents

Work has continued throughout 2012/13 to reduce the extent of severe harm or death resulting from incidents occurring within the Trust. The aims to maintain our excellent performance in Infection Prevention and Control, improve upon our achievements with the risk assessment and prophylaxis of patients for Venous Thromboembolism and the aim to reduce the incidence of harm caused from medication errors has been the focus of our patient safety work programme.

The Outcome measures identified in the last Quality Account were:
1 – Reduction in the incidence of hospital related venous thromboembolism
2 – Reduction in the incidence of healthcare associated infection (C difficile)
3 – Reduction in the incidence of medication errors causing serious harm or death
4 – Safe delivery of babies, reduction in admissions of full term babies to neonatal care
5 – Reduction in harm to children caused by failure to monitor children properly within the Trust

1 - Risk assessment and prophylaxis of patients for venous thromboembolism (VTE)
An important measure to help reduce the incidence of VTE in hospital patients is the assessment of the risk of each individual patient, therefore it is expected that a VTE risk assessment is carried out for all hospital in-patients on admission, after 24 hours and / or at any subsequent change in clinical condition .

VTE risk assessment was audited throughout 2012- 13 and showed an increasing compliance in assessment at patient admission to hospital. Performance with regard to repetition of VTE assessment 24 hours after admission to hospital or at a change in the patient's condition was less good and we will concentrate on improving these elements during 2013 – 14. A VTE risk assessment has now been added to the in-patient Prescription Chart. The chart was totally revised during 2012 – 13, and it is hoped that this will provide a more easily seen prompt to clinicians to carry out further risk assessments when indicated. Auditing of performance will continue.

Appropriate prophylaxis (preventative measures such as compression stockings and / or low molecular weight heparin injections) was audited throughout the year and this requires improvement so raising awareness and auditing will be continued throughout the next year.

2 - Infection prevention and control

Infection prevention and control continues to remain a key priority for the Trust. We have successfully met our challenging reduction objectives for both MRSA bacteraemia and C. difficile infection again this year as detailed below. This is influenced by an ongoing focus on the Saving Lives high impact interventions, key of which is hand hygiene and by ongoing work around antimicrobial prescribing. Hand hygiene compliance is reported on a monthly basis to the Directorate clinical, management and governance leads for discussion and action through the Directorate governance and risk meetings.

The monthly Hand Hygiene Audit is undertaken by the ward manager or matron within clinical areas, who assess the compliance of individuals against the Hand Hygiene Policy. Hand Hygiene before and after patient contact is assessed. All staff groups are audited and the audit data is then entered into the Trust data capture system, Synbiotix.

The data is immediately analysed and results are published on the electronic system. The results are then presented, reviewed and actions are planned at the Directorate meetings. Directorates are required to report on a quarterly basis to the Infection Prevention and Control Committee on their compliance with all the Saving Lives interventions that are applicable to their areas. Items from this can then be escalated to the Patient Safety Committee.

The presentation of the data and the detail of performance within each staff group, have played a significant part in the Trust's continued annual improvement in performance.

The figure below demonstrates the Trust's continual improvement in compliance with Hand Hygiene from April 1st 2012 to 31st March 2013. The average annual compliance is 90% compared to 82% in the previous year.

Figure 1. Annual Hand Hygiene compliance 1st April 2012 to 31st March 2013

 8. Hand Hygiene AuditMonthly Hand Hygiene compliance audit		Compliance	90%
	Hand hygiene before patient contact.	**Hand Hygiene after patient contact.**	**All elements performed?**
Average %Compliance:	**92%**	**97%**	**90%**
Doctors	87%	94%	85%
Nurses	95%	98%	94%
HCAs	94%	97%	92%
Others	89%	94%	86%

This year continued work on improving this compliance will be a focus for all staff.

Inpatient areas are also auditing the Department of Health Saving Lives High Impact Interventions such as peripheral cannula insertion and ongoing care on a monthly basis as well as other quality indicators in order to help focus work on areas of care requiring improvement.

The principles of the Saving Lives Bundles are based around achieving 100% compliance with each element within the Bundle. Monthly audits are undertaken within each area and all elements of the bundles are audited. The compliance rate for each element is then calculated along with the overall compliance for the whole bundle. Elements which fall below 100% are immediately noted and clinical areas are required to action plan to improve performance.

A focus on improving documentation of peripheral cannula insertion and labelling of lines has taken place over 2012 – 2013. An improvement overall for the peripheral cannula care bundle has been noted for this year including both these issues (Figure 2) compared to the previous year (Figure 3).

Figure 2 – Peripheral Cannula Care Bundle: On insertion and Continuing Care April 2012 – March 2013

 2. High Impact Intervention No.2Peripheral Intravenous Cannula Care Bundle: On Insertion	Compliance	93%

	Hand Decontaminaton.	Personal Protective Equipment.	Skin Preparation.	Dressing.	Documentation.	All elements performed?
Average %Compliance:	**99%**	**99%**	**100%**	**100%**	**94%**	**93%**
Doctors	99%	99%	100%	99%	92%	91%
Nurses	97%	99%	100%	99%	97%	95%
HCAs	97%	100%	100%	100%	95%	92%
Others	100%	100%	100%	100%	97%	96%

Figure 3 – Peripheral cannula Care Bundle: On insertion and Continuing Care April 2011 March 2012

 2. High Impact Intervention No.2Peripheral Intravenous Cannula Care Bundle: On Insertion	Compliance	89%

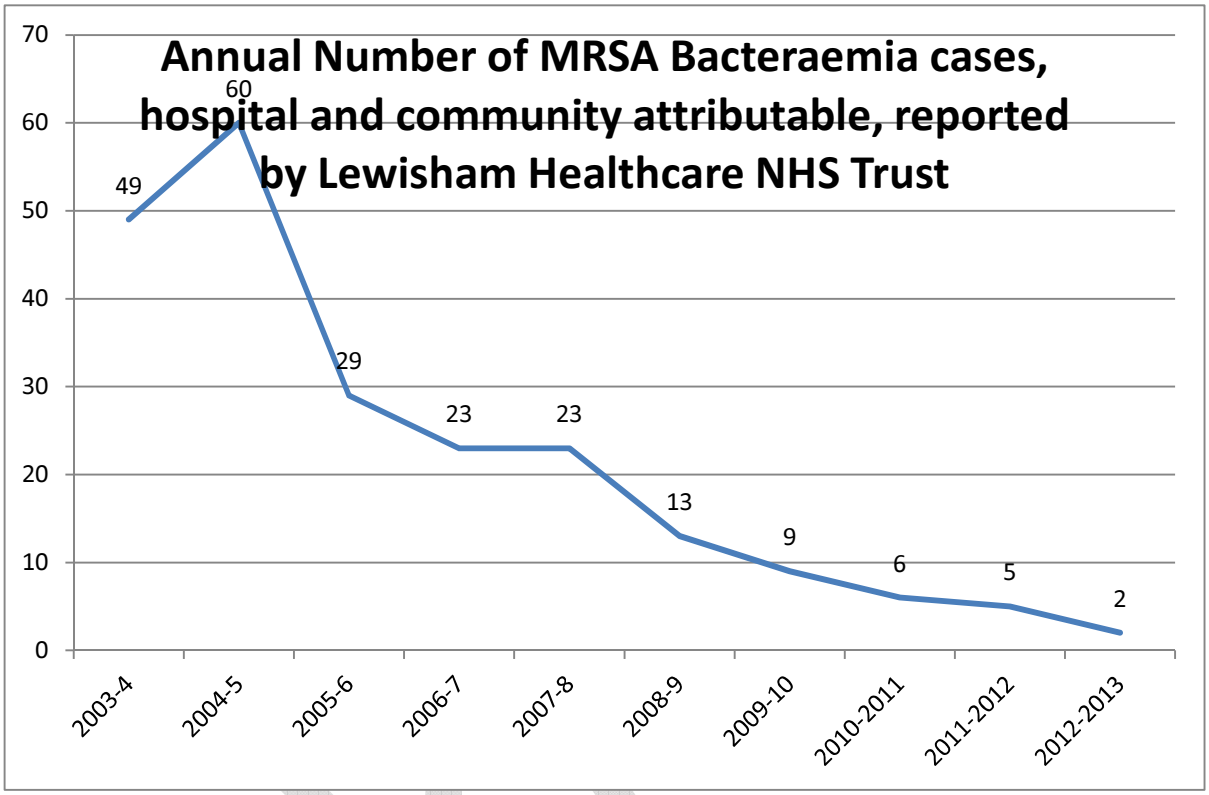
	Hand Decontaminaton.	Personal Protective Equipment.	Skin Preparation.	Dressing.	Documentation.	All elements performed?
Average %Compliance:	**97%**	**99%**	**100%**	**100%**	**92%**	**89%**
Doctors	98%	99%	100%	100%	91%	89%
Nurses	95%	100%	100%	99%	94%	89%
HCAs	90%	98%	100%	100%	88%	80%
Others	97%	100%	100%	100%	94%	92%

We continue to ensure we comply with the national mandatory reporting requirements in relation to healthcare-associated infection, two of which have local reduction objectives (MRSA bacteraemia and *Clostridium difficile* infection).

a) **MRSA bacteraemia –** This year the Trust's annual local reduction objective was no more than 1 Trust attributable cases of MRSA bacteraemia (MRSA in the bloodstream). One case was reported and so the target was achieved. There was also 1 community

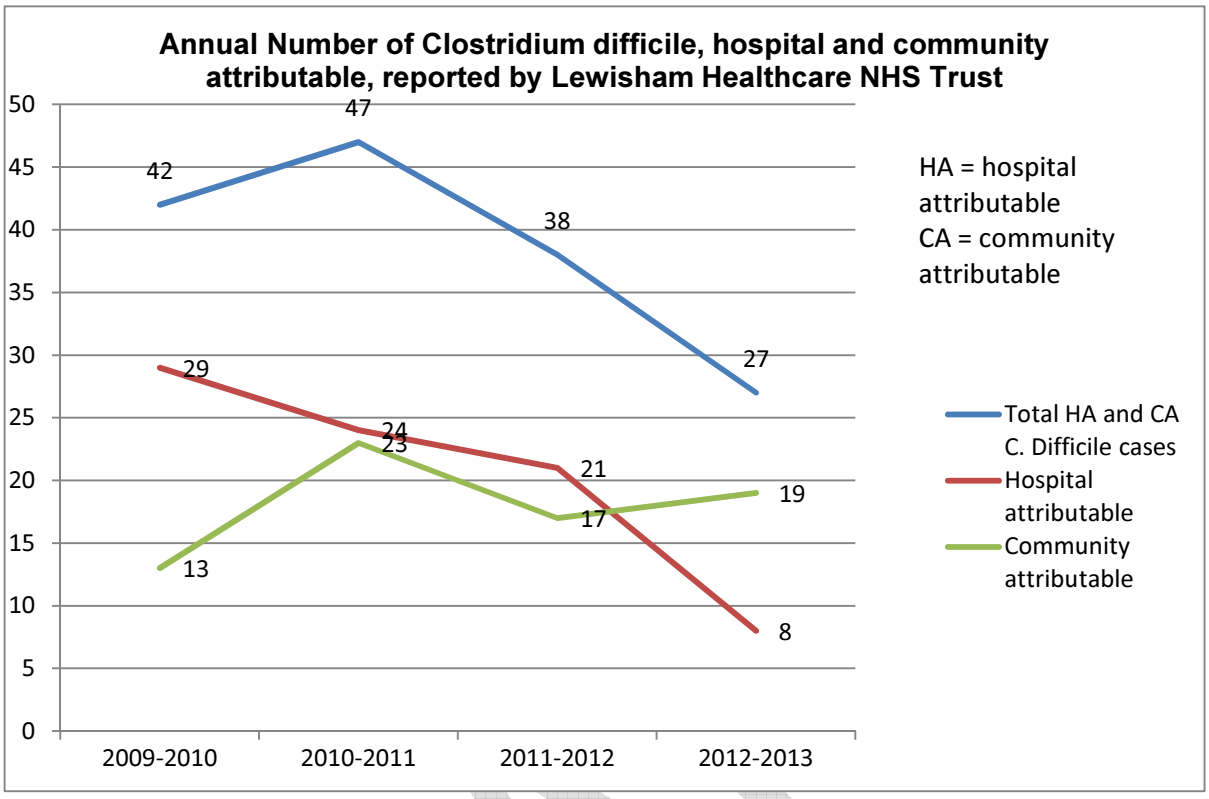
attributable case during this period giving a total of 2 cases reported via the Trust laboratory for the year.

Figure 6 Trend Graph showing annual MRSA Bacteraemia cases



b) ***Clostridium difficile* (C. diff) Infection –** This year the Trust had an annual local reduction objective of no more that 17 Trust attributable cases of C. diff infection. Only 8 cases were reported representing a significant achievement against the target.

Figure 7 Trend Graph demonstrating Clostridium cases per month



c) **Glycopeptide Resistant Enterococci (GRE) bacteraemia** – Reporting of GRE bacteraemia has been mandatory since April 2004 although there are no local targets for this. There has been only one GRE bacteraemia during this year.

d) **MSSA bacteraemia** – Reporting of MSSA bacteraemia (sensitive *Staphylococcus aureus* in the bloodstream) has been mandatory since 2011 although there are no local targets set. The Trust has reported eight Trust attributable cases.

e) **E. coli bacteraemia** – Reporting of E. coli bacteraemia has been mandatory since 2011. No local target for reduction has been set. The Trust reported 21 Trust attributable cases up to the end of March 2013 and 70 community attributable cases.

f) **Orthopaedic surgical site infection** – The Trust is required to undertake surveillance of at least one category of orthopaedic surgery for a minimum of three months every year. During this year the Trust looked at total hip and knee replacements over a three month period from October to December 2012. A total of 25 hip replacements were monitored during the quarter of which none have developed a surgical site infection to date. Fifty total knee replacements were monitored over the same period again none of which developed a surgical site infection.

g) **Infection Control Training** - The mandatory infection control training programme has been delivered as scheduled for 2012-2013. The Trust target is 85% of staff who require training has received this. As of the end of March 2013 training figures show 82% for

clinical staff and 84% for non-clinical staff. Taking into account the staff that had booked for training but were unable to attend then compliance would have been achieved. This has involved all groups of staff, both clinical and non-clinical, across all grades.

3 - Incidence of harm from medication errors

There were no medication errors causing serious harm or death in the Trust throughout the year 2012 – 13.

The Pharmacy Department continues to audit medicines related practice in various areas including omitted medicines (i.e.: medicines not given when prescribed), as these and delayed medicines are the highest reported incident type. This may be due to increased awareness in the Trust and the promotion of the Aspiring to Excellence workstream in this area. Such incidents continue to be monitored and issues addressed through ward managers and practice development nurses in each specialty.

During the year a list of 'critical medicines' was produced; these include such medicines as intravenous antibiotics and insulin, which if omitted could lead to harm coming to a patient. Should these be omitted or unable to be given when prescribed for some reason, an escalation process is in place to reduce the risk of harm to the patient.
We will continue to work to reduce the number of omitted prescribed medicines overall, but especially those on the critical medicines list.

Pharmacy also monitor compliance with the processes surrounding controlled drugs via ward pharmacists but also through undertaking periodic audits, the results of which are reported to the Patient Safety Committee.

Where any problems are identified training is provided by the Lead Dispensary Pharmacist and ward pharmacists to areas where incidents have occurred on the correct handling of controlled drugs and record keeping in the CD register. All controlled drug incidents will continue to be investigated as per local policy and reported to the Trust accountable officer along with the CCG on a quarterly basis.

Pharmacy errors are addressed through the local pharmacy error monitoring scheme and staff involved with recurrent errors are provided with re-training and monitoring until the lead is satisfied that they are safe to return to practice.

Table showing compliance of inpatient wards with Controlled Drugs processes (latest data are for 2011 / 12)

		Q4 Jan 2011	Q1 May 2011	Q2 Aug 2011	Q3 Nov 2011	Q4 Feb 2012	Average Q1-Q4 2011/12
Percentage Ward Compliance	CD Register stored in Locked cupboard	53.2%	71.1%	73.3%	80.8%	85.4%	77.7%
	CD Order book stored in Locked cupboard	59.6%	64.4%	81.8%	76.5%	93.7%	79.1%
	Only CDs stored in CD cupboard	68.0%	71.1%	80.0%	70.2%	87.5%	77.2%
	CD Keys kept separate to other keys for the area	38.3%	57.7%	51.0%	44.6%	35.4%	47.2%
	CD keys held by person or designated deputy in charge at all times	93.6%	97.7%	93.3%	91.4%	95.8%	94.6%
	CD cupboard kept locked when not in use	100.0 %	97.7%	100.0 %	100.0 %	100.0 %	99.4%
	Recording CD receipts from pharmacy into CD registers correctly	73.0%	77.7%	61.3%	72.3%	66.6%	69.5%
	Daily CD checks being carried out and documented	83.0%	93.3%	80.0%	84.7%	93.7%	87.9%
	Total Number of Wards Audited	47	45	45	47	48	46.3

Number of wards with Discrepancies	7	3	7	9	8	6.8
Total number of CD Discrepancies	7	6	7	14	18	11.3
CD Discrepancies as a Percentage of Total CDs Checked	1.4%	1.1%	1.3%	2.8%	3.1%	2.1%
Total Number of Expired CDs on wards	31	6	4	12	4	6.5
CDs checked that were expired as a percentage of Total CDs Checked	6.2%	1.1%	0.8%	2.4%	0.7%	1.2%
Total number of CDs Audited	499	537	529	500	581	536.8

4 - Reduction in admissions of full term babies to neonatal care

The numbers of full term babies admitted to neonatal care is reported on the Maternity Dashboard every month and reviewed at the Women and Sexual Health Directorate's monthly governance and risk meeting. The numbers fluctuate monthly (the highest being 18 babies in one month at the beginning of 2012 – 13, to 4 babies in another month) but have shown an overall reduction throughout the year. It is of course necessary that some babies are admitted to NICU owing to their medical condition, and therefore entirely appropriate, however all such admissions are reviewed to ensure that any care management problems related to maternity care can be identified and investigated at the earliest opportunity. Monthly monitoring will continue throughout 2013 - 14.

5 - Risk of severe harm or death in children:

The Paediatric Early Warning Scoring system (PEWS) was introduced within the children's areas of the Trust early in 2012 – 13 including within the short stay unit within the Children's Emergency Department. The use of the chart by nurses was audited twice during the year to measure effectiveness.

Following the first audit some additional training for staff was put in place and how to use the PEWS chart was made part of the routine induction process for all new clinical staff working in the in-patient children's areas. Further auditing indicated a positive impact by showing that should any child's condition start to deteriorate, the use of the chart did enable nurses to identify that deterioration early and escalate the situation appropriately to medical staff.

Review of children's cardiac arrest calls from low dependency areas.

During the year 2012 – 13 there was one peri-arrest situation in the Children's inpatient ward and no actual cardiac arrests.

