Quality Account 2013/14

CONTENTS PAGE

ABOUT OUR QUALITY ACCOUNT 2013/14

Welcome to the Central London Community Health Trust (CLCH) Quality Account for 2013/14. The Quality Account is a summary of our performance in the last year in relation to our quality priorities and national requirements. We have incorporated feedback from our clinical teams this year showing how they have changed the way they deliver care in order to improve the quality of our services.

What is a Quality Account?

A Quality Account is an annual report that providers of NHS healthcare services must publish to inform the public of the quality of the services they provide. This is so you know more about our commitment to provide you with the best quality healthcare services. It also encourages us to focus on service quality and helps us find ways to continually improve.

Why has CLCH produced a Quality Account?

CLCH is a community healthcare provider providing healthcare to people in their homes and the local community and therefore we are statutorily required to publish a Quality Account. This is the third year that we have done so.

What does the CLCH Quality Account include?

Over the last year we have collected a lot of information on the quality of all of our services within the three areas of quality defined by the Department of Health: safety, clinical effectiveness and patient experience. We have used the information to look at how well we have performed over the past year (2013/14) and to identify where we could improve over the next year, and we have defined six main priorities for improvement which we set out later in our Quality Account. Throughout the account we have described how *Quality Matters* providing real stories of how our services have implemented quality. For the first time this year, to provide you with further information, we have also attached, as an appendix, the Trust's annual complaints report.

This Quality Account covers the four boroughs in which we were working during 2013/14: Hammersmith and Fulham (H&F), Kensington and Chelsea (K&C), Westminster, and Barnet. Further information can be found about this on the publications section of our website www.clch.nhs.uk

Developing the Quality Priorities 2012/13

The development of the Trust's Quality Account and Quality Priorities has been done in consultation with a variety of internal and external stakeholders. To make sure that our priorities matched those of our patients, carers, partners and the wider public, we invited a range of individuals and groups to contribute to our quality account. We also have a Quality Stakeholder Reference Group (QSRG, with representatives from Healthwatch and local authority overview and scrutiny committees (OSCs) which provided comments and feedback. More detailed information regarding the response to the consultation can be found at the end of the section on our quality priorities for 2014/15

How can I get involved now and in future?

At the end of this document you will find details of how to let us know what you think of our Quality Account, what we can improve on and how you can be involved in developing the report for next year.

If you would like to receive a printed copy of the CLCH Quality Account, please contact us via e-mail to **communications@clch.nhs.uk** or telephone us on **020 7798 1420**.

ABOUT CLCH

We provide healthcare from more than 160 locally based sites and in many cases in people's own homes in order to make access to our services as easy as possible.

The full range of CLCH services includes:

- Adult community nursing services – including 24 hour district nursing, community matrons and case management
- Child and family services - including health visiting, school nursing, children's community nursing teams, speech and language therapy, blood disorders, and children's occupational therapy
- Rehabilitation and therapies - including physiotherapy, occupational therapy, foot care, speech and language therapy, osteopathy
- End of life care – for people with complex, substantial, ongoing needs caused by disability or chronic illness.
- Specialist services to include Offender health services – at HMP Wormwood Scrubs
- Continuing care – services for older people who can no longer live independently due to a disability or chronic illness, or following hospital treatment
- Specialist services – including elements of long term condition management (diabetes, heart failure, lung disease), community dental services, sexual health and contraceptive services, psychological therapies
- Walk-in and urgent care centres – providing care for people with minor illnesses, minor injuries and providing a range of health promotion activities and advice.

Further and more detailed information will be made about our services in our annual report but if you would like more information now about our services in each area, please visit our website www.clch.nhs.uk

Map to be inserted here

CHIEF EXECUTIVE'S STATEMENT

TBC

STATEMENT OF THE CHAIR OF THE QUALITY COMMITTEE

TBC

LOOKING BACK - QUALITY IN 2013/14

Progress against our Quality Strategy and Risk Management Strategy

Quality Strategy: The Quality Strategy was created to provide a framework through which improvements in the services the Trust offers to patients can be focused and measured. Three campaigns were identified to focus the quality improvements the Trust wished to make, with clear objectives described, to be achieved over a three year period. The three campaigns are:

- Campaign 1: A Positive Patient Experience;
- Campaign 2: Preventing harm;
- Campaign 3: Smart, Effective Care.

Each Campaign was divided into two key components, Gathering Feedback and Improving Services and has clear high level vision statements of where we aim to be as a Trust in year one, two and three.

Campaign One This campaign had seven key performance indicators (KPIs) for 2013-14. Of these six were fully achieved, with one not being achieved.

The KPI not yet achieved is: *There will be a 5% reduction in complaints related to poor communication and attitude.*

Year	Total Complaints	About attitude of staff	Percentage
2012-13	113	19	16.8
2013-14	93	18	19.3

An action plan has been developed with the relevant services to improve the position next year including:

- Continued rollout of the Trust's Excellence in Customer Service Training for staff.
- A review and restructure has taken place for some reception teams which aims to create consistency in roles across administration and reception services and improve patient experience and care.

Campaign Two This campaign had four KPIs for 2013-14, three of which were fully achieved and one not achieved.

The KPI not achieved was 95*% of incidents will be reviewed by the handler within 7 days and 100% within 14 days* as the year end position was 88%. In response to this, it has now been agreed that Patient Safety Managers will continue to work with the divisions to encourage timely review of each incident.

Campaign Three This campaign had four KPIs, one of which was fully achieved with two being partially achieved. During the course of the year one KPI became no longer applicable.

The details of those KPIs partially achieved were:

Each service has a defined set of clinical standards (based on Trust /CQC/NICE/professional clinical guidelines. To ensure full achievement with this KPI, the Clinical Effectiveness Group is working with services to produce two clinical standards to be monitored throughout the year. Work is also ongoing to set KPIs related to clinical standards for 2014/15.

Ten teams across the Trust will develop and pilot exemplar team/service quality assurance measures: To ensure full compliance with this KPI, CLCH is working with Buckingham University to develop an exemplar ward/team assessment tool.

The KPI that became no longer applicable was: *CLCH will achieve NHS Litigation Authority (NHSLA) level 2.* This was because the NHSLA changed its assessment process and no longer undertakes assessments.

KPIs from Quality Strategy

	QUALITY STRATEGY	Level of achievement	Comment
1	**Campaign One: A Positive Patient Experience**	**Due Date:31st March 2014**	
1.1	Regular reports are received at service level across 100% of services which include feedback from patients	Fully Achieved	
1.2	Compassion in Care will be launched across the organisation, with a clear work plan	Fully Achieved	
1.3	Recommendations from the Francis report will be taken forward	Fully Achieved	
1.4	Divisional objectives will be written to improve the patient experience	Fully Achieved	
1.5	Divisional objectives are cascaded to individual team members	Fully Achieved	
1.6	Implement the 15 steps challenge across the organisation	Fully Achieved	
1.7	There will be a 5% reduction in complaints related to poor communication and attitude	Not achieved	The figures show an increase of 2.5% since last year.
2	**Campaign Two: Preventing Harm**	**Due Date:31st March 2014**	
2.1	Themes arising from incidents will be collated and analysed by division and discussed at integrated governance meetings	Fully Achieved	
2.2	Base line “level of harm" (Total number of incidents 2012/13) will be established by each Division	Fully Achieved	
2.3	Serious incidents reduced by 10%	Fully Achieved	The reduction was 30%
2.4	95% of incidents will be reviewed by the handler within 7 days, 100% within 14 days.	Not Achieved	Year-end position was 88%. PSMs working with divisions to encourage timely review of each incident.

3	Campaign Three: Smart Effective Care	Due Date:31st March 2014	
3.1	Each division will have three clinical outcomes, based on NICE guidance, with clear method of assessment	Fully achieved	
3.2	Each service has a defined set of clinical standards (Based on Trust /CQC/NICE/professional clinical guidelines)	Partially achieved	The Clinical Effectiveness Group is working with services to produce two clinical standards to be monitored throughout the year. Work is also ongoing to set KPIs related to clinical standards for 2014/15.
3.3	Each division will provide relevant evidence for clinical effectiveness NHSLA level 2 standards	NHSLA has suspended the assessment process.	As there is no further NHSLA assessment this KPI will not be reported going forward. The clinical effectiveness group will set and monitor criteria for linked policies on NICE and professional guidance.
3.4	Ten teams across the Trust will develop and pilot exemplar team/service quality assurance measures	Partially achieved	CLCH is working with Buckinghamshire University to develop an exemplar ward/team assessment tool. The assessment tool comprises of a set of quality indicators to assess the level of quality at which wards/teams are currently performing at, as well as evidence their performance against those quality indicators. The indicators are based on the Trusts Quality Strategy campaigns, Care Quality Commission assessment standards and the six C's, (care, compassion, courage, commitment, competence and communication). Teams will be encouraged to apply for exemplar status and assessed against the indicator criteria to identify their strengths and areas for development. It is proposed that the pilot teams will nominate themselves for exemplar status in the New Year.

Risk Management Strategy (RMS)

The purpose of the Risk Management Strategy was to detail the Trust's framework within which the Trust leads, directs and controls the risks to its key functions in order to comply with Health & Safety legislation, Terms of Authorisation and its strategic objectives. The document outlined the work plan for 2013/14 including key success criteria (KPIs). The work plan is managed by the Chief Nurse and Director of Quality Governance and is divided into four progressive steps, moving from Basic, through Bronze to Silver, then Gold, with deadlines set throughout the year.

There are 31 KPIs associated with the RMS and these were broken down as follows:
Basic (8); Bronze (6); Silver (9), and Gold (8).

Out of the total 31 KPIS, 29 (including all of the basic, bronze and silver KPIs) were fully achieved, and 2 were partially achieved.

The details of those partially achieved are:

90% of services are using their risk registers and service improvements can be clearly demonstrated. This was because not all services were able to identify risks although proactive risk assessments have been carried out.

90% of service lines have a CLIPS (Complaints, Litigation, Incidents and Patient Advice and Litigation Service (PALS)/ quality group where they identify key themes and actions and report into the divisional group. This was partially achieved as Specialist Community Nursing Therapies (SCNT) achieved a total of 88% and because some services are very small consisting of one or two staff so arranging a CLIPS meeting was not been possible. However going forward the new Clinical Business Units (CBUs) will each have a CLIPS meeting.

Whilst good progress has been made this year, some KPIs (as described above) in both strategies were not fully achieved. These will be taken forward for 2014-15, along with the year two targets taken from both the strategies.

