Lewisham Healthcare NHS

NHS Trust

Draft 1.1 (Version 30)

QUALITY ACCOUNT 2012-2013

Document Version Control

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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

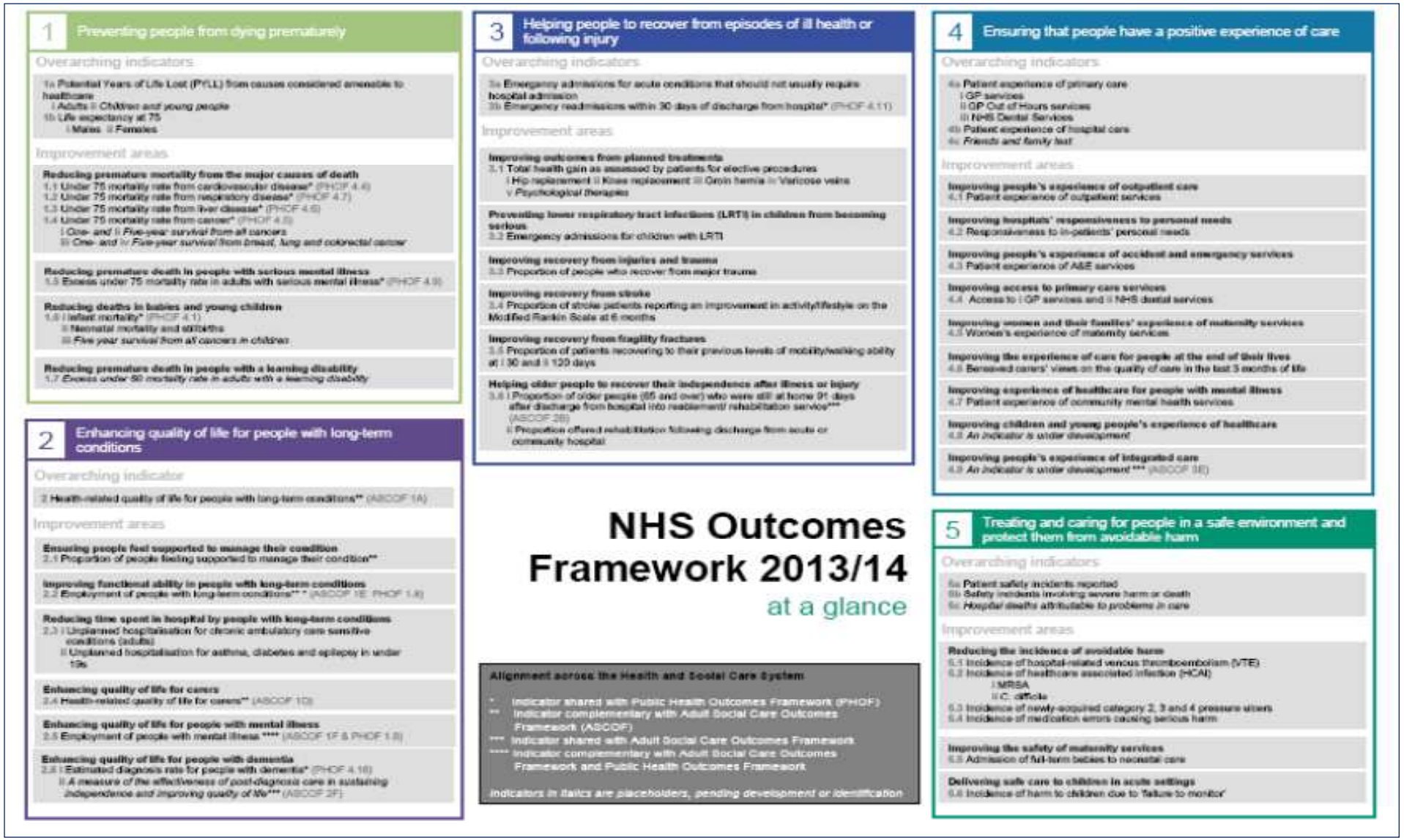
this provides for the foundation on which our priorities for improvement will be built over the coming years.

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

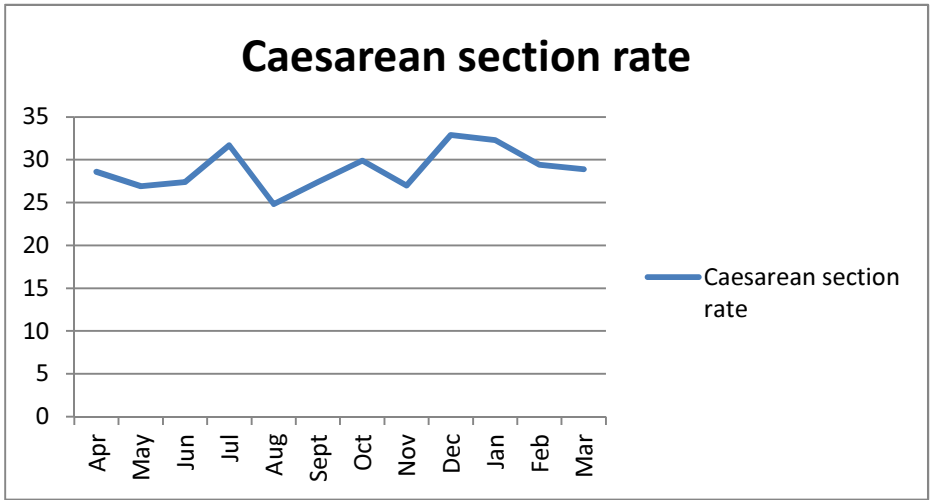
2.1.1 (iii) Priority 3 - Improving the safety of maternity services

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.

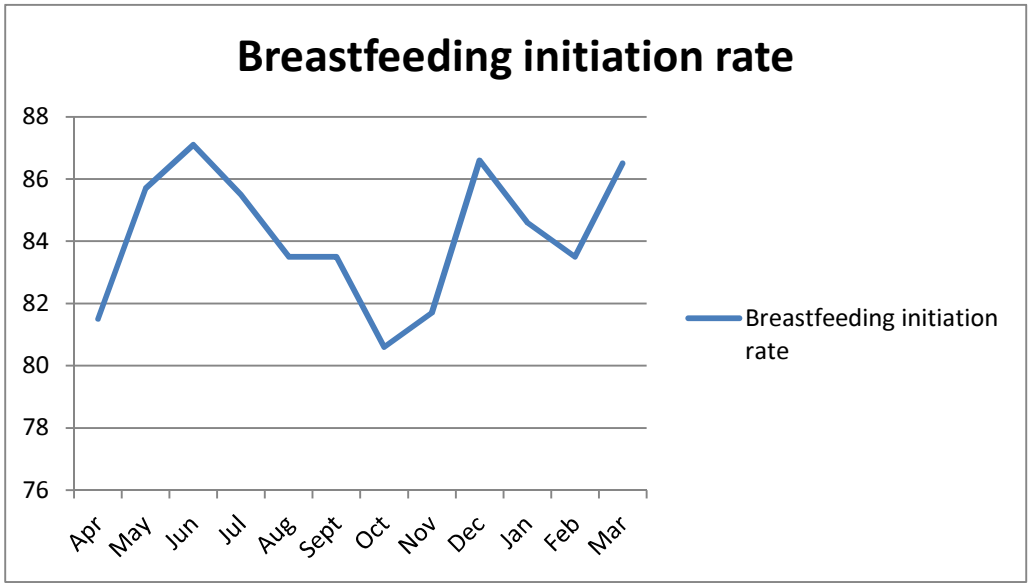
The Maternity Unit maintains a 'Maternity Dashboard' which is reviewed every month at the Directorate Governance and Risk meeting and is sent quarterly to the Trust's Patient Safety Committee. This helps senior staff to monitor the quality of care being given within the unit via trends in areas including 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

