Lewisham and Greenwich NHS
NHS Trust

Quality Account 2014-2015

QUALITY ACCOUNT 2014-2015
Draft Version 1.6

Contents

GLOSSARY

A&E	Accident and Emergency
AAR	After Action Review
CAS	Central Alerting System
CAP	Clinical Audit Programme
CCG	Clinical Commissioning Group
C. diff	Clostridium difficile
CEFM	Continuous Electronic Foetal Monitoring
CEO	Chief Executive Officer
CF	Cystic Fibrosis
CHKS	Independent provider of healthcare intelligence, benchmarking and quality improvement services
CLRN	Comprehensive Local Research Network
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRN	Comprehensive Research Network
CTG	Cardiotocography
DNA	Did Not Attend
ED	Emergency Department
EoT	End of Treatment
FFT	Friends and Family Test
GP	General Practitioner
HNA	Holistic Needs Assessment
HPA	Health Protection Agency
HQIP	Health Quality Improvement Programme
HRG	Healthcare Resource Group
HSCIC	Health and Social Care Information Centre
HWBE	Health and Well Being Events
IA	Intermittent Auscultation
ICD	Internal Classification of Diseases
IG	Information Governance
LCA	London Cancer Alliance
LCP	Liverpool Care Pathway
LGT	Lewisham and Greenwich NHS Trust
MCRN	Medicines for Children's Research Network
MINAP	Myocardial Ischaemia National Audit Project
MRSA	Methicillin-resistant *Staphylococcus aureus*
NHFD	National Hip Fracture Database
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NICU	Neonatal Intensive Care Unit

NIHR	National Institute for Health Research
NNAP	National Neonatal Audit Programme
NRLS	National Reporting Learning System
OPCS	Office of Population Censuses and Surveys
OSC	Overview and Scrutiny Committee
OWL	Outcomes with Learning
PALS	Patient Advice and Liaison Service
PbR	Payment by Results
PHE	Public Health England
PROMS	Patient Reported Outcome Measures
PVL	Panton-Valentine Leukocidin
QEH	Queen Elizabeth Hospital
RAMI	Risk Adjusted Mortality Index
RCoA	Royal College of Anaesthetists
R&D	Research and Development
SBAR	Situation Background Assessment Recommendation
SHMI	Summary Hospital Mortality Indicator
SUS	Secondary Uses Service
TARN	Trauma Audit and Research Network
UHL	University Hospital Lewisham
VTE	Venous Thromboembolism

PART 1

1. Statement of Quality from the Chief Executive

Welcome to the 2014–15 Quality Account for Lewisham and Greenwich NHS Trust.

This is the first publication of the Quality Account for a full year of our organisation, following the merger of lewisham Healthcare NHS Trust with Queen Elizabeth Hospital Woolwich (part of South London NHS Trust) and reflects the performance of the Trust from April 2014 to March 2015.

I hope you find the report a useful guide to our performance and achievements over the last year and our priorities going forward as we continue to work towards embedding what we have achieved, transforming our services, addressing on-going challenges and working with local people and other local organisations to improve healthcare in Lewisham, Greenwich and Bexley and beyond.

The past twelve months has been an extremely busy, demanding and challenging period for our organisation as we embarked on major ambitious projects to transform some of our services and deliver on quality and safety improvement plans following our CQC inspection in February 2014.

Staff have also worked extremely hard throughout the year in supporting the organisation to respond to the increasing local demand for our services and to ensure the success of some of our major projects. We have successfully implemented a brand new electronic patient record system at the Queen Elizabeth Hospital and in response to improving the emergency and other clinical pathways for patients, we have successfully delivered on a number of our planned initiatives.
We have built and opened our brand new birth centre, the A&E Clinical Decision Unit and the Discharge and Transport Lounge at the Queen Elizabeth Hospital. We have created additional bed capacity at the Lewisham Hospital site with the expansion of our dedicated stroke facilities and have developed and opened the surgical assessment units at both sites.

Whilst the majority of our CQC improvement plan focussed on the QEH Accident and Emergency environment and the flow of patients through the emergency care pathway, there were other areas where improvements were required.
Staffing within wards areas has increased and our vacancy rates have fallen continuously throughout the year.
Infection Control practices and hand hygiene compliance has improved and all staff are encouraged to challenge any non-compliance observed.
Waste management and secure control of clinical waste management has also been addressed with the building of robust, secure storage compounds across the Trust.

Whilst making significant progress and improving quality and safety during 2014/15, our focus still remains on maintaining a strong operational and financial ‘grip’ on the business ensuring we meet all service quality and performance standards, consistently deliver a good patient experience and are able to demonstrate more efficient use of resources. A key priority going forward will be to continue to work with local partners to embed the emergency pathway, develop a pathway for the frail and elderly, maximise the use of community and social care teams and further develop plans for an effective ambulatory care model.

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

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

PART 2

2.1 Our Quality priorities for 2015-16

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

Our quality strategy for 2015-16 is to ensure that we improve our contribution to the provision of healthcare for our patients both in the community and in hospital settings as well as focusing on the challenge of our transformation of services and our challenging financial plans.

We have developed a set of priorities drawn from the review of the work undertaken during 2014-15 and also those areas which still require on-going improvements. These priorities form the basis of the Divisional business plans, our CQUIN initiatives, the Sign Up to Safety Pledges and the overall Trust Strategy and operating plans.

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

Each of the priorities fits under the key themes of quality:

Patient Safety – having the right systems and staff in place to minimize risk of harm to our patients and, if things go wrong, to be open and learn from our mistakes

Clinical Effectiveness – providing the highest quality care, with high-performing outcomes whilst also being efficient and cost effective.

Patient Experience – meeting our patient's emotional as well as physical needs.

How we chose our priorities

Throughout the year our progress towards achieving the 2014-15 priorities has been monitored and reported at meetings held across the Trust and with key stakeholders being present at these meetings, these include our local commissioners, local Healthwatch, Patient Welfare Forum and Patient User Groups.

The progress of our performance with these priorities has been reviewed and although there have been significant achievements made throughout the year, there is still room for improvement where the priorities are focussed on basic safety practices and enhancing patients' experience. Therefore, we have committed to continuing our work to improve patient safety by:

- reducing avoidable harm,
- being open and exercising our duty of candour,
- and committing to the national Sign up to Safety programme with our safety pledges.

We have also committed to continue our work to improve the clinical pathways for patients to achieve better outcomes and enhances experience for patients.

These priorities have been developed with the Trust Divisions and have been both supported and approved by our Trust Board, the Trust Quality and Safety Committee and our Clinical Commissioning Quality Review Group.

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

The following tables outline the 2015/16 quality priorities and why we have chosen them.

2.1.1 Patient Safety Priorities

Patient Safety Priorities

Our quality priorities and why we chose them	What success will look like
i) Improving our Hand Hygiene Compliance Reduction in avoidable infections relies on good compliance with hand hygiene standards. Our CQC inspection found that although there were many areas where excellent compliance was observed, there were some areas where non-compliance was observed and through our own internal audits, there is still improvement to be made.	We will achieve 90% compliance across all Departments
ii) Early recognition and treatment of the deteriorating patient The early recognition and detection of deteriorating patients has been shown to improve the clinical outcomes for patients. Our review of incidents has shown that we need to improve the early detection of patients in whom their clinical condition has deteriorated by ensuring regular monitoring of observations is carried out and ensuring proactive intervention of the results of these observations is taken.	We will ensure successful roll out of our new Early Warning Score Observation Charts across all sites We will introduce the use of the SBAR communication tool in all clinical areas to support robust escalation and handover of care We will implement the Sepsis toolkit across all areas and will conduct monthly audits on performance
iii) Improving the Safety of Maternity Services Not only can babies be severely harmed by failures in assessment of the wellbeing of the foetus the impact of harm has life changing effects for the child and all members of their family. The loss of a baby as a stillbirth also has significant impact for parents. Our priority is set around minimising the risk of these events.	Achieving return to national comparable rate for stillbirths Increase detection of growth restricted babies in utero Reduce poor neonatal outcomes associated with poor / inadequate foetal surveillance in labour, whether intermittent auscultation (IA) or continuous electronic foetal monitoring (CEFM)

iv) Continue our focus on the aim to reduce the number of grade 2, 3, and 4 hospital acquired pressure ulcers and ensure where pressure ulcers are acquired within our provision of community services, timely completion of root cause analysis is undertaken and learning is shared across our community areas.

Pressure ulcers can be serious and distressing and often result in extended lengths of hospital stay for patients: mortality rates can increase particularly from infection. An increasingly elderly and frail patient population in our area who often have several co-morbidities raises the risk for patients of developing pressure ulcers.
Significant progress was made during 14/15 with weekly pressure ulcers panels running with support from our CCGs to understand the root causes and contributory factors. This work has led to a more focussed approach to addressing the challenges, particularly within our community services, and continued collaborative work is still required for 15/16

Improve the accuracy of the Waterlow score for patients in hospital and community services we provide and achieve at least 90% compliance with completion of scores -100% of eligible clinical staff in community services and 85% of all ward staff (from a Training Needs Analysis - TNA) to have undertaken the new electronic learning package on pressure ulcer prevention and management
- Monitor incidence of grade 2, 3, and 4 pressure ulcers attributable to Trust for reporting and reduction

v) Reduction in the number of patient falls and harm incurred

Although the Trust has made significant progress with its work on patient falls, the Trust continues to have many patient falls reported. Older people and those who are frail are at risk of life changing harm and increased mortality if they sustain a fracture or a head injury as a result of the fall.

Reduce the incidence of harm sustained from patient falls by 10% by the end of year

vi) Help people to understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress

Embed the new organisational culture further to ensure that all staff know they are expected to report and learn from all incidents, serious incidents, complaints, claims and case reviews.
The Trust's values and behaviours have been explained through training and staff focus groups. Policies for the new organisation, learning from the best of the legacy organisations, have been created and widely disseminated and include a policy about raising concerns ('whistleblowing').

Increase in Incident reporting
Identify appropriate staff to undertake Root Cause Analysis Training
Promote and provide opportunities to share the learning identified by incident investigations, complaints and claims, CAS alerts, and other national initiatives
Ensure there is an annual staff awards process and ceremony to include a Patient Safety Award.