The peri-arrest event involved an ill child who was being monitored using an oxygen saturation monitor. A sudden decrease in the child's oxygen saturation had been noticed, therefore the nurses had called a doctor to come to review the child. Shortly after this, the child's heart rate lowered considerably and resuscitation was started as the doctor arrived on the ward. The heart rate improved with the resuscitation efforts and the doctor was able to intubate the child and transfer them to the Evelina Unit at St Thomas' Hospital for ongoing care. This was an example of good monitoring, early identification of deterioration, with quick escalation and appropriate action taken which fortunately in this case resulted in a good outcome.

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The following diagram is the Paediatric Early Warning Chart used within Lewisham Healthcare NHS Trust Children's areas.

Review of children's cardiac arrest calls from low dependency areas. During the past year there have been very few cardiac arrests in children within the hospital, which is perceived to be due to earlier identification, escalation and appropriate action being taken for the deteriorating child.

Reviews of appropriate intravenous therapy regimes based on age and weight for children. During 2012 – 13 retrospective audit was undertaken quarterly. This demonstrated that practice was consistent with safe guidelines. No adverse incidents were reported on the Trust's incident reporting system. Repeated audits continued to demonstrate good practice.

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3.1.1. (iii) Priority 3 – Learning from patient safety incidents

To ensure the Trust continued to treat and care for people in a safe environment, protect them from avoidable harm and to deliver continued improvement in the levels of reporting of safety incidents, during 2012/13 the Trust focussed on indicators which measure the readiness of the Trust to report harm and on learning outcomes to address safety issues.

During 2011, the Trust set up two groups to ensure that learning was gained from patient reviews of patient safety incidents. The Aspiring to Excellence programme [A2E] and the Outcomes With Learning Group [OWL] were established and made significant improvements in the way in which patient safety incidents were reported and managed and how lessons learnt from such incidents were shared across the organisation.

Outcomes With Learning Group
This group met 6 times during 2012 – 13. Its purpose is to ensure that patient safety issues and risks of harm are reported and investigated in a timely manner. It also oversees whether action plans arising from investigations into patient safety incidents, complaints and claims have been effective and risk reduction methods sustained where necessary.

Examples of learning during the year include:

- A review of the implementation of actions arising from a report from the Ombudsman about a complaint related to a delay in treating a patient with intravenous antibiotics when he had signs of sepsis. The Trust has adopted the NICE guideline for sepsis which requires the urgent administration of intravenous antibiotics following diagnosis.

- A review of learning gained from a case of C. difficile in a hospital inpatient which affirmed the need for appropriate antibiotic therapy, and the value of the presence of a consultant microbiologist and an antibiotic pharmacist attending general consultant ward rounds.

- The review of an action plan arising from a serious incident investigation into an outbreak of an infection on NICU in a previous year (from which no babies came to significant harm) was presented. This incident had led to a review of the facilities in NICU and resulted in the Trust funding a major refurbishment of the ward which ensured that hand washing basins were better sited, additional entrance doors added to create an additional compartment, and that there was no overcrowding of cots, to reduce the risk of spread of infection.

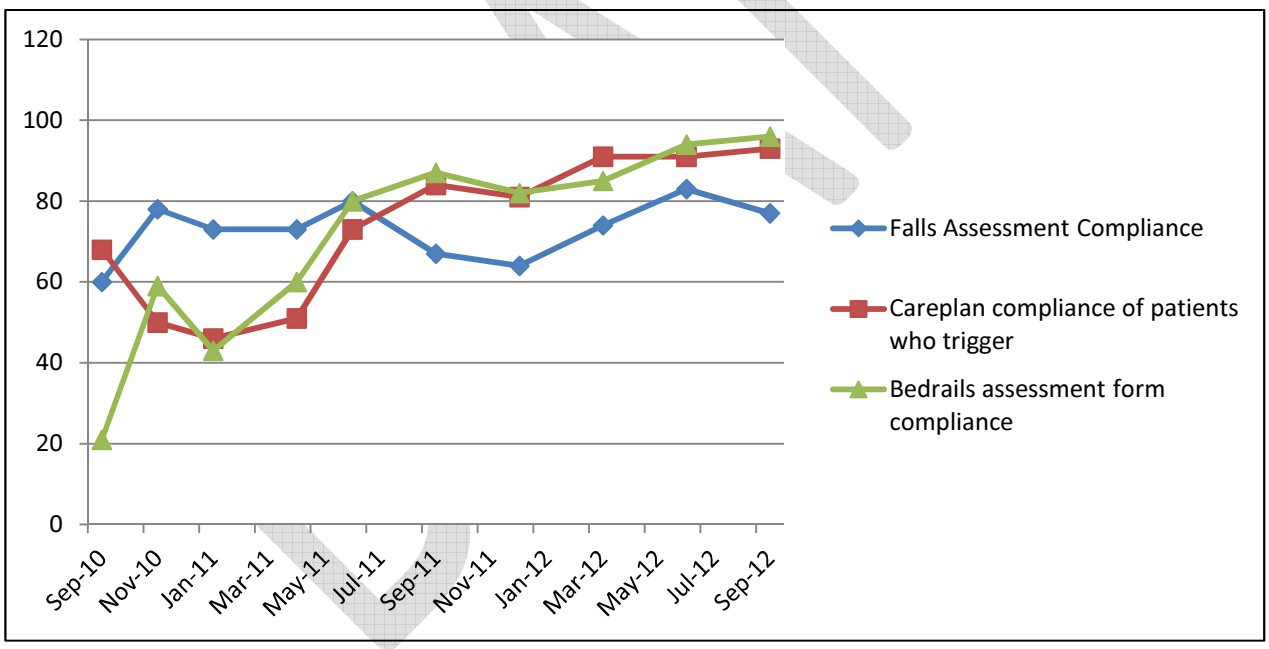
- **Never Events**
  These are events which ought not to occur because previously issued national guidance should already have been implemented to prevent them.
  The Trust had no Never Events during 2012 – 13, and the OWL Group received assurance about the implementation of actions arising from previous such events, 2 involving swabs that had inadvertently been retained after operations, and 1 where the incorrect side tonsil had been operated on (the side operated on had looked diseased at the time of the surgery but was not the side that the patient had previously been consented for). One of these Never Events had occurred during 2009 and two at the end of 2011 – 12.

- **In patient Falls**
  The Falls Prevention Specialist Nurse presented a review of progress on the Aspiring to Excellent programme reduction of harm from in patient falls. Whilst there are still significant numbers of reported patient falls in hospital, several interventions have been put in place to reduce the likelihood of harm arising. These include:
- an updated falls risk assessment tool and care plan which are included in the nursing documentation booklets so completed on admission and revisited at least every week whilst a patient is in hospital. Audit results have shown a significant increase in completion of

these assessments achieving around 80% although there is still room for improvement. 96% of patients had bedrails assessments completed

- The Trust now has 47 very low level beds which can be lowered to less than a foot above floor level to reduce the risk of falling from a height for patients vulnerable to this risk.
- falls assessment training has been added to mandatory update training for staff
- slipper socks
- falls indicators
- on line incident reporting – monthly reports on the numbers and types of falls in their ward sent to ward managers
- introduction of post fall flow chart including neurological observations
- in hospital falls team reviews
- individual patients have their falls risk score handed over to the next shift at ward handover time
- patients should not be left unattended in the toilet
- early provision of walking frames by physiotherapy and physiotherapy reviews at weekends
- training needs analysis carried out to target falls training at correct staff
- new cot bumpers purchased for each adult ward
- provision of 'rummage boxes' for patients with cognitive impairment (there seems to be a strong link with falls for patients with cognitive impairment)

During the year 2012 – 13 there were 24 moderate injuries from falls, and one severe harm incident from inpatient falls. The Trust will continue to strive towards having zero harm come to patients from falls whilst in hospital.



- **Maternity Incidents**

A thematic review of serious incidents investigated in Maternity was undertaken and reviewed by the Group. It was noted that 'skills drills' have been successfully implemented during 2012 - 13 for obstetricians, midwives, neonatologists, and anaesthetists. These different disciplines meet together in the Trust's Simulation Suite to work through mock emergency scenarios in obstetrics. This allows staff to be filmed, watch how they perform and learn from mistakes in a safe environment to prepare them should they need to use those skills in a real situation.

- **Pressure Ulcers (Grade 3 and 4)**

There continue to be a number of grade 3 and 4 pressure ulcers identified within the Trust both in hospital and community care. In response a Pressure Ulcer Prevention working group was resumed at the end of 2012- 13 which will report to Aspiring to Excellence. This will bring together all the themes and action plans arising from root cause analysis into why pressure ulcers have developed, under one group that will closely monitor incidence and the effectiveness of harm reduction measures throughout 2013 – 14. A reduction in the number of grade 3 and 4 pressure ulcers has therefore been made a priority for the Trust for the coming year.

Number of Grade 3 and 4 pressure ulcers reported by year

Year	Hospital acquired	Community acquired	Total
2010 – 11	14	4	18
2011 – 12	16	26	42
2012 - 13	26	27	53*
TOTAL	54	59	113

*one investigation involved development of a PU in community and then another in different position during subsequent hospital admission.

Note: reporting of Grade 3 and 4 pressure ulcers to NHS London (Strategic Health Authority) started in June 2010. Hospital and community services in Lewisham integrated formally on 1 August 2010.

The reason for the increase in reported G3 and 4 pressure ulcers is not easy to establish but could include:

- **a true increase in incidence**
- **an increase in identification and reporting.**

During the first few years of reporting the most likely explanation is an increase in reporting as staff become more aware of the issues.

- **Documentation and Pressure Ulcers**

  The updated nursing assessment and care plan templates including those for assessing the risk of the development of pressure ulcers for a patient, and already used within the hospital inpatient areas were adapted for use by District Nurses and this was rolled out within the community towards the end of 2012 – 13. The effectiveness of this change is currently being audited.

3.1.2 Clinical Effectiveness

3.1.2 (i) Priority 1 – Continuation of work in reducing premature mortality and increased survival rates from cancer

In 2012 the achievement of the aims for this priority would be measured by the following outcomes:

- Increase in the number of patients being screened for Bowel and Lung Cancer
- Extension of the age range for screening to 75 years
- Improved Cancer staging for Lung, Bowel, Breast and Upper Gastrointestinal Tumours.

Cancer is a major cause of premature mortality with variations in the outcomes for different sections of the population. This is nationally recognised and the Department of Health, the National Cancer Action Team (NCAT) and National Awareness and Early Diagnosis Initiative (NAEDI) have led on several TV and media campaigns during 2012-13 to increase public awareness of symptoms and increase early diagnosis. The patient population for Lewisham Healthcare NHS Trust has significant numbers of people from black and ethnic minorities (B.M.E.) and those with lower socio-economic backgrounds. There are plans to continue the "Be Clear on Cancer" campaigns for lung and bowel throughout 2013-2014.

Lung

The aims of the national lung cancer awareness campaigns were to encourage and empower a person with the following symptoms to make an appointment to see their doctor and ask for a chest X-ray:

- a new and persistent cough for more than 3 weeks
- recently started to feel breathless
- has blood flecks in their phlegm

The national campaign ran from 8 May to 30 June 2012. The campaign featured on national TV, press and radio and was promoted through a wide range of channels.

The aims of the national campaign were to:

- improve public knowledge of the symptoms of lung cancer
- reduce barriers to presentation by encouraging people to see their GP earlier; and
- create awareness and understanding that early diagnosis increases the chance of curative treatment and therefore better survival outcome.

The target age groups were men and women over the age of 55 years. The campaign showed improved awareness in the symptoms of lung cancer and increased confidence in recognising the symptoms. The data has indicated there was an increase in the number of two-week wait referrals decreased (March 2011 – April 2012 compared with March 2012 – April 2013 – Figure 1

Figure 1 – 2 Week wait referrals for suspected Lung Cancer April 2011 – March 2013

Figure 1 - Lung 2 week wait referrals												
	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2011 - 12	32	51	31	25	32	25	28	30	27	28	19	29
2012 - 13	23	18	16	27	16	22	23	10	17	23	21	23

Lewisham Healthcare NHS Trust saw a vast increase in referrals for chest X Rays and chest CT scans compared with the same period in the previous year. – Figure 2 (chest X Rays saw a 10% increase). Further analysis is pending to identify if the increased referral activity was specific to the target groups.

Figure 2 – Referrals for Chest X-rays and CT Scans April 2011 – March 2013

					Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
General X-Ray	A	1	XCHES	Chest XR	2,434	2,731	2,748	2,629	2,463	2658	2682	2,728	2,816	2,917	2,983	2,943
CT Scanning	C	6	CCHEC	CT chest with contrast	20	23	46	27	36	29	30	35	25	33	34	35
CT Scanning	C	6	CCHES	CT Chest	3	4	4	9	10	13	8	13	5	17	7	9
CT Scanning	D	12	CCHESB	CT chest and biopsy	3	3	3	1	3	2	3		1		1	
CT Scanning	C	6	CCHAC	CT chest/abdo with contrast	34	26	25	35	23	38	31	31	22	32	31	33

					Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
General X-Ray	A	1	XCHES	Chest XR	2,672	3,221	2,989	2,976	2,817	2734	3139	3,029	3,017	3,225	3,025	3,308
CT Scanning	C	6	CCHEC	CT chest with contrast	33	39	33	39	33	36	44	41	38	34	42	36
CT Scanning	C	6	CCHES	CT Chest	18	29	17	29	18	20	18	29	34	26	23	31
CT Scanning	D	12	CCHESB	CT chest and biopsy	1			1	2				3	3	5	3
CT Scanning	C	6	CCHAC	CT chest/abdo with contrast	34	31	42	33	36	24	35	31	22	40	52	46

Highlights from the NAEDI report include:

- Recognition of campaign adverts was high: 82% of those questioned recognised at least one advert (TV, radio or press)
- There was a significant rise in spontaneous awareness that “cough/hoarseness” (41% to 50%) and “persistent/prolonged cough” (12% to 15%) are signs of lung cancer, and an increase from 18% to 33% in people saying “a cough that doesn’t go away for 3 weeks or more” is definitely a warning sign of lung cancer.
- 72% of those surveyed agreed that the advertising would make them "more likely to go to their GP or doctor"

Sector-wide analysis is due to be circulated, which reviews the relationship between the increased

attendance and whether this has contributed to an increase in detection rates and indeed patient outcomes.

Approximately 19% of adults in Lewisham smoke and the rate of smoking related deaths ishigher than the national average. A new, multi-borough pilot is currently being discussed. This would include the patient population of Greenwich, Lambeth, Lewisham and Southwark. The local project aims to increase awareness and access to Chest X-Rays and Chest CT scans. A risk tool is being developed to support Primary Care leads to identify which patients should be sent for the appropriate diagnostic tests.

The Trust is working closely with the integrated cancer system, London Cancer Alliance, to improve early diagnosis, particularly in COPD patients. The CNS Project Group is developing an action plan to review why at risk groups are less likely to attend screening and how healthcare professionals can improve these statistics. The Lewisham Healthcare NHS Trust Lung pathway group is developing the Education Strategy in collaboration with Guy's and St Thomas' NHS Foundation Trust and local commissioners. The aim is to increase understanding of the patient population needs and barriers to accessing healthcare services, improve access to clinics and nurses and improving the interface between Primary and Secondary healthcare professionals.

Local commissioners are reviewing how local pharmacies can be included in early diagnosis workstream as suspected Lung Cancer patients may attend a pharmacy instead of their GP. It is anticipated this work will be developed during 2013-14

Bowel

Bowel cancer is England's third most common cancer, with around 34,000 new cases each year. It affects both men and women and is responsible for around 13,200 deaths a year. Around 9 out of 10 people diagnosed with bowel cancer are aged over 55 and those with a family history are at more risk.

General awareness of the early symptoms is low, but early detection of bowel cancer makes it more treatable. It is estimated that 1,700 additional lives could be saved each year if England's bowel cancer survival rate matched the best in Europe.

A national campaign ran from January – March 2012 and was repeated August – September 2012. The target groups were men and women over the age of 55 years old. There were also local campaigns targeting B.M.E. groups, for example an information stand in Lewisham Shopping Centre and local media.

The Department of Health and NAEDI have published highlights on the impact of the campaigns:-

- Statistically significant increases in the public's unprompted awareness of blood in stool (27% to 42%) and looser stool (10% to 23%)
- A 29.3% increase in attendances to general practice (a measure of behaviour change) amongst patients over 50 with the campaign related symptoms. The number of attendances by men reporting campaign-related symptoms during the campaign period increased by 37.3%, compared with 21.9% for women

An analysis of the number of urgent GP (two week wait) referrals for colorectal cancer and endoscopy activity indicates:

- there was an increase in the number of two week wait referrals for the Trust for suspected colorectal cancer in the months during and after the first campaign.

- the East of England (which was one of the two pilot regions) observed a 48% increase in two week wait referrals for suspected colorectal cancer but the increase in the other region (South West) was only 5.5%.
- a statistically significant increase in activity for the Endoscopy department (colonoscopy, flexible-sigmoidoscopy and Gastroscopy). The growth in demand from January 2012 is reflected in an increase in activity (See Figure 3 and Figure 4)

Figure 3 – Colorectal referrals 2011-2013

Figure 3 - Colorectal referrals received													**Total**
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
2011 - 12	75	69	55	72	81	90	85	71	75	86	102	132	993
2012 - 13	116	84	61	87	72	86	105	68	80	89	85	81	1014

Figure 4a – Endoscopy referrals January 2012 – February 2013

Endoscopy Referrals Received				
JANUARY 2012 - MARCH 19th 2013				
	Colonoscopy	**Flexi-Sigmoidoscopy**	**Gastroscopy**	**TOTAL**
Jan-12	78	35	100	213
Feb-12	31	15	66	112
Mar-12	122	83	110	315
Apr-12	131	63	142	336
May-12	125	87	148	360
Jun-12	132	75	126	333
Jul-12	124	80	150	354
Aug-12	114	56	149	319
Sep-12	174	67	137	378
Oct-12	181	70	152	403
Nov-12	196	70	168	434
Dec-12	108	55	85	248
Jan-13	190	81	174	445
Feb-13	152	65	143	360
Mar-13	93	41	73	207
TOTAL	**1951**	**943**	**1923**	**4817**

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Figure 4b – Number of Colonoscopies January 2011 – March 2013

Bowel Cancer Screening Activity			
Number of colonoscopies	**2011**	**2012**	**2013**
Jan	54	49	59
Feb	43	47	43
Mar	66	42	39
Apr	41	54	
May	44	54	
Jun	59	35	
Jul	48	48	
Aug	51	46	
Sep	50	51	
Oct	65	67	
Nov	66	42	
Dec	57	45	
Total	**644**	**580**	**141**

Although the analysis shows an overall increase in activity (both referrals to secondary care and endoscopy activity), the Trust has maintained positive waiting times (less than 6 weeks for Endoscopy diagnostics testing).

Due to the national campaign, the organisation has adjusted the pathway to cater for the increased activity and to ensure waiting times are kept to a minimum. Patients are now referred via the 2WW pathway and would attend an outpatient appointment to ensure they referred to the appropriate diagnostic test. This has been effective and further pathway process mapping will be carried out to ensure the pathway is proving the best patient experience and is as efficient as possible.