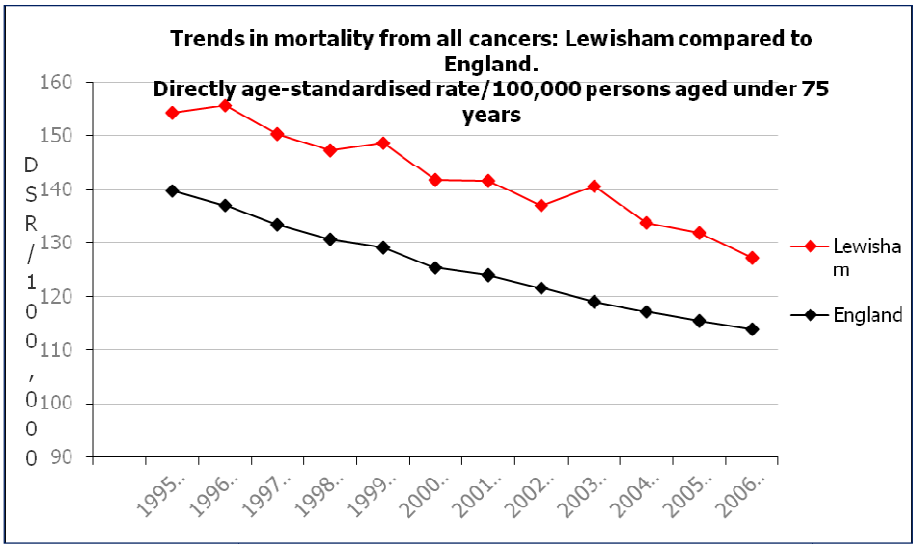
2.1.2 (i) Priority 1 – Reducing premature mortality and increased survival rates from breast, lung and colorectal cancer

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**

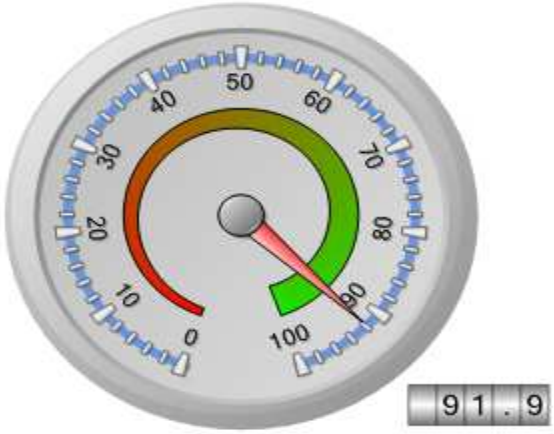
Hospital Site Details		Total responses in each category for A&E Department								
Hospital Site Details		Total responses in each category for A&E Department						Total Number of people eligible to respond	Total number of responses for each A&E department	Response rate for each A&E department
Site code	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:

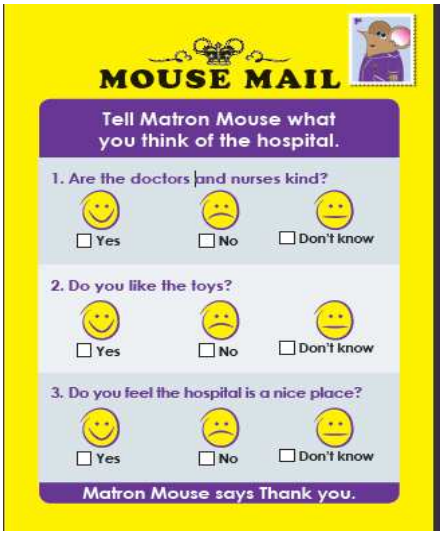
1. Completion of the refurbishment of the Labour Ward
2. Improvement in the National Midwifery Survey results 2013

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

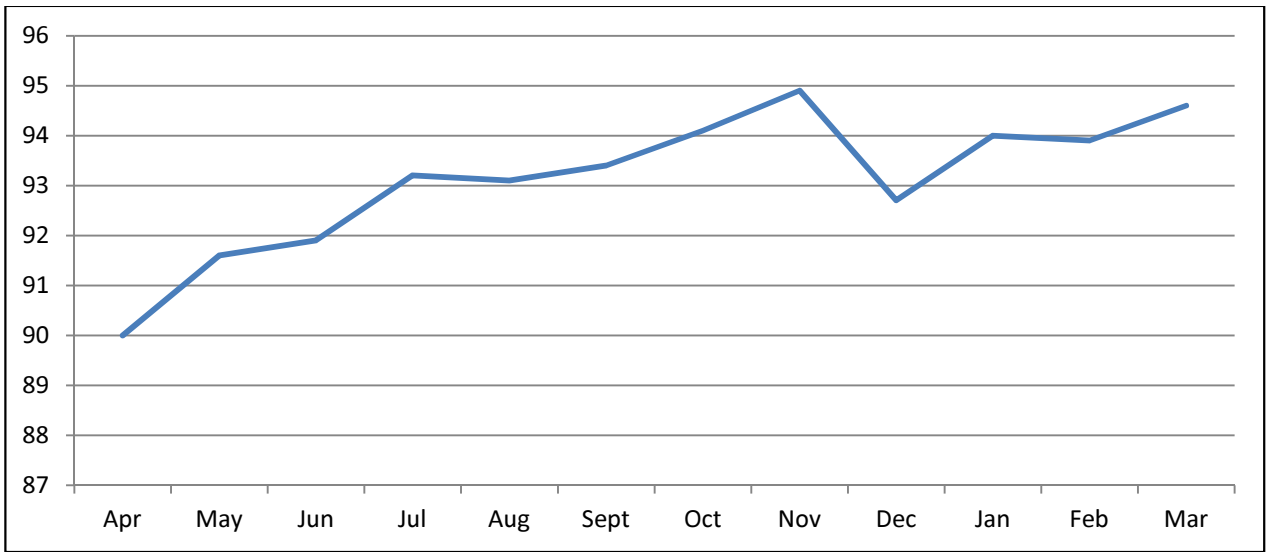
2.2.1 (i) Patient Safety Indicator 1 – The percentage of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism during 2012/13

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.