2.1.3 Clinical Effectiveness

Clinical Effectiveness Priorities	
Our quality priorities and why we chose them	**What success will look like**
i) To continue the work on embedding the process for mortality reviews across the Trust During 2014/15 the Trust established a process for the review of patient mortality in all specialties. Whilst much work has been undertaken, the processes need to be embedded across all specialties to ensure regular reporting of findings, learning from the reviews and sharing the learning across the organisation. The Trust mortality rate had increased during 13/14 and although much of this has been investigated, further, continued work will ensure that all elements which contribute to the mortality rates such as clinical practice decision-making, clinical documentation, comorbidity recording and clinical coding are fully reviewed, understood and action taken where required.	Aim for Trust SHMI of 100 or less Monthly reviews of those deaths in low risk groups Presentation of reviews and learning at Trust Wide Mortality group and Divisional Governance groups Introduction of co-morbidity and clinical coding proforma for all deaths Reduction in inaccurate clinical coding of deaths
ii) We will continue to focus providing individualised care for patients with dementia and their carers and will expand this work into intermediate and community care During 2014/15 the Trust built on its early work with dementia patients and their carers and established a 'dementia friendly' ward to improve the experience for dementia patients. The Trust also established it's Carer's Survey which has provided much welcomed feedback on how to improve services for dementia patients. This year we will build on this work and will focus on the discharge plans and communication with GPs and Community Services for dementia patients and will also expand this work into intermediate and community care provided by the Trust	Established dementia screening and assessment process for patients in intermediate and community care Established Carer's Survey for carers within intermediate and community care settings Development of discharge plan and communication for GPs specific to dementia care for patients

iii) Improving the quality and effectiveness of care to children and young people with complex needs and long term conditions. As the provider responsible for services for children across the hospital and community settings we aim to improve the care to be provided closer to home for children and young people: supporting reduction in length of stay and preventing readmission to hospital and re-attendance in the emergency department.	We will scope and analyse the care and movement of children and young people with complex needs and long term conditions that could be shifted from hospital into the community through rapid response and early discharge We will redesign and develop collaborative pathways to pilot during quarter 4 of the year and will aim to introduce new pathways at the start of 2015/16

2.1.4 Patient Experience

Patient Experience Priorities

Our quality priorities and why we chose them	What success will look like
i)To further embed the Friends and Family Test across community and outpatient services. The Trust has implemented the National Friends and Family Test (FFT) across all of its services. We have used feedback we have received to help us identify service improvements. Because the feedback is so useful we would like to ensure that all services are fully involved with the Friends and Family Test.	100% services will have FFT feedback. All services will be able to demonstrate that they have analysed and used the feedback to inform the service about quality
ii) To continue to roll out the After Action Review process within the Trust by incorporating AAR training in the Trust training programme and supporting the development of AAR conductors In 2014 the Trust planned and implemented a project to roll out After Action Review (AAR). AAR is a method to enable a structured conversation between the multi-disciplinary team to explore events and identify what has gone well and what has not gone well. It is a process for learning from mistakes and from good practice. The project has been successful and we would now like to train more staff to undertake AARs and to encourage the routine use of this type of structured conversation.	AAR training is incorporated in the Trust training programme. Audit of AAR shows that staff understand the principles and are embedding it in their daily practice
iii) To develop cross-divisional learning from patient stories and feedback The Trust collects feedback from a range of sources including structured surveys, the Friends and Family Test, and complaints, compliments and concerns raised by individuals. Learning from all of these is shared locally by the services or individuals involved. We would like to ensure that where appropriate, learning is shared across services and across divisions.	Learning is shared through structured discussions at the Patient Experience Committee. Evidence of change through learning is reported.
iv) To improve the provision of 'welcome to the ward' information through the use of innovative design. The Trust is looking at ways of ensuring that patients receive and understand essential information about their stay in hospital.	. Pilot project to ensure key information is made available to patients is completed. Patients report that they have seen and understood the information as measured through a patient survey to evaluate the pilot.

v) Hello my name is campaign 'The Trust has signed up to be part of the national 'Hello my name is' campaign, started by Dr Kate Granger and supported by NHS England.	Project plan developed Project milestones achieved Surveys show that staff always introduce themselves

2.2 Statements of assurance from the Board of Directors

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

A review of our services

During the 2014-15 reporting period Lewisham and Greenwich NHS Trust provided services in over 35 NHS specialties, this includes both hospital and community services. A detailed list of services provided is available on our website.

The Trust has reviewed all the data available on the quality of care in all of these services through its performance management framework and assurance processes.

The income generated by the NHS services reviewed in 2014/15 represents 100 per cent of the total income generated from the provision of NHS services by the Trust for 2014/2015

National Quality Indicators

For 2014/2015 there are nine statutory quality indicators which apply to acute hospital trusts. All trusts re required to report their performance against these indicators in the same format with the aim of making it possible for a reader to compare performance across similar organisations.
For each indicator our performance is reported with the national average and the performance of the best and worst performing trusts.

2.2.1 Patient Safety

2.2.1 (i) Patient Safety Indicator 1 – The percentage of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism (VTE) during 2014/15

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

We believe our performance reflects the following, that:

- The Trust has a process in place for collating the data on venous thrombo-embolism assessments;
- Data is collated internally and then submitted on a monthly basis to the Department of Health;
- Data compared to peers, highest and lowest performers, and our own previous performance, as set out in the table below.

VTE assessment rate		2014/15
Lewisham and Greenwich NHS Trust		
Assessed	**Newly merged**	93,094
Admitted	**Newly merged**	97,765
Assessment Rate		95.2%
National Average	95.67%	96.1%
Best performing Trust	100%	100%
Worst performing Trust	79.86%	88.4%

Source: www.england.nhs.uk

2.2.1 (ii) Patient Safety Indicator 2 – The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during 2014/15

Whilst recognising the new reporting requirements for the purpose of Quality Accounts, national data will not be available on the rate of C. difficile reported per 100,000 bed days until after the publishing date of the Quality Account on 30th June 2015.

The mandatory surveillance reporting is via Public Health England (PHE) who collect and publish the data on monthly 'counts' as opposed to rate per 100,000 bed days. Once per year in July, the PHE publish the data as a rate per 100.000 bed

days. This data will not be available for the publication of the Trust Quality Account. Therefore, the Trust has calculated it rate per 100,000 bed days using the bed availability and occupancy data as referenced below.

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

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

C.difficile rate per 100,000 bed-days	2013/14	2014/15
Lewisham and Greenwich NHS Trust		
Trust apportioned	**48**	**37**
Total bed days	**299,849**	328,135
Rate per 100,000 bed days (Trust apportioned)	**16**	11.2
National Average	14.7	TBC
Best performing Trust	1.6	TBC
Worst performing Trust	37.1	TBC

Source: https://www.gov.uk/government/statistics/clostridium-difficile-infection-monthly-data
Source for bed days calculation: http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/

The most recent data published by Public Health England is for the monthly counts' of C.difficile.
The data below demonstrates the mandatory reporting made to Public Health England through 2014 – 2015 and also shows data from peer organisations:

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

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

Reporting Period: April 2014-March 2015

Trust Type	PHE Centre	Trust Name	April 2014	May 2014	June 2014	July 2014	August 2014	September 2014	October 2014	November 2014	December 2014	January 2015	February 2015	March 2015
-NHS Trust	London	Bart's Health	6	8	5	5	9	6	6	11	11	9	11	11
-NHS Trust	London	Croydon Health Services	1	1	2	2	1	1	1	1	1	1	2	1
FT	London	Guy's & St. Thomas's	5	5	8	6	4	5	2	2	2	6	2	4
FT	London	Homerton University Hospital	1	1	0	0	1	1	1	1	0	0	0	1
FT	London	King's College Hospital	6	8	10	6	3	6	3	6	6	12	5	6
-NHS Trust	London	Lewisham & Greenwich	1	2	4	1	5	7	4	2	1	2	2	6
-NHS Trust	London	North Middlesex University Hospital	3	6	6	3	5	2	1	4	5	4	3	4

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

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

- Developing a Trust wide C. difficile action plan
- 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 site based multidisciplinary weekly C. difficile review groups / ward rounds which allows for the review of care and progress of any patients with C. difficile
- Undertaking root cause analysis on all Trust attributable C. difficile cases to allow any learning for practice to be understood and shared
- Continuing to undertake joint audit work with the facilities staff to ensure that on-going standards of cleanliness are maintained.

2.2.1 (iii) Patient Safety Indicator 3 – The number and rate of patient safety incidents reported within the Trust and the number and percentage of such patient safety incidents that resulted in severe harm or death for 2014/15

Number and Rate of Patient Safety Incidents Reported within the Trust

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

There is no nationally established and regulated approach to the reporting and categorising of patient safety incidents, so different trusts may choose to apply different approaches and guidance when reporting categorising and validating patient safety incidents. The approach taken to determine the classification of each incident, such as those 'resulting in severe harm or death', will often rely on clinical judgement. This judgement may differ between professions. For this reason, data reported by different trusts may not be directly comparable.As Trusts are required to report all incidents to NRLS within a two day timeframe (from the time the organisation became aware of the incident and the reporting of the incident internally), there may be occasions where following full investigation of the incident and additional information being obtained, the category and impact of harm of an incident will have changed. In these circumstances, the Trust will re-upload the information into the NRLS system so that the accurate information is displayed.

All incidents involving severe harm or death were declared and investigated as serious incidents and the reports offered to the patient or their family once concluded. The implementation of any learning arising from the investigations is reported to the governance groups within each clinical Division and the sustainability of learning reviewed and monitored via the Trust's Outcomes With Learning group [OWL].

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

- The trust has a process in place for collating the data on patient safety incidents;
- Data is collated internally and then submitted on a monthly basis to the NRLS;
- Data is compared to peers, highest and lowest performers, and our own previous performance as set out in the table below.

Patient Safety Incidents	Oct 13-Mar 14	Apr 14-Sept 14
Lewisham and Greenwich NHS Trust		
Total reported incidents	**4,915**	**5,251**
Incident reporting rate per 1,00 admission	**16.76**	

Please note change in NRLS reporting for Apr14 to Sept 14 to

.	**Per 1,000 bed days**	**33.92**

Incidents causing severe harm or death	**17**	**34**
% of incidents causing severe harm or death	**0.30%**	**0.60%**

Medium Acute Trusts (all Trusts are categorised by size)		
Lowest incident reporting rate	5.8	0.24
Highest incident reporting rate	74.9	74.96
Lowest incidents causing severe harm or death	0%	0%
Highest incidents causing severe harm or death	2.30%	3.10%
Acute Trusts average % of incidents causing severe harm or death	0.70%	0.50%

The table below shows the current reporting of patient safety incidents and the number where severe harm and death have occurred during the 2014/15 year to date, NRLS published data for the period of October 2014 to March 2015 is not available at the time of writing this report.

Patient safety incidents reported within the Trust per month

2014 - 15	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Running total
Number	936	841	935	933	838	1015	1032	949	1066	1061	848	1324	11,778

For the period between April 2013 and March 2014 a total number of 7,322 incidents were reported to the NRLS from the Trust, however, this included incidents reported from our merged site Queen Elizabeth Hospital Woolwich. It is difficult to assess the previous reporting rate from the Queen Elizabeth site as the data was merged within three hospital sites, however, we continue to work on encouraging all reporting of incidents.

Patient Safety Incidents where the impact may have caused severe harm or death

2014 - 15	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Severe harm/death	2	5	6	6	6	6	4	4	10	3	7	6	65

2.2.2 Clinical Effectiveness

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

The Summary Hospital-level Mortality Indicator or SHMI, is a mortality measure that takes account of a number of factors. It includes patients who have dies while having treatment in hospital or within 30 days of being discharged from hospital. The SHMI score is measured against the NHS average which is 100. A score below 100 denotes a lower than average mortality rate and therefore indicates good, safe care. To help understand the SHMI data, Trusts are categorised into one of three bands:

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

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

- The Trust has a process in place for collating data on hospital admissions from which the SHMI and derived;
- Data is collated internally and then submitted on a monthly basis to Health and Social care Information Centre [HSCIC] via the Secondary User Service [SUS]. The SHIMI is then calculated by the HSCIC;
- Data is compared to peers, highest and lowest performers, as set out in the table below.

Summary Hospital-level Mortality Indicator	Jan 13 – Dec 13 (published July 14)		Apr 13 – Mar 14 (published October 2014)		Jul 13 – Jun 14 (published January 2015)		Oct 13 – Sept 14 (published April 2015)	
	SHMI	Banding	SHMI	Banding	SHMI	Banding	SHMI	Banding
Lewisham and Greenwich NHS Trust	99	Band 2 'As expected'	103	Band 2 'As expected'	106	Band 2 'As expected'	107	Band 2 'As expected'
Best Performing Trust	62	Band 3	0.53	Band 3	54	Band 3	59	Band 3
Worst Performing Trust	117	Band 1	1.19	Band 1	119	Band 1	119	Band 1

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

Making 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.