South East London Bowel Cancer Screening Centre (SELBCSC) received the final version of the inspection report from the London Quality Assurance team on 27 August 2012. The report contained 85 recommendations to be implemented. Positive progress is being made with these recommendations with 52 already resolved (all outstanding have approved implementation/action plans).

The Cancer Reform Strategy (2007) stated that the NHS Bowel Cancer Screening Programme should extend the age range for screening to invite men and women up to their 75th birthday. The QA advised the Trust would need to complete a series of key tasks before age extension can take place. This included agreement of the Service Level Agreement between Lewisham Healthcare NHS Trust (the host Trust) and King's College Hospital NHS Foundation Trust (the sub contracted Trust), reinforcing the governance structure for the Bowel Cancer Screening Centre and review the current model, leadership and line management structure to ensure the SEL BCSC functions as a cohesive, single screening centre with strong leadership.

Following intensive work by the Screening Centre, from 11th March 2013, the NHS Cancer Screening Programme has given approval for the Screening Centre to extend the age range for the programme to 74 (from the current age range of 60 – 69) to the local populations in Lewisham, Greenwich, Bexley and Bromley at Lewisham Hospital NHS Trust. Age extension of the service to

the boroughs of Southwark and Lambeth at Kings College Hospital NHS Foundation Trust will follow in 2013. The service is available to people aged 60- 69; individuals over 70 may continue to self-refer.

Other positive developments include the recruitment of a Health Promotion Officer. This role will be hugely beneficial to the patient population as this rile is dedicated to developing a co-ordinated programme of work to raise awareness of bowel cancer screening and to improve the local screening uptake rate. The Screening Centre has already held a health promotion event and further borough-specific events are planned throughout 2013-14. Other key priorities include developing training for health professionals on bowel screening (primary and secondary care leads) and providing support to those areas where uptake is particularly low with thorough knowledge of local factors.

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3.1.2 (ii) Priority 2 – Dementia – Improving the diagnosis, treatment and quality of life in a long term condition

Within the NHS Outcomes Framework 2012/13, enhancing quality of life for people with long term conditions was a major aim.

Dementia affects an estimated 670,000 people in England, and the costs across health and social care and wider society are estimated to be £19 billion – both figures are set to rise with the ageing of the population. Currently only around 42% of people with dementia in England have a formal diagnosis despite the fact that timely diagnosis can greatly improve the quality of life of the person with dementia by preventing crises (and thus care home and hospital emergency admission) and offering support to carers (who are invariably under stress).

It is estimated that 25% of general hospital beds in the NHS are occupied by people with dementia, rising to 40% or even higher in certain groups such as elderly care wards or in people with hip fractures.

The presence of dementia is associated with longer lengths of stay, delayed discharges, readmissions and inter-ward transfers. Many admissions are because of ambulatory conditions (about 40%) such as urinary tract or respiratory infections, which could be managed in the community.

For 2012/13 the Trust was committed to improving the care and experience of patients with dementia and their carers by achieving better awareness, early detection and diagnosis, specialist referrals and high quality treatment in every setting. The outcome measures which were set are outlined below:

1. Increased number of patients being screened for dementia
2. Increased numbers of patients being risk assessed for dementia
3. Increased numbers of patients being referred for specialist diagnosis
4. Increased use of locally developed 'Dementia Passport' for patients across health and social care

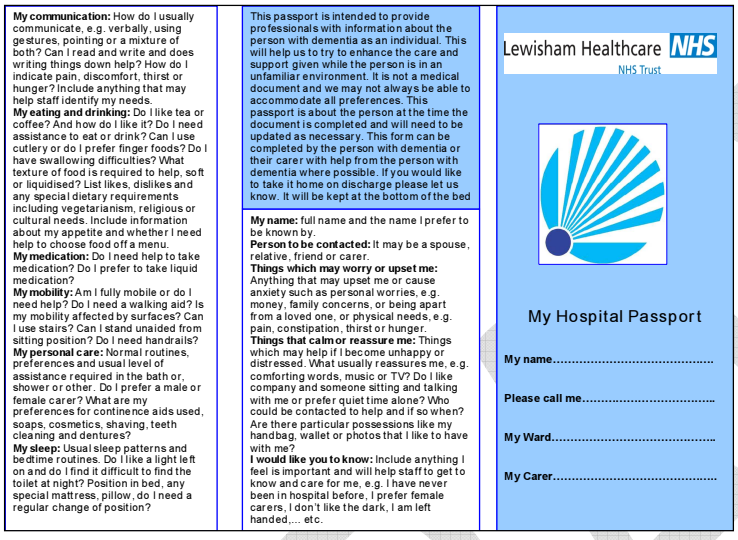
In 2012/13, the Trust established a process for screening, risk assessing and referring patients for dementia. The aspiration of this was to develop a system within the Trust which increased the identification of patients with dementia and other causes of impaired cognition. This is to help ensure that reasonable adjustments can be made in their care to take into account their dementia, and to engender appropriate referral and follow up after they leave hospital.

The screening process applied to all patients aged 75 and over, who were admitted to the hospital as an unplanned (emergency) admission and who stayed in the hospital for at least 72 hours. Patients who already had a diagnosis of dementia or delirium or who met a number of other exclusions were not included.
These criteria were in line with the National Dementia CQUIN (part of the Commissioning for Quality and Innovation (CQUIN) scheme). The patients (or their family or carer) were asked whether he or she had been more forgetful in the last 12 months to the extent that it significantly affected their daily life. If the answer to this question was yes, then a more detailed assessment was completed and where necessary, the patient was then referred electronically to their GP for specialist assessment and care.

Data from January 2013 showed that in that one month the Trust screened 231 patients (95% of relevant patients). Of these 100% of those requiring further assessment received it, and 96% of those patients who needed specialist referral were referred appropriately.

Going forward into 2013/14, the Trust will be continuing to screen, assess and refer patients for Dementia as appropriate. In addition, as per the National CQUIN requirements for 2013/14, the Trust will be working towards ensuring that there is sufficient clinical leadership of dementia care, that staff will continue to be trained, and that there is support in place for carers of people with dementia to feel adequately supported.

Where patients have already been identified as having dementia, the Trust is committed to promoting the use of the dementia passport. The dementia passport is based on the Alzheimer's tool 'This is Me'. This is a simple and practical tool that people with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests. Once the passport has been completed, the patient or their carer can bring the passport with them to all clinic or hospital appointments. This enables health and social care professionals to see the person as an individual and deliver person-centered care that is tailored specifically to the person's needs. It can therefore help to reduce distress for the person with dementia and their carer. It can also help to prevent issues with communication, or more serious conditions such as malnutrition and dehydration.



The Trust will initially be distributing the passport in the memory clinic. Implementation on the wards will be led by the clinical dementia lead. The launch of the passport will be running alongside the use of the cognition visual alert tool which is used to highlight a patient with a cognitive difficulty by placing a visual tool over the patient's bed. The cognition alert can immediately inform all health care professionals to the fact that a patient has a cognitive difficulty. It is quick and easy to use and it promotes discussion within the Multi Disciplinary Team when the patient's care is being reviewed.

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The Introduction of the Communication Visual Alert Tool

The "Communication" – visual alert tool.

This sign will alert all healthcare professionals that an individual has a communication difficulty/problem which may include: hearing problems, sight problems, language difficulties, learning difficulties, dementia etc.

Background

The idea was developed following a patient complaint. An elderly lady was nursed in a side room. Due to communication difficulties (hearing & sight problems) there were additional needs with regards to meeting nutritional needs and compliance with medication. It became very apparent that after 3 days on the ward, some staff were not aware that the patient was partially sighted and hard of hearing, resulting in medicines being left on the table and meals were often left to get cold.

Communication problems, if not recognised promptly by ALL health care professionals - can have a huge impact on compliance with medication & meeting nutritional needs in addition lead to lack of understanding, social isolation etc.

The "C" alert will immediately inform all Health care professionals to the fact that a patient has a "Communication" difficulty. It is an alert for a wide range of problems, therefore does not breach confidentiality. It is quick and easy to use and it promotes discussion within the MDT.

ADD IN ROLL OUT PLAN AND FEEDBACK FROM PATIENTS.

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3.1.2. (iii) Priority 3 – Improving outcomes from planned procedures

During 2012 the Trust set PROMS as a clinical effectiveness priority and also as a driver to improve the outcomes experienced by patients undergoing varicose vein, groin hernia and hip and knee replacement surgery. A review of the PROMS performance is shown in section 2.0 and whilst the Trust compares favourably to our local peers, the Trust aims to continually strive to improve the health gain of patients following surgery performed within the Trust.

The additional outcome measures were set out as follows:

1. Improved outcomes scores for patients undergoing groin hernia, varicose vein surgery and hip and knee replacements (adjusted average health gain)
2. Establishment of local, continual and ongoing patient experience surveys within surgical in-patient areas
3. Reduction in Length of Stay for elective surgical procedures (varicose vein, groin hernia and hip replacement, knee replacement, abdominal hysterectomy and colectomy

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Surgery Patient Experience - Adult Inpatient Survey				
Survey Questions	**Trust Score 2011/12**	**Trust Score 2012/13**	**Trust Score +/-**	**Surgery Score 2012/13**
Your Treatment				
Did you find someone on the hospital staff to talk to about your worries and fears?	**72.16**	**80.09**	**+7.93**	**81.77**
Do you feel you were involved in decisions about your care and treatment, as much as you wanted to be?	**75.56**	**80.18**	**+4.62**	**81.03**
If you have been given medicines to take home, did a member of staff tell you about medication side effects to watch for when you went home?	**68.96**	**79.56**	**+10.60**	**84.64**
Have you been informed who to contact if you get worried about your condition when you are discharged from hospital?	**65.43**	**81.6**	**+16.17**	**82.07**
*Do you feel that you have been given enough privacy when discussing your condition or treatment?	**88.14**	**89.64**	**+1.50**	**89.89**
During you stay do you feel that nurses talked in front of you as if you weren't there?	**82.25**	**89.15**	**+6.90**	**87.38**
Do you have confidence and trust in the nurses treating you?	**New Question May 2012**	**87.28**	**Not available**	**87.28**
Friends & Family Test Question (Department of Health)				
How likely are you to recommend our ward to friends and family if the needed similare care or treatment?	**New Question Oct 2012**	**86.32**	**Not available**	**87.99**
Number of offers to inpatients				**557 offers**
Waiting List or Planned Admission				
How do you feel about the length of time you were on the waiting list before your admission to hospital?	**89.40**	**88.00**	**-1.40**	**90.26**
Was your admission date changed by the hospital?	**91.06**	**89.74**	**-1.32**	**90.35**
All types of admission				
From the time you arrived at the hospital, did you feel that you had to wait a long time to get a bed on a ward?	**75.54**	**74.46**	**-1.08**	**70.95**
The Hospital and Ward				
When you were first admitted to a ward, did you share a sleeping area (for example a room or a bay) with patients of the opposite sex?	**95.79**	**98.22**	**+2.43**	**98.34**
Percentage of patients who stayed on 3 wards or more.	**13.58%**	**7.69%**	**+5.89**	**4.33**

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After you were moved to another ward, did you ever share a sleeping area with patients of the opposite sex?	**100**	**98.83**	**-1.17**	**98.66**
Surgery Patient Experience - Adult Inpatient Survey				
Survey Questions	**Trust Score 2011/12**	**Trust Score 2012/13**	**Trust Score +/-**	**Surgery Score 2012/13**
During your stay in hospital so far, have you ever had to share the same bathroom or shower area with patients of the opposite sex?	**93.35**	**97.90**	**+4.55**	**97.65**
Danger Signals				
Has a member of staff told you about any danger signals you should watch for when you go home?	**54.52**	**69.89**	**+15.37**	**72.54**
Doctors and Nurses				
During your stay, do you feel that doctors talked in front of you as if you weren't there?	**83.52**	**89.71**	**+6.19**	**60.73**
When you have important questions to ask a nurse, do you get answers that you can understand?	**82.25**	**79.3**	**-2.95**	**82.65**
Overall				
Overall, do you feel that you have been treated with respect and dignity during your stay in hospital so far?	**89.77**	**90.84**	**+1.07**	**90.88**
Overall, are you happier with the care you have received during the day, during the night or both?	**22.31%**	**23.16%**	**Day**	**20.76**
	3.08%	**2.25%**	**Night**	**2.88**
	74.62%	**74.59%**	**Both**	**76.36**
Food and Beverages				
In your opinion have you had enough help from staff to eat your meals?	**83.18**	**80.69**	**-2.49**	**81.52**
During your stay, have you always been offered a hot drink at breakfast, mid-morning, lunchtime, mid- afternoon, supper time and before bed?	**87.6**	**79.33**	**-8.27**	**82.66**

During 2012-13 the Trust has been working to establish ongoing patient experience surveys within surgical in-patient areas. The patient experience survey is conducted on a rolling basis to capture information regarding the patients experience during their stay at the Lewisham Healthcare NHS Trust.
Questions related to privacy, dignity and respect, waiting time, communication with the clinical staff and the quality of food and beverages they receive during their stay at the Trust are included in the survey and the positivity score calculated.

For example, in the survey carried out in February, 2013, the Trust had a positivity score of 90.20 out 100 for the question 'Do you feel that you have been given enough privacy when discussing your condition or treatment?'. The Trust also achieved a positivity score of 92.75 for the question,

'Do you have confidence and trust in the nurses treating you?' in the patient survey carried out in January, 2013.

The surveys are conducted by paper survey and through patient interviews. The interviews are conducted by members of the patient experience team and trained volunteers. The results of the survey are fed back to the ward staff and posted on ward notice boards. If the surveys have shown that there are areas where improvement is needed, then an action plan for improvement is put in place.

The inpatient survey findings and any subsequent action plans for improvement are monitored via regular reports to the Directorate Governance and Risk Committees and the Trust Patient Experience Steering Committee. This committee is attended by a wide range of Trust representatives such as the Director of Knowledge, Governance and Communications, the Head of Patient Experience and members of the Patient Welfare Forum.

Reduction in Length of Stay for elective surgical procedures (varicose vein, groin hernia and hip replacement, knee replacement, abdominal hysterectomy and colectomy)

Reducing a patient's length of stay is a significant contributory factor in the patient's experience and their perception of the outcome of surgery. Through the work undertaken during 2012/13 with the PROMS programme and the length of stay of elective surgical patients, the Trust has aimed to reduce the length of stay of those patients undergoing surgery with a particular focus on abdominal hysterectomy and colectomy surgery.

Length of stay is a widely used indicator of health performance. It is viewed as an important performance indicator for costing and a key measure of efficiency of NHS care. Reducing a patient's length of stay is a significant contributory factor in the patient's experience and in patients' perception of the outcome of surgery. A reduced length of stay can also release capacity in the system, including beds and staff time. Lewisham Healthcare NHS Trust monitors length of stay data as a measure of clinical effectiveness.

The Trust set the reduction in the length of stay for elective surgical procedures (varicose vein, groin hernia and hip replacement, knee replacement, abdominal hysterectomy and colectomy) as a priority for 2012-13.

The table below shows the average length of stay for the six elective surgical procedures: hip replacement, knee replacement, abdominal hysterectomy and colectomy.

Table 1 compares the Trust's Length of Stay figures with the National Benchmark for the years 2011-12 and 2012-13.

Table 1: Comparison of Trust's Length of stay figures with the peers for the years 2011-12 and 2012-13

Procedure	Year 2011-12		Year 2012-13	
	Trust	National Benchmark	Trust	National Benchmark
Hip	4.93	6.13	4.94	5.46
Knee	6.68	5.99	7.00	5.57
Hysterectomy	4.32	4.66	3.74	3.23
Colectomy	6.65	8.26	8.43 (6.90	6.16

			without the outlier)	

The varicose vein and Groin Hernia procedures continue to be performed as a day case during 2012-13 in the Trust and the majority of these patients are not admitted overnight

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Table 2 provides a quarterly breakdown of the Length of Stay figures for the Trust compared with the National Benchmark for the same time period.

Table2 : Quarterly Length of stay figures for the Trust for the years 2011-12 and 2012-13

Procedure	Year 2011-12								Year 2012-13							
	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Quarter 1		Quarter 2		Quarter 3		Quarter 4	
	Trust	National	Trust	National	Trust	National	Trust	National	Trust	National	Trust	National	Trust	National	Trust	National
Hip	4.43	6.08	5.19	6.10	5.12	5.73	4.99	6.61	4.32	6.26	5.62	5.89	5.26	5.16	4.58	4.52
Knee	8.04	5.63	6.19	5.70	6.15	6.28	6.34	6.36	8.32	6.23	7.12	5.96	7.81	5.31	4.76	4.79
Hysterectomy	No data	4.43	No data	3.66	3.44	6.22	5.20	4.34	3.12	3.32	4.26	3.30	3.65	3.24	3.92	3.06
Colectomy	6.36	7.02	6.81	8.00	7.28	10.66	6.13	7.35	7.97	7.00	7.20	6.26	10.88 (4.75 excluding the outlier)	5.45	7.67	5.93

The data shows that for the last two years the Trust continues to perform better than the national average for Hip replacement. This is mainly due to the introduction of the ERAS programme in the Trust resulting in an improved quality of care of the patients undergoing elective hip replacement by facilitating early discharge. Enhanced Recovery Programme After Surgery Programme [ERAS] is an evidence based programme of care which utilises a multi-modal approach with the aim of enhancing the patient experience and improving patient outcomes. The programme aims to improve the quality of pre-operative preparation, peri-operative care and post-operative recovery and rehabilitation thereby improving clinical outcomes, reducing morbidity, enabling early discharge and enhancing the patient experience. Recovery of patients on the programme is optimised through a number of key elements which include the use of timely nutrition, appropriate analgesia, early enforced mobilisation, and maintenance of appropriate fluid balance and this forms the basis of ERAS.

Since the implementation of the Enhanced Recovery Programme evidence has shown that patients have benefited from a faster recovery, a reduced length of stay and an enhanced experience.

The trust is in a unique position of having community and acute services under one banner. This has facilitated a seamless pathway for patients not seen anywhere else in the country. The key components of the pathway of care delivered at Lewisham are as follows:

- Pre Assessment staff refer all elective hip patients to the community team immediately. The team then visits the patient at home and start education and assessment for aids early to avoid delays later in the journey.
- The Physiotherapist and Orthopaedic Nurse Specialist from the community team now regularly attend the Hip and Knee Club which is run by the Senior Orthopaedic Practitioner. Patients meet in a group with others about to undergo this surgery and are given information regarding the surgery and expected length of stay.
- The patients have a pre-admission home visit by the team's Occupational Therapist where the information is re-emphasized
- The community team's Orthopaedic Nurse Specialist attends the weekly Multidisciplinary Team meeting on the elective ward so that any barriers to discharge are quickly identified and solutions can be found.
- Each patient is seen post operatively by the community nurse and occupational therapist.
- Orthopaedic Nurse Specialist now spends some time working with the staff on the elective ward to try and increase the early mobilization of patients who have undergone elective hip and knee surgery.