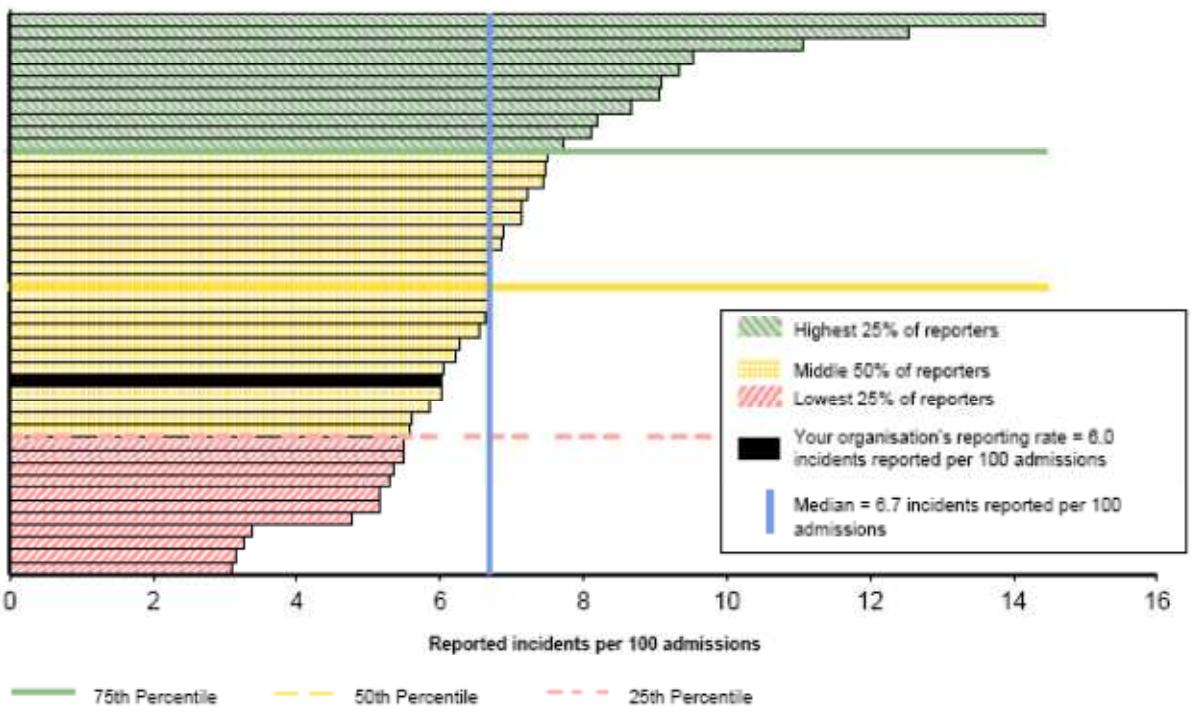
Lewisham Healthcare NHS Trust considers that this data is as described for the following reasons:

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.

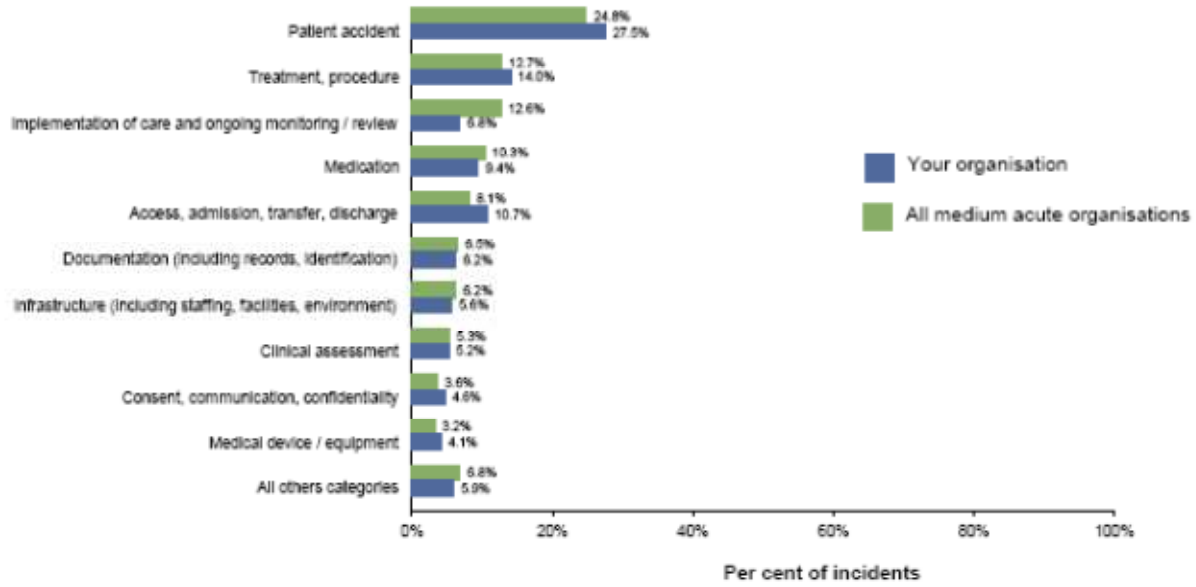
Lewisham Healthcare NHS Trust intends to take the following actions to improve this percentage/proportion/score/rate/number:

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

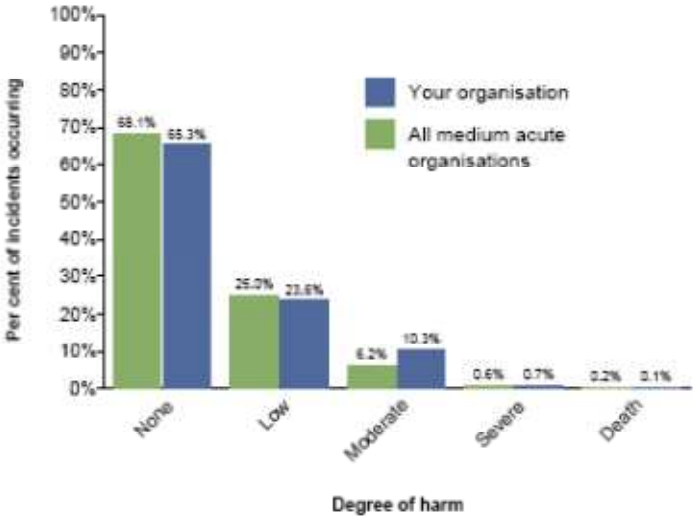
What type of incidents are reported in your organisation?

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.

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.

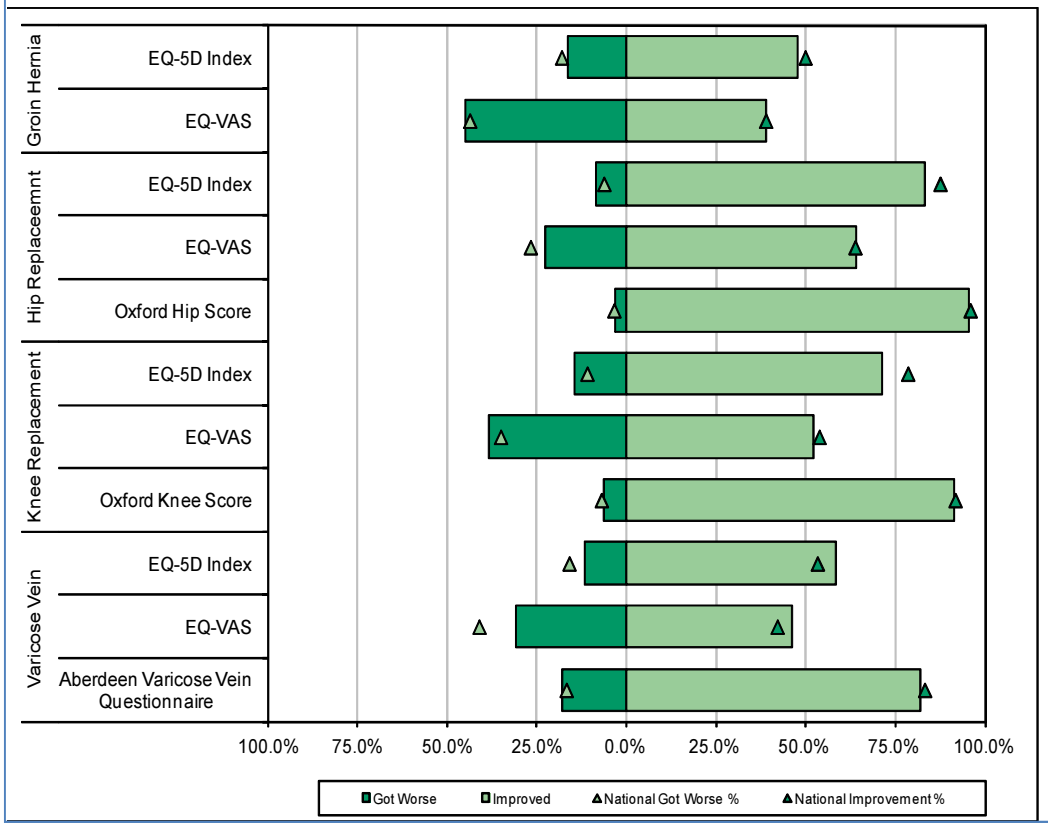
The 'Key Facts' sheet provides the ability to select the 'Key Facts' for one organisation at a national , SHA of responsibility, PCT of responsibility or provider level.