	RISK MANAGEMENT STRATEGY		
1	**Basic Category**	**Due Date: 30th June 2013**	**Update**
1.1	All Divisional risk registers in place	Fully achieved	
1.2	Corporate risk register is in place.	Fully achieved	
1.3	Each Division has a quality group in place.	Fully achieved	
1.4	The Patient Safety & Risk Group is established.	Fully achieved	
1.5	Risk is being integrated throughout the organisation.	Fully achieved	
1.6	All staff are well supported and trained in risk management.	Fully achieved	
1.7	Recommendations of external risk reviews have been implemented.	Fully achieved	
1.8	The Board is receiving service specific and outlier information in relation to key risks	Fully achieved	
2	**Bronze Category**	**Due Date: 30th Sept 2013**	
2.1	Corporate risk register in place and 75% of risks are now being managed in a timely manner.	Fully Achieved	
2.2	50% Service level risk registers are in place across the organisation.	Fully achieved	
2.3	50% of service lines have a CLIPs/ quality group in place which report to the Divisional group.	Fully achieved	

2.4	The Patient Safety & Risk Group is well attended and reporting effectively to the Quality Committee.	Fully Achieved	
2.5	Service level score cards are being used to manage risk KPIs.	Fully achieved	
2.6	The Committees and Board are receiving risk data which is benchmarked and identifies key outliers.	Fully achieved	
3	**Silver Category**	**Due Date: 30th December 2013**	**Update**
3.1	75% Service level risk registers are being consistently completed and managed and discussed at Divisional level.	Fully achieved	
3.2	The corporate risk register is well challenged and 85% of risks are being reduced on the register within timescales.	Fully Achieved	
3.3	75% of service lines have a CLIPs/quality group in place and themes and service improvements are being identified.	Fully Achieved	
3.4	All Patient Safety sub groups have clear objectives and are reporting to the PSRG.	Fully Achieved	
3.5	The Quality Committee is satisfied with the information received from PSRG.	Fully Achieved	
3.6	Incident reporting is increasing in line with Quality Strategy objectives with a reduction in harm.	Fully Achieved	
3.7	The KPIs used for risk have been reviewed at service level to meet individual service needs.	Fully Achieved	
3.8	Risk targets are being met across the trust.	Fully Achieved	
3.9	Benchmark and outlier information is being well presented to Committees and Board.	Fully Achieved	

4	Gold Category	Due Date: 31st March 2014	Update
4.1	90% of services are using their risk registers and service improvements can be clearly demonstrated.	Partially Achieved	As described above
4.1a	Allied Primary Care Services (APCS)	Partially achieved	Currently stands at 78%. All areas have reviewed possible risks. Going forward the new CBUs will review risks and bring new ones forward through the agreed process.
4.1b	Children's Health and Development (CHD)	Partially achieved	Currently stands at 87%. All areas have reviewed possible risks. Going forward the new CBUs will review risks and bring new ones forward through the agreed process.
4.1c	Networked Community Nursing and Rehabilitation (NCNR)	Fully Achieved	
4.1d	Specialist Community Nursing (SPCN)	Partially achieved	Currently stands at 80%. All services have been reviewing possibly risks and taken them forward if necessary. Going forward the new CBUs will review risks and bring new ones forward through the agreed process.
4.2	Service improvement can be demonstrated from risks on the corporate risk register and 95% of risks are reduced within set timescales.	Fully Achieved	
4.2a	APCS	"	
4.2b	CHD	"	
4.2c	NCNR	"	
4.2d	SPCN	"	

4.3	90% of service lines have a CLIP/quality group where they identify key themes and actions and report into the divisional group.	Partially Achieved	
4.3a	APCS	Fully Achieved	
4.3b	CHD	Fully Achieved	
4.3c	NCNR	Fully Achieved	
4.3d	SCNT	Partially achieved	Currently at 88% as some of the services are very small consisting of one or two staff and a CLIPS meeting has not been possible to achieve. Going forward the new CBUs will each have a CLIPS meeting.
4.4	The Patient Safety and Risk Group (PRSR) is able to demonstrate clear improvements in risk reporting and management.	Fully Achieved	
4.5	The Quality Committee is assured that risk is being well managed throughout the Trust.	Fully Achieved	
4.6	Incident reporting is increasing in line with Quality Strategy objectives with reduction in harm.	Fully Achieved	
4.7	There are clear KPIs from service level to Board which are being met and there is clear evidence of service improvement.	Fully Achieved	
4.8	Reports to the Board demonstrate clarity and accuracy and clearly identify outlier and benchmarked information and plans for improvement.	Fully Achieved	

QUALITY MATTERS - FAMILYSTART

The following is feedback provided from families that participated in the Family Start programme. FamilyStart was a pilot programme for children aged 4-12 years and their families providing a personalised approach to make healthy lifestyle choices together. FamilyStart took place over 6 months (April to October 2013) and offered families 3 appointments with a school nurse either at school or a health centre in Kensington and Chelsea. Topics covered included healthy and regular eating, portion sizes, snack options, food label reading, physical activity information and support to be more active.

Year 3 – Parent of a completer child

"My daughter's measurements were showing that she was overweight and it was good that somebody looked after us rather than just informing us about it. I called the school nurse directly who was very flexible with the dates and times for the appointments. I saw the same person, and I think it's very good to see the same person rather than changing. The School nurse was very nice, warm, and very careful with her choice of words as obesity is a very sensitive matter for children. I enjoyed the programme as it makes you aware of different ways of doing things, and makes children aware of certain things as well, which will change the outcome. However the programme should be longer, maybe 5 appointments, with the first appointments being every 4 weeks and then every 6 weeks."

Reception – Parent of completer children

"The teacher advised us we should be seen. I didn't know my children were overweight, they were measured in school and I received the letter saying they were overweight. I contacted the school nurses after receiving the letter with their measurements, then I saw a lady and she was very nice. She measured them and told me exactly what they should drink, types of milk and juice, and what types of food they should eat. It was good. I saw different school nurses, I don't blame them but I'm a kind of person that like to deal with one person, then you can build a relationship, they know you and you don't need to explain every time the same. All the school nurses we saw were happy and friendly, they knew what they were doing, especially the second one. She was dealing with the children in a very professionally way, I was happy with her. I didn't know my children were overweight, now I know the weight they should be, I didn't know they should got out and be active every day, now I know. People need advice. The advices were very helpful and I'm really happy with them, I don't have any complaint."

Reception – Parent of a non-completer child

"I wasn't worried about anything because I know how I feed my family. All my children see a paediatrician in London and Paris and I knew there was no problem with my daughter. I went to the school and talked directly to the school nurse and asked to do the measurements again because I couldn't take that. The school nurse was very friendly and relaxed. She took all the measurements and she said "sorry they made a mistake. There is nothing wrong with her height and weight, they are in proportion". I was very happy with the fact my daughter was measured. I was not worried about her weight but if you were I would be happy to do the programme to know what to do about it. This is fantastic, because sometimes we don't really check things and you don't realise. But when you have people to go and check this and let you know I think it is the best thing.

I was really happy with the service you provided because this was followed up, it was not something that you just receive a letter and nothing else is done, you were concerned and ready to help me, and this is really good. This is very good especially because you see lots of overweight children.
I'm happy with what you guys are doing."

Year 6 – Completer child

"I was seen by the school nurse in the school and the clinic. At first I didn't know why I was there, in my first appointment I was told that I was booked for the family start programme and from then I liked it and I was interacting more. What I liked the most was probably coming down and have like a meeting/appointment, it was quite fun. Every single time I went I had to be measured for my height and weight. I don't remember what BMI is but the nurse explained every single event, she would always discuss things, the first thing she would do was discussing my weight and how I had improved it, and this was clear. She was nice and I was comfortable being there talking to her. My weight lowered by 1kg in the first appointment, in the second it lowered by more, the third it was the same amount as the second, it was decreasing, and the height was ascending. The school nurse said she was proud and the results were excellent, and on the last day, the last appointment she said I had improved that I was not overweight anymore, which meant I had lost weight and followed the rules, and I was healthy weight.
I don't eat as much as I did before, I eat more healthily, I do more physical activity, I easily participate in more events with sports. I feel happy and more confident. I liked the programme."

OUR WORK ON RESPONDING TO NATIONAL ENQUIRIES AND REPORTS

We incorporated the findings from the Francis Report published in February 2013 together with the Government's initial response, the Keogh Review, the Berwick Report and the Cavendish Review. The Clwyd-Hart review of complaints was also considered and the recommendations included in our revised complaints policy.

The majority of milestones set in the original Francis Matrix and the updated national report matrix have been met and in January 2014 an assessment of the risk of not achieving all the milestones was presented to the quality committee. Six of the milestone areas have been achieved; six were partly achieved and three remain outstanding.

The outstanding milestones were:

- Reduction in paperwork for front line staff (by a third), creating time to care by introducing electronic/ digital solutions to reduce paperwork
- Audit of recruitment processes to demonstrate values questions asked and staff survey to shows high levels of understanding and commitment to Trust values
- Audit of dementia, mental health and learning disability care and of vulnerable adults policy

	Milestones (extracted from Maturity Matrix)	***RAG status (April 2014)***	***Comment***
1	Wide programme of training in relation to Duty of Candour Candour and transparency fully understood by all staff	Partial	Work commenced but "wide" roll out will need to be associated with annual mandatory training updates and therefore will be achieved throughout 2014/15 Two "being Open" sessions were commissioned by the L&D team and delivered in December with 40 participants attending. Further discussion since between Head of L&D and Head of Patient Safety regarding further training but firm plans for roll out are yet to be decided.
2	Reduction in incidents of avoidable harm	Partial	Improved / increased incident reporting may mean actual numbers not reduced; other measures e.g. patient safety thermometer may give better indication of harm See also comment re point 10 below.
3	Reduction in paperwork for front line staff (by a third) Creating time to care by introducing electronic/ digital solutions to reduce paperwork	Not achieved	Work is still on-going but reductions in paperwork are not being realised. Electronic systems are being implemented slowly.

4	Staffing levels reviewed using evidence	Achieved / On-going	Evidence for staffing levels in community settings weak, professional opinions still required. Reviews undertaken and presented to the Board
5	Leaders at all levels to have agreed objectives with regard to engaging with patients (back to the floor activities) All staff (with the exception of some administrative staff) visit a clinical area and talk with at least one patient and members of staff once a week	Achieved	"Clinical Fridays" commenced. Some changes made to process after initial visits.
6	Active engagement with Health and Wellbeing boards and achieve all commissioning quality objectives	Achieved	Stakeholder engagement good; validation / agreement of CQUIN achievement still awaited
7	Staff survey results triangulated with patient feedback to plan development	Achieved	Integrated Performance KPUIs across Quality, operations, Finance and HR are in discussion for agreement at Board after which these will be disseminated via Divisional structure and incorporated in subsidiary performance frameworks
8	Performance data published on trust website; communications team publish outcomes; performance measures open and transparent	Partial	The Quality Information Balanced Scorecard form and content is agreed and in prototype testing, to be released on the Intranet via QlikView by the end of April
9	Exceed expectations and achieve exemplar team status	Partial	The Exemplar team project is underway and good practice/ measures from Salford are being reviewed; system will be in place to start to access teams for exemplar status with roll out in 2014/15

10.	Trust Never events substantially reduced within the year	Achieved	CLCH has had no incidents of national reportable 'Never Events' since the list was published by Department of Health, in 2011. For Internal SIs : Total 2012-13 was 11. Total for 2013-14 was 21. The target to reduce the number of Bespoke Never Events has not been achieved. With the improvements in the risk management arrangements across the Trust and great scrutiny of incidents reported, the number of cases has increased this year. It is anticipated that the improvements will be seen in 2014-15 as the lessons learned from this year's cases are cascaded across the trust via the CLIPS meetings and newsletters.
11.	Accountability framework for managers devised with clear outcomes for actions when things go wrong Trust regulatory regime in place for all patient/ client facing groups Barring systems especially in relation to HCAs to be explicit Prior to any national roll out of re-validation of nurses all RNs to have support to ensure up to date and fit for purpose	Partial	Disciplinary policies in place; Expectations discussed as part of PADRs. Further work with Staff Side organisations will be needed before a barring scheme can be implemented. Support is in place for RNs but further work will be needed in 2014/15 to access impact of revalidation
12.	Audit of recruitment processes to demonstrate values questions asked Staff survey shows high levels of understanding and commitment to Trust values	Not achieved	Audit will be completed by April.
13.	Stronger voice for clinical staff expressed through a clinical leadership forum	Achieved	Clinical Leadership Group is being established. Membership identified. Inaugural meeting in April 2014. CRG has been in place throughout 2013/14
14.	HCA workforce demonstrate high levels of skill and are receiving training and supervision	Partial	Support and training in place but further work is needed to ensure all staff in this group access. This will be linked to further development of the use of competencies/ and use of skills training/ simulation

15.	Audit of dementia, mental health and learning disability care Audit of vulnerable adults policy	Not achieved	No plans in place. Under discussion to be included in work plans for 2014/15 but audits will not be achieved by April 2014.