An overall improvement in of Length of Stay figures for the Hysterectomy procedures carried out in 2012-13 is also observed. The Trust has continued to make reductions this year and is currently only 0.51 above the national average. The trend is also evident in the quarterly Length of Stay scores for hysterectomy surgeries carried out in 2012-13.

Compared to last year, the length of stay for the Colectomy procedures carried out at the Trust seemed to have increased. On investigation it was found that there was a significant outlier in the data due to one patient with very complex symptoms who had a length of stay of over two months. This particular patient was taken off ERAS pathway due to the complexity of the symptoms.

The increase in the length of stay for the Knee procedures carried out at the Trust was investigated by the Orthopaedic consultants who looked at six months worth of data for the patients undergoing knee replacement surgeries at the Trust.
It was found that 82% of the patients during the selected time period were discharged within 7 days. There were cases of patients who stayed for 13, 21, 24 and 28 days but that was due to medical complications and 2 of these patients were HDU (High Dependency Unit).

3.1.3 (i) Priority 1 – Continuation of work programme to improve the patients' experience and responsiveness to patients' personal needs

The National Inpatient Survey results were published in April 2013. While these results show that we still have much to do to maintain and improve the standards of our services, Lewisham was pleased to be in the top 20% of Trusts for aspects of our surgical care. In particular people felt that our team explained their treatment in a way that they could understand. In relation to most other aspects of care we were as good as most other hospitals in England, and we were pleased to see

that in aspects of basic care, our scores had improved since 2011. For example, people felt that they had more confidence and trust in our nurses in 2012. This is a tribute to how hard our nurses have worked during a difficult period of change and uncertainty for the Trust.

There are things we could improve. In particular, we need to focus on the experience people have of discharge from hospital, the length of time that they wait, and the information that they are given to take home.

Our National A&E Survey results were also published in 2012. These results were a little disappointing, and reflected the fact that the survey was conducted during the period when the A&E and Urgent Care Departments were under refurbishment. Surveys that we have undertaken since the department moved into its new premises have shown a much improved picture. Nevertheless, we have developed a comprehensive action plan, including the implementation of new systems to improve patient flows, the recruitment of staff to manage this, and the implementation of training for staff to improve communication of test results for example.

A&E and Urgent Care Centre Survey Results 2012		
Ranking	**Question**	**Satisfaction Rating**
1	Overall, did you feel you were treated with respect and dignity while you were in the department?	94.62
2	Did the doctors and nurses listen to what you had to say?	93.01
3	Did you have enough time to discuss the reason for your visit with the doctor or nurse?	92.96
4	Were you given enough privacy when being examined or treated?	92.31
5	How clean was the clinical area where you were seen for your assessment and/or treatment	88.97
6	Did a doctor or nurse explain your condition or treatment in a way that you could understand	87.6
7	Did you feel welcomed when you arrived in the department?	86.25
8	Did you have confidence and trust in the doctors treating you?	85.27
9	In your opinion, how clean was the department waiting area?	84.83
10	Was the main reason you went to the department dealt with to your satisfaction?	82.44
11	Did hospital staff tell you about what danger signs regarding your illness or treatment to watch for when you went home?	80.81
12	Overall, how would you rate the care you received?	78.82
13	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the department?	77.32
14	Did you feel you were given enough privacy when booking in at reception?	76.75
15	Did you feel that the department was relaxing and comfortable?	75.64
16	Were you told how long you would have to wait to be examined?	49.33

The most up-to-date information that Lewisham Healthcare NHS Trust has to tell us what people think of our A&E and adult inpatient services, is the results of our on-going Friends and Family Test. Lewisham Healthcare has been offering this test to patients since October 2012. Hundreds of people have used the opportunity to feed back their experiences, and over 90% tell us that they would be extremely likely or likely to recommend our services to friends or family.

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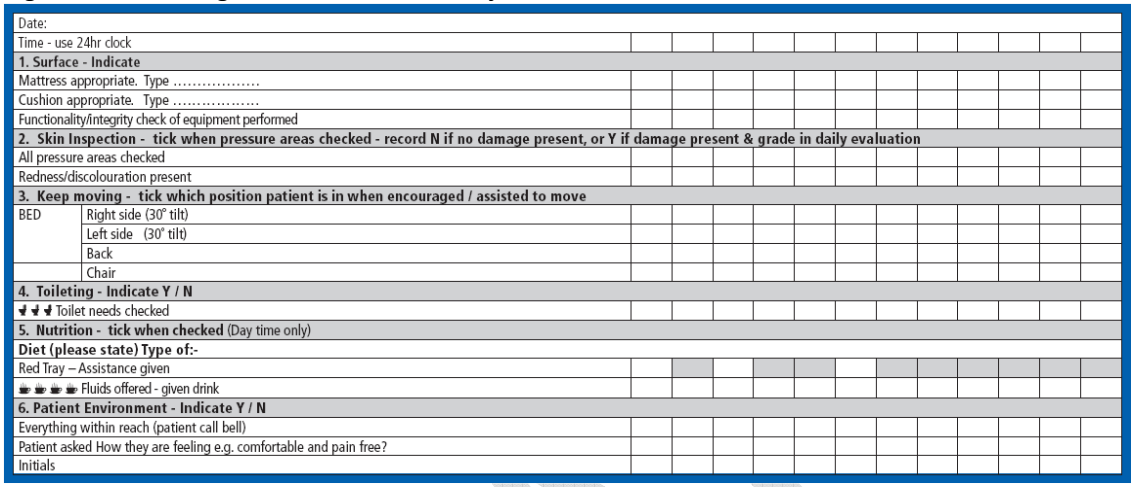
3.1.3 (ii) Priority 2 - To improve the communication and interaction between nurses and patients on our adult inpatient wards

Lewisham Healthcare has undertaken a programme of work to improve the quality of nursing on our wards. In 2011 new nursing assessment documentation was piloted. This has now been rolled out on all the adult inpatient wards. This comprehensive documentation is designed around the patient and requires regular interaction between nurse and patient to check basic needs are being met.

Figure 1. Nursing Notes – the 2 hourly round



Date:													
Time - use 24hr clock													
1. Surface - Indicate													
Mattress appropriate. Type ……													
Cushion appropriate. Type ……													
Functionality/integrity check of equipment performed													
2. Skin Inspection - tick when pressure areas checked - record N if no damage present, or Y if damage present & grade in daily evaluation													
All pressure areas checked													
Redness/discolouration present													
3. Keep moving - tick which position patient is in when encouraged / assisted to move													
BED	Right side (30° tilt)												
	Left side (30° tilt)												
	Back												
	Chair												
4. Toileting - Indicate Y / N													
Toilet needs checked													
5. Nutrition - tick when checked (Day time only)													
Diet (please state) Type of:-													
Red Tray – Assistance given													
Fluids offered - given drink													
6. Patient Environment - Indicate Y / N													
Everything within reach (patient call bell)													
Patient asked How they are feeling e.g. comfortable and pain free?													
Initials													

During this 2 hourly rounding the nurse checks diet, drinks, comfort and pain relief, and checks that the patient's overall needs are being met. It has significantly improved performance with key indicators such as hospital acquired pressure sores, and requires regular communication with the patient on a range of issues. This has been shown to enhance the patients' wellbeing. Ward managers undertake monthly audits of documentation. The wards were 96% compliant at January 2013 (April 2012 89%)

The handover between shifts has been standardised to ensure that it includes all relevant patient information including communication issues as well as clinical need. This includes the use of a coded message to indicate where there are communication issues (a coloured spot on the white board).

Nurse training at all levels includes aspects of patient experience. The band 5s and HCAs receive training based around the Amanda Waring video 'What do you see'. This short film highlights the importance of maintaining a person's dignity during care. Amanda Waring states on her website: "My film has been used around the world to re-enforce person centred care and the expectation of treating others as you would wish to be treated no matter what age, race, colour, creed or disability". This training has been well received by staff. In addition, existing HCA training and new training for band 5s focuses on caring with compassion and ensuring privacy and dignity, focussing on issues such as not talking as if the patient wasn't there. There is a back to basics approach. This training has been running since spring 2012.

The Band 7 nurse training programme equips our clinical nurse leaders with the skills and knowledge to ensure that we provide high quality nursing care. The programme covers the Care Quality Commission standards which set the level of quality expected in relation to patient experience and safety. It also explores specifically what makes a good patient experience and how we can measure this. The training enhances ward management leadership to strengthen visibility between ward manager and patients, and it equips the ward manager with skills to deal with staff that needs additional support. The Senior Nurses Group also had training using the 'Tale of 2 wards' which is about getting patient care right so that dignity is promoted.

Information about our patients' experience is regularly fed back to the senior nurses group and is displayed on every adult inpatient ward. The results are discussed at ward meetings to ensure that all staff are aware of any outstanding issues and to remind staff of NMC standards. Patient experience is being included in Nursing Metrics (a new meeting set up monthly to look at a range of indicators) and formalised ward specific action plans will be presented on a 3 monthly basis by the responsible ward manager and matron.

The effectiveness of these improvements is constantly measured through a programme of ongoing patient surveys, audits and inspections. For example, the Patient Welfare Forum undertakes 4 ward inspections a month, the results of which are reported to staff. Senior nursing staff have also undertaken mock CQC visits reviewing care on the wards against the Care Quality Commission standards.

Because of these measures, the Trust can demonstrate significant improvements in patient assessment, but we know there is room for improvement in care planning. Work is now going on to target improvement and we will ensure that patient care plans are developed in collaboration with the patient.

Work in 2013/14 will continue to focus on getting the basics right. To that end the Trust is developing a new nursing and midwifery strategy which will be built around the Chief Nursing Officer's six C's: care, communication, compassion, courage, competency and commitment.

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3.1.3 (iii) Priority 3 – Improving the experience of children in and out of hospital care

Woodland Children's Day Care Unit

The Woodland Children's Day Care Unit has treated more than 3,000 patients since opening at University Hospital Lewisham in September 2010. It is a 16 bedded unit for children needing a short surgical or medical procedure, who can go home on the same day.

In 2011/2012 a number of initiatives were introduced to improve the service provided for children using the unit. These include the introduction of a twice weekly nurse-led pre-assessment clinic for patients undergoing elective ear, nose or throat surgery. This helps staff to recognise at any early stage any potential issues that need to be dealt with prior to a child's surgery. In the summer of 2012, Children and Young People's Services completed a survey looking at the child's and parents' experience. They achieved an overall satisfaction score of 95.64%

New children's emergency services
Lewisham is one of the few Trusts in London to have a separate children's Emergency Department. This means that children wait and are assessed in a dedicated area away from other patients.

The children's Emergency Department has been upgraded and opened its doors to the public in April 2012. The new facilities include a purpose-built play area for children and larger treatment bays to improve the patient experience.

To measure children's experience, the team have developed a character called 'Matron Mouse'. Children are invited to post their 'message to matron' in a post box in the department.

Matron Mouse

"Outstanding" services for keeping children and young people safe
In March 2012, the services that keep Lewisham's children and young people safe were judged "outstanding" by the Care Quality Commission and Ofsted. Lewisham is the only borough in London to be judged "outstanding" in this report, and one of only three boroughs in the country.

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The report was released following an intensive two-week inspection of the Trust and its partners earlier in the year. It notes the outstanding contribution made by healthcare staff in supporting vulnerable families and ensuring access to services.

End of life nursing support for Children and Young People

Research shows that families bringing up children with life-limiting or life-threatening conditions often do not get the support they need when it comes to end of life care. In particular, while the vast majority people prefer for end-of-life care to be delivered in their home or a community setting, most have to travel to hospital.

This is why the Trust has appointed a specialist end-of-life nurse to work with children and their families. The specialist nurse started in March 2012 and is working closely with the Demelza Hospice and other local agencies to give people more of a choice in how end-of-life care is delivered, so they can continue family life with minimal disruption.

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3.1.3 (iv) Priority 4 – Improving Maternity Services

In 2012, the Trust set out the following indicators for the improvement of the Lewisham Healthcare NHS Trust Maternity Services:

The indicators for the improvement of maternity Services in Lewisham are:

- Improved Maternity satisfaction Scores
- Implementation of the Maternity Services Improvement Plan
- Implementation of the Maternity Services Patient and Public Engagement Strategy

The Maternity Services improvement plan included the Midwifery Improvement Plan and Mat5 Special Measures Action Plan. The latter was put in place in 2011 in response to feedback from mothers who had used the services in the form of the National Maternity Services survey and following a series of quality rounds and environmental rounds which highlighted the areas for improvement. While many of the actions were completed during 2011, when the new Head of Midwifery was appointed in that year, she identified a range of areas for further improvement based on concerns raised by staff, women who used the service, inadequate performance in relation to some indicators, and reported incidents. A comprehensive Midwifery Improvement Plan was put in place to pick up issues outstanding from the Mat5 Special Measures Action Plan, and to encompass a range of other areas that the Head of Midwifery identified for improvement.

In order to measure the success of these plans for change, the Head of Midwifery put in place a strategy for gaining and using the feedback of women who use the service. Building on the existing surveys, comments cards and the Maternity Services Liaison Committee 'Walking the Patch' reports, the Head of Midwifery also requested a survey in the format of the National Maternity Survey so that the service would be able to accurately measure improvements to the service benchmarking against the results of the 2010 national Maternity Survey.

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Results of 2012 Maternity Survey

Women's Experience of Maternity Care	Score 2010	Score 2012
Care During Pregnancy (Antenatal Care)	82	86
Were you given a choice of having your baby at home?	76	78
Dating Scan: Was the reason clearly explained to you?	83	88
Were the reasons for having a screening test for Down's syndrome clearly explained to you?	86	86
20 Week Scan: was the reason for this scan clearly explained to you?	83	91
Labour and Birth	72	76
During labour, could you move around and choose the most comfortable position?	72	81
During labour and birth, did you get the pain relief you wanted?	76	72
If you had a cut or tear requiring stitches, how soon after the birth were the stitches done?	58	65
Did you have skin to skin contact with your baby shortly after the birth?	82	86
Staff during Labour and Birth	78	86
Did you have confidence and trust in the staff caring for you during labour and birth?	74	84
If you had a partner or a companion with you during your labour and delivery, were they made welcome by the staff?	85	92
Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you?	70	78
Thinking about your care during labour and birth, were you spoken to in a way you could understand?	87	89
Thinking about your care during labour and birth, were you involved enough in decisions about your care?	79	85
Overall, how would you rate the care received during your labour and birth?	75	85
Care in hospital after the birth (Postnatal Care)	63	65
Looking back, do you feel that length of your stay in hospital after the birth was appropriate?	65	60
After the birth of your baby, were you given the information or explanations you needed?	59	64
After the birth of your baby, were you treated with kindness and understanding?	65	71
Feeding the baby during the first few days after birth	58	55
Did you feel that midwives and other carers gave you consistent advice?	58	51
Did you feel that midwives and other carers gave you active support and encouragement?	57	59

In addition the service has reviewed other sources of feedback including complaints, postings on website such as NHS Choices and Patientopinion.org, and data collected on a feedback kiosk located on the postnatal ward. There are also plans for an end of pathway survey incorporating the Department of Health Friends and Family Test.

Improvements have been targeted on two key areas:
The adequacy of staffing
The quality of the environment

Staffing of the Midwifery Service has gone through considerable change during 2012. The department has been awarded additional funding. Through this it has been able to recruit 10 newly qualified midwives. The new midwives have been employed on a preceptorship programme. Preceptorship is a way of providing newly qualified midwives and nurses with a structured transition phase. This ensures that they can develop their confidence and apply their knowledge from academic studies and placements in a safe and supported way, and that they can provide effective care more quickly. The new midwives have each been allocated a nominated person who they can contact for help and advice. They are also given training to develop their skills, including a rotational programme over the course of a year so that they experience all aspects of the service. The midwives on this programme have a different uniform so that it is clear to other staff that they may need help and support until they have gained sufficient confidence and experience. Anecdotally, midwives on the preceptorship programme have received very positive feedback from mothers who have been under their care.

In addition to the 10 new midwives, a new team of support workers has been recruited for the labour ward. A new approach has been adopted with this intake of support workers. They are clearly identifiable through a change in uniform, wearing a grey tunic that helps women to distinguish who they are in the team. To improve efficiency and effectiveness they have also been trained so they can provide support more effectively with the management of emergencies and use

more equipment on the ward. 7 permanent and 3 bank support workers have been employed. They have been set different shift times to the midwives. This means that the midwives and support workers have some overlap in their shifts which helps to improve continuity of care and communication.

Lewisham Healthcare NHS Trust has processes in place to ensure that staffing levels on all wards are safe at all times. In the labour ward, women should have 1:1 care. Work has been done to ensure that the escalation policy, which requires an alert to be sent out if staffing levels fall short, is followed without exception. If there are not enough staff to provide 1:1 care on the labour ward, staff will be brought in from other areas, such as the antenatal ward, birth centre, outpatient's clinic or community, until the situation is resolved. During such a situation, an amber alert would also be sent to the London Ambulance Service to ensure that women were not brought in from outside the area to give birth at Lewisham.

Staff are also being supported with more training. The simulation suite at Lewisham Hospital is being more effectively utilised with regular skills and drills training for midwives. The team use the manikins in the suite to run through the skills required for the rarer birthing situations such as shoulder dystocia, breech birth and haemorrhage. This ensures that should the midwives encounter these situations in real life, they are fully able to manage them effectively and with confidence. Midwives have 5 annual study days and a training programme which most of the midwives will have completed by April 2013. There is a midwifery practice day to keep the staff up to date with changes in practice, and a supervisor's day during which staff can work through high risk cases and scenarios.

If something does go wrong and a complaint is made, work has been done to ensure that the investigation is thorough and that the team learn from the mistakes. Supervisors of midwives will arrange to visit families who make a complaint in their own home. They will visit in the evening or at the weekend if necessary so that the partner can be present. They will take the records to the meeting and go through all the issues with the family which helps to ensure that the Trust fully understands the issues, and helps to answer questions that the family might have. The Supervisors of Midwives will then share any learning with staff.

The environment is also a key part of people's experience of our services. A safe, comfortable and clean environment is very important to a good experience. Having refurbished the postnatal ward in 2011/12, Lewisham Healthcare has brought the labour ward up to the same standards as the acclaimed birth centre. It has been redesigned to ensure that women have a much better experience, with a welcoming reception at front of house and bays with beds instead of a waiting room with seats. This means that women who need examination or are in the early stages of labour can be made comfortable immediately on arrival.

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3.2 INVOLVEMENT

Overview

Who has been involved?

The Trust has consulted widely about the content of this Quality Account, namely the Trust Board, senior nursing, midwifery, clinical and management staff, patients and the public. The Patient's Welfare Forum, the Lewisham Local Healthwatch was also consulted. This is a network of people and organisations or groups who represent the views and ideas of lots of different people. More information on Healthwatch is available from www.lewisham.gov.uk. Feedback was also obtained from the local clinical commissioning group, our local commissioners and the local overview and scrutiny committee.