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.

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

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

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

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

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

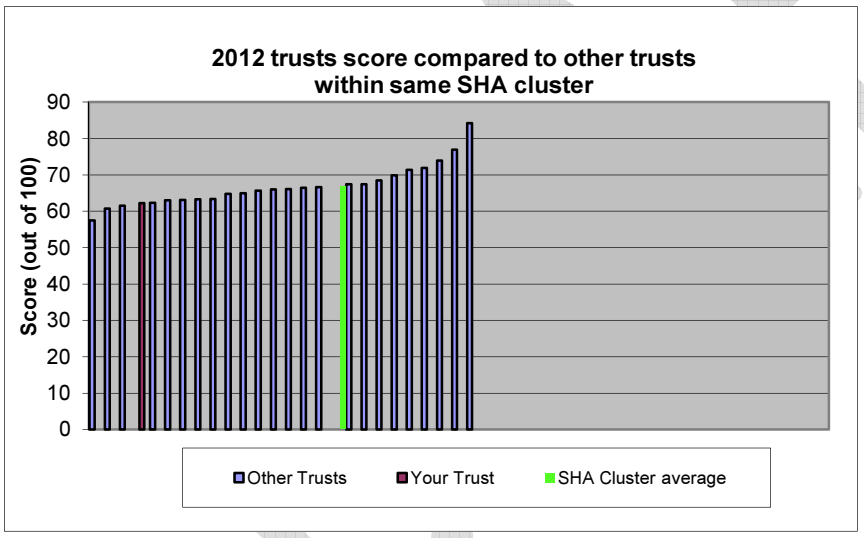
2.2.3 Patient Experience

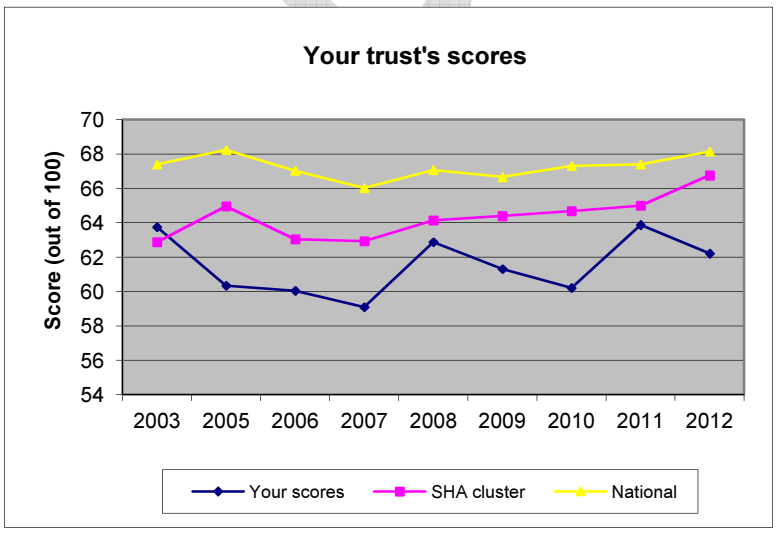
2.2.3 (i) Patient Experience Indicator 1- The Trust's responsiveness to the personal needs of the patients

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



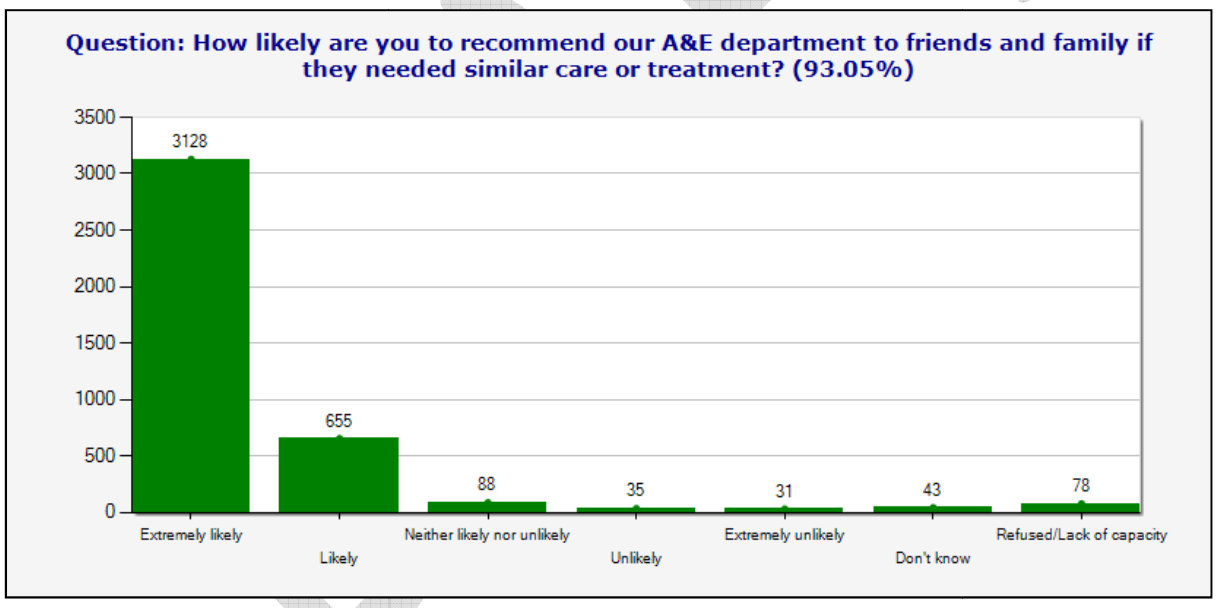


The Lewisham Healthcare NHS Trust intends to take / has taken the following actions to improve this rate and so the quality of its services by:

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.

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

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

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.

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

				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%

				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).

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.