When the HSCIC publishes the National SHMI scorings on a quarterly basis, they also publish a number of contextual indicators, including the percentage of patients who have died at each trust and those who were receiving palliative care. The method used to calculate trusts SHMI score currently makes no adjustments for palliative care patients. This means that any trusts which have a high number of palliative care patients may appear to have a higher number of deaths than expected using the SHMI scoring system. For example, a trust which has an onsite hospice or palliative care unit would have a higher number of deaths than other trusts.
Therefore, this higher number of deaths may not be an indicator of poor care being provided, but rather, a reflection of the type of patients that are being treated within that trust.

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

Percentage of deaths with palliative care coding	Jan 13 – Dec 13 (published July 14)	Apr 13 – Mar 14 (published October 2014)	Jul 13 – Jun 14 (published January 2015)	Oct 13 – Sept 14 (published April 2015)
Lewisham and Greenwich NHS Trust	27.82%	28.71%	29.53%	29.9%
Lowest percentage Trust	1.3%	6.4%	7.4%	7.5%
Highest percentage Trust	46.9%	48.5%	49%	49.4%

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

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

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

- 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.

2.2.2 Clinical Effectiveness

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

Patient Reported Outcome Measures (PROMS) measure quality from the patient perspective, and seek to calculate the health gain experiences by patients following one of four clinical procedures. We are reporting on patients who have had a hip replacement or a knee replacement.

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.

We have not carried out a statistically significant number of varicose vein treatments or hernia repairs (defined as fewer than 30 cases) so they are not reported here.

The figure below show the published HSCIC PROMs data for the reporting period up to September 2014

i) The Table below shows the published PROMS data for the Trust for Hip Replacement Surgery

Average adjusted health gain	April 2013 – March 2014	April 2014 – September 2014 (published February 2015)
Lewisham and Greenwich NHS Trust	**0.432**	**N/A – fewer than 30 participants**
National Average	0.436	0.442
Worst Performer	0.342	0.35
Best Performer	0.545	0.501

ii) The Table below shows the published PROMS data for the Trust for Knee Replacement.

Average adjusted health gain	April 2013 – March 2014	April 2014 – September 2014 (published February 2015)
Lewisham and Greenwich NHS Trust	**0.264**	**N/A – fewer than 30 participants**
National Average	0.323	0.328
Worst Performer	0.215	0.249
Best Performer	0.416	0.394

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

- The published data from HSCIC only covers the reporting period April 2014 – September 2015.
- The Trust has identified that the number of procedures for hernia and varicose vein surgery is fewer than that which is statically significant for the recording of data for the PROMS.
- The Trust performance for its PROMS is comparable to the national average for Hip replacement surgery and lower for Knee replacement surgery.

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

- 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.
  - Switching to an electronic patient tracking system for participation in PROMS programme.

- Review the cases where patients have reported a deterioration to understand why and identify any areas for improvement in each of the procedure processes.

2.1.2 Clinical Effectiveness

2.1.2 (iv) Clinical Effectiveness Indicator 3 – Reduction in emergency readmissions within 28 days of discharge from hospital .

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

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

Lewisham and Greenwich NHS Trust monitors the readmission rate using the national data sources and also through CHKS, an independent leading provider of healthcare intelligence.

Currently, the national 28 readmission data is only available up until 2011-12 The Trust has already reported on it last year as part of the 2013- 14 Quality Account. According to the national sources the publication of emergency readmissions to hospital within 28 days of discharge indicators has been delayed this year due to the change in contracting arrangements. Though it has been indicated that the data may be available sometime later this year, no specific timeline has been shared with the Trust.

However, the readmission data for the year 2014-15 is available through CHKS as shown in the tables 1, 2, and 3 below.

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

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

Table 1 below shows that the readmission rate for the Trust was below that of peers.

The QEH site (Table3) shows a similar trend for the first quarter of the year 2014-15, with the readmission rate better than peers. However, the rate is higher than peers for the rest of the year.

As part of collaborative working with key partners, admission avoidance, management of patients with long term conditions and working with our community services is part of the Trust's on-going strategy to minimising its readmission rates.

Table1: Lewisham and Greenwich NHS Trust readmission within 28 days

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trust	6.2%	6.4%	4.6%	6.1%	6.5%	6.5%	6.9%	6.5%	6.7%	7.3%	6.9%	4.2%
Peer	7.6%	7.6%	7.3%	7.3%	7.2%	7.4%	6.4%	7.5%	7.9%	6.9%	6.4%	4.6%

Table 2 University Hospital Lewisham readmission within 28 days

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
UHL	5.8%	5.5%	5.1%	6.4%	5.9%	6.1%	5.7%	5.3%	5.1%	6.0%	5.5%	3.7%
Peer	7.6%	7.6%	7.3%	7.3%	7.1%	7.4%	6.4%	7.5%	7.9%	6.9%	6.4%	4.6%

Table3 Queen Elizabeth Hospital readmission within 28 days

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
QEH	6.7%	7.6%	4.4%	6.0%	7.7%	7.5%	8.6%	8.2%	8.6%	8.8%	8.5%	4.9%
Peer	7.6%	7.6%	7.3%	7.3%	7.2%	7.4%	6.4%	7.5%	7.9%	6.9%	6.4%	4.6%

CHKS Peer Group

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

2.2.3 Patient Experience

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

The national data presented below is the published data from HSCIC data which demonstrates the Trust performance compared to the national average, the highest scoring trust and the lowest scoring trust

Patient Experience - responsiveness to personal needs of patients	2012/13	2013/14
Lewisham and Greenwich NHS Trust	**76.5**	**74.8**
National Average	71.4	76.9
Highest scoring Trust	88.2	88.2
Lowest scoring Trust	68	67.1

SouSource https://indicators.ic.nhs.uk/webview/

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

In 2012 the Trust did some work to try to understand why we did not do very well against this set of indicators. In particular, we analysed all the National Inpatient Survey results and the comments that patients made about our services and identified some specific issues for patients around the effectiveness of communication.

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

This included work to improve the communication between nurses and patients on the wards and to improve communication with patients about their discharge home, and work to increase quality monitoring on the wards through increased use of Quality Ward Rounds.

Friends and Family Test

The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.

The following table shows the latest nationally published results.

Patient recommendation to family and friends	Feb-15	Response rate	Recommendation rate		Response rate	Recommendation rate
Lewisham and Greenwich NHS Trust	**A&E**	**21.50%**	**89%**	**Inpatient**	**45.84%**	**93%**
National Average		21.20%	88%		39.50%	95.00%
Highest scoring Trust		47%	98%		62.88%	99.00%
Lowest scoring Trust		1.60%	55%		4.19%	82.00%

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

2.2.3 (ii) Patient Experience Indicator 2 – The percentage of staff employed by the Trust who would recommend the Trust as a provider of care to their family and friends

The annual staff survey is used to understand staff experience and perceptions on a wide range of subject areas. The survey is undertaken by all NHS organisations enabling comparisons between similar trusts and to compare the experiences of staff in a particular trust with the national picture.

The table below demonstrates the overall response to the Staff Friends and Family Test for the Test for the 2014 Staff Survey.

Lewisham and Greenwich NHS Trust 2014 Annual Staff Survey	Q12 To what extent do these statements reflect your view of your organisation as a whole? d) If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Base (number of respondents)
	%	%	%	%	%	n
	5	10	27	43	14	1,397

The table above demonstrates that 57% of those staff who responded would recommend the Trust to friends and family and a further 27% of respondents neither agreed nor disagreed that they would recommend the Trust to friends and family.

The Following table shows how the Trust performed when compared to national results and those which demonstrated the highest and lowest scores.

Staff recommendation to family and friends	**Composite scores for recommendation of the trust as a place to work or receive treatment**	
	2013	**2014**
Lewisham and Greenwich NHS Trust	**3.85**	**3.59**
National Average	3.67	3.7
Highest scoring Trust	4.35*	4.28*
Lowest scoring Trust	3.01*	2.99*

* denotes scores for Acute Trusts only

Source: NHS Picker Institute Annual Staff Survey 2014

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

During 2014, the organisation has been extremely busy and has had a number of significant challenges. All staff have been extremely busy undertaking work to address these challenges and although much progress has been made, we still have much work to do in our aim to be the organisation and employer of choice for staff.

During 2014/15 the Trust has been actively recruiting to fill its vacancies and over 340 nurses have been recruited. The Trust has also undertaken its Safer Staffing review and new staffing establishments were agreed and implemented for all inpatient areas.

The Trust also launched its first Staff Awards scheme during 2014 to celebrate the success of merger and to recognise the continued high performance of staff, The Trust saw over 300 employees being nominated for their work, commitment and going beyond the 'call of duty'.

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

Further analysis of the 2014 staff survey will be undertaken to understand the results fully. This analysis will include:

- Reviewing the data by division, site, staff group, and demographic group where possible.
- Comparing the outcomes with the Trust wide local survey carried out late 2013.
- Further interrogation to department/ ward level where useful, using web based portal provided by Quality Health, supporting development of local action plans.
- A detailed communication and action plan will then be drawn up for further discussion and implementation. This will need to be visible and prioritised appropriately to ensure that improvements can be achieved
- Working with our Organisational Development and Human Resources Teams to establish a broad staff engagement group representative of the organisation
- Continue to promote staff engagement with all Trust activities, including quality, patient and staff priorities
- Creating a working environment where staff are supported to develop and where development opportunities are supported
- Continue Staff Briefing sessions with Chief Executive Officer [CEO] and participation from staff in Non-Executive and Executive Walkabouts
- Continuation of the production of Weekly Bulletin advocating and celebrating successes of the Trust

2.3 Participation in Clinical Audit

Overview

Participation in Clinical Audits

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

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

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

National Audit and Confidential Enquiries Programme

During April 2014 to March 2015, 44 National Clinical Audits and 5 National Confidential Enquiries covered NHS services that Lewisham and Greenwich NHS Trust provides. During that period Lewisham and Greenwich NHS Trust participated in 100% (44/44) National Clinical Audits and 100% (5/5) National Confidential Enquiries of the National Clinical Audits and National Confidential Enquiries which it was identified as eligible to participate in.