The Trust has consulted widely about the content with the final version incorporating all comments, being published at the end of June 2013.

The Trust Board

The Trust Board has been actively involved in setting the quality priorities for the Trust. Items on quality are discussed at every Board meeting and at frequent Board seminars. This year has seen the introduction of the Quality Account Dashboard which has been presented and discussed through the Integrated Governance reports to the Trust Board. The Quality Account Priorities Dashboard demonstrates the Trust's performance on quality indicators which are selected by the Trust and monitors performance against priorities set throughout the year.
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 patient safety walk rounds, which visit clinical departments to better understand, in an informal setting, any issues that the staff feel could affect the quality and safety of services they deliver.

Staff

The Trust's Management Executive, which comprises the Chief Executive, the Medical Director, the Director of Clinical and Academic Strategy, the Executive Directors, the Director of Business Development, the Director of IT and the five Directors of the Clinical Service Directorates have been involved in significant discussions around Quality Accounts. There have been presentations and discussions at regular intervals.

Key leads and stakeholders from within each of the five Clinical Directorates 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 2013 – 2014.

There is a Clinical Leaders Group for the Trust Management Executive to work with the General Managers and Deputy Directors for each of the clinical directorates, other clinical directors e.g. the Director of Pharmacy and Heads of Nursing, once every month. Quality Accounts have regularly been on the agenda of this meeting to enable wider discussion with the clinical leads throughout the Trust.

The Trust Clinical Quality Committee, Patient Safety Committee and Patient Experience Committee, which have Executive, Non-Executive, Clinical Team members, Patient Welfare Forum members and members of our local Healthwatch, have Quality Accounts as a standing agenda item and valuable input has been received from these committees.

The Directorate Governance and Risk meetings have also been used to consult widely on the Quality Accounts with Directorate Governance, Risk and Audit Leads participating in the review of the priorities.

3.3 STATEMENTS FROM CLINICAL COMMISSIONERS, LOCAL HEALTHWATCH AND OSC

ANY STATEMENTS PROVIDED FROM YOUR COMMISSIONERS, HEALTHWATCH OR OSCs

i) Commissioners/ Clinical Commissioning Group [CCG]

ii) OSC

iii) Healthwatch

iv) Patient Welfare Forum [PWF]

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1.4 EXTERNAL AUDIT LIMITED ASSURANCE REPORT

ADD IN KPMG AND GRANT THORTON REPORTS

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3.5 STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY ACCOUNT

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

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

• the Quality Accounts presents a balanced picture of the trust's performance over the `period covered;

• the performance information reported in the Quality Account is reliable and accurate;

• there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;

• the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and

• the Quality Account has been prepared in accordance with Department of Health guidance.

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

By order of the Board

NB: sign and date in any colour ink except black

.....Date.....Chair

.....Date.....Chief Executive

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3.6 FEEDBACK

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

The Head of Communications,
Lewisham Healthcare NHS Trust,
Waterloo Block,
University Hospital Lewisham,
Lewisham High Street,
London SE13 6LH.

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

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APPENDIX 1. LIST OF SERVICES PROVIDED AT LEWISHAM HEALTHCARE NHS TRUST

Service Types
Acute and Elderly Medicine Directorate
Acute Adult Medical Wards
Accident and Emergency Department and Urgent Care Centre (UCC)
Adult Therapies
Community Matrons
Discharge Lounge
District Nursing including Continence Nurse
Elderly Care wards including Alder and Clinical Assessment Service
Falls
Intermediate Care
Pharmacy
Safeguarding Vulnerable Adults
Stroke Service (Beech and Community pathway)
Children and Young People Directorate
Children Day Care ward
Children Emergency Department
Children Inpatient ward
Children Outpatient Department
Community Children's Nursing Team
Children's Specialist Nurses
Community Paediatrician Team
Family Nurse Partnership Team
Health Visiting Team
Immunisation Team
Neonatal Intensive Care Unit
Occupational Therapy (Children)
Physiotherapy (Children)
School Age Nursing Service
Special Needs Nursing Team
Speech and Language Therapy (Children)
Safeguarding Children Service
Specialist Medicine
Adult Outpatients Service
Appointments Team and Choose & Book
Cancer Services
Cardiac Physiology
Community Head and Neck Team
Foot Health Service
Home Enteral Nutrition Team (Adults)
Musculoskeletal Service
Nutrition and Dietetics
Orthotics Service
Palliative Care
Pathology
Phlebotomy
Radiology
Speciality Medicine
Specialist Nursing Teams
Speech and Language Therapy (Adults)
Surgery

Adult Surgical wards
Anaesthesia
Clinical Site Management
Clinical Technicians
Critical Care
Critical Care Outreach
Ear, Nose and Throat Outpatients Department
Endoscopy
HIP Team
Pain Service
Plaster Technician
Preadmissions
Surgical Specialities
Surgical Specialist Nurses
Synergy Contract Management
Theatres
Tissue Viability
Women and Sexual Health
Alexis Clinic
Gynaecology Outpatient (Hysteroscopy, Colposcopy, Subfertility, Menopause)
Gynaecological Surgery
Maternity and Midwifery Service
Obstetrics
Sexual and Reproductive Health
Women's Health Outpatients

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APPENDIX 2 - THE FULL PROGRAMME OF CQUINS FOR 2012-13

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APPENDIX 3 – FULL LIST OF LOCAL AUDITS REVIEWED DURING 2012-2013

Clinical Speciality	Project Title
A&E	Telephone calls to on-call doctors assessed using the SBAR tool
A&E	Asthma Management in UHL A+E A Comparison with Audits 2009 & 2011
A&E	Sepsis & Septic Shock CEM Audit 2012 (Local Audit)
A&E	Consultant Sign-off in the Emergency Department (Local Audit)
A&E	Pain Audit - January 2012
A&E	Deliberate self harm audit
A&E	DVT Pathway Audit
A&E	Urinary Rentention Re-Audit Jan 2012
A&E	Arrival time to Analgesia for Sickle Cell Patients
A&E	Pain Management Audit 2012-2013
A&E	Deliberate Self Harm 2012-2013
A&E	Deep Vein Thrombosis Pathway Audit
A&E	CG25 - Sedation in Violence Audit
Anaesthetics & Pain Relief	Fasting and mobilisation post elective Caesarean section - Re-audit
Anaesthetics & Pain Relief	Use of strong opioids analgesics in chronic pain
Anaesthetics & Pain Relief	NICE IPG 285 Ultrasound-guided regional nerve block
Anaesthetics & Pain Relief	Evaluation of Chronic Pain Outpatient Clinic Services
Anaesthetics & Pain Relief	Ultrasound guided catheterisation of the epidural space (NICE IPG 249)
Anaesthetics & Pain Relief	Supervision of Anaesthetics Trainees
Anaesthetics & Pain Relief	GIFTASUP Preoperative Fasting Audit
Anaesthetics & Pain Relief	Supervision of anaesthetic trainees 2011-12
Anaesthetics & Pain Relief	Audit of Anaesthetic Documentation
Anaesthetics & Pain Relief	What do trainees think of their consultant anaesthetists in 2012?
Anaesthetics & Pain Relief	Stress at work audit

Anaesthetics & Pain Relief	How do anaesthetic trainees spend their week?
Anaesthetics & Pain Relief	Management of Post Partum haemorrage
Anaesthetics & Pain Relief	Postoperative Pain and Mobilisation after lower limb arthroplasty in ERAS patients
Anaesthetics & Pain Relief	Audit on central venous catheter insertion-icu/anaesthesia
Anaesthetics & Pain Relief	Anaesthetic Audit Activity
Anaesthetics & Pain Relief	Delays in Anaesthetic Recovery
Anaesthetics & Pain Relief	Documentation audits - anaesthetic charts
Cardiology	Audit Of CT Coronary Angiography
Care of the Elderly	Falls in Elderly. Auditing UHL performance (Re-Audit)
Care of the Elderly	Audit of readmissions of patients on Beech ward in 2010
Children & Young People Therapies	After school gym audit
Children and Young People Therapies	SLT Drop in Clinic Audit
Children and Young People Therapies	Watergate CYP Therapies Input
Children Services	Audit of unexpected admissions to NICU
Children's Services	Accuracy of Prescribing on Children's Inpatient Ward Re-audit
Children's Services	Audit of Prolonged Jaundice Clinic
Children's Services	Audit of the refferal and response process between Lewisham paediatric A&E department and Lewisham Social Services
Children's Services	Urine Pad Audit
Children's Services	Accuracy of prescribing on children's inpatient ward-reaudit
Children's Services	Facing the future 2012 RCPCH
Children's Services	Investigation of diagnosis and treatment of suspected Encephalitis of children in UHL
Children's Services	Patient journey for haematological patients on long term transfusion programme-reaudit
Children's Services	Admission temperatures of neonates admitted to NICU
Children's Services	Re-audit of patient journey for haematological patients on long term transfusion programme
Children's Services	Review of criteria for commencing phosphate supplements
Children's Services	Oxygen Saturation Limit Levels for preterm Infants

Children's Services	Two year follow up of premature neonates and neonates with Hypoxic Ischaematic Encephelopathy (HIE)
Community Children's Nursing Team	Sharps bin audit
Community Children's Nursing Team	Clinical audit of Asceptic Non-touch Technique within the Community Children's Nursing Team
Community Children's Nursing Team	Records Audit
Community Matrons	Audit of Community Matron Record Keeping
Community Paediatric Medical Team	The development of a skill mix approach to the post diagnostic follow up of children with Autism Spectrum Disorders
Continence Care	Catheter Care Audit Record keeping
Continence Care	Patient Satisfaction Survey
Dermatology	An audit of Alitretinoin (Toctino) for the treatment of chronic hand eczema in the Department of Dermatology, UHL
Dermatology	An audit of Alitretinoin (Toctino) for the treatment of chronic hand eczema in the Department of Dermatology, UHL
Dermatology	An audit of Azathioprine prescribing in the Department of Dermatology, UHL
Dermatology	Atopic Eczema in Children - Compliance with NICE Guidelines CG 57
Diabetes	Audit on DNAR Form Documentation
Diabetes	Re-audit (2) hypoglycaemia treatment boxes
District Nursing	Audit of District Nursing Record keeping
District Nursing	Confidentiality (Caldicott) management audit 2012
ENT	Balloon sinuplasty: frontal balloon sinuplasty. Need to recruit cohort to compare. All FESS patients (NS) have SNOT 22
ENT	Voice Clinic: what professional groups use the service?
ENT	Tonsillectomy 2011
ENT	Are Admission Forms for Surgery being Completed Adequately?
ENT	Post Adenotonsillectomy Telephone Follow Up
Foot Health	Nail surgery referral and outcome audit 2011-2012
Foot Health	CG10 - Diabetic Foot Assessment
Foot Health	Nail Surgery Referral and Outcome Audit 2012-2013
Gastroenterology	PEG service at Lewisham Hospital 2010-2011
Gastroenterology	ERCP audit

Gastroenterology	JAG Audit
Gastroenterology	TA187 - Crohn's Disease - Infliximab and Adalimumab
General Medicine	Audit on Management of Charcot Neuropathy in Diabetic Patients
General Medicine	Diabetes Transitional Care Audit
General Medicine	Clinical coding (appropriateness) for chest pains
General Medicine	Infective Endocarditis
General Medicine	Resuscitation Equipment Audit
General Medicine	DNAR Audit
General Medicine	Oxygen Safety
General Medicine	Audit of Prevention of Mother to Child Transmission of HIV
General Surgery	ITON Audit_Improve Operative Notes
Health Visiting	Hand Hygeine Audit - Health Visiting Team
Health Visiting	Midwife Discharge Audit
Health Visiting	Parental engagement; developmental invite letters
Health Visiting	New birth audit
Health Visiting	Clinic attendance
Health Visiting	Jaundice pathway
Health Visiting	Infant Jaundice
Health Visiting	Parental Engagement experience of ages and stages questions
Health Visiting	Staff Perception of ages and stages tool
Health Visiting	Yearly Records Audit
Heart Failure Team	Community heart failure satisfaction survey 2012
Home Enteral Nutrition Team	Referral audit 2011
ICU	Calculating ventilaor asscociated pneumonia (VAP) rates and adherence to the VAP bundle on our intensive care
ICU	Sedation Audit
ICU	Audit of the AKI Management Bundle
ICU	Cardiac Arrest Audit

Infection Control	An Audit of Essential Steps - Preventing Infection undertaken in community setting
Infection Control	Safe Use and Disposal of Sharps Audit
Lewisham Adult Therapies Team	Evaulation of referrals to community speech and language therapy of adults with Parkinson's Disease
Neurology	Falls and impact on people with Parkinson's disease: survey of 110 patients attending regional clinics
Neurology	Use of Dopamine Agonists in Parkinson's Disease and whether indications and side effects are being documented and charted and acted upon
Nutrition & Dietetics	Audit of referrals to the dietician at the HIV Clinic
Nutrition and Dietetics	Red Tray re-audit
Orthopaedics	Smoking Cessation Advice in Fracture Clinics
Orthopaedics	Value of post-op CRP in TKR
Pathology	High Grade LBC cytology with Low Grade histology outcome
Pathology	Audit of antibiotic delivery in patients with Neutropenic sepsis post chemotherapy
Pathology	Audit of end-to-end turnaround time for metabolic work referred to St. Thomas's hospital
Pathology	Review of extreme causes of Hyperferritinaemia
Pathology	Octaplex Audit
Pharmacy	Safe and Secure Handling of Medicines in Community Clinics
Pharmacy	Audit of Patient Group Directions (PGD) in A&E
Pharmacy	Compliance agaisnt pharmacy endorsement
Pharmacy	HIV homecare audit
Pharmacy	An Audit to Establish Adherance to Prescribing Standards
Pharmacy	A Re-Audit to determine the number of omitted and delayed doses at LHNT
Pharmacy	Audit to assess the adherence to Trust Strong Potassium Chloride Policy
Radiology	Use of Lumbar Spine xrays in the A&E Department
Radiology	Application of Anatomical Markers within the Primary Beam Re-Audit
Radiology	Foundation Doctors Knowledge of Radiation Legislation and Exposure Audit
Radiology	Appropriateness of usage of computed tomography pulmonary angiography (CTPA) and isotope perfusion scan in the investigation of suspected pulmonary embolism in pregnancy
Radiology	CT head lens exclusion
Radiology	Patient satisfaction survey in the Radiology Breast Unit

Radiology	Patient satisfaction With Informed Consent for Lung Biopsies
Rheumatology	TA160 Osteoporosis Primary Prevention
Rheumatology	Audit of Rheumatology telephone advice line
Rheumatology	Audit of anti TNF use in patients with Ankylosing Spondylitis (AS)
Rheumatology	Bronchiectasis Audit at UHL
Rheumatology	Audit of anti TNF use in patients with rheumatoid arthritis (RA)
Risk Team	Audit of Completion of Consent to Treatment Forms
Safeguarding	Effectiveness of the Safeguarding checklist in practice
Safeguarding Team	Audit of One to One Supervision
Safeguarding Team	Experiential Learning Forum Audit Report
Safeguarding Team	Audit of records of Children Subject to a Child Protection Plan
Safeguarding Team	NICU safeguarding audit
Safeguarding Team	Reflective Learning Forums
School Nursing/Special Needs/Community Nursing	Gastrostomy & Medication Audit
School Nursing/Special Needs/Community Nursing	Correct Use of Patient Group Directives
Sexual & Reproductive Health	Audit of EllaOne prescribing at Lewisham Healthcare Family Planning Clinics
Sexual & Reproductive Health	Faculty of SRH workforce census
Sexual & Reproductive Health	Department of Sexual & Reproductive Health (SRH) Audit of Records of Nurses Issuing Under Patient Group Direction in SRH clinics
Sexual and Reproductive Health	Re-audit of young people under 16 attending SRH clinics in Lewisham over a 31 day period
Therapies	Audit of direct (face-to face) and indirect (patient related) activity of Speech & Language Therapists with adult stroke patients on Beech ward
Therapies	Service evaluation of joint physiotherapy and podiatry clinic
Therapies	Joint Physiotherapy & Podiatry Clinic Service Evaluation
Therapies	Do patients goals change from hospital to home
Therapies	Documentation audit (adult outpatient physiotherapy)

Vascular	Clarivein
Women's Services	Obesity in Pregnancy Re-Audit
Women's Services	Pain Management post caesarean section
Women's Services	Blood Results Re-Audit
Women's Services	Term pre-labour rupture of membranes
Women's Services	Born Before Arrival (BBA)
Women's Services	Audit of newborn blood spot request repeat samples at LHNT during April and May 2012: Standard 5. Quality of blood spot sample
Women's Services	Instrumental Delivery Audit
Women's Services	Perineal Trauma
Women's Services	Reaudit of Incomplete excision after LLETZ
Women's Services	Outcome of methotrexate management of ectopic pregnancies
Women's Services	Bladder Care
Women's Services	Audit of time of decision to delivery of emergency caesarean section
Women's Services	Birth Centre Transfer Audit
Women's Services	Audit of DAU Services 2012
Women's Services	Accuracy of colposcopy in predicting high grade CIN
Women's Services	Intra operative cell salvage (IOCS) use in maternity

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South London and Maudsley NHS
NHS Foundation Trust
http://www.slam.nhs.uk

Proposed Changes to Lewisham Adult Mental Health Services

May 2013

Foreword

We would like to make changes to NHS adult mental health services in Lewisham. We hope to invest over the next year to reorganise the way our community teams work.

These changes are being driven by a number of factors, including the need for us to identify more cost effective ways of working and respond to reductions in the resources available to NHS and social care in Lewisham. At the same time, we are working with health, social care, primary care and voluntary sector partners in the local area we serve to look at how the whole system of care can be organised better so that patients receive high quality care and we make most effective use of the resources available to us.

We believe we could be better at supporting patients with serious mental health problems in their recovery. By reorganising our teams to deliver care based on the best evidence of what works, we can focus on supporting the most unwell patients, helping to prevent them from relapsing and having to be readmitted to hospital. If this proves successful, it should over time reduce dependence on hospital care. If we can reduce the cost of hospital care we can reinvest resources into other services.

We also want to improve how we respond to people when they become unwell, either for the first time or in a crisis by aligning our teams with Lewisham's primary care neighbourhoods so that we can be more responsive to GPs during extended surgery hours and provide faster assessments of people in mental health crisis.

For people who no longer need formal treatment we want to work more closely with GPs and voluntary groups to help support their independence. And for people with stable mental health needs, making the journey back to the care of their GP we will develop new teams to help and support them through their recovery.

Changing the way we do things now is the best way for us to ensure we can provide a service tailored to the needs of Lewisham residents in future. We have to adapt not only to the financial environment but to other factors, including an ageing population and changes to the way our services will be commissioned in future. The world is changing and we have to change with it. The changes we are proposing build on the work we have done over the last decade or more to help people at an early stage in their illness, rather than reacting when they reach 'crisis point' when the only option available is to admit them to hospital. It is about focusing upon recovery rather than just treating illness. We believe that our proposals could help us to make a lasting difference to people's experience of mental health care and support our goal of improving mental health for all.