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

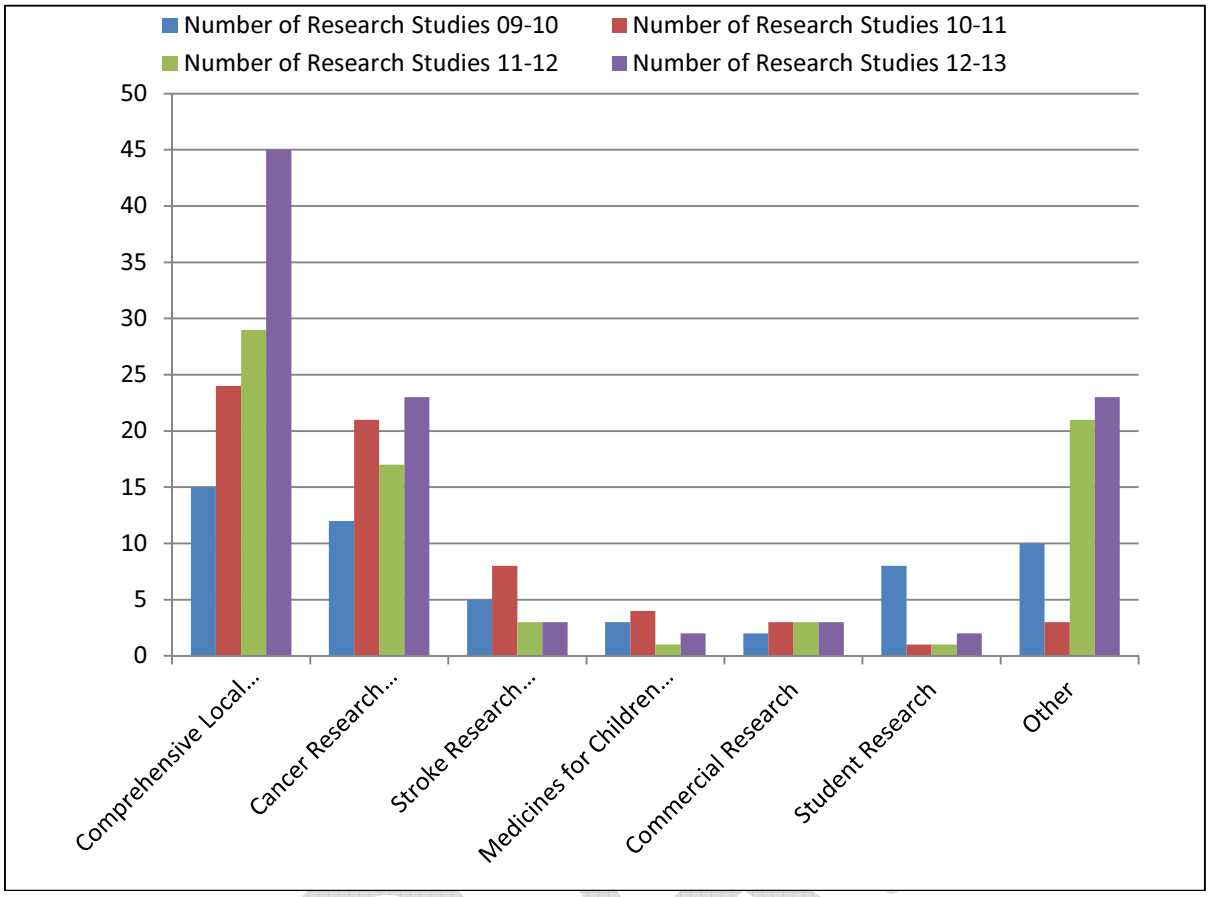
"The number of patients receiving NHS services provided or sub-contracted by Lewisham Healthcare NHS Trust in 2012-13 that were recruited during that period to participate in research approved by a research ethics committee was 306."

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.

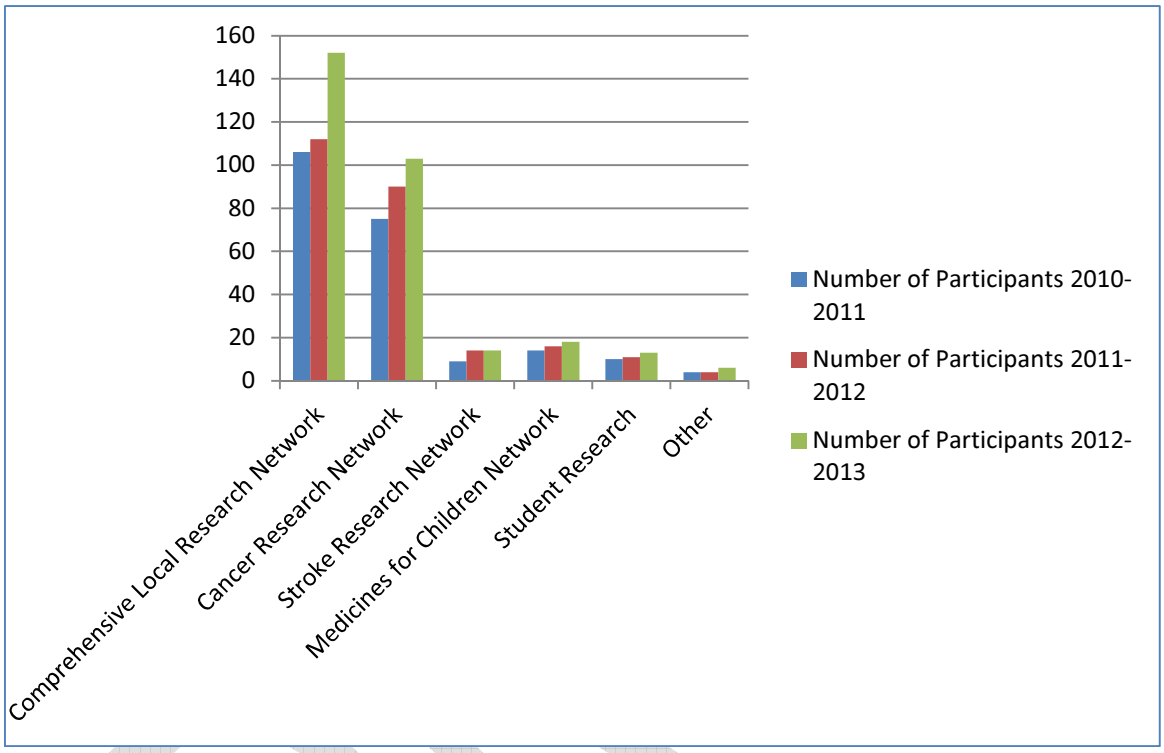
Close working relationships with other research networks including the South East Stroke Research Network and the Medicines for Children Research Network have also resulted in increased patient recruitment and clinical trials being set up in these areas.

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**	

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)).

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.

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.

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.

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.

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.

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

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.

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)