The full maturity matrix can be found at appendix two.

QUALITY MATTERS – MSK SERVICE
The musculo-skeletal service in Barnet developed a physiotherapy group specifically for Farsi-speaking patients which included translation. The service won a CLCH innovation award and was reported in the Chartered Society of Physiotherapy Journal

OUR QUALITY IMPROVEMENTS 2013-14

This section describes how we performed against the 10 quality priorities we set ourselves last year.

POSITIVE PATIENT EXPERIENCE

Our priorities for improving the patient experience in 2013/14 were:

- Ensure that we are providing compassionate care to all our patients
- Act on patient feedback to help ensure long lasting improvements
- Implement the 15 Steps Challenge

Ensure that we are providing compassionate care to all our patients

Compassion in Care Project

As well as being a quality priority, this was also part of campaign one of the Trust's Quality Strategy and with reference to the recent report 'Compassion in Practice, Nursing, Midwifery and Care Staff, Our Vision and Strategy' (Cummings and Bennett, 2012), work was taken forward across the Trust to promote compassionate care and the Compassion in Care project was launched across four pilot sites on October 4th 2013. The project is being taken forward with City University, building on work previously undertaken with them on dignity in care, best practice guidance in care for older people in acute settings and quality of life in care homes. The project aims to promote compassionate care with frontline staff initially across pilot areas in different clinical contexts namely; adult rehabilitation services, HMP Wormwood Scrubs and the Pembridge Palliative Care Unit. It provides expert facilitation of front line care staff in the development of projects and work streams to help deliver the 6Cs (care, compassion, competence, communication, courage and commitment) in line with the NHS England Compassion in Practice vision and strategy

A number of Compassionate care projects were identified in the pilot areas. These included the development of vision and values based philosophy of care statements by the multi- disciplinary teams working within the rehabilitation units, a social activity programme within one of the rehabilitation units and a documentation and communication project across our rehabilitation wards. At the Pembridge Palliative Care Unit a proposal was written for Schwartz rounds by the Chaplain, and a project has been developed across the day centre and the inpatient unit to promote patient well-being by the multi-disciplinary team. The project was launched very successfully in the prison and two Compassion in Care projects have been identified, and are being taken forward by prison nursing staff. Senior staff from the Department of the Health who visited the Trust were interested in the project and its impact on care delivery and its measurement in practice. The Chief Nurse for England has agreed to visit the Trust on May 12th to be a guest speaker at the Trusts Compassion in Care celebration event.

The Compassion in care project has been rolled out successfully across the Community settings and excellent projects have also been identified within the Children's and Adults Division. The Compassion in Care Co-coordinator has also met with staff from the Community Palliative Care Team to identify projects. Work is also being taken forward with the Picker Institute to identify Compassion in care indicators of success which are aligned to the model of Compassionate

relationship centered care which is currently being developed with City University and will be presented to the Compassion in Care Board for their approval prior to their implementation.

Exemplar Ward/Community Assessment Tool.

The draft Trust exemplar ward/ community assessment tool has been developed in collaboration with Buckingham University. This draft exemplar assessment tool incorporates the Essence of Care standards; the 6C's and key clinical indicators and also provides evidence for Care Quality Commission standards. The draft assessment framework is designed around thirteen standards, supporting clinicians in practice to understand how they deliver care, what works well and where further developments are needed. It is proposed that the exemplar teams will also demonstrate innovation and creativity in practice. The draft tool, once approved in the Trust, will be taken forward in different clinical settings and, it is envisaged that the process of its development and findings will be written up for publication with Buckinghamshire University.

Acting on patient feedback to help ensure long-lasting improvement

Specifically that each Division should have clear objectives in place to improve the patient experience based on analysis of feedback and incidents. These objectives to be cascaded to individual staff level and every member of staff to have at least one objective to improve the experience they offer to their patients. The Net Promoter score to be consistently above 75 in each Division.

During 2013-14 we established a comprehensive patient experience feedback programme across our 66 services. This included telephone, paper and electronic surveys, the collection of patient stories, reporting of complaints and complements, and the introduction of clinical visits using the *15 step challenge*. Feedback on experience is gained from patients across our services, and each division has a formalised action plan for improvement based on this. The information and resultant action plans are presented and monitored at the Patient Experience Committee on a monthly basis.

As part of staff appraisal, individuals are required to link their development objectives to trust objectives, including the delivery of safe, effective and person centered care to patients and ensuring our patient and staff survey feedback improves year on year and is above the NHS for all services.

The Friends and Family Test has been added to our patient surveys to provide a simple measure of people's experience (net promoter score). During the year, we adopted the National method for calculating our net promoter score which required us to adjust our target from 75 to 62%. We achieved this measure within some of our services, and this remains a focus for our future improvement.

In response to the following question in the 2013 staff survey 65% of our staff agreed with the following statement. "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"

Implement the 15 Step Challenge

Specifically that the 15 step Challenge will be launched across the organisation. A Both Sides now approach to be taken with patients. Patient stories to be collected digitally coded and analysed. Findings from work will be used to initiate continuous improvement cycles

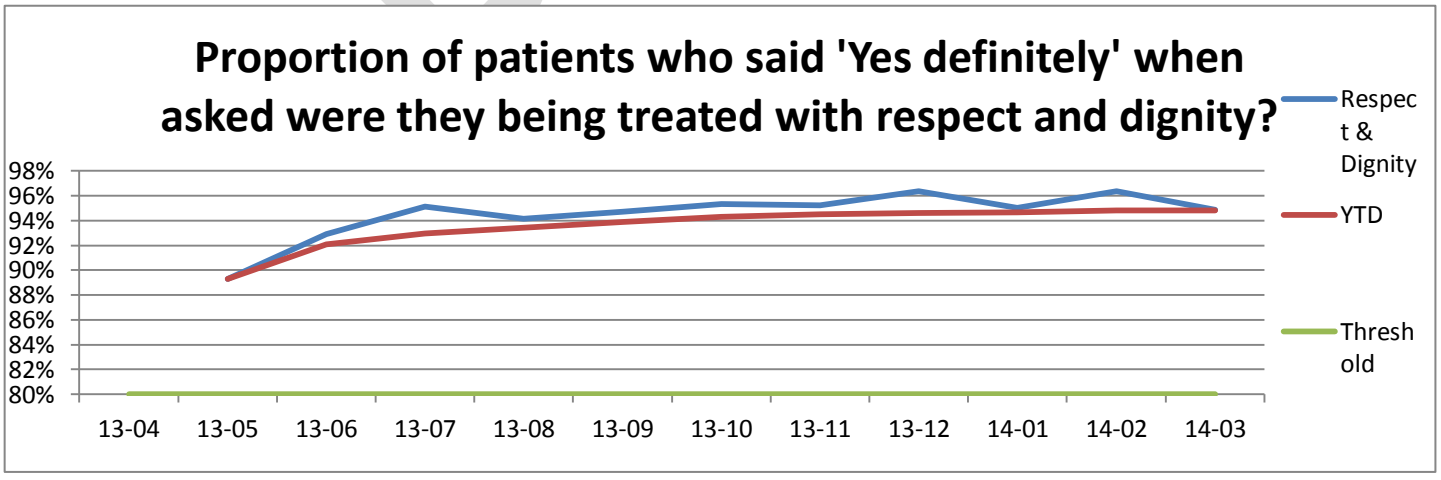
The *15 steps challenge* is a tool to help staff and patients work together to identify improvements that will enhance patient experience and it is coordinated by the Patient and Public Experience (PPE) team. The challenge is based on the concept that a patient can tell what kind of care they will receive within 15 steps of entering a site.

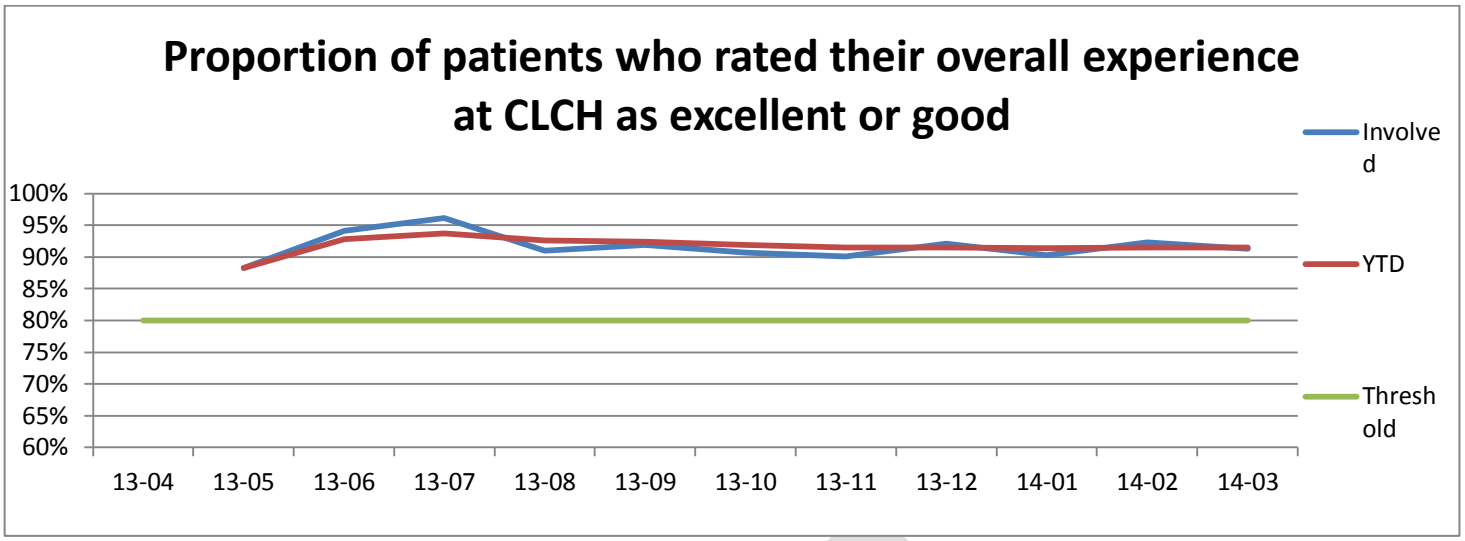
The tool is utilised by taking a visiting team, comprised of board members, trust members, patient representatives and staff members from the quality directorate, to various sites and focussing on sites which accommodate bedded patients. During the visit, the team are asked to record their observations of first entering the site. They then speak to patients and their families (if they are available). The themes they focus on in these conversations are whether the patients feel the site is: Welcoming, safe, caring, well organised and calm. Following the visit, the feedback is recorded and then shared with divisional director and senior manager of the service. An action plan is created based on the feedback and a review visit will take place 6 months after the initial visit.