Dr Martin Baggaley, Medical Director

1. Executive Summary.

Significant review and engagement work has taken place in Lewisham since 2010 to agree a new model for community adult mental health services. The process, led initially by Lewisham Primary Care Trust, in partnership with a range of stakeholders, GPs and South London and Maudsley NHS Foundation Trust, identified a number of key changes that need to take place to improve local services and in particular, to ensure that service users receive care within the most appropriate settings.

In addition to improving the quality and responsiveness of the service, attention was given to cost and productivity, and in line with the PCT 3 year QIPP development plan, financial efficiencies in the region of £800K were identified, most of which would have required reduction in staffing.

During this developmental phase, SLaM was involved in similar service reconfigurations in other boroughs and came to understand that there was a strong link between the removal of resource and concerns about quality. Reduction in community investment tended to lead to increased caseload sizes, resulting in teams becoming focussed almost exclusively on crisis work. This led to increased inpatient admissions and less proactive working with people using the recovery approach – thus leading to greater caseload sizes and relapse rates among service users who could have remained well.

Identifying these as possible risks to Lewisham services, led the Clinical Commissioning Group (CCG) and SLaM to reconsider the existing plan and to explore a proposal whereby resources were not removed from community services. Instead consideration could be given to the redesign of community team care pathways to make significant improvements to the rate of relapse and associated hospital admission rates. Such an approach would focus on diverting patients away from hospital settings and providing treatment in the community thereby identifying financial efficiency related to inpatient beds rather than from community teams.

In this paper we propose an enhanced adult mental health model with three key area of focus. **1. Relapse prevention**; requiring the remodelling of community teams to systematically deliver interventions that have good evidence in treating and supporting patients with serious mental health problems in their recovery and in reducing their relapse. This approach is very innovative and should reduce dependency in the medium - longer term for hospital based care. **2. Improving the capacity and competency of assessment and crisis resolution services**. Configured in line with the four primary care neighbourhoods and echoing similar reconfigurations of adult social care staff, the mental health assessment teams will have the

ability to respond to GPs during extended surgery hours and to respond in a timely manner to crisis situations. **3. Provide new pathways for people not requiring secondary services.** To be achieved through working closely with GPs and other voluntary sector providers to support the independence of people no longer requiring formal treatment. This will also be supported through the development of Low Intensity Teams (LIT) who will carefully facilitate the transition of care between secondary and primary for people with stable, non relapsing mental health needs.

The scale of the financial efficiencies that can be delivered from a reduced dependency on hospital based care is significantly dependent on community mental health teams' ability to reduce relapse. This impact is contingent on the capacity of the community mental health team and their ability to introduce new levels of skilled intervention. As such, SLaM is in discussion with the CCG about possible investment into Lewisham adult services to help facilitate a greater pace of change, improvement and efficiency.

2. Current Adult Mental Health Services.

The current adult mental health services in Lewisham were developed in line with the National Service Framework (NSF) for mental health. The frameworks and standards prescribed within this process were designed to improve quality of care for people with serious mental health problems and to address variation in approaches to care provision that had developed over time.

Implementation in Lewisham (1999), was achieved by enhancing the services delivered from the three existing community mental health teams (CMHT) at Northover, Southbrook Road and Speedwell, who each developed the following additional service components; Community Forensic, Assertive Outreach, Early Intervention and Home Treatment Teams.

These services have served the borough well. However, recent guidance; New *Horizons* and *Next Stage Review* papers of 2009, and *No Health Without Mental Health* paper of 2011, require services to give a greater emphasis to delivering services that promote self-directed support, self-management, personalisation, and a shift of emphasis to maintain more people in primary care with input from third sector providers.

In addition to national changes, local developments at South London and Maudsley NHS Foundation Trust have provided an opportunity for delivery of innovative service approaches, based on the translation of clinical evidence, into services for local patients. This approach is a

key element of the approach taken by King's Health Partners, which is one of three Academic Health Science Centres (AHSC) in London, and in which SLaM is a partner.

On becoming a member of the AHSC in (2011), SLaM reconfigured its service delivery approach to one of Clinical Academic Groups (CAGs). Each CAG brings together clinical services, research and education to focus on the needs of particular groups of service users. The CAGs involved in this review are; Psychosis CAG, Mood, Anxiety and Personality (MAP CAG) and Psychological Medicine CAG.

Each CAG, through its close working with research activity and training, has developed clinical care pathways designed to improve the quality of patient care and outcomes through the delivery (where commissioned) of evidence based care and interventions.

The process of implementing CAG structures and associated care pathways has not yet been fully implemented in Lewisham.

The current configuration of community services for adults with mental health problems is fully integrated with London Borough of Lewisham Social Services and provides integrated mental health and social care in the following teams:

- Assessment and Brief Treatment: dealing with new referrals to the service, crisis intervention and short term work. Provided by the Mood, Anxiety and Personality CAG.

- Early Intervention: working with young people with a first or second episode of psychosis from 18 to 35 years old. Provided by the Psychosis CAG.

- Forensic Service: working with people who have a history of offending in the context of their mental illness. Provided by the Complex Care pathway of the Psychosis CAG.

- Home Treatment Team: 7 days a week, extended hours, borough wide community based acute treatment at home as an alternative to treatment in hospital. The service mainly provides crisis planning, support in maintaining and improving social networks and also looks to prevent a relapse. Provided by the Psychological Medicine CAG.

- Support and Recovery Services are for people who suffer severe and enduring mental illnesses. The service provides interventions and treatment to people with complex needs who have difficulty engaging with services and often require repeat hospital admission.

- Integrated Psychological Therapy Team (IPTT) provides assessment and delivery of a full range of therapies to people with complex psychological needs. The service was recently

reconfigured to bring together a range of services delivered in Lewisham and at the Maudsley Hospital. Provided by the MAP CAG.

- IAPT (Increasing Access to Psychological Therapy) provides therapy; primarily cognitive behaviour therapy and counselling to people at a primary care level. Implemented in 2009, the service provided treatment to 4559 patients, which equates to 12% of those in Lewisham experiencing depression or anxiety.

Further detail of the current services; staffing and caseload, are listed in Appendix A.

3. Approaches to developing proposed changes.

Identifying the key areas for future change was developed in a series of stakeholder events focused on developing mental health improvement plans to respond to NHS Quality, Innovation, Productivity and Prevention (QIPP) requirements.

The first seminar took place on 30th September 2010, led by Joint Commissioning with the two lead Mental Health GPs, lead SLaM clinicians and management and London Borough of Lewisham (LBL) staff, and was attended by 40 people. A second Mental Health QIPP meeting was held at the 11th Lewisham Mental Health Stakeholder Event in November 2010 open to all members of the general public attended by some 250 people. The event was coordinated by Lewisham Mental Health Partnership Board (MHPB) of Lewisham CCG, South London and Maudsley NHS Foundation Trust (SLaM) Lewisham Adult Services and London Borough of Lewisham. Again some 40 people attended the second event including GPs, service users, cares, voluntary sector and SLaM staff. Follow up workshops were held at subsequent years' Lewisham Mental Health Stakeholder Events.

Plans concerning mental health QIPP re configuration has also been discussed at the following meetings:

- Lewisham Mental Health Partnership Board
- Lewisham Mental Health Commissioning Executive
- NHS Lewisham Clinical Commissioning Executive Committee
- South London and Maudsley NHS Foundation Trust (SLaM) Core Contract meeting
- LBL Community Services Directorate Management Team Meeting
- NHS Lewisham Senior Management Team Meeting
- NHS Lewisham and LBL Adult Joint Strategic Commissioning Group
- NHS Lewisham and LBL Adult Joint Strategic Partnership Board
- Mayor and Cabinet when LBL savings are required
- NHS Lewisham Board for PCT savings
- All Mental Health voluntary sector providers commissioned
- Joint Consultative Forum – SLaM led patient and voluntary sector forum
- Healthier Communities Select Committee

In November 2012 focus groups were organised by service user consultants with the specific aim of gaining input into the emerging proposals: three groups for service users and one for carers were held on the 13th, 14th, 15th and 16th November 2012. In addition a meeting with Lewisham Users Forum was arranged for the 20th of November, and a meeting on the 21st with Family Health Isis. Commissioners and staff from SLaM also attended GP neighbourhood meetings where possible to discuss priorities from primary care, and jointly held two workshops as part of the Lewisham Mental Health and Wellbeing Day on the 7th of December. Overall some 150 people participated in these events.

4. Feedback from stakeholders

The following issues have been identified from stakeholder feedback as pertinent to improving Lewisham Adult Community Mental Health Services;

- Setting clear thresholds of eligibility for secondary care and discharge back to primary care
- Providing training to primary care to manage client group
- Ensuring consistent access to prompt advice and support from secondary care
- Ensuring primary and secondary care clinicians consistently have rapid access to clinical information as required
- Review of those that no longer require secondary care support in order to facilitate discharge
- Bolstering generic voluntary sector provision to deliver community support
- Reviewing culturally specific voluntary sector provision in line with borough demographics to deliver community support
- Recognising the support needs of those already within the Mental Health system
- Supporting secondary care clinicians to discharge people from caseloads where appropriate
- Instilling consistency across both primary and secondary care clinical teams/GPs so that people have access to the best possible treatment wherever they access care

5. Strategic Case for Change.

The following national and local priorities have also been taken into account in developing these draft proposals

5.1 No Health without Mental Health (2011)

This Department of Health guidance identified the following six objectives for mental health services

(i) More people will have good mental health

More people of all ages and backgrounds will have better wellbeing and good mental health. Fewer people will develop mental health problems – by starting well, developing well, working well, living well and ageing well.

(ii) More people with mental health problems will recover

More people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live.

(iii) More people with mental health problems will have good physical health

Fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health.

(iv) More people will have a positive experience of care and support

Care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure that people's human rights are protected.

(v) Fewer people will suffer avoidable harm

People receiving care and support should have confidence that the services they use are of the highest quality and at least as safe as any other public service.

(vi) Fewer people will experience stigma and discrimination

Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will decrease.

5.2 Joint Strategic Needs Assessment.

Severe Mental Illness (SMI) describes a range of disorders characterised by psychosis, where individuals become apparently detached from reality. These conditions affect

approximately 0.7% of the UK population, and include schizophrenia and bipolar disorder (previously known as manic-depression).

Consistent with its demographic, Lewisham is thought to have substantially higher rates of SMI than England with a prevalence of 1.1% therefore affecting approximately 2900 people. About half of these are managed in primary care, with additional support for the remainder available via acute community and in-patient services.

Common Mental Illness (CMI) describes a range of mental health problems characterised by their self-limiting nature and of which a significant proportion remain undiagnosed. These conditions include anxiety/neuroses, sleep disorders and phobias. CMI is common; a third of the population suffer from CMI during their lifetime however, the majority (around 75%) go undiagnosed.

In Lewisham approximately 20% of 16-74 year olds are thought to suffer at any one time, totalling over 36,000 people annually. The consequences of CMI for the individual vary, but the effects sociologically and economically for the borough are immense. A range of talking therapies and medications are available to treat these problems, for the most part managed by GPs and psychologists.

5.3 Delivering Quality Innovation Productivity and Prevention (QIPP)

In March 2011 NHS South East London Cluster agreed to savings which would reduce the Lewisham Mental Health budget by £4.5m between 2011 and 2014. These savings form part of the contribution to the required £20 billion NHS Quality, Innovation, Productivity and Prevention (QIPP) efficiency savings.

5.4 Delivery of Care Pathways.

Care pathways are descriptions of the steps involved in treating and supporting a service user, and are designed to ensure that each service user can be clear about what care we deliver and can receive the best possible outcome. By using pathways to make sure that the right evidenced based care is provided at the right time in the right place, by the right person, services can be more efficient and provide better patient experience.

The Psychosis, Psychological Medicine and MAP CAGs have over the last 2 years, developed and piloted care pathways, taking input from staff and service users across all four boroughs to identify evidence-based best practice and trialling implementation in Lambeth and Croydon. Most of what is in the pathways is already familiar to staff as they include current practice. The difference will be the consistency of what is available to service users and a more structured approach.

The adult mental health pathways developed include:

- Psychosis: Early Intervention, Acute (inpatient services), Complex Care (inpatient placements and supported housing) , and Promoting Recovery (community teams)
- Psychological Medicine: Home Treatment Team, Liaison
- Mood, Anxiety and Personality: Engagement, assessment and stabilisation (EAI) and treatment pathways for anxiety, depression and personality disorder.

6. Key elements of proposed model.

6.1. Full implementation of care pathways and Clinical Academic Group structures.

Care pathways are designed to provide care and treatment that is focused on the needs of people with similar conditions or diagnosis. Although partially implemented, the Lewisham, community mental health teams are primarily configured in respect of the duration of care a person is likely to require, rather than in meeting the specific needs presented by people with particular conditions. As such, the full benefit of the pathways has not yet been realised.

The teams are currently divided into Support and Recovery teams who provide an ongoing service to people irrespective of diagnosis / area of need and Assessment and Brief Treatment Teams (ABT), who provide initial assessments and time limited interventions.

This generic configuration does not allow the teams to provide the dedicated care pathway focus that can benefit people with particular areas of need. It provides a sub optimal approach to people with longer term non psychotic disorders such as depression, anxiety disorders, traumatic stress disorder or personality disorder (to those cases requiring a level of input which cannot be provided by the recently formed Lewisham Integrated Psychological Therapies Service (IPTT).

Similarly the benefits of delivering a more specialised 'Promoting Recovery' service for psychotic illness cannot be fully realised by the current Support and Recovery teams while they continue to be responsible for managing all long term and disabling mental health conditions regardless of diagnosis.

The proposed model will allow delivery of the care pathways.

6.2. Improving Access and Interface between Primary and Secondary Care.

The initial referral for a mental health assessment (currently 1,700 per year) we believe is a crucial component of the overall mental health care system in Lewisham in respect of; the individual along with their family wanting a better experience, of the referrer

wanting a more responsive service with better communication, ourselves needing to gate keep the resources available and the commissioner wanting quality outcomes that are value for money.

We propose to enhance this 'front-end' assessment function to make it easier and quicker for GPs (and others) to refer patients into the system. This will strengthen our ability to manage demand for services and ensure that patients are directed to the most appropriate mental health service to meet their needs.

It is also important that once a person is assessed as needing a secondary mental health service, they receive an effective evidence based treatment. The assessment services have always been good at engaging people and stabilising their distress, however up until now evidence based treatments in community teams have been mainly for people with psychotic illnesses.

The Enhanced Assessment teams we propose should provide the following services:

- Assessment of all referrals from primary care and other referral sources (including police and other statutory services, emergency services and inpatient wards) of people who are not known to secondary care services. Referrals will be screened and in discussion with referrers some will be signposted to alternative sources.

- Face to face assessment of referrals from primary care and other referral sources, with signposting or onward referral to other sources of treatment and support including IPTT and IAPT.

- Working closely with Home Treatment Team to provide urgent assessments in primary care settings outside traditional office hours.

- Linked working with Reablement services in the Local Authority to facilitate, where appropriate, the management of people with social care needs in primary care.

- Linked working with Home Treatment Team to support people in a crisis to remain in primary care when possible. This is particularly so for people with a diagnosis of psychosis who have been successfully treated and discharged but at times may need extra support to remain in primary care.

6.3. Reducing relapse in psychosis.

We recognise that psychosis is a Long Term Condition which may have a relapsing and remitting course. There is some evidence that using specific early warning sign focussed interventions lead to a significant reduction in the number of people who relapse compared with usual care, although the *time* to relapse does not differ between these two groups. Similarly the risk of rehospitalisation is significantly lower with early warning sign interventions compared with usual care although the *time* to

rehospitalisation does not differ between these two groups (Training to Recognise the Early Signs of Recurrence in Schizophrenia, Cochrane Review 2013).

At the moment Service Users with a diagnosis of psychosis in Lewisham fall into four groups:

1. No admissions in past 3 years (55%)
2. One admission in past 3 years (23%)
3. Two admissions in past 3 years (12%)
4. Three or more admissions in the past 3 years (11%)

For Service Users who relapse there are a range of interventions set out within NICE guidelines, research and best practice reports to treat and prevent relapse. The intention within the new model would be to develop the range and volume of interventions available and to provide them earlier, so reducing both the number and severity of relapses. The interventions include:

- Antipsychotic medication
- CBT for Psychosis
- Family Interventions
- Vocational interventions

There are also a range of activities that support people in their lives by ensuring that they are able to manage and maintain their activities of daily living and achieve their recovery goals, these include:

- Assessment of need and eligibility for services and development of recovery and support plans to meet identified needs
- Assessment, procurement and monitoring of funded support packages
- Assessment of risk and implementation of plans to minimise their impact
- Child and adult safeguarding assessments and formulation and delivery of care plans in relation to identified risks
- Education and support in relation to lifestyle, for example, the impact of drug use on psychosis, this includes motivation interviewing
- Interventions and education which promote medication concordance
- Administration of medication including depot injections and blood monitoring
- Physical health checks
- Monitoring for early warning signs of relapse and putting actions in place to reduce risk of major relapse at this point (this may include review and alteration to medication regimes, increased contact for people who are socially isolated, daily supervised medication or assessment and introduction of a specific personalised support package).

At times people will also require more intensive interventions involving up to twice daily visits for a period of time provided within the Home Treatment Team. A proportion of Service Users are admitted to inpatient care.

Current staffing resources (both in terms of numbers and qualification/experience) limit the range, number and frequency of the interventions that can be undertaken, this leads to a focus on crisis management rather than proactive early intervention and hence impact on the availability to reduce the number and severity of relapses. The proposal is to enhance the staff resources (both numbers and skills) and operate with smaller caseloads such that care co-ordinators are more proactive, able to deliver more interventions more frequently, and better able to direct the focus of activity promptly to those in greatest risk of relapse.

Work with the IAPT SMI teams has indicated that each therapist can carry out approximately 12 hours of face to face work with Service Users a week. Current care co-ordinator caseloads are high so people in crisis may receive increased visits at the expense of those who are at less risk of relapse at that time. The teams also have limited access to medication advice, review and changes to medication regimes. There is also limited availability of CBT for Psychosis and Family Interventions, so not all people who would benefit are able to receive them. Vocational input to teams is minimal which means either assessments of need or interventions, or both, are missing. The increase in Consultant Psychiatrists, Psychologists and vocational/Occupational Therapists in the teams will increase the interventions available.

The Promoting Recovery teams would have systems in place to allow the Care Co-ordinators to focus on non-crisis work for set times in the week and other times when they actively manage patients in crisis or showing early signs of relapse. The Care Coordinators need to have comprehensive assessments and formulations of their patients' needs with a resultant recovery care plan to address them. This is likely to involve a combination of interventions including medication, psychology interventions and vocational interventions as well as looking at social care needs and liaison with other services. Crisis work slots will involve more working across the team so the Service Users are held by the team as well as having input from the Care Co-ordinators. This will include a small group of Service Users in each team receiving daily supervised medication either through their attendance at the team base or via daily visits.