The tables below show:

- The National Clinical Audits and National Confidential Enquiries that Lewisham and Greenwich NHS Trust was eligible to participate in during April 2014 to March 2015
- The National Clinical Audits and National Confidential Enquiries that Lewisham and Greenwich NHS Trust participated in, and for which data collection was completed during April 2014 to March 2015, are listed alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

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

Audit Title		Eligible UHL	Eligible QEH	Participated UHL	Participated QEH	Reporting Period	% Submission Rate - UHL	% Submission Rate - QEH
No	**National Clinical Audits**							
1	Acute Myocardial Infarction & Other ACS (MINAP)	Yes	Yes	Yes	Yes	1st April 2014 – 31st March 2015	In progress	In progress
	Acute Myocardial Infarction & Other ACS (MINAP Validation Study)	Yes	Yes	Yes	Yes	4th February 2015 – 23rd March 2015	100%	100%
2	Adult Community Acquired Pneumonia	Yes	Yes	Yes	Yes	1st December 2014 – 31st January 2015	In progress	In progress
3	Adult Critical Care (ICNARC CMPD)	Yes	Yes	Yes	Yes	1st April 2014 – 31st March 2015	100%	100%
4	Bowel Cancer (National Bowel Cancer Audit)	Yes	Yes	Yes	Yes	1st April 2012 – 31st March 2013	100%	69%*
5	Cardiac Arrhythmia (Cardiac Rhythm Management Audit)	Yes	Yes	Yes	Yes	1st April 2013 – 31st March 2014	62 cases	203 cases
6	Chronic Obstructive Pulmonary Disease (COPD) – Secondary Care	Yes	Yes	Yes	Yes	1st February 2014 – 30th April 2014	78 cases	53 cases
	Chronic Obstructive Pulmonary Disease (COPD) – Pulmonary Rehabilitation	Yes	Yes	Yes	Yes	12th January 2015 – 10th April 2015	In progress	In progress
7	Coronary Angioplasty (PCI)	No	Yes	N/A	Yes	1st January 2013 – 31st December 2013	N/A	99%
8	Diabetes (National Adult Diabetes Audit)	Yes	Yes	Yes	Yes	1st January 2013 – 31st March 2014	In progress	In progress
9	Diabetes - Pregnancy in Diabetes (NPID)	Yes	Yes	Yes	Yes	1st January 2014 - 31st January 2015	25 cases	18 cases
10	Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	Yes	Yes	Yes	1st April 2013 – 31st March 2014	100%	100%
11	Elective Surgery (National PROMS Programme)	Yes	Yes	Yes	Yes	1st April 2013 – 31st March 2014	70.8%	
Audit Title		**Eligible UHL**	**Eligible QEH**	**Participated UHL**	**Participated QEH**	**Reporting Period**	**% Submission Rate – UHL**	**% Submission Rate – QEH**

No	National Clinical Audits							
12	Epilepsy 12 (Childhood Epilepsy)	Yes	Yes	Yes	Yes	1st January 2013 – 12th May 2014 – Service Descriptor Questionnaire	100%	100%
						Clinical Audit	15 cases	0 cases
						PREM Responses	0 responses	10 responses
13	Falls and Fragility Fractures (Inpatient Falls Audit Pilot)	Yes	Yes	Yes	Yes	10th February 2014 – 17th February 2014	100%	100%
14	Falls and Fragility Fractures (National Hip Fracture Database)	Yes	Yes	Yes	Yes	1st January 2013 – 31st December 2013	185 cases	279 cases
15	Fitting Child (College of Emergency Medicine)	Yes	Yes	Yes	Yes	1st August 2014 – 31st January 2015	100%	100%
16	Heart Failure	Yes	Yes	Yes	Yes	1st April 2012 – 31st March 2013	79%	261 cases*
17	Inflammatory Bowel Disease – Adult	Yes	Yes	Yes	Yes	12th September 2011 – 28th February 2015	29 cases	3 cases
	Inflammatory Bowel Disease – Paediatric	Yes	No	Yes	N/A	12th September 2011 – 28th February 2015	In progress	N/A
18	Intermediate Care	Yes	Yes	Yes	Yes	1st May 2014 – 31st August 2014	98%	
19	Lung Cancer (NLCA)	Yes	Yes	Yes	Yes	1st January 2013 – 31st December 2013	≥75% 304 cases	<50% 170 cases*
20	Mental Health (College of Emergency Medicine)	Yes	Yes	Yes	Yes	1st August 2014 – 31st January 2015	100%	100%
21	National Cardiac Arrest Audit	Yes	Yes	Yes	Yes	1st April 2014 – 31st March 2015	100%	100%
22	National Comparative Audit of Blood Transfusion – Patient Information and Consent	Yes	Yes	No	Yes	13th January 2014 – 4th April 2014	0%	100%
Audit Title		**Eligible UHL**	**Eligible QEH**	**Participated UHL**	**Participated QEH**	**Reporting Period**	**% Submission Rate – UHL**	**% Submission Rate – QEH**
No	**National Clinical Audits**							

23	National Comparative Audit of Blood Transfusion – Red Cell Survey 2014	Yes	Yes	Yes	Yes	24th February 2014 – 18th May 2014	100%	100%
24	National Comparative Audit of Blood Transfusion – Transfusion in Sickle Cell – Cycle 1	Yes	Yes	Yes	Yes	1st September 2014 – 30th January 2015	100%	100%
25	National Emergency Laparotomy Audit	Yes	Yes	Yes	Yes	1st January 2014 – 30th November 2014	73%	59%
26	National Joint Registry	Yes	Yes	Yes	Yes	1st January 2013 – 31st December 2013	102%	
							287 cases	61 cases
27	Neonatal Intensive and Special Care (NNAP)	Yes	Yes	Yes	Yes	1st January 2014 – 31st December 2014	100%	100%
28	Oesophago-Gastric Cancer	Yes	Yes	Yes	Yes	1st April 2011 – 31st March 2013	61% - 80%	
29	Older People (College of Emergency Medicine)	Yes	Yes	Yes	Yes	1st August 2014 – 31st January 2015	100%	100%
30	Parkinson's Disease	Yes	Yes	Yes	Yes	4th February 2015 – 30th September 2015	In progress	In progress
31	Pleural Procedures	Yes	Yes	Yes	Yes	1st June 2014 – 31st July 2014	100%	100%
32	Prostate Cancer	No	Yes	N/A	Yes	1st April 2014 – 31st July 2014	N/A	73 cases
33	Rheumatoid and Early Inflammatory Arthritis	Yes	Yes	Yes	Yes	1st February 2014 – 30th April 2015	88 questionnaires	24 questionnaires
34	Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	Yes	Yes	1st April 2014 – 31st March 2015	74% 144 cases	81% 69 cases
35	Severe Trauma (Trauma Audit & Research Network)	Yes	Yes	Yes	Yes	1st January 2014 – 31st December 2014	50% 94 cases	56% 48 cases

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

Table 2: Audits on the HQIP list no longer collecting data in 2014-15

	Audit Title
1	Adult Bronchiectasis
2	NaDIA – Diabetes Inpatient Audit
3	Familial Hypercholesterolaemia
4	National Audit of Dementia
5	National Audit of Seizure Management (NASH)
6	Non-Invasive Ventilation (NIV)
7	Paediatric Pneumonia

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

Enquiry Title		Eligible UHL	Eligible QEH	Participated UHL	Participated QEH	Reporting Period	% Submission Rate – UHL	% Submission Rate – QEH
No	**National Confidential Enquiry**							
1	Maternal, Infant and Newborn Clinical Outcome Review (MBBRACE)	Yes	Yes	Yes	Yes	1st April 2014 – 31st March 2015	100%	100%
2	NCEPOD – Death Following Lower Limb Amputation	Yes	Yes	Yes	Yes	Organisational Questionnaire	100%	100%
		No	Yes	N/A	Yes	Clinician Questionnaires	N/A	100%
		No	Yes	N/A	Yes	Case Note Extracts	N/A	100%
3	NCEPOD – Gastrointestinal Haemorrhage	Yes	Yes	Yes	No	Organisational Questionnaire	100%	100%
		Yes	Yes	Yes	Yes	Clinician Questionnaires	100%	86%
		Yes	Yes	Yes	Yes	Case Note Extracts	100%	100%
4	NCEPOD – Tracheostomy Care	Yes	Yes	Yes	Yes	Organisational Questionnaire	100%	100%
		Yes	Yes	Yes	Yes	Clinician Questionnaires	93%	64%
		Yes	Yes	Yes	Yes	Case Note Extracts	100%	100%
5	NCEPOD – Sepsis	Yes	Yes	Yes	Yes	6th May 2014 – 20th May 2014	80% In progress	100% In progress

Table 4 – Additional National Clinical Audits that Lewisham and Greenwich NHS Trust Participated in during 2014-2015

Audit Title		Eligible UHL	Eligible QEH	Participated UHL	Participated QEH	Reporting Period	% Submission Rate – UHL	% Submission Rate – QEH
No	**National Clinical Audits**							
1	BHIVA – Survey on Pregnancy	Yes	Yes	Yes	No	1st April 2014 – 25th July 2014	100%	100%
2	Cardiac Rehabilitation Audit	Yes	No	Yes	N/A	1st April 2014 – 31st May 2015	100% In progress	N/A
3	Complicated Diverticulitis Audit	Yes	Yes	Yes	Yes	1st July 2014 – 28th February 2015	100%	100%
4	Diabetes – Morbidity and Mortality Review	Yes	Yes	Yes	Yes	1st September 2014 - 9th January 2015	100%	
5	Hepatitis B in Pregnancy	Yes	Yes	Yes	Yes	1st April 2014 – 31st March 2015	In progress	In progress
6	ORCHESTRA – Orchidopexy Audit	Yes	No	Yes	N/A	1st September 2014 – 30th November 2014	In progress	N/A
7	RCOG – Each Baby Counts	Yes	Yes	Yes	Yes	1st January 2015 – 30th June 2015**	In progress	In progress
8	BAD Paediatric Eczema Audit	Yes	Yes	Yes	Yes	1st January 2015 – 13th March 2015	100%	
9	HiSLAC – Point Prevalence Study	Yes	Yes	Yes	Yes		47 surveys	

**** This audit will be continuing for 3 years.**

Reviewing Reports of National Clinical Audits

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

The reports of National Clinical Audits and Confidential Enquiries were reviewed by Lewisham and Greenwich NHS Trust between January 2014 to December 2014 and some of the actions that Lewisham and Greenwich NHS Trust will be taking to improve quality are detailed below:

Trauma Audit and Research Network (TARN) – The Trust has employed a dedicated data analyst on each of the acute hospital sites to increase and improve the quality of data submissions to this annual audit. Focussed work has already seen an increase in the number and quality of cases submitted to the audit.

National Neonatal Audit Programme (NNAP) – Both University Hospital Lewisham (UHL) and Queen Elizabeth Hospital (QEH) were highlighted as an outlier in 2012 for the proportion of babies with appropriate Retinopathy Of Prematurity (ROP) screening (UHL 63% and QEH 33% against a 100% standard). In total 65 units were identified as an outlier to this question in 2012. Adherence to this standard has improved greatly in the 2013 audit with both UHL and QEH achieving a 97% adherence to the standard.

Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) – The number of nSTEMI patients admitted to a cardiac unit or ward in the 2013-14 audit has almost doubled since 2012-13. University Hospital Lewisham admitted 47.4% of patients to a cardiac unit or ward (compared to 28.7% in 2012-13) and Queen Elizabeth Hospital admitted 21.7% (compared to 10.6% in 2012-13). This is still below the National Average of 53% in 2012-13 and 56% in 2013-14 and work will continue in 2015-16 to improve the availability of dedicated cardiac beds for patients being admitted with Acute Coronary Syndrome or Acute Myocardial Infarction.

National Hip Fracture Database (NHFD) – The performance at University Hospital Lewisham (UHL) was identified as having deteriorated since the previous year's audit. An Orthogeriatric operational group was convened by the Medical Director to review mortality and performance, and identify areas of potential weakness with the aim of improving the quality of care, and outcomes for all patients admitted to the Trust with hip fractures. The group reviewed three years' worth of data to identify trends and produced an action plan to improve performance that was monitored via the Divisional level Governance committees and the Trust Quality and Safety Committee.
Areas of good practice identified by the audit include the high number of patients returning home within 30 days at Queen Elizabeth Hospital (QEH) Woolwich and the above national average compliance with specialist assessments provided to patients; Falls assessment 100% at UHL, 99.5% at QEH against a national figure of 94.6%. Also the number of pressure ulcers grade 2 and above developed during admission was well below the National figure of 2.9% at 0.6% for UHL and 0.4% for QEH respectively.

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

The reports of 329 local audits were reviewed by the Trust between April 2014 to March 2015. The examples below taken from across the Trust demonstrate some of the actions taken to improve the quality of our services. A full list of the local audits reviewed is attached in Appendix 3

Children's Services – The Oncology Dieticians at Queen Elizabeth Hospital Woolwich have been instrumental in the introduction of a new meal system following feedback from patients on the less than satisfactory quality of meals and snacks on offer in the oncology children's ward. The introduction of the new system has been complimented by patients, there are more food choices at meal and snack times, and they have provided feedback stating it has improved their experience in hospital.