The visits occur approximately every two months and some of the common themes which have been identified in the visits so far are;

- Storage space,
- Handover between different clinical teams,
- Communication and management of expectations around treatment and discharge.

Since October 2013, more than twenty members of staff have been trained to capture patient stories across our organisation. A programme of patient stories has been agreed with each of the divisions and learning from these is linked to patient experience action plans. Patient stories now form a routine element of learning from patient experience and a patient story is presented at each of our trust Board meetings. A process for gathering digital patient stories has been developed, and the first of these is available on the trust website.





QUALITY MATTERS – PRINCESS LOUISE NURSING HOME

The Trust was awarded a fund from the Department of Health to improve the environment for patients with dementia in Prince Louise Nursing Home

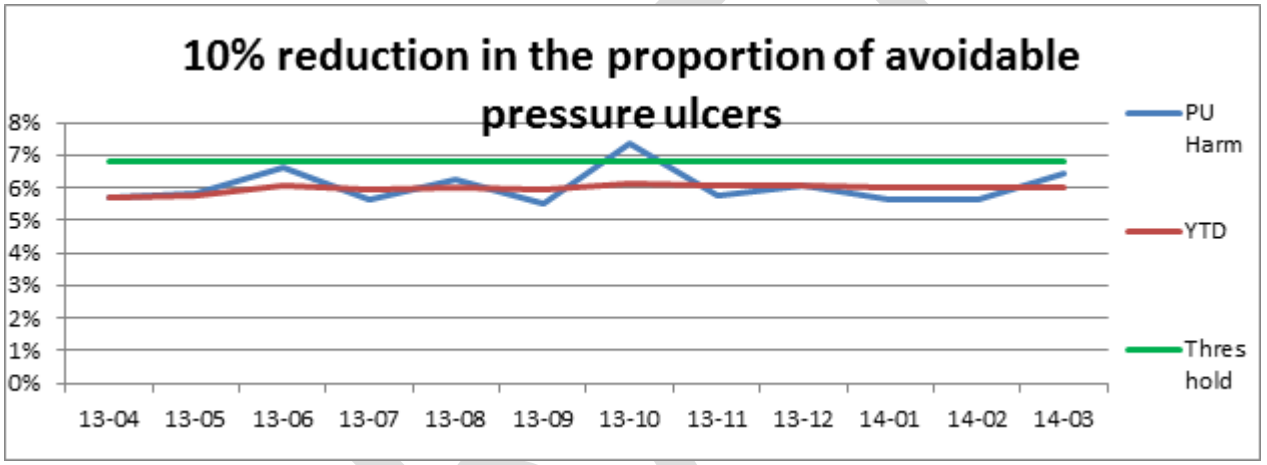
PREVENTING HARM

Our quality priorities for 2013/14 relating to Preventing Harm were to:

- Reduce number of avoidable pressure ulcers in the community by at least 10%
- Reduce the number of catheter associated urinary tract infections in the community by at least 10%
- Reduce the number of falls that cause harm in bedded rehabilitation services by at least 10%
- Reduce the number of new VTE by at least 10%

Reduce the number of avoidable pressure ulcers in the community by at least 10%

We made steady progress against this target in 2013/14. The incidence of pressure ulcers was reduced and we achieved our target to reduce pressure ulcer by 10%. The prevalence of pressure ulcers was reduced and we achieved our target to reduce pressure ulcers by 10%. In order to achieve our 10% reduction we needed to have a prevalence of pressure ulcers at under 6.9%.



We undertook a range of measures and initiatives to achieve the reduction in pressure ulcers in 2013/14 as follows:

May 2013

- NICE poster distributed to clinical teams
- Wound Assessment and Evaluation Forms amended and distributed to all clinical teams.
- Pressure ulcer prevention and management training and audit provided in 4 Barnet independent Nursing Homes.

June 2013

- SSKIN and Top Tips posters distributed to all clinical teams.
- Tissue Viability Team site set up on the CLCH Hub providing access to the whole suite of pressure ulcer prevention and management resources.
- Pressure ulcer training reviewed to incorporate DATIX reporting.
- District Nurse contact details provided to the Wheelchair Service to improve liaison between clinicians.

July 2013

- New CLCH Prevention and Management of Pressure Ulcer Policy produced and launched.
- Pressure ulcer training places offered to independent Residential and Nursing Homes.

August 2013

- Pressure ulcer safeguarding checklist distributed to all clinical teams and to Barnet Nursing Homes.

September 2013

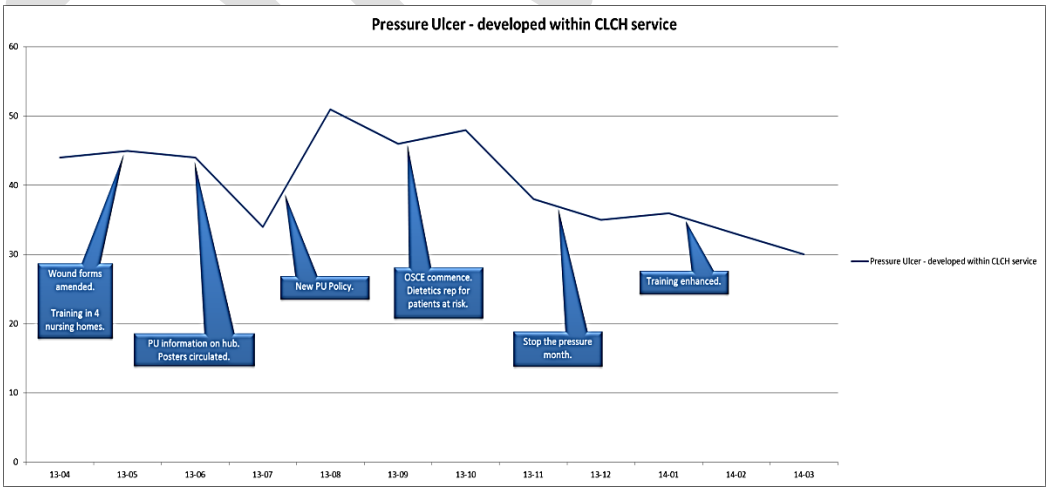
- Barnet dietetics service opened access for referrals to patients with and at risk of developing pressure ulcers.
- Observed Structured Clinical Examinations commenced to test clinical competency following training.

November 2013

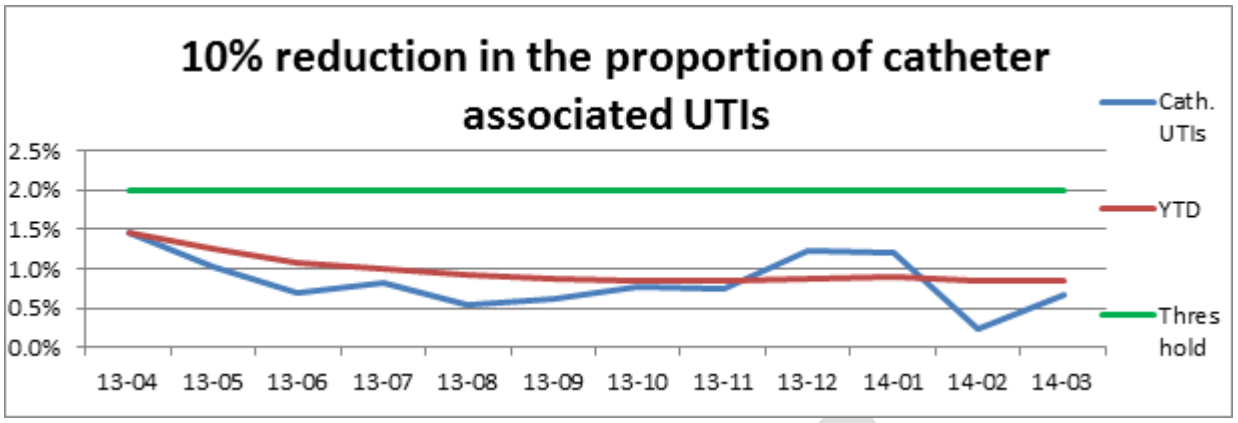
- Stop The Pressure month campaign roadshow taken around various sites across the 4 boroughs.

January 2014

- Pressure ulcer training reviewed to enhance wheelchair and seating section of training.
- Moving and handling advisor identified suitable equipment, i.e. sling and hoist, that can be used when dressing pressure ulcers particularly on heals and other hard to reach areas. Details distributed to clinical teams.
- Patient information leaflets regarding pressure ulcer prevention, distributed to podiatrists.
- NICE Pressure Clinical Audit for District Nursing: audit report produced by JL and sent to managers and Clinical Leads.
- NICE Pressure Clinical Audit for District Nursing: Poster produced, data being added by Quality Team.
- Documents and resources produced by the CLCH Pressure Ulcer Working Group sent to Community Education and Provider Network.
  We were one of only 3 trusts that submitted these resources and the only Trust that submitted the full set.



Reduce the number of catheter associated urinary tract infections by at least 10%

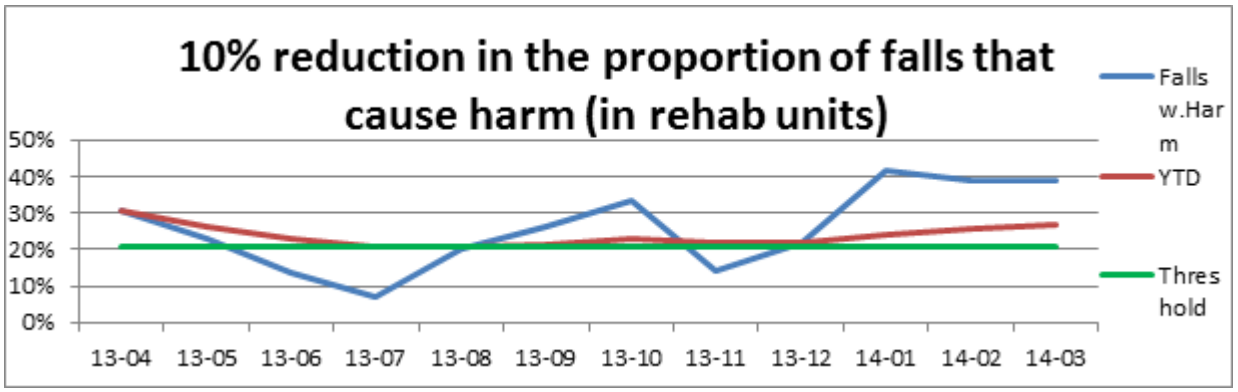


CLCH nurses and doctors with guidance from the CAUTI Steering Group successfully reduced the number of urinary catheters in situ and associated infections across CLCH by more than 10% during 2013-14.

Factors contributing to the reduction in infection included heightened awareness amongst staff and patients / carers, and more frequent assessments on whether urinary catheters in place were needed or whether alternative solutions were available. Greater awareness was achieved with training, the use of flow charts, the design and distribution of a patient leaflet, improving documentation of catheter care, and the purchase of more bladder scanners with associated training.

Going forward we will continue to work on ensuring there are valid reasons to insert or maintain a urinary catheter in situ. Alternative solutions will be considered to avoid long term catheterisation where possible. This will further reduce the risks and rates of catheter associated infection.