Overall the Promoting Recovery teams will aim to move the Service Users 'up a group' so that people in group 4 would move to group 3, group 3 to 2, 2 to 1 and group 1 will be in primary care.

6.4. Providing appropriate levels of care in the right place (LiTT and new relationship with primary care)

A new service (Low Intensity Treatment Team) will be developed to support people who are stable and at low risk of relapse having had no admissions in the last 3 years to prepare for discharge to primary care. The team will provide:

- A medication service
- An assessment and implementation of support of packages that help support the Service User to remain well
- A service to provide support and advice to primary care to enable them to take back responsibility for on-going care and treatment where appropriate

50% of current Service Users fall into the cohort of people who are stable and at low risk of relapse. Of this group 40% cannot be discharged because of the complexity of their medications, 40% have on going social care needs that require them to remain within services with the current model of provision and 20% (10% of total caseload) can be supported through the LiTT team back into primary care.

6.5. Providing improved pathways for people with mood, anxiety and personality disorders.

We propose to develop 'Community MAP Treatment Services' who will provide specific care and treatment for people with non psychotic disorders. This service will work closely with the primary care level IAPT Service and Integrated Psychological Therapy Service (IPTT) which provides complex psychological therapy

The treatment teams will provide the following services:

- Treatments for depression and anxiety which are recommended by NICE guidelines as being provided in secondary care, including specialist review of medication, care co-ordination under the Care Programme Approach, and specific psychological treatments where indicated which cannot be provided by IPTT due to the complexity of the client's presentation.

- Treatments for bipolar affective disorder which are recommended by NICE guidelines as being provided in secondary care, including specialist review of medication and care co-ordination under the Care Programme Approach, or long term outpatient follow-up in secondary care where preferred by client and GP, and specific psychological treatments where indicated.

- Treatments for personality disorder which are recommended by NICE guidelines as being provided in secondary care, including care co-ordination under the Care Programme Approach, and specific psychological treatments where indicated which cannot be provided by IPTT due to the complexity of the client's presentation.

- In addition, people with a diagnosis of a psychotic illness who have not been in contact with secondary care services in the previous year will be assessed by the A&T teams and may benefit from the proposed reablement element of the service, or will be referred to the Promoting Recovery teams if appropriate.

7. Proposed Service Configuration and Accommodation.

It is proposed that the current configuration for mental health services of three catchment areas and associated teams is changed to align with the four primary care neighbourhoods as outlined in the map in Appendix B. This allows a greater coherence between primary care and the secondary care teams and helps support the working relationships between secondary care and the CCG.

This would require the reconfiguration of the three current Assessment and Brief Treatment teams into four locality teams and the reconfiguration of the three current Support and Recovery Teams into four Recovery teams each with 1WTE Consultant Psychiatrist post per team. The Early Intervention Teams would then operate as a single team based in the same building as would the Community Forensic Team. The remaining teams would continue to operate as they do currently serving the whole borough. Proposed accommodation for the teams is outlined in Appendix C. The in patient services would remain as they are with 1WTE Consultant Psychiatrist post per ward.

8. Investment and Productivity.

Discussions are underway between SLaM and the CCG with respect to potential investment from SLaM in developing this enhanced service. Investment will be made against realizing savings in reduced dependency on hospital based care through preventing relapse and by reducing the length of stay for those who are admitted.

9. Equalities and Quality Impact Screening.

Equalities leads and service leads have jointly completed the equalities relevance checklist. This process identified that the proposed service development will have no differential negative impact on any of the protected characteristics, but there was a potential positive impact on race. People from BME communities are more likely to be admitted onto the wards and this model seeks to reduce admissions. As plans develop, the equalities impact will be reviewed. Any impact on service users and carers in respect of changes to team location will be carefully planned with them and full consideration given to personal issues and circumstances.

10. Stakeholder Engagement

Before any changes are implemented, we intend to engage fully with stakeholders in Lewisham mental health services and will be preparing a detailed plan outlining this process.

Appendix A

Current Adult Mental Health Services provided by South London and Maudsley NHS Foundation Trust

Function	Teams	Caseload / Beds*	Clinical Staffing in whole time equivalents (wte)**
Acute Inpatient Wards	Powell Clare Wharton	18 beds 17 beds 18 beds	Average of 17 nurses per ward, 1 consultant, 1 manager and sessional Psychology and Occupational Therapy input
Psychiatric Intensive Care Unit	Johnson	10 beds	23 nurses, 1 consultant, 1 manager and sessional Psychology and Occupational Therapy input
Triage Ward	Triage Ward	Total: 16 beds	31 nurses, 1.2 consultants, 1 manager and sessional Psychology and Occupational Therapy input
Assessment and Brief Treatment	Speedwell CMHT Southbrook CMHT Northover CMHT TOTAL	262 384 357 1003	1 care co-ordinator/1 social worker/1 team leader/1 Consultant 2 care co-ordinators/1 team leader/1 Consultant 2 care co-ordinators/1 social worker/1 team leader/1 Consultant
Support and Recovery	Speedwell CMHT Southbrook CMHT Northover CMHT TOTAL	337 360 386 1083	8 Nurses/3 Psychologists/10 social workers/1 team leader/1 Consultant/1 Occupational Therapist/1 Care Support Worker 10.7 Nurses/5.6 social workers/1 team leader/1 Consultant 7 social workers/9 Nurses/1 team leader/1 Consultant

Function	Teams	Caseload / Beds*	Clinical Staffing in whole time equivalents (wte)**
Home Treatment Team	Lewisham Home Treatment Team	Episodes: 916	22 Nurses, 1 Consultant, 1 team manager, 1 social worker
Early Intervention	Lewisham Early Intervention Service (LEIS)	176	4 Nurses/5 social workers/2 Supp Worker/1 Voc-Welfare Officer/1 Consultant /1 Occupational Therapist
Social Inclusion and Recovery Service	Occupational Therapy Self Directed Support TOTAL	89 81 170	3 Support Workers 6 Occupational Therapists 4 Vocational Specialists
Complex Care Wards	Heather Close	29 beds	23 Nurses/1 Occupational Therapist/1 Activity Coordinator/9 Support Workers
Placement Team and High Support Housing	Enhanced Recovery Team Edward Street	87 13 beds and 4 independent flats	3 Social Workers / 2 Nurses 18 Healthcare Assistants / 5 Nurses
Community Forensic Team	Speedwell Forensics Northover Forensics Southbrook Forensics TOTAL	70 62 67 199	6 Social Workers 6 Nurses 1 OT

*** caseloads as at 13th May 2013**

**** Staff numbers exclude administrative staff and trainees but include team management**

Current Accommodation

Currently service users are seen at three community sites: Speedwell, Southbrook Road and Northover. Whilst these buildings have their limitations in terms of accessibility, it is proposed that these will continue to be the team bases until better alternatives have been identified.

Staff are also based in a number of other buildings in the borough including Ladywell House and Kirkdale. The Trust is currently considering vacating these buildings and relocating staff into the Ladywell Unit as well as other community bases.

SLaM also owns the Lee Centre which is currently occupied by Family Health ISIS and Network Arts.

Speedwell: 62 Speedwell Street, Deptford, London, SE8 4AT

Southbrook: 1 Southbrook Road, Lee, London, SE12 8LH

Northover: 98-102 Northover, Downham, Bromley, BR1 5JX

Current Structure

The community teams in Lewisham are split across three sectors each with a small Assessment and Brief Treatment (ABT) team, and a Support and Recovery Team.

The ABT team do time limited work and any client who needs an allocated worker will be referred into the promoting recovery service. This model of working differs significantly from that now provided by equivalent services in the other boroughs served by SLaM, as the relatively small level of staffing in the ABT teams does not allow them to provide longer term or specialised treatment for non-psychotic conditions such as depression, anxiety disorders, traumatic stress disorder or personality disorder (those cases requiring a level of input which cannot be provided by the recently formed Lewisham Integrated Psychological Therapies Service (IPTT), which also provides treatments for these conditions). The benefits of the condition specific care pathways being delivered in other boroughs to patients with these conditions cannot be offered in Lewisham, and the positive aspects of SLaM's reconfiguration into CAGs has not been fully realised. Similarly the benefits of delivering a more specialised Promoting Recovery service for psychotic illness cannot be fully realised by the Recovery and Support teams while they continue to be responsible for managing all long term and disabling mental health conditions regardless of diagnosis.

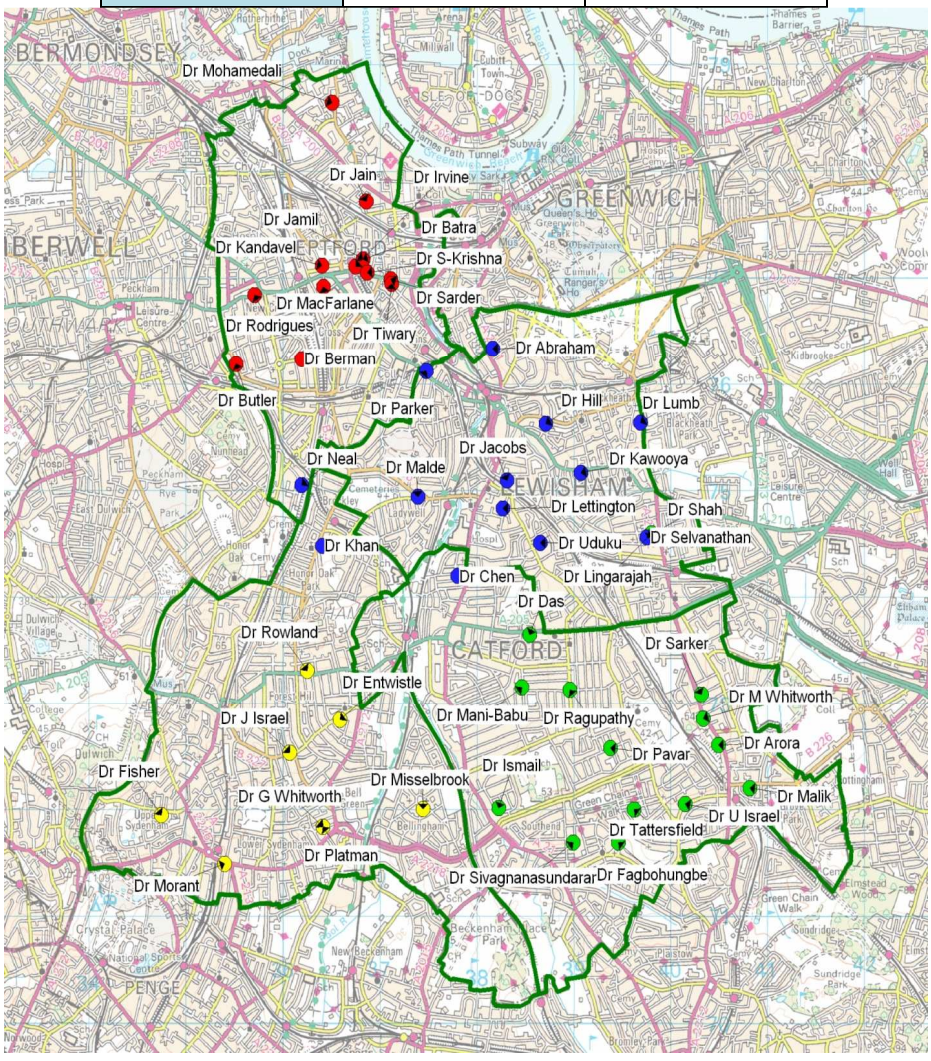
Each of the three current sectors relates to a defined group of GP practices but the three sectors do not map onto the four GP neighbourhoods. Thus each of the six teams in the three sectors must develop its own working relationships with the practices in its area, without being able to take advantage of the networks and opportunities for face to face contact available at neighbourhood level.

Appendix B

GP Neighbourhoods

There are four GP neighbourhoods in the borough of Lewisham co-operating within their areas to deliver services in primary care. Currently there are just over 300,000 patients registered in Lewisham:

Neighbourhood	Registered patients	Percentage
1	64,924	21%
2	108,948	36%
3	63,590	21%
4	68,916	22%
Total	306,378	100%



Appendix C

It is proposed that the following teams will be based in the identified buildings but that all community bases will be used flexibly with the ability to book consultation rooms through an electronic booking system.

The longer term Estates strategy for the Trust is to reduce accommodation costs by implementing flexible working and providing staff with mobile technology. The aim will be to create one or two hubs in each borough and work with other public services to provide local accommodation to see patients. This may involve relocating Lewisham sites to more central locations.

Current Accommodation	Current teams	Proposed teams
Speedwell Centre	Speedwell Assessment and Treatment Early Intervention in Psychosis Team Community Forensic Service Speedwell Support and Recovery team	Neighbourhood 1 Promoting Recovery Team Neighbourhood 2 Promoting Recovery Team Neighbourhood 1 Assessment and Liaison Team Neighbourhood 2 Assessment and Liaison Team
Southbrook Road	Southbrook Assessment and Treatment Early Intervention in Psychosis Team Community Forensic Service Southbrook Support and Recovery team	Early Intervention in Psychosis Team Community Forensic Service
Northover Centre	Northover Assessment and Treatment Early Intervention in Psychosis Team Community Forensic Service Northover Support and Recovery	Neighbourhood 3 Promoting Recovery Team Neighbourhood 4 Promoting Recovery Team Neighbourhood 3 Assessment and Liaison Team

Current Accommodation	Current teams	Proposed teams
	Team	Neighbourhood 4 Assessment and Liaison Team
Ladywell House / Ladywell Unit	Enhanced Recovery Team (Complex Care placements team) Home Treatment Team	to move to Ladywell Unit or alternative accommodation.

The Trust owns an additional property in Lewisham, the Lee Centre, that is used for the provision of mental health services. For the past year the Lee Centre has been used by the voluntary sector to provide services for people with mental health problems. The Trust proposes to continue with this arrangement with formal lease terms in place with the voluntary providers currently using the Lee Centre.

HEALTHIER COMMUNITIES SELECT COMMITTEE			
Report	NHS 111: Briefing		
Ward	All	Item No.	7
From	Hayley Sloan, SEL NHS 111 Lead, NHS South London		
Class		Date	29.05.13

What is the current status of NHS 111 in South East London?

NHS 111 continues to run well in Bexley, Bromley and Greenwich since the service began on 12 March 2013. There have been steady improvements since the Easter weekend, which is very encouraging. The majority of people calling the service are getting through quickly and receiving timely clinical call backs when necessary.

Since the beginning of April:

- Over 95% of calls are answered by a health advisor within 60 seconds
- Call abandonment rates have effectively sat at 0%
- Of the total number of calls referred to a clinical adviser (25-35% of triaged calls), around 12-13% are put into a queue for a call-back from a clinician. Approximately 60-70% of these call-backs to patients are made within ten minutes of the initial call to 111
- 10-12% of calls have resulted in an ambulance being dispatched
- Around 75-80% of these dispatches are conveyed by LAS

The main area where we need to see further improvements is in call backs to patients by clinical advisers (nurse clinicians). We are in regular communication with NHS Direct about their plans for clinician staffing at the call centre and the impact this has patients waiting for a clinical call back. NHS Direct have established processes for managing clinical call back queues to ensure that there are no high-risk calls waiting for a clinical call-back.

When is the service likely to begin in Lambeth, Southwark and Lewisham?

At this stage, we are not able to give a start date for the service in Lambeth, Southwark and Lewisham. This is mainly for two reasons:

- Whilst we are pleased with the overall improvements in the NHS 111 service so far, we are still seeking assurance that the service will be able to operate at an effective level with the addition of three more boroughs. For us patient safety is paramount and a stable, efficient, responsive and high quality service needs to be available across the whole of south east London.

- Secondly, NHS England is currently undertaking a review of NHS 111 at national level. This is because of poor performance issues that have been reported in some parts of the country. The outcome of the review could mean that NHS England will make changes to the way in which the service is commissioned, the way it operates and how it is fully rolled out around the country. While we wait for this National Review to be completed it would not be appropriate to start the service in Lambeth, Southwark and Lewisham.

How will the National Review being carried out by NHS England affect the SEL NHS 111 service?

The National Review will include a review of the sustainability of the current model of service into 2014, the ability of providers to maintain delivery of these services and an appraisal of the provider market. Until the results of this review are available, it is difficult to determine what the exact impact on the SEL NHS 111 service will be. However, south east London commissioners are considering various options should it become necessary to adapt or change the service provision we currently have in place.

Committee	Healthier Communities Select Committee	**Item No**	10
Report Title	Select Committee Work Programme		
Contributors	Scrutiny Manager		
Class	Part 1	**Date**	29 May 2013

1 Purpose

1.1 To advise Members of the select committee of the work programme for the municipal year 2013/14.

2 Summary

2.1 At the beginning of the municipal year, each select committee drew up a draft work programme for submission to the Business Panel for consideration.

2.2 The Business Panel considered the proposed work programmes of each of the select committees on 14 May 2013 and agreed a co-ordinated overview and scrutiny work programme, avoiding duplication of effort and facilitating the effective conduct of business.

2.3 However, the work programme is a "living document" and as such can be reviewed at each select committee meeting so that members are able to include urgent, high priority items and remove items that are no longer a priority.

3 Recommendations

3.1 The select committee is asked to:

- note the work programme attached at **Appendix B** and discuss any issues arising from the programme;
- specify the information and analysis required in the report for each item on the agenda for the next meeting, based on desired outcomes, so that officers are clear on what they need to provide;
- note all forthcoming executive decisions, attached at **Appendix C**, and consider any key decisions for further scrutiny.

4. The work programme

4.1 The work programme for 2013/14 was agreed at the meeting of the Committee held on 16 April 2013 and considered by the Business Panel on 14 May 2013.

4.2 Following the last meeting, the following changes to the agenda for this meeting have been agreed by the Chair:

- That the 'New Cross Gate Healthy Living Centre' be added to the May meeting.
- The HIV services item that had been moved to July, to be extended into a broader item on sexual health services.

An updated work programme is attached.

4.3 The Committee is asked to consider the work programme and consider if any urgent issues have arisen that require scrutiny and if any existing items are no longer a priority and can be removed from the work programme. Before adding additional items, each item should be considered against agreed criteria. The flow chart attached at **Appendix A** may help members decide if proposed additional items should be added to the work programme. The Committee's work programme needs to be achievable in terms of the amount of meeting time available. If the committee agrees to add additional item(s) because they are urgent and high priority, Members will need to consider which medium/low priority item(s) should be removed in order to create sufficient capacity for the new item(s).