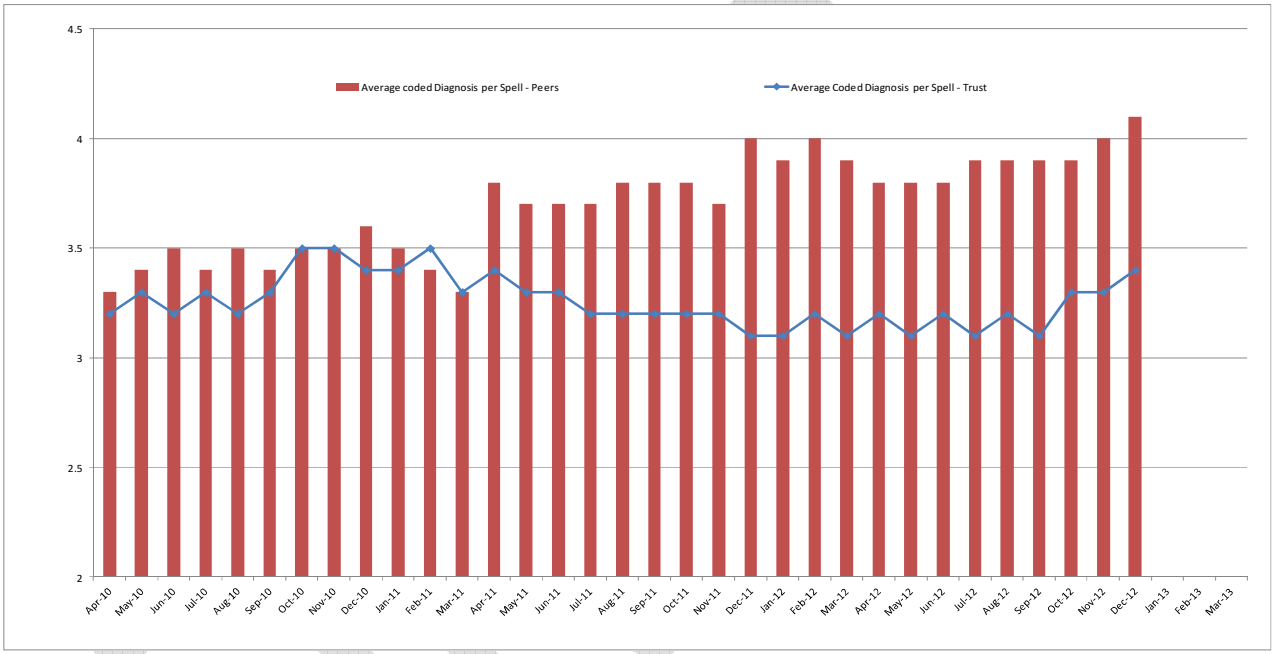
Month	Unacceptable primary diagnosis		Diagnosis non-specific		Sign and symptom as a primary diagnosis		Average Diagnosis per coded episode		Trust DQ Score		Trust DQ Score (HRG V4)	
	Trust	Peer	Trust	Peer	Trust	Peer	Trust	Peer	Trust	Peer	Trust	Peer
2012/13-YTD M9	**0.01%**	**0.07%**	**15.51%**	**18.25%**	**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:

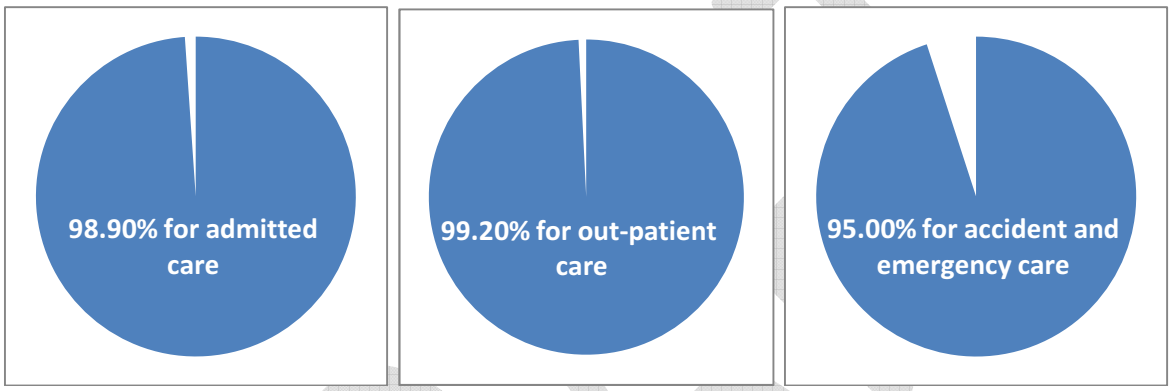
a) which included the patient's valid NHS number was:

98.90% for admitted care;

99.20% for out-patient care; and

95.00% for accident and emergency care.

Valid NHS number in records

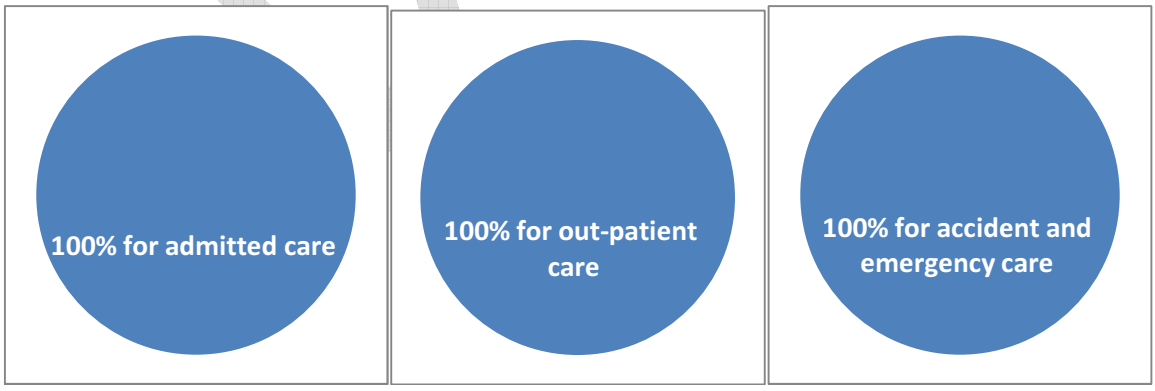


a) Which included the patient's valid General Medical Practice Code was:

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:

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.

Part 3

3.0 REVIEW OF QUALITY PERFORMANCE in 2012/13

3.1.1 Patient Safety

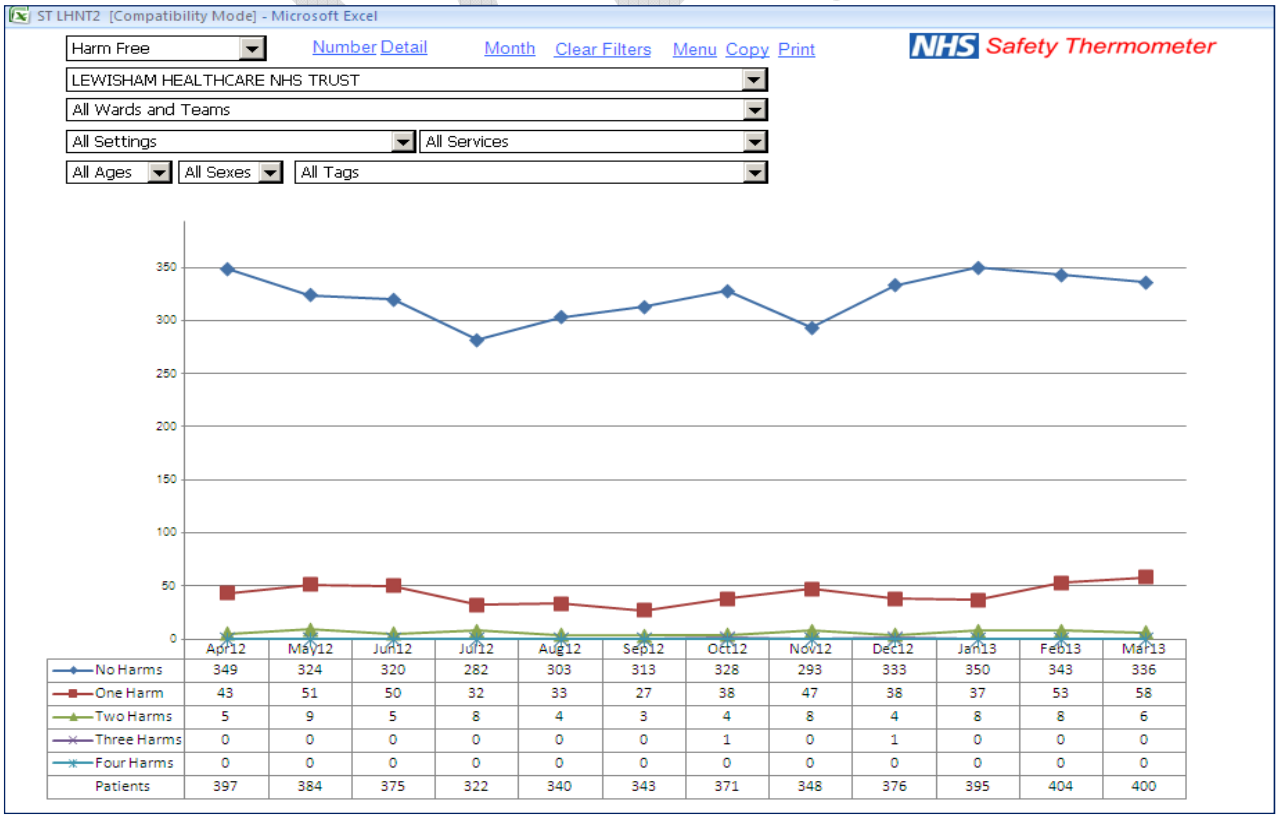
1.1.1. (i) Priority 1 – Implementation of the NSH Safety Thermometer to monitor and measure 'harm free care'