Cystic Fibrosis – The Cystic Fibrosis (CF) team at University Hospital Lewisham implemented a personalised text message reminder that was sent to patients who Did Not Attend (DNA) adult CF clinic appointments. The messages included details of upcoming appointments including the time of the appointment to ensure that those patients known to be colonised with pan-resistant organisms did not cross-infect those without these organisms. DNA rates in the adult CF clinic improved from 23.5% before the introduction of the text message reminder to 5.1% afterwards. The CF team continue to utilise this system.

Paediatric Anaesthesia – An initial audit in 2011 reported that 51% of parents and carers at University Hospital Lewisham identified that their child's overall operative experience could be improved by receiving more preoperative anaesthetic information. Following this audit the Anaesthetic Team provided copies of the Royal College of Anaesthetists (RCoA) Information leaflets explaining to all parents and guardians of children the process for general anaesthetic. Links to the RCoA website were also provided for parents and children to access copies of the leaflets online. The re-audit in 2014 reported that only 15% of parents and carers felt they required more information about anaesthetic. Work continues to improve this figure in 2015.

Trauma – The Anaesthetics and Orthopaedics teams are working in conjunction to improve patients experience pre-operatively by refining fasting times, particularly in relation to the provision of clear fluids. An initial audit in 2014 identified that patients were attending trauma theatre with prolonged fasting times. In line with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines, patients are now being offered limited clear fluids up until 2 hours prior to the procedure and a light breakfast is being provided for patients on an afternoon operating list.

Maternity – Following an audit to determine practice and adherence to local and national guidance with bladder care, the Maternity Division hosted a 'Bladder Care Week'. Throughout this week various events were held to promote to staff the importance of bladder care following delivery and good documentation. A protocol has been developed within the Division to further support this work and further training sessions are being made available to continue promoting good practice and raising awareness amongst staff.

Podiatry – A joint podiatry and physiotherapy service was set up in 2012 with the aim of reducing the waiting time for non-complex patients to receive orthotic prescription whilst receiving physiotherapy treatment. Run by a senior physiotherapist and senior podiatrist an evaluation of the service in 2013 identified the clinic had reduced the wait times for patients to be seen by a podiatrist when referred by a physiotherapist from 18 weeks to 4 weeks. In 2014 a further evaluation of the service noted a reduction in the average total patient contact time in podiatry had reduced from an average 5.98 sessions (in 2012) down to 1.98 sessions as a consequence of more rapid access to the joint clinic service and immediate access to the podiatry department for

review appointments. This has resulted in a more tailored treatment plan to meet the patient's actual needs/requirements.

Paediatric Emergency Department – A new discharge checklist has been developed by the Consultants in the Emergency Department to ensure all children with asthma are provided with a care plan when being discharged home following an attendance with acute exacerbation of asthma. In addition to follow up actions that may be required at home it also signposts children and their carers to services in the community that can support them in the first instance, with the aim of reducing unnecessary attendances to the Emergency Department.

2.4 Participation in Research

Overview

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

Lewisham and Greenwich NHS Trust, research activity is led by the R&D Director, two Associate R&D Directors, Head of R&D and supported by the Associate Director of Workforce and Education.

Lewisham and Greenwich NHS Trust works collaboratively with the London South Comprehensive Research Network (CRN) whose remit includes the Trust's research in rheumatology, paediatrics, age and aging, neurology, critical care, dermatology, respiratory medicine and more recently Hepatology, Gastroenterology, Women's Health, Cardiology, Diabetes, Epilepsy and HIV. In addition, the Trust also hosts commercial research and supports a small number of other projects either forming part of a staff member's higher degree, or led by a local investigator in an area key to the Trust.

The NIHR Clinical Research Network comprised of 15 NIHR Local Clinical Research Networks. The network for the South London area is known as the NIHR Clinical Research Network (CRN): South London.

The CRN South London is made up of 30 Specialty Groups across a broad range of clinical areas. It incorporates the existing London (South) Comprehensive Local Research Network (CLRN) together with Topic Specific Networks, such as the South East London Cancer Research (SELCRN), the Greater London Primary Care Research Network, the South East Stroke Research Network and the London and South East Medicines for Children Research Network (MCRN).

The Trust's research portfolio continues to expand, with an increase in the number of research studies opened and in the number of patients recruited into studies. The Trust continues to focus on studies that are of good quality and are relevant to the needs of the population it serves. This has been done by working collaboratively with the Comprehensive Research network (CRN).

The Trust conducted 128 active research studies in 2014-15. As stated below, 672 patients were recruited to participate in research studies approved by a research ethics committee.

Statement of Patient Participation in Research

Six hundred and seventy two patients whose care was provided or subcontracted by Lewisham and Greenwich NHS Trust were recruited to clinical research approved by a research ethics committee during 2014-15.

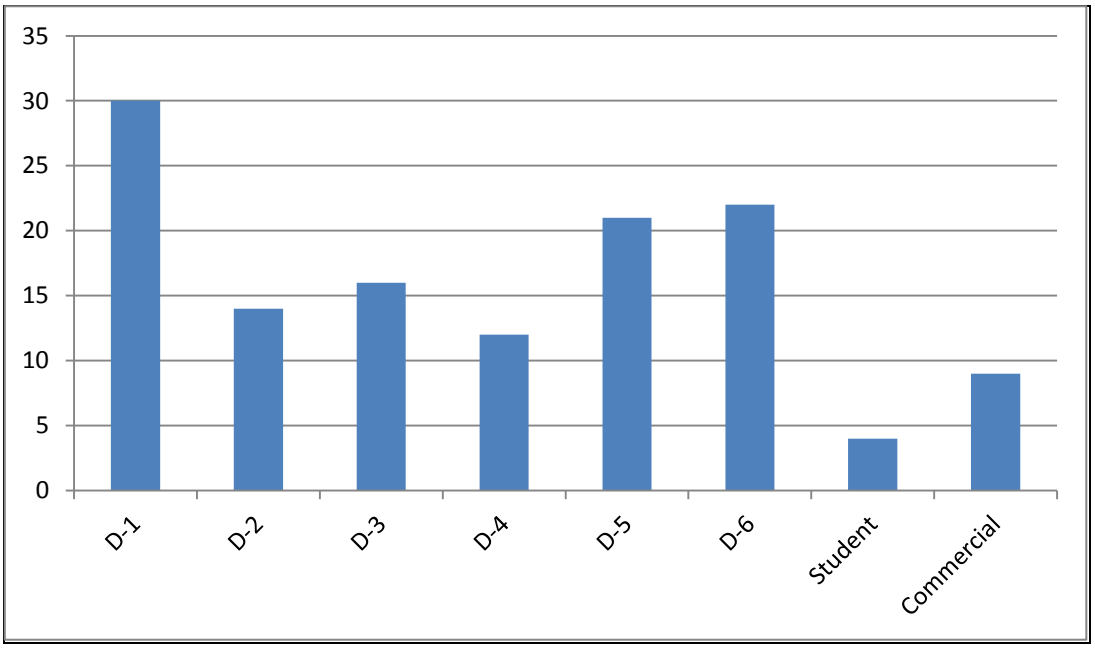
Participation in Clinical Research

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

The Trust R&D Department have actively engaged with local NHS organisations and the South London CRN to streamline R&D Governance processes against nationally-adopted metrics designed to improve delivery of study recruitment.

The current portfolio for 2014-15 is 128 research projects that have been active within the Trust. These have spanned a number of different specialties (see figure below).

Research Active studies by CRN Divisions:



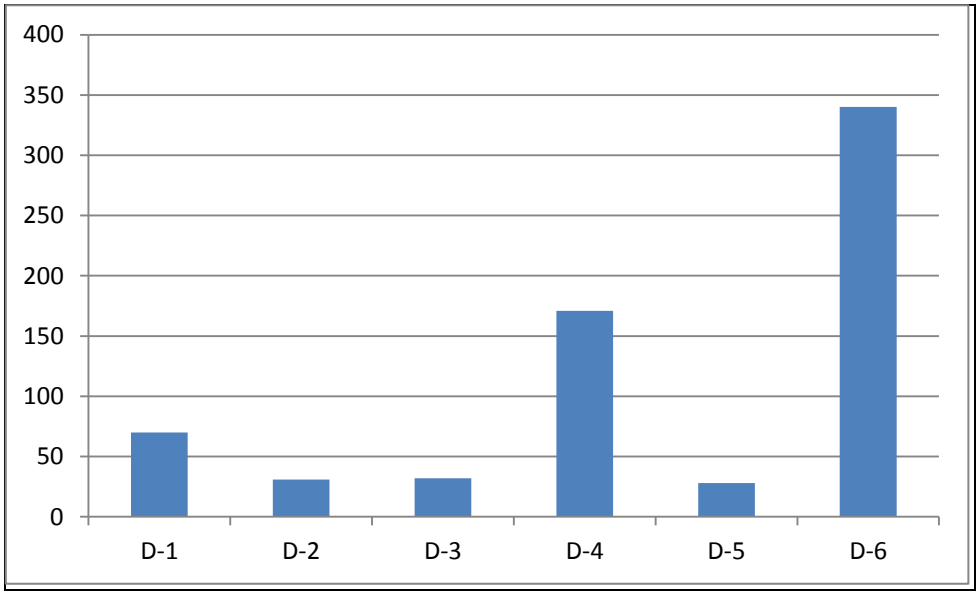
Division 1:	Cancer
Division 2:	Diabetes, Stroke, Cardiovascular, renal, metabolic and Endocrine Disorders
Division 3:	Children, genetics, Haematology, Paediatrics, reproductive Health and Childbirth
Division 4:	Dendron, Mental Health and Neurology
Division 5:	Primary Care, Age and Aging, Dentistry, Health Services Research, Public Health, MSK, Dermatology.
Division 6:	Anaesthesia/Peri-operative Medicine and Pain management, critical care, Injuries/Emergencies, Surgery, ENT, Infectious Disease/Microbiology, Ophthalmology, Respiratory, Gastroenterology, Hepatology

Lewisham and Greenwich NHS Trust has continued to work closely with the CRN Cancer Division to provide access to cancer research locally. This allows patients to be offered the opportunity to participate in research nearer to their home.

Lewisham and Greenwich NHS Trust has been highlighted for its success in recruiting to target with the CRN in 2014-15; it is very much anticipated that this growth and success to recruiting to clinical trials will continue From the merger of Queen Elizabeth Hospital.

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

Patients recruited to studies by CRN Divisions:



Division 1:	Cancer
Division 2:	Diabetes, Stroke, Cardiovascular, renal, metabolic and Endocrine Disorders
Division 3:	Children, genetics, Haematology, Paediatrics, reproductive Health and Childbirth
Division 4:	Dendron, Mental Health and Neurology
Division 5:	Primary Care, Age and Aging, Dentistry, Health Services Research, Public Health, MSK, Dermatology.
Division 6:	Anaesthesia/Peri-operative Medicine and Pain management, critical care, Injuries/Emergencies, Surgery, ENT, Infectious Disease/Microbiology, Ophthalmology, Respiratory, Gastroenterology, Hepatology

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 and Greenwich NHS Trust.

Setting the Benchmark for Best Practice

Lewisham and Greenwich NHS Trust hosted stands on both its main acute sites for International Clinical Trials Day. This gives the R&D Team the opportunity to talk to patients and staff about the new 'OK to ask me!' campaign spearheaded by Lewisham and Greenwich NHS Trust and the CRN.