Reduce the number of falls that cause harm in bedded rehabilitation units by at least 10%



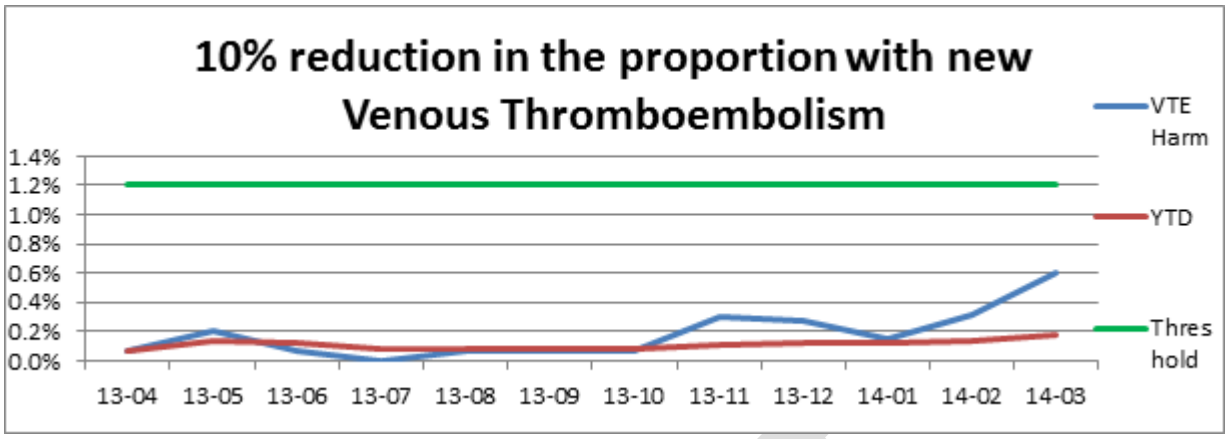
Falls Steering Group

Following the creation of the Falls Steering Group a number of actions were put into place to reduce the number of falls. These included neurological observations training with falls training on all units now implemented. A slips, trips and falls link workers forum has been established with training for Falls link workers now in place. Training packages have also been created for district nursing teams. Slips, trips and falls e-learning has been launched with bespoke training for children's' and offender health services currently being developed. In depth work to understand falls at three of the four of the trust's hotspots, namely Jade ward, Marjorie Warren Ward, Princess Louise Kensington has been undertaken. The work at Pembridge is ongoing but is yet to be completed.

Other initiatives to reduce the number of falls include a trial of "colours reducing falls" an award winning scheme that will be piloted on Jade ward in 2014. An updated version of the bed rail policy is being produced to ensure compliance with best practice and there has been a review of equipment on all wards, for example cot sides and footwear as well as beds that lower to floor.

Despite these initiatives, we have not yet achieved the reductions we aimed for this year. We will be reviewing the action plans associated with falls prevention and work will continue on this project.

Reduce the number of new venous thromboembolism by at least 10%



(Further information to be provided on this)

SMART EFFECTIVE CARE

(We are awaiting further information on elements of this section)

Our objectives in 2012/13 related to smart, effective care were as follows:

- Each service within CLCH will aim to achieve at least 3 clinical outcomes based on best practice
- Strengthen and streamline clinical record keeping to support patient pathways
- Reduce the number of unplanned hospital admissions for patients with long term conditions that are on CLCH case loads.

Each service within CLCH will aim to achieve at least 3 clinical outcomes based on best practice

'Campaign Three of the Quality Strategy, Smart, Effective Care', stated that CLCH would build on the substantial organisational work that had developed Patient Reported Outcome Measures (PROMs) and identify a catalogue of clinical outcomes that clearly demonstrated 'measures of success' with each service expected to have a method of assessing these outcomes.

CLCH Clinical Outcome Framework.

Although the measurement of clinical outcomes is increasingly prevalent within the NHS, it is still and under developed area within community Trusts. To address this CLCH has developed a local clinical outcomes framework with the group defining a clinical outcome as follows:

A Clinical Outcome is a measurable change in health status, attitude or behaviour of an individual, group of people or population which is attributable to an intervention or series of interventions.

To date, more than 150 clinical outcomes have been developed with the majority being agreed by the Clinical Effectiveness Group. Further work is required to identify a suite of measures against the outcomes agreed, to capture baseline data, apply improvement goals and to develop this work to reflect value.

Strengthen and streamline clinical record keeping to support patient pathways

Work this year included: *Awaiting final information*

Reduce the number of unplanned hospital admissions for patients with long term conditions that are on CLCH case loads.

Further information awaited on this section

Work this year included:

- Implementing systems of care, i.e. virtual wards/village models and evolving Whole System pathways that improve early prediction of changes in conditions and translation into appropriate interventions.
- Identifying skills sets within community teams to facilitate increased ambulatory care in a community setting and links to appropriate specialist teams to support maintenance in a community setting.
- Use of assistive technology to provid3e early warning of changes in conditions to intervene earlier
- Link the above points to a co-designed Community intervention service that integrates health and social care, particularly re0-ablement, services more effectively.
- Use IT platforms and intra-operability to improve patient information available in an acute, community and primary care setting thus increasing the ability to make decisions on admission or discharge from EDs
- Further develop CIS in-reach functions to identify patients within acute wards earlier and reduce both length of stay and definition of an appropriate final discharge destination.

QUALITY MATTERS - DENTAL SERVICES

The Community and Specialist Dental Service treats patients from vulnerable groups who are unable to access high street Dentists for various reasons such as physical, medical or behavioural issues. Sometimes, it can be challenging to collect meaningful experience feedback from these patients due to communication difficulties such as speech, language, literacy.

The service took part in the pilot for capturing patient stories with a group of patients who have learning disabilities and/or their parents/carers. The stories were taken by Speech and Language Therapists in either in the dental clinic or the patient's own home. Ten stories will collected over the 3 Inner Boroughs (5 from Westminster, 3 from Kensington and Chelsea and 2 from Hammersmith and Fulham)

Positive themes were friendly, patient staff with a good understanding of the complex needs of their patients; appointment times to suit them and appreciation of the extra time given to their appointment due to their additional needs; overall satisfaction with the quality of service provided.

Areas for improvement were also identified. These were that signage in some Health Centres were hard to find and difficult to read; unclear of where to go on arrival as no specific Dental reception in most areas and the Front of House staff did not have details of dental appointments; patients weren't aware of who their appointment was with or for what they were attending for; some patients found the dental treatment uncomfortable; literature/leaflets given to patients are difficult to read/understand.

In response to the feedback received the following changes were made within the service:

- Easy read signage placed in Health Centres
- The Dental service records system (Kodak R4) has been installed on the Front of House Reception PCs so the patient's arrival can be recorded and Dental Staff are aware the patient has arrived
- The appointment letters have been adapted to Easy read and show a photo of the front of the building, a photo of the Dentist/Therapist they have an appointment with and a clock face to indicate the time of the appointment.
- Training for Dentist/Therapists in Inhalation Sedation which means that all patients can now be offered an appointment for treatment under sedation
- All patient leaflets are now available in Easy-read

The service is the process of contacting the patients who took part in patient stories to thank them and explain the changes made to the service as a direct result of their feedback.

LOOKING FORWARD

OUR PRIORITIES FOR IMPROVEMENT 2014/15

In this section we have detailed our quality improvement priorities for the coming year. The identification of priorities including consultation process is described in more detail in the next section.

Positive Patient Experience

1. We will improve user involvement and participation in developing and improving services at the trust
2. All services will actively use patient feedback for improvement including using new feedback through the Family and Friends Test (FFT)

Preventing Harm

3. We will continue to demonstrate an increase in the reporting of incidents across the trust whilst reducing the level of harm caused to patients
4. We will reduce the incidence of medication errors across the Trust by a minimum of 10%

Smart Effective Care

5. We will seek further improvement in consistent communication between the community nursing teams and the patient's GP after initial assessment of a patient and following discharge.
6. We will ensure that, where national clinical guidelines have been produced by the National Institute for Health and Clinical Excellence (NICE) which are relevant to the care we provide, we will demonstrate we are using them in everyday practice

How Will We Monitor Progress on these Aspects of Quality Improvement?

All of these elements will be measured; some monthly, some quarterly so that the Trust can show that it is improving the experience of the patients, their safety and the effectiveness of the services.

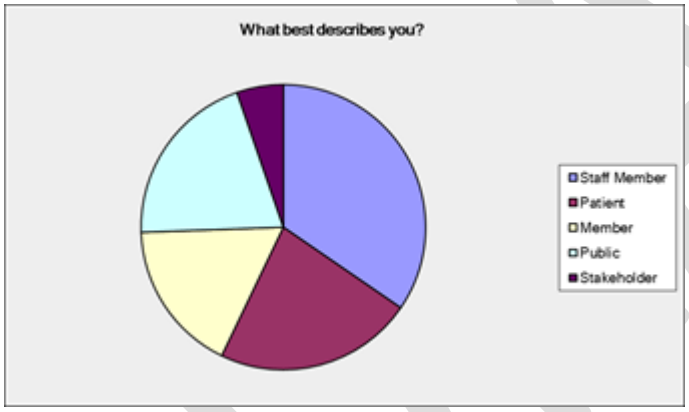
The progress on all planned quality improvements will be monitored monthly by the Trust Quality Committee. This committee will report at least quarterly directly to the Trust Board of Directors.

WHO DID WE INVOLVE AND ENGAGE WITH TO DETERMINE OUR QUALITY PRIORITIES?

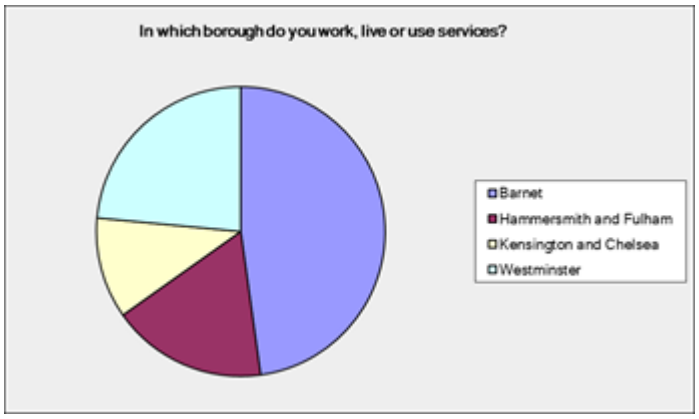
An initial long list of quality priorities was drawn up based on discussion with Trust groups as well as by looking at our performance against a range of quality indicators. We then consulted on the long list with members of the public and staff via the survey as detailed below. In addition we wrote to the chairs of Health watch, Overview and scrutiny Committees and CCG Chairs asking for suggestions to be included in the account. Based on this we chose our list of quality priorities for 2014/15.