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

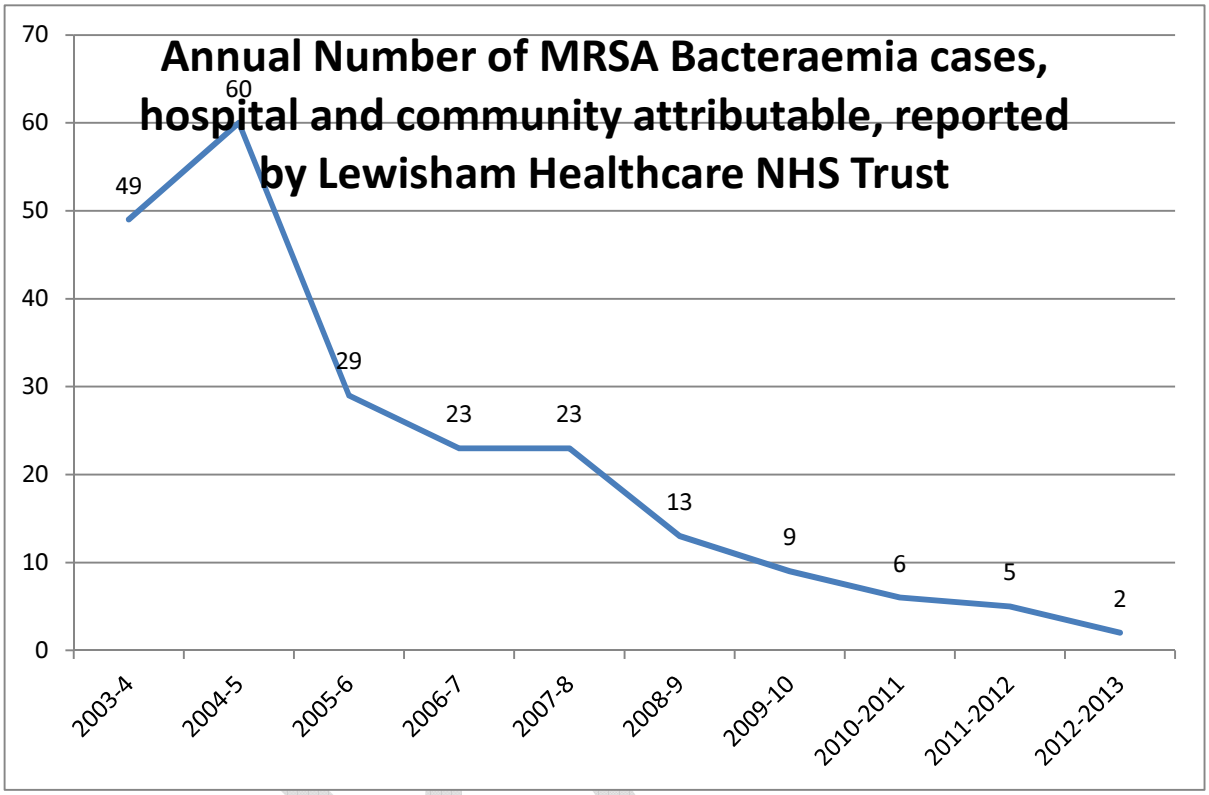
	2. High Impact Intervention No.2Peripheral Intravenous Cannula Care Bundle: On Insertion				Compliance	89%
	Hand Decontaminaton.	Personal Protective Equipment.	Skin Preparation.	Dressing.	Documentation.	All elements performed?
Average %Compliance:	**97%**	**99%**	**100%**	**100%**	**92%**	**89%**
Doctors	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

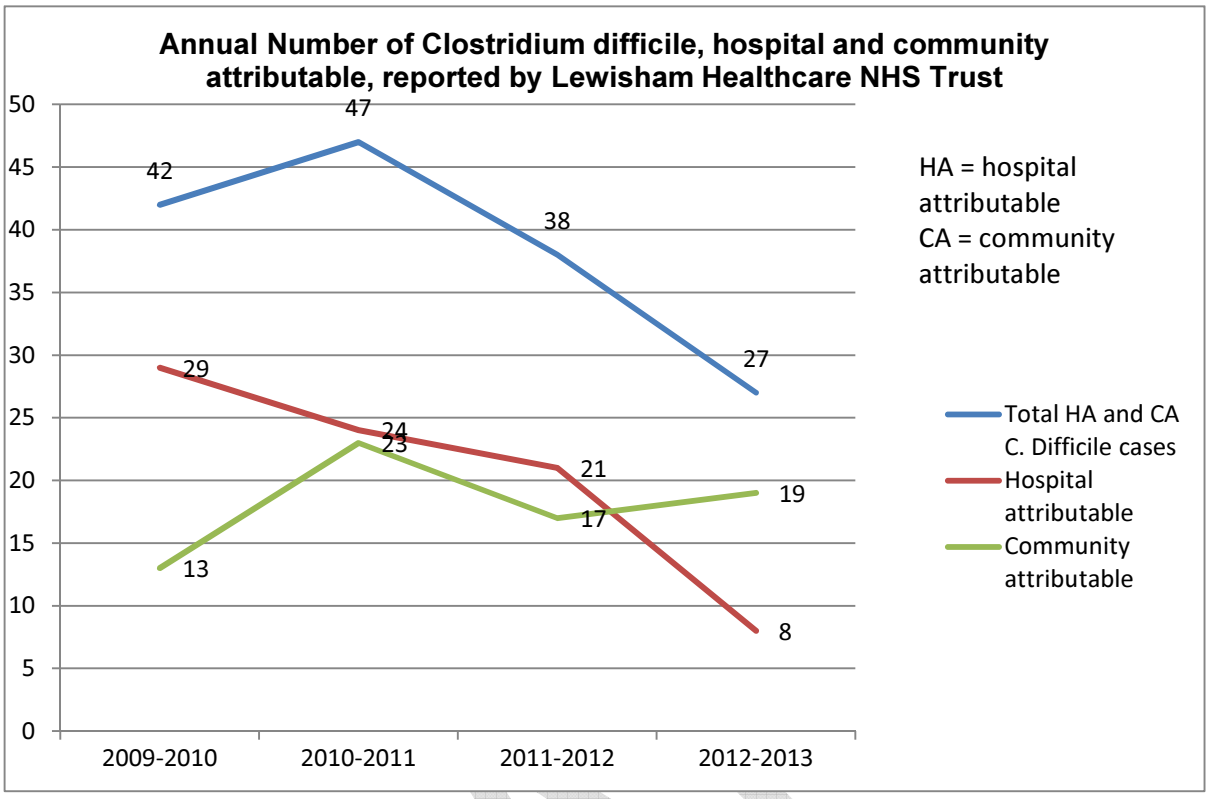
attributable case during this period giving a total of 2 cases reported via the Trust laboratory for the year.