The 'It's OK to ask me!' campaign was launched on May 30th, 2014. The aim of this campaign is to inform and empower patients to be proactive in seeking involvement in clinical trials; it also gives researchers and clinicians the opportunity to further engage with patients and the public.

Further evidence of setting the benchmark for best practice, the 'OK to ask me!' campaign has been adopted by neighbouring District General Hospitals across South London, since its launch at Lewisham and Greenwich NHS Trust.

2.5 Goals agreed with Commissioners (CQUINs)

A proportion (2.5%) of Trust's income in 2014-2015 was conditional on achieving quality improvement and innovation [CQUIN] goals agreed between Lewisham and Greenwich NHS Trust and Lewisham, Greenwich and Bexley Clinical Commissioning Groups and NHS England

The Trust achieved 88.025 % of its CQUIN goals for April 2014 – March 2015 &
Add in reference to website for CQUIN Goals 15/16 when agreed.

2.6 What others say about the provider

Care Quality Commission (CQC)

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

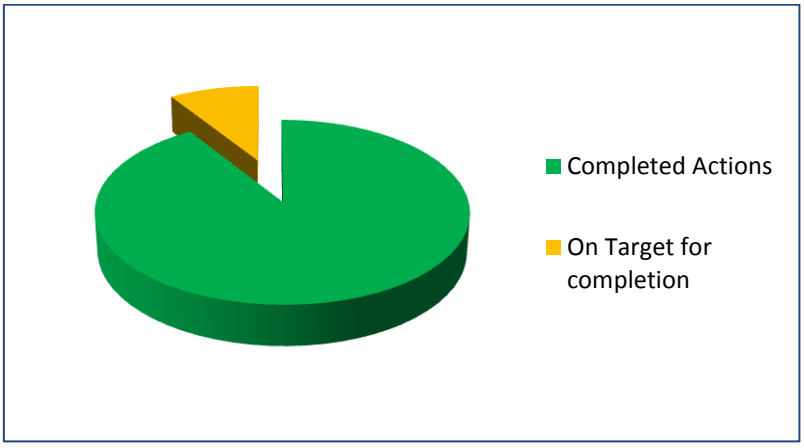
The Care Quality Commission has not taken enforcement action against Lewisham and Greenwich NHS Trust in 2014-2015.

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

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

A comprehensive plan was developed around the improvements needed, and actions were formed detailing how the Trust was to address all of the improvement needed and the timescales in which to complete this. The plan is monitored internally by the Board and externally by our health economy partners.

To date (2nd April 2015), the Trust has completed 91% of its actions overall. Many of the completed actions have already made an impact – the formation of discharge lounge, a transport lounge and an operational clinical decision unit at Queen Elizabeth Hospital has enabled patients to be seen quicker when they arrive and has provided a comfortable space for them to wait before they leave – freeing up beds for more patients to arrive.



The remaining actions within the plan include the implementation of a pathway specifically designed to care for frail elderly patients, ensuring that our most vulnerable patients are cared for

in specially designed areas; completion of an extensive recruitment plan for additional consultants and the completion of the plan for our Ambulatory Unit.

2.7 Data Quality

Quality data is data that is:

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

The Trust measures many different aspects of Data Quality – from the presence of a General Practitioner and NHS Number recorded within a patient record, to the detail and depth within the clinical coding associated with an admission.

Data quality is taken very seriously by the Trust as it can impact on the quality of patient care provided to patients. The Trust's Data Quality scorecard shows performance against key targets, and is used to identify areas for improvement. The scorecard, which contains over 90 measures, is updated on a monthly basis, and key Data Quality metrics are included on the Trust Board scorecard.

Work continues looking at the Trust's depth of clinical coding, which is often used as a proxy for the complexity of the condition / how ill patients admitted to the Trust are.

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:

The performance for 2014/15 is outlined below:

<u>which included the patient's valid NHS number was:</u>

99.69% for admitted care; - UHL = 99.39%, QEH = 100.00%

99.53% for out-patient care; - UHL = 99.54%, QEH = 99.52%

97.16% for accident and emergency care; – UHL = 96.81%, QEH = 97.51%

<u>Which included the patient's valid General Medical Practice Code:</u>

100% for admitted care; - UHL = 100%, QEH = 100%

100% for out-patient care; - UHL = 100%, QEH = 99.99%

100% for accident and emergency care; – UHL = 100%, QEH = 100%

2.8 Information Governance Toolkit

Information Governance (IG) is the way in which the NHS handles all organisational information – in particular the personal and sensitive information of patients and employees. It requires 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 2015) the Trust has achieved an overall score of 75% and has been graded as satisfactory.

2.9 Clinical Coding

Payment By Results

Payment by Results (PbR) is the method by which the Trust receives payment for patients seen and treated within the Acute setting. Each patient's condition, what treatment they received, how they were treated and how long they were in hospital for is used to allocate each patient to a nationally agreed category. The categories, which are called Healthcare Resource Groups (HRGs), have a national tariff which is used to determine the amount that the Trust is reimbursed for patient care. The HRGs are based on the Clinical Coding recorded against each episode of care, it is important that the coding is accurate so that the Trust is not over or under paid. In addition to this, the coded data forms part of the patients clinical record and is used to help identify where improvements in service can be made. The data is also submitted nationally to the Secondary Use Service (SUS) , who collect national data to allow them to look at trends and patterns across the NHS as a whole

The Trust did not have its Admitted Patient Care Clinical Coding audited as part of any national audit programme in 2014/15.
However, a number of internal Clinical Coding audits as well as a clinical coding audit commissioned by our three local CCGs were undertaken to look at any changes in Trust coding practice since the organisational change (merger) in 2013/14. The Trust is awaiting Commissioner feedback around actions / action plans following this audit. The report that supported the audit identified areas for improvement but did not identify any change in Clinical Coding practice over time.

The CCG commissioned audit was targeted at areas that commissioners were interested in for various reasons (high volumes, public health agenda and high cost) , and the results cannot be taken to be representative of Trust coding quality. The Trust achieved IG Toolkit Level 2 for Clinical Coding in 2014/15

The results demonstrated the following:

Site	Area ALL	Qtr (Q4 13/14 or Q1 14/15)	Spells	HRG Change / error rate	Primary Diag. correct %	Secondary Diag - correct %	Primary Proc – correct %	Secondary Proc – correct %
ALL	ALL	ALL	317	7.3 %	89%	90.5%	94.5%	82.4%
National comparator - Median (Capita PbR audit data 2012/13)				7.0	91.2%	88.6%	93.3%	82.6%

The Trust also has a programme of internal coding audit and has appointed a trainee auditor to support the Trust coding auditor. Senior coders review coding with clinicians to help understand local practice to ensure the clinical coding accurately reflects casemix.

Divisional leads also work with clinical teams in their areas to review coding on a regular basis to identify coding errors and to educate clinicians about how coders translate clinical documentation into the codes and classifications (ICD and OPCS) allocated to Trust activity.

Part 3

3.0 REVIEW OF QUALITY PERFORMANCE in 2014/15

3.1.1 Priority 1 Embedding the new organisational culture

Our quality priorities and why we chose them	What success will look like	How did we do?
3.1.1. (i) Development of the Clinical Strategy We can see substantial opportunities to improve our services as one Trust operating across two sites. Currently some of our services, including our emergency care pathway, do not meet the high expectations we and others have of us. An aim of this plan is to enable us to level up the quality of our services across our acute sites and then to improve them still further.	- Continued development of our clinical strategy - Delivery of year 1 of the Clinical Strategy - Improvements to elements of the emergency care pathway & diagnostics	- We partially achieved this. - We are continuing to develop our Five Year Clinical Strategy and have delivered on a number of improvements to the emergency care pathway. - We have scoped the entire emergency care pathway and have worked on a number of areas which can cause delays. - We have created extra bed capacity on the QEH site and have established a model of Rapid Assessment and Treatment - We have established the role of emergency flow co-ordinators, to ensure the flow of patients is managed appropriately. - We have developed a Clinical Decision Unit and discharge lounge on the QEH site and have expanded and extended the discharge lounge at the UHL site. - We have also developed Surgical Assessment Units on both sites - We have created an additional 24 Stroke beds at the UHL site, bringing together all of the Trust's management of Stroke patients onto one site - We have developed robust processes for managing medical fit patients and have established Healthcare at Home provision for those patients requiring additional packages of care. - We have reduced our waiting times for diagnostics in four modalities and will continue this work as we work towards seven day working in radiology services.
3.1.1. (ii) Promoting a culture of 'Putting patients first' with care and compassion in nursing 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.	- Delivery and implementation of the Nursing and Midwifery Strategy priorities	- We achieved this - The Trust Nursing and Midwifery Strategy was launched in May 2014 during the Trust' International Nurses Day events. - Introduction of the 'Sage and Thyme communication training is being rolled out across the Trust. It is included in the preceptorship programme for all newly qualified staff. - We have implemented band 5 and band 6 development programmes across the Trust and have a planned programme for delivery for all Band 7 Ward leaders - All support staff across the Trust have access to a HCA induction programme and a range of apprenticeship programmes - All elements within our strategy are part of every nurses/midwives induction

		- We have developed a programme to instil our core values and behaviours which is being rolled across all wards and departments - We have developed a core Clinical Indicator set for Nursing and Midwifery that is able to demonstrate the quality of nursing and midwifery care - We publish core and service specific Clinical Indicators sets openly and transparently using the "Knowing How we are Doing Boards" to reflect this information on a ward/ department basis. - We have developed Board quality walk arounds with Senior Nursing and Non-Executive and Executive teams. These form part of our internal quality inspections - We continue to share patient feedback and stories to help us improve services and care delivery - We continue with our on-going partnership with our two higher education institutes, Kings College London and the University of Greenwich to ensure positive learning experiences for students nurses and midwives in the Trust
3.1.1. (iii) Promoting a workforce which has the right staff, with the right skills in the right place, focussing on Nursing and Midwifery for 2014–2015 Nationally nursing and midwifery staffing levels had been under significant scrutiny since the publication of the Francis report (2013), which identified unacceptable delays in addressing the issues of shortage of skilled nursing staff.	- Reduction in Nursing and Midwifery vacancy levels - Implementation of Return to practice Programme - Implementation of the Acuity and Dependency Tool.	- The Trust has successfully implemented the Return to Practice programme in partnership with the University of Greenwich. To date seven applicants have been successful and five more applicants are about to commence the programme. - The Safer Nursing Tool has been successfully implemented across the Trust and we have undertaken bi-annual safer staffing reviews using the acuity and dependency tool. We have further work to do to embed acuity and dependency into everyday clinical practice and the coming year we will integrate this within our e-rostering tool. - The Trust vacancy levels for Nursing and Midwifery have dramatically reduced from 2013/14 and a successful overseas recruitment programme has assisted with filling long term vacant posts. - In March 2014 there were 303.37 Registered nursing vacancies and in March 2015 this has reduced to 220.07 Vacancies in non-registered nursing posts were 35.21 in March 2014 and reduced to 14.9 in March 2015 In midwifery, there were 51.57 vacant posts for registered midwives, this had reduced to 37.49 in March 2015. For midwifery support roles, the level of vacancies was 16.12 in March 2014, which had reduced to 6.02 in March 2015.
3.1.1 (iv) Care Quality Commission action plan	- Implementation of all year 1 actions within	- We have achieved this for year 1. - All planned actions with the timeframe for