The responses by group and borough were as follows:

What best describes you?		
Answer Options	**Response Percent**	**Response Count**
Staff Member	34.6%	46
Patient	22.6%	30
Member	17.3%	23
Public	20.3%	27
Stakeholder	5.3%	7
	answered question	**133**



In which borough do you work, live or use services?		
Answer Options	**Response Percent**	**Response Count**
Barnet	47.8%	55
Hammersmith and Fulham	17.4%	20
Kensington and Chelsea	11.3%	13
Westminster	23.5%	27
Other (please specify)		22
	answered question	**115**



The following information shows how staff and members of the public ranked our suggested priorities:

Positive patient experience		
Answer Options	**Response Percent**	**Response Count**
We will develop and implement an end of life strategy for the Trust which improves the experience for patients, their relatives friends and carers	35.6%	47
We will reduce complaints and PALS comments related to poor attitude or communication by 10%	40.9%	54
All services will actively use patient feedback for improvement. (This will be evidenced by demonstrating to the Patient Experience Group that they have delivered measurable in-year improvements in response to patients' feedback)	48.5%	64
We will publish more information about the performance of our services,	12.1%	16
We will improve user involvement and participation in developing and improving services at the trust	49.2%	65
Other (please specify)		12
	answered question	**132**

Preventing harm		
Answer Options	**Response Percent**	**Response Count**
We be in the top 10% of community trusts in England in relation to incidence of NEW pressure ulcers acquired in our care	22.7%	29
We will reduce the incidence of falls resulting in harm in our bedded units by 10%	25.8%	33
We will continue to demonstrate an increase in the reporting of incidents across the trust whilst reducing the level of harm caused to patients	41.4%	53
We will reduce the incidence of medication errors across the Trust	46.1%	59
We will continue to reduce the prevalence of harm to patients as demonstrated by the patient safety thermometer	22.7%	29
All medication errors involving high risk medication, anticoagulants and insulin to be defined as never events. The Trust target for 2013/14 is zero events	38.3%	49
Other (please specify)		9
	answered question	**128**

Smart effective care		
Answer Options	**Response Percent**	**Response Count**
We will ensure that, where national clinical guidelines have been produced by the National Institute for Health and Clinical Excellence (NICE) which are relevant to the care we provide, we will demonstrate we are using them in everyday practice	37.7%	49
We will ensure that each service will identify and publish a minimum of 6 clinical outcomes based on NICE guidance and international best practice.	16.2%	21
All services will actively measure 3 clinical outcomes and will be able to demonstrate that they have delivered against an expected threshold of acceptable performance.	16.2%	21
We will make further improvements in the standard of our record keeping. We will audit our performance every quarter.	20.0%	26
We will work with our partners to demonstrate improvements in integrated care with both healthcare and local authority partners how measured	35.4%	46
We will seek further improvement in consistent communication between the community nursing teams and the patient's GP after initial assessment of a patient and following discharge.	45.4%	59
We will further reduce the amount of hospital admissions for patients receiving our services	16.9%	22
Other (please specify)		6
	answered question	**130**

REVIEW OF QUALITY PERFORMANCE – REQUIRED INFORMATION

CARE QUALITY COMMISSION

The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England. From April 2010, all NHS Trusts have been legally obligated to register with the CQC. CLCH is registered with the CQC and its current registration status is *registered without conditions.* Furthermore the CQC has not taken enforcement action against CLCH during 2013/14 and CLCH has not participated in any special reviews or investigations by the CQC during the reporting period.

Summary of inspections

During 2013/14 the CQC undertook, as part of their scheduled programme of inspections, 8 unannounced inspections at 8 of the trusts registered locations. As part of this process, the CQC found that CLCH was meeting all the essential standards of quality and safety as follows.

Finchley Memorial Hospital Walk-in Centre – Inspection Date: 29th April 2013

The Trust was found to be meeting the following standards
Outcome 1 – Respecting and involving people who use services
Outcome 4 – Care and Welfare of people who use services
Outcome 6 – Co-operating with other providers
Outcome 7 – Safeguarding people who use services from abuse
Outcome 14 – Supporting workers

Finchley Memorial Hospital Intermediate Care Ward – Inspection Date: 18th June 2013

The Trust was found to be meeting the following standards
Outcome 4 – Care and Welfare of people who use services
Outcome 6 – Co-operating with other providers
Outcome 11 – Safety, availability and suitability of equipment
Outcome 16 – Assessing and monitoring the quality of service provision
Outcome 17 – Complaints
Outcome 21 – Records

St Charles Urgent Care Centre – Inspection Date: 31st October 2013

The Trust was found to be meeting the following standards
Outcome 4 – Care and Welfare of people who use services
Outcome 6 – Co-operating with other providers
Outcome 8 – Cleanliness and infection control
Outcome 13 – Staffing
Outcome 17 – Complaints

However in respect of complaints CLCH was asked to consider the following:
The provider may wish to note that some of the recent complaints had not been responded to within the timescales set out in the policy. In response to this, the Customer Services Manager will ensure that in future, where possible, that complaints are managed and responded to within the guidelines outlined in the complaints policy. Furthermore the policy is being revised to ensure that the timescales are made absolutely clear.

Parsons Green Walk-in Centre – Inspection Date: 31st October 2013

The Trust was found to be meeting the following standards
Outcome 4 – Care and Welfare of people who use services
Outcome 6 – Co-operating with other providers
Outcome 8 – Cleanliness and infection control
Outcome 13 – Staffing
Outcome 17 – Complaints

In respect of cleanliness and infection control CLCH was asked to consider the following *The provider may wish to note that there were some individual areas where more cleaning was needed, such as windowsills and some of the examination couches. The provider may wish to note that there were some sharps bins that had not been dated when they had been put together and there were some full sharps bins in clinical rooms .*In response to this, an action plan template was issued and actions were completed by the service in December 2013. The Estates and Facilities Manager met with the cleaning company and more checks have since been put in place. The examination couches have now been re-upholstered. All sharps bins were immediately reviewed / dated and disposed of in the correct manner and all staff were reminded of the correct procedure.

Pembridge Palliative Care Unit – Inspection Date: 14th November 2013

The Trust was found to be meeting the following standards
Outcome 1 – Respecting and involving people who use services
Outcome 4 – Care and Welfare of people who use services
Outcome 8 – Cleanliness and infection control
Outcome 12 – Requirements relating to workers
Outcome 17 – Complaints

In respect of cleanliness and infection control, CLCH was asked to consider the following: *The provider may wish to note that there were areas in some of the communal bathrooms where there were potential infection control hazards such as staining to the floors or tears in the fabric. During the inspection the provider resolved to address these issues.* In response an action plan was agreed and the required works were completed in the first week of February 2014.

Princess Louise Nursing Home – Inspection Date: 28th November 2013

The Trust was found to be meeting the following standards
Outcome 1 – Respecting and involving people who use services
Outcome 4 – Care and Welfare of people who use services
Outcome 8 – Cleanliness and infection control
Outcome 13 – Staffing
Outcome 17 – Complaints

In respect of care and welfare of people who use services, CLCH was asked to consider the following; *the provider may wish to note that not all medical emergency drugs and equipment was kept in the same place on each floor, and where it was kept on each floor varied. Not all staff were aware of where this equipment was.* In response the following actions were completed, all emergency drugs i.e. anaphylactic kit are now kept in the drug trolley on each unit. This is being handed over daily and a laminated label is placed outside the drug trolley indicating an emergency drug is inside and its expiry date. Clear and visible signs are displayed in each unit to indicate the location of resuscitation bag and defibrillator.

Jade Ward, Edgware Community Hospital – Inspection Date: 2nd December 2013

The Trust was found to be meeting the following standards
Outcome 1 – Respecting and involving people who use services
Outcome 4 – Care and Welfare of people who use services
Outcome 5 – Meeting nutritional needs
Outcome 13 – Staffing
Outcome 14 – Supporting workers
Outcome 16 – Assessing and monitoring the quality of service provision

Edgware Community Hospital Walk-in Centre – Inspection Date: 24th/30th January 2014

The Trust was found to be meeting the following standards
Outcome 1 – Respecting and involving people who use services
Outcome 4 – Care and Welfare of people who use services
Outcome 8 – Cleanliness and infection control
Outcome 14 – Supporting workers
Outcome 16 – Assessing and monitoring the quality of service provision

If you would like further information about the trust's registration and the CQQ's inspection reports, please see the following websites.

http://www.cqc.org.uk/directory/ryx#providertabs-1 for more details regarding registration
http://www.cqc.org.uk/directory/ryx#providertabs-1 for more details regarding inspection.

CQUIN PAYMENT FRAMEWORK:

A proportion of CLCH's income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between CLCH and Barnet CCG, and CLCH and the three CCGs which make up North West London (NWL) Clinical Commissioning Groups

Our achievements against the CQUIN goals for 2014/15 are detailed in the following table:

(Please note information in the table is still draft in some cases)

CQUIN	Goal	Plan TOTAL £	Forecast 13/14 £
NHS Safety Thermometer	To reduce avoidable pressure ulcers in NHS provided care	98,705	98,705
Frequent A&E attenders	Improving attendance to admission rate of frequent attenders and related 4 hour breach profile in A/E departments,	987,054	908,090
Cloud and IT Systems	Scoping, preparation for large scale rollout and piloting of a single clinical information system across primary and community care services. Development and implementation of the diagnostics cloud to allow access to full diagnostics information shared across multiple settings of care.	394,822	394,822
Frail Elderly	The agreed aim of the service is to improve awareness of clinical support in the community by hospital staff in order to decrease average length of stays and bed occupancy rates. This should also lead to an improved outcome for patients so that their discharge is more effectively managed and synchronised better with transport and homecare arrangements.	493,527	394,822
INWL TOTAL		**1,974,108**	**1,796,438**

NHS Safety Thermometer	To reduce avoidable pressure ulcers in NHS provided care	101,984	101,984
Outcomes	Commissioners wish to incentivise the development of robust outcome measures for Community Healthcare services. This is a validated outcome measure that utilises a variety of domains to assess a patient's health status. The intention of the CQUIN is to assist the development, use and reporting of this outcome measure for the Musculoskeletal Physiotherapy Service and the Parkinson's Service.	173,373	173,373
Falls	Building on the 2012/13 CLCH CQUIN from NHS NCL which focused on ensuring the capture of information regarding patients who are at risk of falling and ensuring that actions are taken to address issues that have arisen. The intention is to embed these assessments in the District Nursing Teams' standard operating procedures.	40,794	15,297
Pressure Ulcers	Improved outcomes for patients with pressure ulcers	203,968	201,419
Integrated Care	Integrated care is significantly affected by how providers work together to transform unscheduled care into planned care and to normalise this way of working, for specific cohorts of patients while enabling those patients to maximise their self-care skills. The goal of this CQUIN is to achieve as much system change as possible and focuses on embedding the multidisciplinary case conference as a routine tool	292,899	292,899
Prevention	To encourage more successful quits among patients who smoke by improving the stop smoking offer for patients seen in selected community services in North Central London.	181,532	180,965
School Nursing	To improve adolescent health outcome (11-18 yrs.)	25,292	25,292
NCL TOTAL		**1,019,842**	**991,228**
TOTAL		**2,993,950**	**2,787,667**

QUALITY MATTERS - DEVELOPING A MENTAL HEALTH PATHWAY IN OFFENDER HEALTHCARE

Developing an integrated mental health pathway involves establishing a single point of referral for primary care mental health referrals

A health needs assessment in January 2013, identified that the prevalence of mental health disorders was higher in the prison population than in the local community. A high proportion of prisoners experience symptoms of mild to moderate depression and anxiety and many demonstrate incidents of non-suicidal self-harm.

Eighteen months prior, Offender Healthcare developed a primary care mental health (PCMH) model which replicated on a small scale, the model of care provided by the Kensington and Chelsea PCMH service. This service was based on the Improving Access to Psychological Therapies (IAPT) and provided an assessment with options for Step 2 guided self-help on the wings or attendance in groups run in the Seacole Centre.