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.

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.

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.

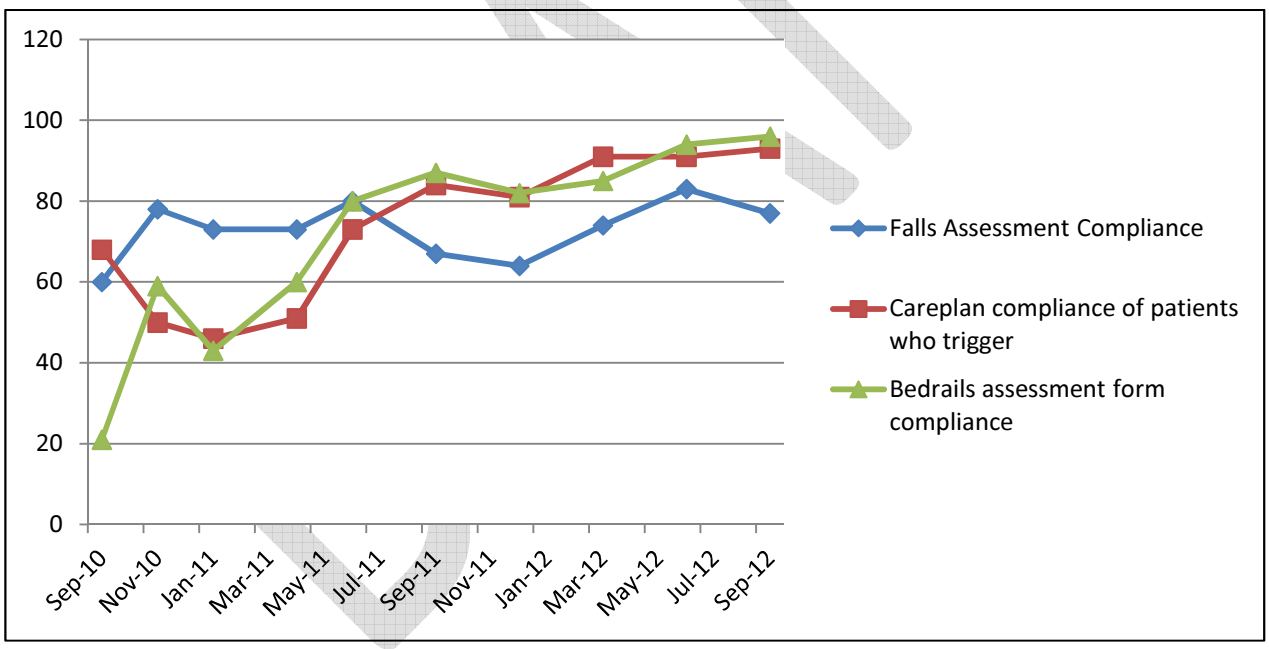
- **Never Events**
  These are events which ought not to occur because previously issued national guidance should already have been implemented to prevent them.
  The Trust had no Never Events during 2012 – 13, and the OWL Group received assurance about the implementation of actions arising from previous 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**

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.

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

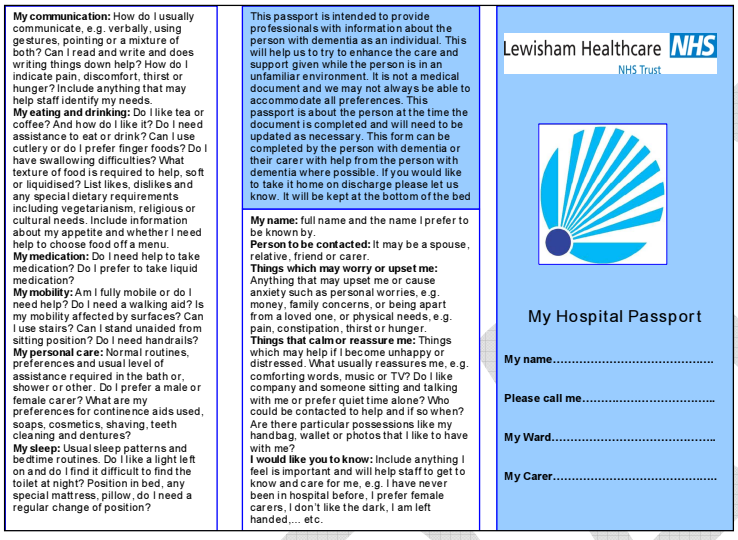
In 2012/13, the Trust established a process for screening, risk assessing and referring patients for dementia. The aspiration of this was to develop a system within the Trust which increased the identification of patients with dementia and other causes of impaired cognition. This is to help ensure that 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.

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

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**

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

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.

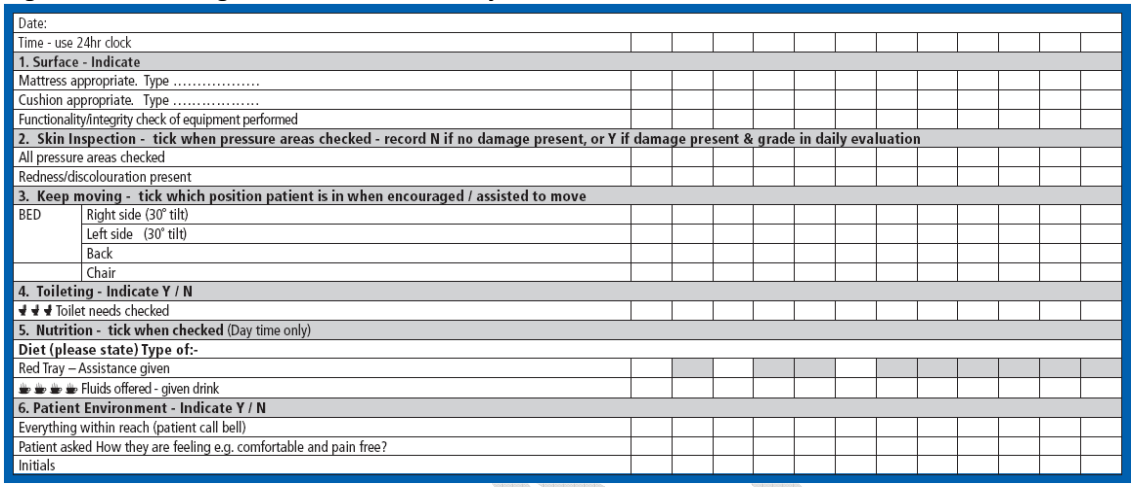
A&E and Urgent Care Centre Survey Results 2012		
Ranking	**Question**	**Satisfaction Rating**
1	Overall, did you feel you were treated with respect and dignity while you were in the department?	94.62
2	Did the doctors and nurses listen to what you had to say?	93.01
3	Did you have enough time to discuss 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.

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.

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.

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.

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.

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.

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]

1.4 EXTERNAL AUDIT LIMITED ASSURANCE REPORT

ADD IN KPMG AND GRANT THORTON REPORTS

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

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

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

APPENDIX 2 - THE FULL PROGRAMME OF CQUINS FOR 2012-13

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