In February 2014, the new organisation was inspected by the Care Quality Commission [CQC] under the new method of inspections. In May 2014, the Trust received its CQC report on the inspection which identified a number of areas which required.	our CQC action Plan	delivery by May 2015 have been completed. - The Trust action plan and progress can be accessed via the Trust website

3.1.2 Priority 2 Patient Safety

Our quality priorities and why we chose them	What success will look like	How did we do?
3.1.2. (i) Patient Safety Incidents reported Patient Safety relates to treating and caring for people in a safe environment and protecting them from avoidable harm. A priority within the Trust's patient safety strategy was to continue to encourage staff to report incidents, ensure everyone knows how to report an incident, and what to expect afterwards. It was therefore crucial that a culture was fostered within healthcare organisations where staff feel comfortable to raise concerns and to report adverse events, without fear that they will be derided or punished for doing so.	- Increase in reporting of overall numbers of Patient Safety Incidents and identifying trends - Reporting of the rate of patient safety incidents per 100 admissions - Reporting of Never Events and sharing the learning across the organisation - Reporting of rate and percentage of reported incidents which result in severe harm or death - Reporting response times to Serious Incidents to improve the turnaround time. - Increased in reporting evidence of the Being Open (Duty of Candour) process for patient safety incidents involving significant harm (moderate, or severe harm or death)	- We have achieved this. - Our reporting rate has increased across the trust and the rates can be seen on page 1. The rate of incidents resulting in no harm has increased by 8% to 78% and the rates for incidents resulting in low and moderate harm have also decreased. We have seen an increase in the reporting of incidents where severe harm may have resulted and we now review all these cases to establish the actual impact of incident on harm caused. - We have developed a process for sharing the learning and have held events across the Trust to ensure learning is shared from incidents. - We have improved the response and turnaround times of Serious incidents but still have further work to embed to continue to meet our turnaround times. - We have achieved our goal with ensuring that the Being Open/Duty of Candour process has been established and for incidents involving significant harm, a Duty of Candour discussion is performed and /or letter is sent. This is assessed for all cases and is based on the situation at the time. No known breaches of the statutory Duty of Candour have occurred.
3.1.2. (ii) Reducing the incidence of avoidable harm	- Reduce the incidence of events where harm was avoidable	- We partially achieved this. - For 2014-2015 there were 3 Never Events compared to 3 Never Events in 2013-2014. Each of the incidents was different to those which occurred in 2014-2015. However, two were very similar in nature for the 2014-2015 reporting period in that they were related to retained foreign objects post procedure. These have been thoroughly investigated and the learning shared across the organisation and between teams
	- MRSA bacteraemia	- We did not achieve this. For 2014-2015 the Trust had three cases of MRSA bacteraemia which were attributable to the Trust. One case occurred when a blood culture taken in paediatric emergency department was deemed to be a contaminant. The root cause analysis in conjunction with the Health Protection Manager on behalf of the CCG has found no lapses in care (This baby

		was identified as having a PVL MRSA as was other members of its family). The second case was related to an oncology patient who was admitted from Outpatients and was found to be MRSA positive five days following admission. The patient did have a history of chronic cytopenia and was considered to have had a transient colonisation as a result of his prolonged immune-compromised state. The investigation found that the likely source was a cannula site although the cannula site remained clear with no signs of infection. The root cause analysis found that this was an unavoidable case and found no lapses in care, but indeed commended the care provided. The third case was associated with an infected arterial line and there was also a delay in reporting a positive MRSA screen by the laboratory. Changes in practice with regards to documenting the VIP observations for the arterial lines and work has been identified to ensure laboratory staff are aware of the process for flagging results with consultant microbiologists in a timely manner.
	- Incidence of newly acquired Pressure Ulcers	The Trust has achieved significant progress towards reducing the number of newly hospital acquired grade 3 pressure ulcers and has reduced the number from 53 in 2013/14 to 40 in 2014/15.For grade 4 pressure ulcers the incidence has remained the same for 2013/14 there were 4 newly hospital acquired and in 014/15 there were 4. The Trust is continuously working towards reducing hospital acquired pressure ulcers and as well as feature as part of our Sign Up to Safety Plan, the Trust reviews all pressure ulcers incidence on a weekly basis in a joint collaborative with our local CCGs.
	- Incidence of medication errors causing serious harm	• For 2014-15 there was 1 medication error identified in October 2014 which has potentially caused severe harm. The incident occurred in April 2011 and related to a baby born to a mother known to be hepatitis B reactive, who correctly received the hepatitis B vaccine shortly after the birth, but the immunoglobulin which the baby should also have received was inadvertently omitted.
	- Incidence of falls resulting in harm	• For 2014-15 there were a total of 39 falls resulting in moderate, severe harm and/ or death. 32 falls were judged as resulting in moderate harm and 7 falls resulting in severe

		harm and/or death. The Trust has developed and launched it Falls Strategy throughout 2014/15 and introduced Falls Champions across the Trust. All inpatient falls resulting in moderate, severe harm or death are investigated. Where the outcome for a patient has been a fracture, head injury or death a root cause analysis is carried out to find out whether there were any care management problems and to identify any learning points. The patient and / or their family are offered feedback about the findings and any changes being made to help reduce harm to future patients. All lessons learnt are reviewed by the Trust's Falls Prevention and Management sub group of the Aspiring to Excellence Programme and progress is reported to the Trust's Outcomes With Learning Group.
3.1. 2(iii) Improving Maternity Services	- Reduction in admission of full term babies to neonatal care	• This was a new indicator which we commenced recording in April 2014. • The number of term admissions to the Neonatal Unit are documented monthly on our maternity scorecard for each site. This number varies between site and it is important for us to understand the reasons for this. We are planning to review all NNU admission weekly with a multidisciplinary team to have a greater understanding of reasons for admission as well as a review of the antenatal and intrapartum management to see if different management could have reduced the need for admission.
	- Reduction in emergency caesarean section rates	- The Trust has achieved a reduction in total caesarean section rate from 29.0% in 2013/14 to 27.05% in 2014/15. This is slightly above that of the national rate which is 26.2%. The emergency caesarean section rate has also reduced across the Trust and is currently 16% compared to 18.0% in 2013/14. All caesarean section births are audited by a Consultant and presented at regular audit meetings. Monthly workshops are held to increase and promote normality in labour. Regular training and masterclasses in CTG Interpretation have also been established. All areas identified from the regular audits are shared across the services.

	- Increase in number of breastfed babies	- This has been achieved across the Trust and across each acute site. In 2013/14 the average breast feeding initiation rate was 81.9%.Through the focused work of the midwifery department and using peer support workers, the breast feeding initiation rate has increased to 86.5% and more work is continuing through 2015/16.
3.1.2. (iv) Delivering Safe Care to Children in Acute settings	- Reduction in incidence of harm to children due to failure to monitor	- We have achieved this. There were no cases of harm to children where failure to monitor has been identified as a root cause or contributory factor during 2014 – 15.

3.1.3 Priority 3 Clinical Effectiveness

Our quality priorities and why we chose them	What success will look like	How did we do?
3.1.3(i) Reducing premature mortality and increased survival rates from lung and colorectal cancer with early detection The national screening campaigns for bowel and lung cancers in the last two years saw a positive impact on the numbers of patients requesting screening. For 2014-2015, the Trust will continue to extend the age range for bowel cancer screening to 75 years in line with the Cancer Reform Strategy for the borough populations of Lewisham, Greenwich,	- Increase in number of patients being screened for Bowel and Lung Cancer - Continue the extension of age range for screening to 75 years	- We have achieved this for the Bowel Cancer screening, however, the increase is marginal with the number increasing from 744 patients in 2013/14 to 751 patients in 2014/15. However the age extension has been achieved from March 2015. The Screening Centre is presently in the process of implementing a new service known as Bowel Scope Screening. GP registered 55 year olds will be offered a one off procedure called a flexible sigmoidoscopy. Over the next two years, LGT will continue to offer bowel cancer screening to the boroughs of Lewisham, Greenwich, Bromley and Bexley. Additionally from 2015, BSS will be rolled out incrementally to these boroughs. It is envisaged the service will extend delivery of bowel screening to the Queen Elizabeth Hospital in line with service development plans underway for its Endoscopy Unit. We have also seen the increase in the number of patients being screened for suspected lung cancer with an increase in 10,605 radiological investigations from the previous year. - A crucial activity for cancer services in 2015/6 is to review all cancer pathways focussing on delivery of a timed pathway mapped against best practice. This will be a multi-disciplinary process and will support all specialities to improve their current performance. It is anticipated improved performance will be realised during Q2. Included in this work will be improving timely access to treatments whether provided at the cancer centres, Guys and St Thomas's and Kings College Hospitals or locally as well as embedding 6 day a week opening of our chemotherapy unit at Queen Elizabeth site. - Another key focus will be the delivery of the survivorship agenda. This includes implementation of the Cancer Recovery Package comprising of Holistic Needs assessment (HNA), End of Treatment Summaries (EoT) and Health and Well Being Events (HWBE), Stratified Follow Up pathways and development of a comprehensive psychological support service. This work builds on work already being taken forward and will increase the number of patients benefiting for this support.
3.1.3 (ii)Reduce mortality rates amenable to healthcare	- Establishment of new process for Trust and speciality review of all in-hospital deaths - Continued Trust level reporting for Mortality	- The Trust has achieved its set outcome measures, and the Trust mortality rate as calculated by SHMI is 'As expected' (pp. 19). However, the rate has increased and a significant review into understanding the rationale for the increase is underway across

	rates amenable to healthcare	the Trust. - The Trust has established a Trust wide Mortality Review committee which reviews and monitors monthly mortality trend figures both internally collated and externally published data. The Group ensures: - That possible adverse trends are discussed and undertake further investigation into mortality and morbidity trends where this is indicated. - actions are taken to embed learning, triangulated with other quality measures (e.g. complaints, adverse incident and patient feedback). - The Trust focus on Sepsis, Acute Kidney Injury and deteriorating patients and reducing avoidable deaths forms a key part of our sign up to safety plans and a key area to improve outcomes. These are also national CQUINs for 2015/16. -
3.1.3 (iii) Improving outcomes and total health gain as assessed by patients for planned treatments [PROMS]	- Improvement in PROMS scores (health gain) for the Trust for the identified procedures	- Throughout 2014/2015 Lewisham and Greenwich NHS Trust has been monitoring the adjusted average health gain for patients based on the PROMS data (please see pp.21 for PROMS health gain data).
	- Improvement in patient satisfaction scores for surgical patients - Roll out of review processes at Queen Elizabeth Hospital site	- In 2014/2015, The Trust monitored patient satisfaction using the Department of Health Friends and Family Test question 'How Likely would you be to recommend this service to your friends and family?' Overall 91% of in-patients on the six surgical inpatient wards reported that they were 'Extremely Likely' or 'Likely' to recommend the service. Patients also reported an increase in satisfaction when asked about whether they found members of staff to talk about their worries and fears with, and whether they were involved in decisions about their treatment and care. Overall in 2014/2015 more patients felt they were treated with respect and dignity during their stay in hospital when compared with the same period in 2013/2014.
	- Learning from reviews of patient level data	- Patient level PROMS data has been shared with relevant key stakeholders in a timely manner upon publication. Where patients reported deterioration in one of the four clinical procedures, these patients have been highlighted to Clinicians for review. The Clinical Effectiveness Team provides the patient level data to the Clinicians and individual case reviews are undertaken where patients reported a 'worse outcome' and have consented to share their