The Seacole Centre within HMP Wormwood Scrubs prison is a unique therapeutic environment which provided group interventions for those patients with mild to moderate mental health conditions. Due to staffing establishment the centre was not fully utilised and scope of interventions was limited.
An away day in May 2013 with key stakeholders indicated a need to review the model in order to better meet the needs of the patient group, with particular reference to the high turnover of prisoners within the establishment.

There was a clear need for the PCMH service to ensure that there was an integrated pathway between secondary (Mental Health In Reach team - MHIR) and tertiary services (17 bedded inpatient unit - H3) and that key partners / referrers throughout the establishment were aware of referral criteria and interventions available.

In addition to the established budget, additional recurrent funding was allocated by the commissioner and enabled the development of additional staffing and new group resources with external partners to provide an innovative and responsive service to effectively meet the needs of service users.

Changes/Improvement made

The improvement was to ensure there was a clear and integrated mental health pathway and to provide a single point of access to the PCMH service in order to reduce waiting lists and enable patients to have faster access to the appropriate intervention. Further improvements included the following:

- Integrated Mental Health pathway document written jointly by key stakeholders which clearly sets out pathway and resource available
- Monthly working group with key referrers / stakeholders established to ensure involved and aware of changes and developments
- The development of an integrated referral form which provides clear and distinctive criteria between the primary and secondary mental health services, key information to support referrer in decision making and providing referral information to facilitate efficient response from team (attached)
- A member of the PCHM team attends the weekly MHIR team referrals meeting to review and discuss any cases which may be borderline or patients known to both services

- Focussed communication strategy with key stakeholders such as wing nurses, GP's, prison partners to ensure they understand new ways of working and use new referral process
- Ongoing individual follow up with referrers to ensure correct use of form and understanding of new resource and ways of working in order to embed

Furthermore patients are now able to access service more quickly as waiting times have been reduced from four to six weeks for assessment to two weeks. Implementation of a new model for managing initial assessments by team will reduce this further to one week

Patients receive a comprehensive assessment by the PCMH team who identify needs and establish a treatment plan for individual and/or group treatment

An integrated referral form provides information to those referring to assist in decision making and understand criteria for each service - this has helped substantive staff but the service also currently relies on locum GP staff

DATA QUALITY AND INFORMATION GOVERNANCE

CLCH recognises that good quality data is essential for the effective delivery of patient care and to enable continuous improvements in the quality of this care. The Trust is therefore fully committed to improving the quality of the data in use across all of its services. The following is a summary of the actions that CLCH has taken to improve its data quality.

- The data quality strategy and action plan was revised, improved and implemented
- Key roles were appointed to, including the appointment of an interim Trust Data Quality Manager and local Data Quality Leads & Champions for all corporate and clinical directorates
- A Data Quality Forum was set up which now meets on regular basis
- A dedicated online data quality training course for all CLCH staff was created
- The Trust has invested in an upgrade to its business intelligence software.

CLCH also improved its performance reporting against data quality metrics and these are now included in the monthly board reports. A facility has been set up online to allow service managers to monitor the quality of their data against key data quality metrics, and to improve their performance against these metrics. Further improvements to the service include the implementation of a rolling programme of data quality audits across the Trust.

NHS number and General Medical Practice Code Validity

CLCH submitted records during 2013/14 to the Secondary Uses Service (SUS), relating to activity in our walk-in centres. The NHS number coverage for this period was 94.3% and the practice code coverage was 99.7%. The Trust therefore exceeded its target of 90% coverage for both of these measures in 2013/14, and will continue its efforts to improve practice code coverage to achieve the national target of 95.8% during 2014/15.

Clinical coding error rate

CLCH was not subject to the Payment by Results clinical coding audit during 2013/14 by the Audit Commission.

Information Governance Toolkit Attainment Levels

The Trust achieving a score of 75% against the toolkit. This represents overall satisfactory compliance.

PARTICIPATION IN RESEARCH 2013/14

CLCH remains committed to supporting staff and external researchers to undertake high quality research activity to improve and advance healthcare provision. The Trust also aims to become a centre of excellence in `out of hospital community healthcare provision and innovation'.

CLCH currently hosts or sponsors around 38 research studies including interventional (trials), observational and qualitative studies. The latter often considers both staff and patient perceptions and experiences across a range of services.

The Research and Development team consists of the Head of Research & Development, the KRIS Library Team and HealthInform service. HealthInform provides consumer health information to the public and clinical teams within CLCH where requested. The Head of Research & Development is responsible for ensuring that all studies are conducted in line with the Department of Health Research Governance Framework requirements (DH, 2005) and that they have all relevant approvals before commencing.

There were a number of key research related improvements last year. These included a second CLCH Research Conference hosted in September 2013. At the conference, research undertaken within the Trust was celebrated. In December 2013 there was a Research & Service Evaluation staff update event. A monthly research and development newsletter was created for CLCH staff and a research data base was created highlighting the current state of research activity. Furthermore the Trust was actively involved in the National Institute for Health Research (NIHR) Portfolio studies. These are studies that the NHS supports and encourages public involvement in research. CLCH also actively supports the NIHR Research *Saved my life* campaign

The following are examples of studies that CLCH was involved in

- Preventable unplanned admission rates
- Markers identifying risk of viral induced exacerbation in Chronic obstructive pulmonary disease (COPD)
- The last journey together
- How do elders with a fear of falling experience activity restriction?
- The delivery of compassionate care: the role of the middle manager
- Assessing children's language skills

In the future, CLCH is keen to increase its research capability through identifying and supporting staff to take on the roles of either Sponsor or Principle Investigator which are supported by access to relevant training. This would allow the Trust to take part in more NHS supported 'Portfolio' studies. These are studies deemed to be of excellent quality and come with additional resources and support.

The number of patients receiving NHS services provided or sub-contracted by CLCH in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 9.

QUALITY MATTERS - COMMUNITY REHABILITATION

Clinicians identified a training and development need in managing clients with seating and postural needs in the community this includes clients who reside in nursing and residential care.

In order to ensure clinicians were providing appropriate seating and postural care management an awareness session was initially set up to review current static seating available on the joint equipment list and evaluate it effectiveness to meet functional, and health benefits for the clients. The session provided peer learning and expert advice from the manufacturer of products.

CLCH therapies were influential to gain agreement from the equipment commissioning to provide specialist static seating on the standard catalogue. Thereby reducing the waiting time for clients to be provided suitable seating options and reduce secondary health problems, improve function and quality of life.

A CLCH training workshop coordinated by rehab clinicians working at Princess Louise Nursing Home and led by Martina Tierney (Occupational Therapist) a leading figure in the research and development of specialist seating. The workshop delivered training on posture and the principals of correct seating assessment and provision.

The speakers also provided the latest research and evidence on health and wellbeing benefits of seating. Martina and her research team have just published the effectiveness of specialist seating in nursing home with a reduction of pressure ulcers in 88% when seated appropriately in specialist seating packages.

Moving forward a working group has been set up to develop a standardised CLCH assessment form and protocol on the issuing, and review of bespoke specialist seating to ensure clinicians are providing the most effective seating package to meet the clients goals.

PARTICIPATON IN CLINICAL AUDIT

At the start of 2013/14 a thorough review of clinical audit in CLCH was carried out under the auspices of the Medical Director. Following the implementation of new processes for clinical audit across CLCH, both processes and structures were reviewed by our internal auditors, Parkhill, and found to provide 'substantial assurance' to the Board and the organisation. A set of key performance Indicators (KPIs) were agreed with Parkhill and are regularly monitored through the Quality Assurance Team and reported to the Clinical Audit and Research Steering Group, Quality Committee and Audit Committee.

During 2013/14, three national clinical audits covered NHS services that CLCH provides; no national confidential enquiries applied to our services.

During 2013/14, CLCH participated in all of the national clinical audits that it was eligible to participate in and these are listed below.

The national clinical audits that CLCH participated

National Clinical Audits	Participation	Number of cases submitted or reason for non-participation
Chronic Obstructive Pulmonary Disease (COPD)	Yes	Registered for National Clinical Audit Data collection for the Community Trust component of the audit has been moved to 2014/15
National Stroke Audit	Yes	Registered for National Clinical Audit The audit is continuous and will overlap into 2014/15. The initial start-up of this audit was slower for community services during this period. Data collection is continuing.
National Audit of Intermediate Care	Yes	Registered for National Clinical Audit Individual boroughs are still awaiting hard copy results from the National Audit Office. As soon as these have been received, the teams will be preparing a summary of the results and developing an action plan.

The Clinical Audit and Research Steering Group (CARSG) reviews National Clinical Audits which the trust has participated in during previous years to ensure learning from audit findings. CLCH participated in the national Parkinson's Audit in 2012 and we are awaiting a summary report from Parkinson's UK scheduled to be published April/May 2014. Together with recommendations and actions developed by each participating service, this will be reviewed by the CARSG at the next meeting in May 2014.

There were 31 completed clinical audits that were reviewed by the provider between April 2013 – March 2014 and these are listed in the table below. The reports of these clinical audits were formally reviewed by CLCH and the trust will be taking the following actions (as described in the table) to improve the quality of healthcare provided.

(Please note information in the table is still to be finalised in some cases depending on when the audit took place)

No	Item	Service	Outcome and Actions 2013/14
1	Clinical Record Keeping	All Services	We have seen significant improvement in the target compliance achieved for all criteria audited. In the previous 2012/13 audit, 56% compliance was achieved; in the Trust-wide re-audit in 2013/14 services achieved 87% compliance across all criteria audited. The performance target of 85% was therefore achieved and exceeded. Services with less than 85% compliance are targeted for additional audits and/or actions. Further audits in 2014/15 will be undertaken to ensure that the current standards are maintained and improved.
2	Anticoagulation audit into Mechanical Heart valve patients	Anticoagulation	Patients that have undergone mechanical cardiac valve replacement and that are managed within the Hammersmith and Fulham anticoagulation service are being appropriately risk assessed and treated according to their individual clinical history according to best practice and the current clinical guidelines and evidence base.
3	Dental recall audit NICE guideline CG19	Community Dental Services	The repeated audit revealed that one service failed to reach the 80% target set to see patients. This is a big improvement on the previous audit (51%) carried out in 2012. 5 key recommendations have been made including the need to recruit more dentists to see new patients who are now in post. This will be kept under review.
4	Audit of Compliance with NICE Guidance on Antibiotic Prophylaxis for Infective Endocarditis	Community Dental Services	The standards of the audit have been met and is concluded that the dentists in Barnet Community Dental Services are complying with the NICE guidance regarding the prescription of antibiotics for prophylaxis for infective endocarditis.
5	Audit of 6 and 12 month stroke reviews carried out across CLCH (bedded areas)	Community Rehab Service	The National Stroke Strategy (2007) set out the need to conduct holistic stroke reviews at 6 month and 12 months post hospital discharge to ensure that any unmet needs related to stroke are addressed. Stroke Reviews will be re-audited for the period January – March 2014.
6	Compliance to MUST Screening in Continuing Care	Continuing Care	Audit in 3 care homes. Support and training to be continued regarding the use of different aspects of the MUST tool
7	Falls audit	Continuing Care Nursing Homes	Monthly audit of CLCH Multi-factorial Risk Assessment Tool to continue. Feedback to be presented in staff meetings. Incomplete/ untimely assessments to be monitored and the staff responsible questioned in order to offer 1:1 training/supervision as appropriate
8	Liraglutide Starting and stopping following NICE guidelines	Diabetes	Re audit 90% compliant. Each nurse is responsible for ensuring that patients are reviewed 6 monthly as a minimum and if DNA, GP advised to stop Liraglutide