5. The next meeting

5.1 The following substantive items are scheduled for the next meeting:

Agenda Item	Review Type	Priority
1. Emergency Services Review (Evidence and Recommendations)	Standard Review	High
2. Health & Well Being Strategy Delivery Plan	Standard Review	High
3. Outcomes Based Commissioning and Outcomes Based Practice for Adult Social Care	Standard Review	Medium
4. Neighbourhood Working with GP's	Standard Review	Medium
5. Lewisham Hospital – Update	Standard Item	High
6. Leisure Contracts Update	Standard Item	Medium
7. HIV/Sexual Health Services	Standard Review	Medium

5.2 The Committee is asked to consider if any specific information and analysis is required for each item, based on the outcomes the Committee would like to achieve, so that officers are clear on what they need to provide for the next meeting.

5. Financial Implications

5.1 There are no financial implications arising from this report.

6. Legal Implications

6.1 In accordance with the Council's Constitution, all scrutiny select committees must devise and submit a work programme to the Business Panel at the start of each municipal year.

7. Equalities Implications

7.1 There may be equalities implications arising from items on the work programme and all activities undertaken by the select committee will need to give due consideration to this.

8. Date of next meeting

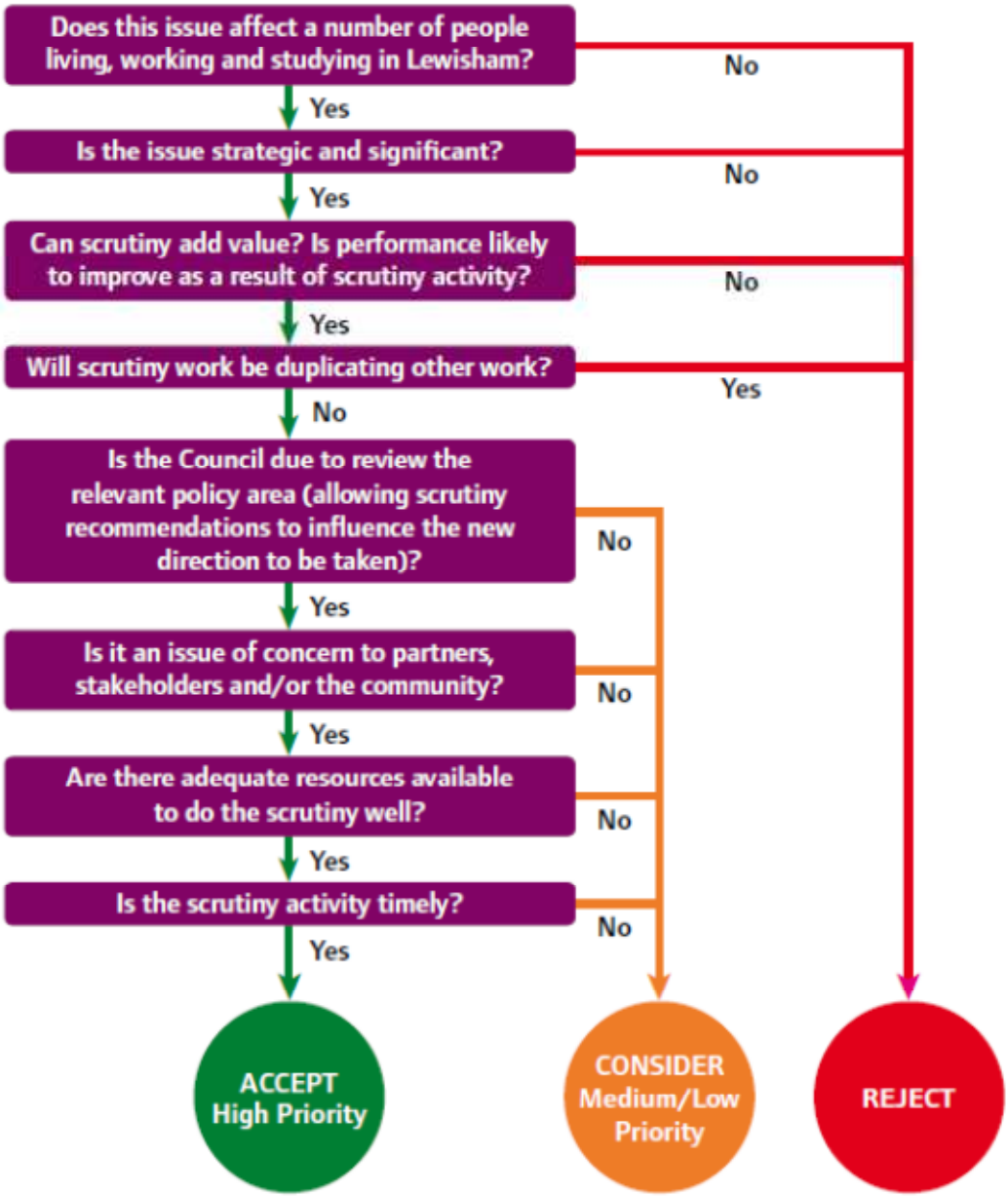
8.1 The date of the next meeting is Tuesday 9 July 2013.

9. Background Documents

Lewisham Council's Constitution

Centre for Public Scrutiny: the Good Scrutiny Guide – a pocket guide for public scrutineers

Scrutiny work programme – prioritisation process

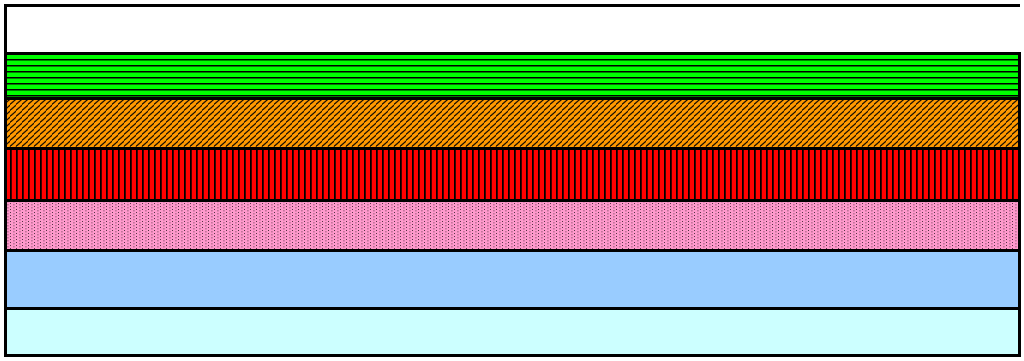


Healthier Communities Select Committee Wo

Work Item
Confirmation of Chair and Vice Chair
Changes in light of the Health and Social Care Act 2012 Report
Community Education Lewisham
Health & Wellbeing Strategy and Delivery Plan
Health Scrutiny Protocol (Revised)
Lewisham CCG South-East London Community Based Care Strategy (incl. CCG's approach to engagement)
Emergency Services Review
HIV Services/Sexual Health Services
Community Mental Health Review
Lewisham Hospital update
NHS Trust Quality Accounts
New Cross Gate Healthy Living Centre

Outcomes Based Commissioning and Outcomes Based Practice for Adult Social Care.
Leisure Contracts Update
‘Extra Care’ Housing Plans
Healthwatch Annual Report
Neighbourhood working with GP's
CQC Local Compliance Manager Update & Lewisham Healthcare NHS Trust inspection report update and Mental Health Adult Placement inspection report update
Improving Health Services in Dulwich and Surrounding Areas – consultation by the Southwark Clinical Commissioning Group
NHS 111 – Update
Library and Information Service
Savings Proposals 2014/15
QIPP - Items from 2013/14 Plans
Reablement
Update on Outcomes of Premature Mortality Review
Learning Disabilities and Healthcare Services
The Healthier Catering Commitment Scheme
Prioritisation process for Public Health expenditure in 2014/15 (incl. Sustainability of Community Health Projects and Initiatives)
Public Health 2012/13 Annual Report

The Francis Report - progress on recommendations
Establishing a South East London urban public health collaborative across Lambeth, Southwark and Lewisham
Francis Report
Interim Evaluation of the North Lewisham Plan



ork Programme 2013/14

Type of review	Priority	Strategic Priority
Constitutional requirement	High	**CP10**
Standard Review	High	**SCS 5, CP1, 8, 9, 10**
Performance Monitoring	High	**CP9**
Standard Review	High	**CP9, 10**
Standard Review	High	**CP10**
Standard Review	Medium	**CP1, 8, 9, 10**
Standard Review	High	**SCS5, CP1, 8, 9, 10**
Standard Review	Medium	**CP8, 9**
Standard Review	High	**CP8, 9**
Standing Item: to keep abreast of all changes and implications	High	**SCS5, CP1, 8, 9, 10**
Consultation	High	**CP9,10**
Standard Review	Medium	**SCS5, CP1, CP9**

Standard Review with consultation event	Medium	**CP8, 9**
Standard Review	Medium	**SCS5, CP9**
Standard Review	Medium	**CP6, 8, 9**
Standing Item	High	**CP1,8,9**
	Medium	**CP1, 8, 9, 10**
Standard Review	High	**CP8, 9, 10**
Standard Review	High	**SCS 5, CP8, 9**
Standard Review	High	**SCS5 CP7,8,9**
Performance Monitoring	Medium	**CP9**
Standard Review	High	**CP10**
Standard Review	Medium	**CP10**
Standard Review	Medium	**CP8, 9**
In-depth review follow up	High	**SCS5, CP9**
Standard review	Medium	**CP8, 9**
Standard review	Medium	**SCS5, CP1, CP9**
Standard review	High	**CP1, 9, 10**
Standard review	Medium	**CP1, 9, 10**

Standard review	Medium	**SCS5, CP1,8,9,10**
Standard review	Medium	**CP9, 10**
Standard Review	High	**SCS2 SCS 5**
Standard review	Medium	**CP9, 10**

Item completed
Item ongoing
Item outstanding
Proposed timeframe
Carried over from last year
item added

Delivery deadline	April	May	July
April			
April			
February			
July			
May			
Sept			
July			
May			
May			
Ongoing			
May			
May			

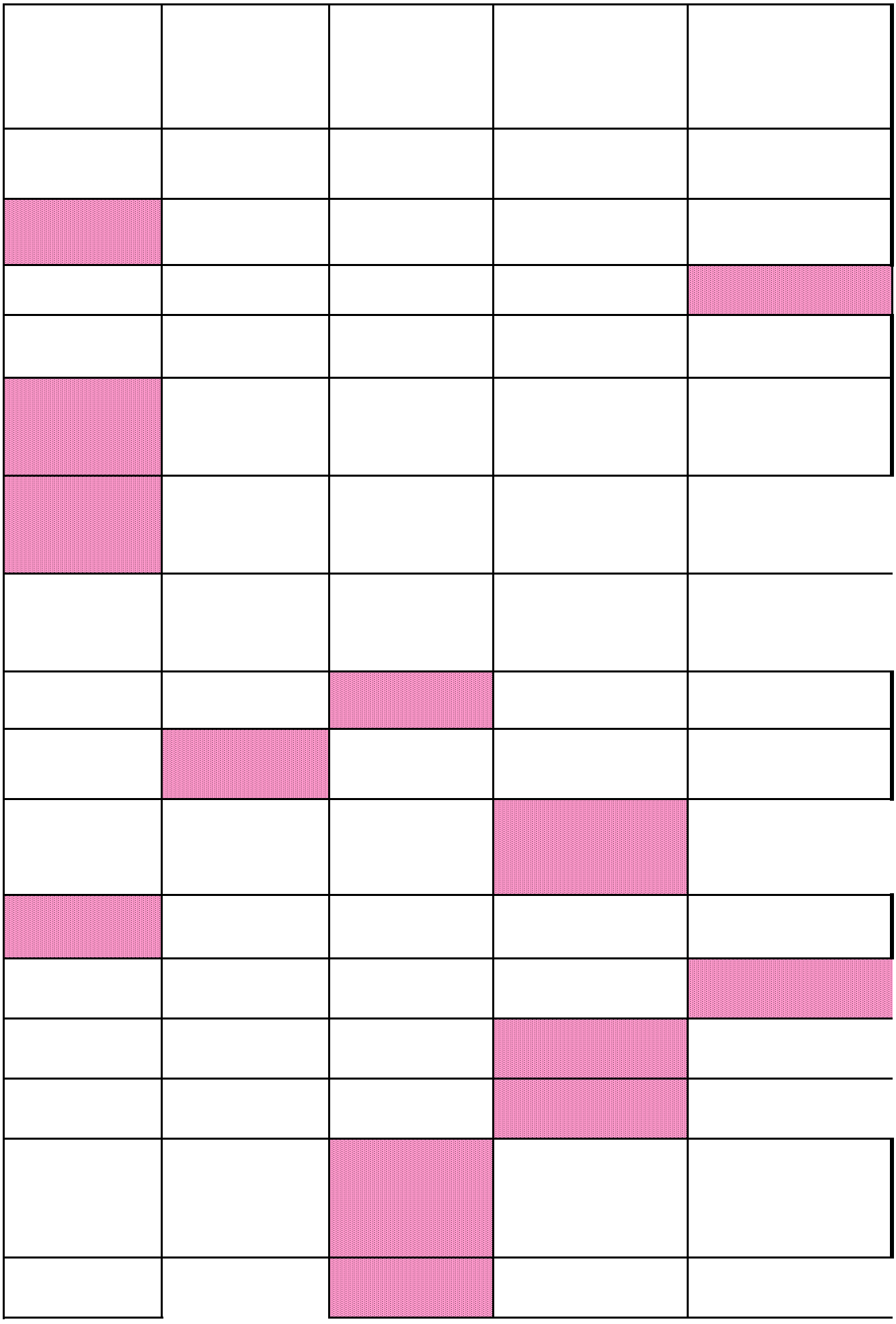
July			Plus an afternoon engagement event
July			
Sept			
March			
July			
Sept			
April			
May			
Dec			
Oct/Nov			
Feb			
Sept			
Mar			
Feb			
Feb			
Dec			
Dec			

Dec			
Dec			
Dec			
Dec			

Meeting Schedule		
1)	Tues	16/04/2013 (dsp. 4 A
2)	Weds	29/05/2013 (dsp. 16
3)	Tues	09/07/2013 (dsp 27 J
4)	Weds	04/09/2013 (dsp. 27
5)	Weds	23/10/2013 (dsp. 15
6)	Weds	11/12/2013 (dsp. 3 D
7)	Weds	05/02/2014 (dsp. 28J
8)	Tues	18/03/2014 (dsp. 6 M

Programme of Work

Sept	Oct	Dec	Feb	March



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SUMMARY OF FORTHCOMING EXECUTIVE DECISIONS

MAYOR & CABINET May 22 2013	
Title and details of Item	Directorate responsible
Response to Children & Young People Select Committee - 'Falling through the gaps' in-depth review	Children & Young People
Response to Children and Young People Select Committee and the Safer Stronger Communities Select Committee on Reshaping Youth Services	Children & Young People/ Community Services
Adoption Statement of Purpose and Children's Guides.	Children & Young People
Fostering Statement of Purpose	Children & Young People
Appointment/ Re-appointment of LA Governors	Children & Young People
Housing Matters Progress	Customer Services
Statement of Community Involvement	Resources & Regeneration
Highway Infrastructure Programme of Investment 2013-14	Resources & Regeneration
Catford Town Centre Local Plan	Resources & Regeneration
Adoption of Site Allocations Local plan	Resources & Regeneration
Development Management Local Plan-Submission Stage	Resources & Regeneration

MAYOR & CABINET(CONTRACTS) May 22 2013

Title and details of Item	Directorate responsible
NO BUSINESS	

MAYOR & CABINET June 19 2013	
Title and details of Item	Directorate responsible
Main Grants Programme – Community Centres	Community Services
Response to London Safety Plan Consultation	Community Services
Response to Children and Young People Select Committee on Strengthening Specialist Provision	Children & Young People
Response to Healthier Communities Select Committee on the implementation of the recommendations or the Premature Mortality Review	Children & Young People
The Oakbridge Federation (Rangefield and Forster Park Federation)	Children & Young People
The Eliot Bank and Gordonbrock Primary Schools Federation	Children & Young People
Appointment/ Re- appointment of LA governors	Children & Young People
Revised Instrument of Government for Abbey Manor College	Children & Young People
Response to Housing Select Committee on the Select Committee Work Programme.	Customer Services
Response to Sustainable Development Select Committee on neighbourhood planning.	Resources & Regeneration
Community Infrastructure Levy (CIL) – Draft Charging Schedule – Version 2	Resources & Regeneration

New Cross Gate Healthy Living Centre Scheme	Resources & Regeneration
Management Report	Resources & Regeneration
Draft Financial Results (outturn) for 2012/13	Resources & Regeneration
One Oracle – Update on Shared Services	Resources & Regeneration

MAYOR & CABINET(CONTRACTS) June 19 2013	
Title and details of Item	Directorate responsible
Building School for the Future Brent Knoll	Resources & Regeneration

Council June 26 2013	
Catford Regeneration Partnership Update	Resources & Regeneration
Catford Town Centre Local Plan	Resources & Regeneration
Adoption of Site Allocations Local plan	Resources & Regeneration
Development Management Local Plan-Submission Stage	Resources & Regeneration
Freedoms of the Borough	Resources & Regeneration

MAYOR & CABINET July 10 2013	
Title and details of Item	Directorate responsible
Permission to consult on proposals to enlarge 1) Coopers Lane Primary School from 2 to 3FE 2) Forster Park Primary School from 2 to 3FE	Children & Young People
Awards of contracts for the construction of 1) the Primary Phase of Prendergast Ladywell Fields College	Children & Young People

2)the enlargement of Adamsrill from 2 to 3FE.	
Generation Playclubs	Children & Young People
Financial Survey	Resources & Regeneration

MAYOR & CABINET(CONTRACTS) July 10 2013	
Title and details of Item	Directorate responsible
Agree the selection/approval of (Fire, Asbestos & Water Hygiene) Contract	Resources & Regeneration
Energy Company Obligation delivery partner procurement decision	Resources & Regeneration
Awards of contracts for the enlargement of John Stainer Primary from 1 to 2 FE	Children & Young People
Reprocurement of the Learning Disability Framework Agreement - Phase 2 Appointment to the Framework	Community Services
Passenger Transport Services Framework	Customer Services

MAYOR & CABINET September 11 2013	
Title and details of Item	Directorate responsible
Housing Supply and Demand	Customer Services
Deptford Southern Housing Sites – results of section 105 consultation and Equalities Analysis process	Resources & Regeneration

MAYOR & CABINET(CONTRACTS) September 11 2013	
Title and details of Item	Directorate responsible
Supporting People Contract Award Report	Community Services

MAYOR & CABINET October 2 2013

Title and details of Item	Directorate responsible

MAYOR & CABINET(CONTRACTS) October 2 2013	
Title and details of Item	Directorate responsible

MAYOR & CABINET October 23 2013	
Title and details of Item	Directorate responsible
Complaints Annual Report 2012/13	Customer Services
Management Report	Resources & Regeneration

MAYOR & CABINET(CONTRACTS) October 23 2013	
Title and details of Item	Directorate responsible

MAYOR & CABINET December 4 2013	
Title and details of Item	Directorate responsible
Management Report	Resources & Regeneration

MAYOR & CABINET March 5 2014	
Title and details of Item	Directorate responsible
Management Report	Resources & Regeneration

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