			responses, a review is undertaken to understand the reason for the deterioration **The learning from these reviews is summarised below:** **Groin Hernia** The review of patient cases identified that patients were discharged home on the same day or the next day following surgery and were followed up directly by their GP. In some instances patients underwent two procedures to repair right and left sided groin hernias over a staggered period of time. This may be a contributing factor in patients who reported a worse outcome. **Knee Replacements** Following knee replacement surgery, the patients reviewed were seen an average of twice in outpatient clinics and discharged from care with no further follow up required. The reviews identified one patient who reported deterioration in mobility and this patient underwent a repeat procedure to improve their Range Of Movement (ROM) and was provided with a further course of physiotherapy treatment to improve their mobility further. **Varicose Vein** Case notes reviewed for Varicose Vein surgery identified that patients often underwent a second procedure for treatment of veins in the other leg at a later stage. When followed up in outpatient clinic they reported satisfaction with the procedure and were discharged from follow up care. -
3.1.3. (iv) Dementia – Improving the diagnosis, treatment and quality of life in a long term condition (Domain 2 of NHS Outcomes Framework)	- Increased number of patients being screened for dementia - Increased numbers of patients being risk assessed for dementia - Increased numbers of patients being referred for specialist diagnosis - Increased use of locally developed 'Dementia Passport' for patients across both hospital sites - Education and training of staff with Dementia Training Programme - Carer experience and		- We achieved this, with 100% of all eligible patients being screened and risk assessed for dementia and increased numbers being referred for specialist diagnosis. - The Dementia Team work across the Trust and have introduced a number of initiatives throughout the year to improve Dementia Services for patients. A pathway for Dementia patients has been developed and implemented across the Trust to ensure a consistent approach to improving Dementia care - The Dementia Passport is being used across the Trust and within the Community. - The Introduction of a Dementia Friendly ward on our QEH site has also seen improved patient and carer feedback via our Carer's Surveys which have been introduced across the Trust along with our Dementia Carer 'Drop in'

	satisfaction survey and learning from results	Sessions. - We have developed a comprehensive Dementia Training Programme for all levels of staff and have trained over 1000 staff at all levels in Dementia Awareness and Dementia care. - The Trust has also developed plans for creating its own Dementia Champions network which will commence in May 2015 during Dementia Awareness Week

3.1.4 Priority 4 Patient Experience

Our quality priorities and why we chose them	What success will look like	How did we do?
3.1.4 (i) Increased response rate for Friends and Family Test in hospital and roll out to community and outpatient services. This was a National Commissioning for Quality and Innovation (CQUIN) target in 2014/15. The aim was to ensure that more people had the opportunity to provide feedback about the quality of care that they had received.	- Continued roll out of the Friends and Family Test in outpatient departments and community - Continue to improve response rates from all areas	- We have achieved this. We have ensured that all of our community and outpatient services are involved in the Friends and Family test. All services have a bespoke plan to ensure that patients have the opportunity to provide feedback using this simple test and many services are now receiving responses from patients. We are reviewing all the comments and suggestions that patients have made about their care and talking to service leads about how these comments can be used to help to continually improve quality. - As well as ensuring that more services have the Friends and Family Test, we have made sure that services that already had it in place are getting more responses back from patients. The national CQUIN set a target response rate of 30% in adult inpatient wards and 20% in Accident and Emergency departments by the end of March 2015. We achieved that target.
3.1.4. (ii) Improving the quality of end of life care. The Department of Health decided to phase out the national Liverpool Care Pathway (LCP) for the care of the dying. As a result the Trust planned to introduce individualised end of life care plans. The Trust End of Life Care Working Group developed 'Principles of Care for Dying Patients'. This was intended to support clinicians in the development of end of life care plans. We planned an education and training programme to support end of life care across the organisation.	- Removal of Liverpool Care Pathway for end of life care patients - Introduction of Principles of Care for Dying Patients - Introduction of a bereavement survey	- We partially achieved this - Removal of the Liverpool Care Pathway for end of Life Care patients Following the Independent review of the Liverpool Care Pathway (LCP) published in July 2013 which recommended the phasing out of the pathway, the Trust stopped using the pathway on 28th April 2014. The documentation was removed from the Trust intranet and all existing paper documentation was removed from wards and departments. Introduction of Principles of Care for Dying Patients - On 28th April 2014 the Trust introduced the 'Principles of Care for dying patients' to support the multi-disciplinary team in developing individualised end of life care plans for patients identified as being in the last days / hours of life. The document outlines 6 Principles that should be considered when patients are being identified as likely to be in the last days/hours of life. The principles are consistent with existing guidance from NHS England and informed by guidance released by the London Cancer Alliance (LCA) . - Introduction of bereavement survey The trust is developing a bereavement survey based on the National Cancer voices Survey tool and

		methodology. A working group has been formed to lead this work. The Trust has permission to use the tool and is currently working through the methodological issues. It is planned to undertake the survey in 2015.
3.1.4 (iii) Priority 3 – Improving women's' experience of postnatal care. The National Survey of Maternity Services showed womens'experience of postnatal care during February 2013 at both hospitals was worse than at other Trusts. As a result of these findings, the maternity department developed an action plan for improvement.	- .Develop and implement action plan for improving postnatal experience of women who use the services	- Both maternity sites carried out a Friends and Family test thematic review of quarters 1 and 2 and developed site and ward specific action plans. - Both sites reported issues with communication, especially around attitude of staff and conflicting advice being given to new parents. - Actions taken on the QEH site: greater scrutiny of information given to new parents by the Senior lead midwife on the ward. Complaints are shared during the daily 'take 5 sessions'; a news bulletin shared with all members of staff on a daily basis. - Actions taken on the UHL site: implemented a daily 'ward huddle' in addition to the daily 'take 5 sessions'. The huddle celebrates good care, communication and feedback but it also addresses themes from FFT and complaints so that staff can reflect and explore solutions to these issues. - Both sites reported issues around the ward environment: - Actions taken on the QEH site: electronic beds have been delivered to the postnatal ward. The postnatal ward is part of the rolling programme for decoration and is due to be painted this year. An application to improve the day room has been submitted to the Charitable funds committee - Actions taken on the UHL site: The ward has been deep cleaned and the maintenance cleaning programme has been changed to reflect the high number of patients and staff that use the environment daily. The estates department has agreed to a full re-decoration of the ward this year. All bathrooms on the postnatal and antenatal wards were re-decorated in the summer of 2014.
	- Measure and monitor the hospital postnatal net promoter scores for maternity Friends and Family and improve scores	- The net promoter scores for FFT were phased out in 2014 and a recommendation basis was used for the FFT. The FFT scores on both sites are reported monthly and show that less than 3% of women would not recommend our service.
3.1.4 (v) – Improving the way in which we manage and learn from complaints We wanted to improve complaint response times by reviewing complaints management processes within the clinical divisions.	- We can demonstrate complaint response monitoring and reporting of response times	- We have partially achieved this with some Divisions reaching their target. Complaints response times remain a challenge for the Trust particularly highly complex complaints. The Trust has now developed a pathway for the management of cross divisional and highly complex complaints which we hope will help in improving our responses. Complaint response monitoring is an on-

We wanted to ensure robust learning from complaints is shared across the organisation. The Trust chose these priorities as each complaint provides us with valuable feedback which enables us to learn and embed service changes throughout the organisation. We also wanted to ensure that people are aware of how they can make a complaint and that they will be supported during the process.	-	We can also show demonstrate that we learn from complaints and use them to inform service improvements and changes in practice	-	going process and the PALS unit produces a weekly report detailing all open complaints which is circulated to the appropriate divisions. The report is also discussed at the Monthly complaints steering committee. The Trust also reports on response times on a monthly basis and this is monitored by the Trust board. Learning and service improvements resulting from complaints are recorded and discussed at the complaints steering committee. Some examples are: ➢ Purchasing wheelchairs to be used by visitors on the Lewisham site. ➢ A review of the administrative processes surrounding appointments to reduce the number of appointments where patients do not attend ➢ Patients on the maternity ward can have one person stay with them overnight.

3.2 INVOLVEMENT

Overview

Who has been involved?

The Trust has consulted widely about the content of this Quality Account, namely the Trust Board, senior nursing, midwifery, clinical and managerial staff, patients and the public. The Patient's Welfare Forum, the local Healthwatch organisations have also been consulted.
We have also been able to consult and gain feedback from three local Clinical Commissioning Groups and our Clinical Quality Review Group.

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

The Trust has consulted widely about the content and the final version will incorporate all comments, being published at the end of June 2015.

The Trust Board

The Trust Board has been actively involved in setting the quality priorities for the Trust. Items on quality are discussed at every Board meeting and at frequent Board seminars. This year has seen the introduction of the Quality Account indicators being introduced onto the Trust scorecards which have been presented and discussed through the Integrated Governance reports to the Trust Board.
The Trust Board is also presented with a performance scorecard which is examined at every Board meeting to assess trends in performance and highlight any issues of concern. In addition, Board members undertake quality walk rounds, visiting clinical departments to better understand, in an informal setting, any issues that the staff feel could affect the quality and safety of services they deliver.

Staff

The Trust's Management Executive, which comprises the Chief Executive, the Medical Director, the Deputy Medical Director for Quality and Safety, the Executive Directors, the Director of Business Development, the Director of IT and the Six Divisional Directors have been involved in discussions around and provision of information for the Quality Account..

Key leads and stakeholders from within each of the Six Clinical Divisions have contributed to the content, the setting of priorities, and agreement of the key outcome measures and have provided the commitment to lead on each of the key priorities for 2015 – 2016.

The Trust Integrated Governance Committee, Quality and Safety Committee and Patient Experience Committee, which have Executive, Non-Executive, Clinical Team members, Patient Welfare Forum members and members of our local Healthwatch, have the Quality Account as a standing agenda item and valuable input has been received from these committees.

The Divisional Governance and Risk meetings have also been used to consult widely on the Quality Accounts with Divisional Governance, Risk and Audit Leads participating in the review of the priorities.

3.3 STATEMENTS FROM CLINICAL COMMISSIONERS, LOCAL HEALTHWATCH AND Overview and Scrutiny Committee

i) Commissioners/ Clinical Commissioning Group [CCG]

To be added in on receipt

ii) Overview Scrutiny Committee

To be added in on receipt

iii) Healthwatch

To be added in on receipt

iv) Patient Welfare Forum [PWF] University Hospital Lewisham)

The Patient Welfare Forum (PWF) is made up of a group of volunteers that hold a number of unannounced inspection visits across wards and departments based at Lewisham hospital and have representatives at numerous official hospital meetings.

We are supported by The Trust Authorities but are independent of the hospital. This gives us the freedom to liaise with patients and staff and the ability to bring to the Trust's notice any issues that come to our attention.

Our visits are conducted on the basis of 'how would we feel' if we came to this ward now, i.e. "is it clean, calm, welcoming, is the bedding clean, is there something tasty for me to eat". We talk to the patients about their hospital experience, ask if they have enough to drink and are generally comfortable.

We pay attention to issues such as hand hygiene, notice boards, Pals leaflets and others.
The PWF members participate in the annual PLACE inspections, contributing to the scoring of PLACE score sheets.

We see ourselves as a critical friend to the Trust, and we are the eyes, ears and voice of the patient. Our comments are received positively and generally acted upon within the constraints of the organisation.

(v) Patient User Group Queen Elizabeth Hospital

To be added in on receipt

3.4. EXTERNAL AUDIT LIMITED ASSURANCE REPORT

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TOTHE DIRECTORS OF LEWISHAM AND GREENWICH NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

To be added in on receipt

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

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

By order of the Board

Chair **Date**

Chief Executive **Date**

3.6 FEEDBACK

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

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APPENDIX 1 – FULL LIST OF LOCAL AUDITS REVIEWED DURING 2014-2015

To Be added