No	Item	Service	Outcome 2013/14
9	Home enteral tube feeding (HEFT) audit compliance with NICE Guidelines CG32	Dietetics	Dieticians to renew feeding regimes and upload to IT system (RIO); ensure wider audit of documentation including H2H form. Ensure that all patients receive home visit within 2 weeks of discharge or to seek justification from staff
10	NICE Guideline Pressure Ulcer CG029	District Nursing	Audit showed that nurses are completing pressure ulcer risk assessments for patients who already have a pressure ulcer but also for those who are potentially at risk of developing a pressure ulcer. Monthly review of all patients on the DN caseload who are at risk of developing a pressure ulcer.
11	6 Week Maternal Contact Clinical Practice Standard Pilot	Health Visiting	This baseline audit arose from the need to ascertain SCPHN compliance with NICE Guidance CG45 (2007) and CG37 (2006). Audited against the Maternal Mood Assessment to identify women with depression at first visit to primary care. Training rolled out to SCPHNs.
12	Mealtime mantra audit	Infection Control	8 wards re-audited all scored 95% and above. All staff handling food to attend Food Hygiene training. Food mantra training to be provided locally by Property services. Individual action plans to be completed within 4 weeks of report received.
13	Hand hygiene validation audits - bedded services	Infection Control	Re-audit scores 93-100%. Meeting was set up with the nursing home manager and staff to discuss the 5 moments for hand hygiene. 1:1 hand hygiene training for all staff on specific wards, after which they were asked to sign a contract to agree that they had completed and understood the training and were aware that any breaches might lead to disciplinary action
14	Endoscopy /day surgery audit	Infection Control	Generally good compliance with CFPP 01-06, Essential Quality Requirements. In order to meet Best Practice, major building work is needed - CLCH senior management currently in discussions with the provider hospital to fund this project. Possible withdrawal of endoscopy services from ECH
15	Aseptic Non Touch Technique(ANTT) validation audit	Infection Control	Generally good ANTT compliance (95%). Poor uptake of eLearning by end of March 2014 - to be re-launched. ANTT eLearning launched mandatory for CLCH staff carrying out invasive procedures. Competency checks by managers as per ANTT policy.
16	Trust-wide hand hygiene audit	Infection Control	Generally good compliance but varied return rate. Non-compliance issues addressed by auditor at the time of audit. Non - compliance issues addressed by individual auditor at the time of audit.
17	Surveillance of MRSA, C diff and CAUTI - bedded services	Infection Control	Every patient with identified infection followed up and cross infection prevented. Individual patients followed up immediately and appropriate IC advice given. No cross infection
18	UNICEF Baby Friendly Stage 3 Mother's Audit No 3 (re-audit)	Public Health Nutrition with: Nursing / Therapies / Children's Health	CLCH likely to receive UNICEF Stage 3 BFI Accreditation as a result of high quality breast feeding services.

No	Item	Service	Outcome 2013/14
19	Safe and Secure Handling of Medicines Audits (services using/stocking medicines)	Medicines Management	Negative assurance received on the quality of audit reports from work conducted under SLA. A review on how these audits are conducted took place after SLAs were withdrawn and services bought in house. Audits to recommence in 2014-15 after re-training of staff and new process in place for conducting them
20	Cold Chain Audit (bedded areas)	Medicines Management	Up to date Cold Chain Policy in place. Robust management of medicines and the cold chain - to be confirmed in next audit in 2014/15
21	Cold Chain Audit (services)	Medicines Management	Up to date Cold Chain Policy now in place. Robust management of medicines and the cold chain - to be confirmed in next audit in 2014/15
22	Antibiotics Audit	Medicines Management	Re-education of prescribers by ward/unit pharmacists and results of audit fed back. Also shared with home managers of units where prescribing was outside of guidelines. Adherence to local antimicrobial guidelines, re-audit in 2014-15.
23	Audit of NICE Guidance for Anxiety (CG22)	Psychological Health	To consider 'dropped out' cases in greater depth in case management to look for patterns or common presentations. Evaluation project on those who drop out of treatment being conducted within service. Currently completing actions.
24	Audit of NICE Guidelines for Depression (CG23)	Psychological Health	New investment offered to service has been targeted at guided self-help, our least intrusive intervention. This team does all initial triage and now triages to their own team wherever possible. More patients are now starting with least intrusive intervention, even if stepped up to more intensive treatment thereafter.
25	Safeguarding - mental capacity and best interest assessment	Safeguarding adults	The overall findings are that supervision is delivered by the CLCH safeguarding teams is compliant with CLCH policy and the experience of the supervisees is positive. A comparison with the CLCH safeguarding supervision 2012 demonstrates improvements in both compliance with supervision policy and practitioners perceptions and rating of supervision in 2013.
26	Enuresis Audit CG -School Nursing	School Nursing	The results demonstrate that there has been an improvement in delivering care for enuresis in line with NICE guidance. Training of all staff in enuresis, assessment, advice re fluids, use of alarms and medication to be provided at least annually at the school nurse training week
27	Compliance with NICE guidelines, particularly obesity NICE guidelines	Specialist Weight Management	The results show that the Specialist Weight Management Service are compliant with all 5 guidelines, and can provide supporting evidence. SWMS are meeting NICE guideline standards and delivering a service that is both evidence-based and provides a positive patient experience.

No	Item	Service	Outcome 2013/14
28	Radiology: missed fractures	Walk in Centre (WiC / UCC	The overall percentage of abnormalities being missed by clinicians in the Walk in Centre is low (< 2% of the total number of images taken). This reflects overall good practice. Some GPs in the WiC are being encouraged to reflect on their competences.
29	Auditing elements of the clinical management of women with acute cystitis symptoms in a NHS Walk-In-Centre	Walk in Centre / UCC	Overall good compliance with the local guidelines was found. 3 key recommendations for improving practice were made.
30	Re-audit of the Management of Upper Respiratory Tract Infections in adults in Soho Walk in Centre – antibiotic prescribing (CG69)	Walk in Centre / UCC	(CG69). Upper respiratory tract infections (URTI) account for a large percentage of increasing attendance. Areas of good practice previously highlighted have been maintained. Guidance and targeted meetings and documentations reviews have been actioned.
31	Chest pain - WIC treatment	Walk in Centre / UCC	Results of audit communicated to all staff with a summary of the relevant parts of the NICE guidelines indicating where practice needs to improve. Discussed same at staff meetings. Planned re-audit in June for period March-May 2014 to assess for improvements in practice.

MANDATED DATA

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death. Central London Community Health NHS Trust considers that this data is as described for the following reasons [insert reasons]. The Central London Community Health NHS Trust has taken the following actions to improve this and so the quality of its services, by undertaking the following actions.

Information on this to be inserted. This is due to the fact that the March 2014 data has been delayed by a technical issue within NRLS. It is anticipated to be available at the end of April 2014.

The other mandated indicator relating to *the percentage of patients being readmitted to a hospital which forms part of the trust* does not apply to CLCH as CLCH has not previously been required to report on this

Review of Services

During 2013/14 CLCH provided and or sub contracted 55 NHS services. CLCH has reviewed all the data available to them on the quality of care in 100% services. The income generated by the NHS services reviewed in 2013/14 represents 100 percent of the total income generated from the provision of NHS services by CLCH for 2013/14.

STATEMENTS FROM OUR LOCAL OVERVIEW AND SCRUTINY COMMITTEES, CLINICAL COMMISSIONING GROUPS AND HEALTHWATCH

To be inserted post consultation

Barnet CCG

Hammersmith and Fulham, Central London and West London Clinical Commissioning Groups

Barnet overview and scrutiny committee

Hammersmith and Fulham Overview and Scrutiny Committee

RBKC and WCC Overview and Scrutiny Committee

Healthwatch Barnet

Healthwatch – Central West London

FEEDBACK

Now that you have read our Quality Account, we would really like to know what you think, how we can improve and how you would like to be involved in developing our Quality Accounts in future. We will be putting a short feedback survey on our website which should only take five minutes to complete.

Go to: **www.clch.nhs.uk** and fill out the survey online. Alternatively you will be able to download a copy of the survey, fill it in and post it to:
Patient and public engagement
Central London Community Healthcare NHS Trust
6th Floor 64 Victoria Street
London
SW1E 6QP

Please write to us if you would like us to send you a paper copy using the address above or via email to **communications@clch.nhs.uk**. Alternatively, if you or someone you know would like to provide feedback in a different format or request a copy of the survey by phone, call our communications team on **020 7798 1420.**

FURTHER ADVICE AND INFORMATION

If you would like to talk about CLCH's services or your experiences

If you would like to talk to someone about your experiences of CLCH services or you need to know If you would like to find a service, please contact our patient advice and liaison service (PALS) in confidence via email **clchpals@nhs.net** or on **0800 368 0412**.

USEFUL CONTACTS AND LINKS

CLCH Patient Advice and Liaison Service (PALS)

e: pals@clch.nhs.uk

t: 0800 368 0412

Switchboard for service contacts

t: 020 7798 1300

Local Healthwatch

Central West London Healthwatch - For Hammersmith and Fulham, Kensington and Chelsea and Westminster

Email: healthwatchcwl@hestia.org

Telephone: 020 8968 7049

Barnet Healthwatch

Telephone: 0208 364 8400 x 218 or 219

www.healthwatchbarnet.co.uk

Local Clinical Commissioning Groups

Barnet CCG

Telephone: 020 8952 2381

www.barnetccg.nhs.uk

Central London CCG

Telephone: 020 3350 4321

www.centrallondonccg.nhs.uk

Hammersmith and Fulham CCG

Telephone: 020 7150 8000

www.hammersmithfulhamccg.nhs.uk

West London CCG

Telephone 0207 150 8000

www.westlondonccg.nhs.uk

Local councils

Barnet

Telephone: 020 8359 2000

www.barnet.gov.uk

Hammersmith and Fulham

Telephone: 020 8748 3020

www.lbhf.gov.uk

Kensington and Chelsea
Telephone: 020 7361 3000
www.rbkc.gov.uk

Westminster
Telephone: 020 7641 6000
www.westminster.gov.uk

Healthcare organizations

Care Quality Commission
Telephone 03000 61 61 61
www.cqc.org.uk

NHS Choices
www.nhs.uk

APPENDIX 1 – COMPLAINTS ANNUAL REPORT

1.0 Introduction

1.1. This is the Complaints Annual Report for Central London Community Healthcare NHS Trust (CLCH) for the period 1 April 2013 to 31 March 2014.

1.2. The current complaint handling regulations were introduced in April 2009 (The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 Statutory Instrument), together with guidance from the Department of Health ('Listening, Responding, and Improving 2009"). A direct relationship between the Ombudsman and health bodies is embedded within the complaints system's structure. The Ombudsman has stated that when the NHS listens to patients and takes action on what they say, it can make a direct and immediate difference to the care and treatment that patient's experience.

1.3. Through its complaints policy, the Trust ensures that people, and those acting on their behalf have their comments and complaints listened to and acted on effectively, and know that they will not be discriminated against for making a complaint.

1.4. The issues raised from complaints are dealt with in a sensitive and timely manner to prevent reoccurrence or escalation of incidents. Staff are trained and supported to do this by acknowledging the problem or concern being raised and where possible resolving the issue at an early stage. The complaints and concerns we receive inform the action plans relating to the Patient Experience.

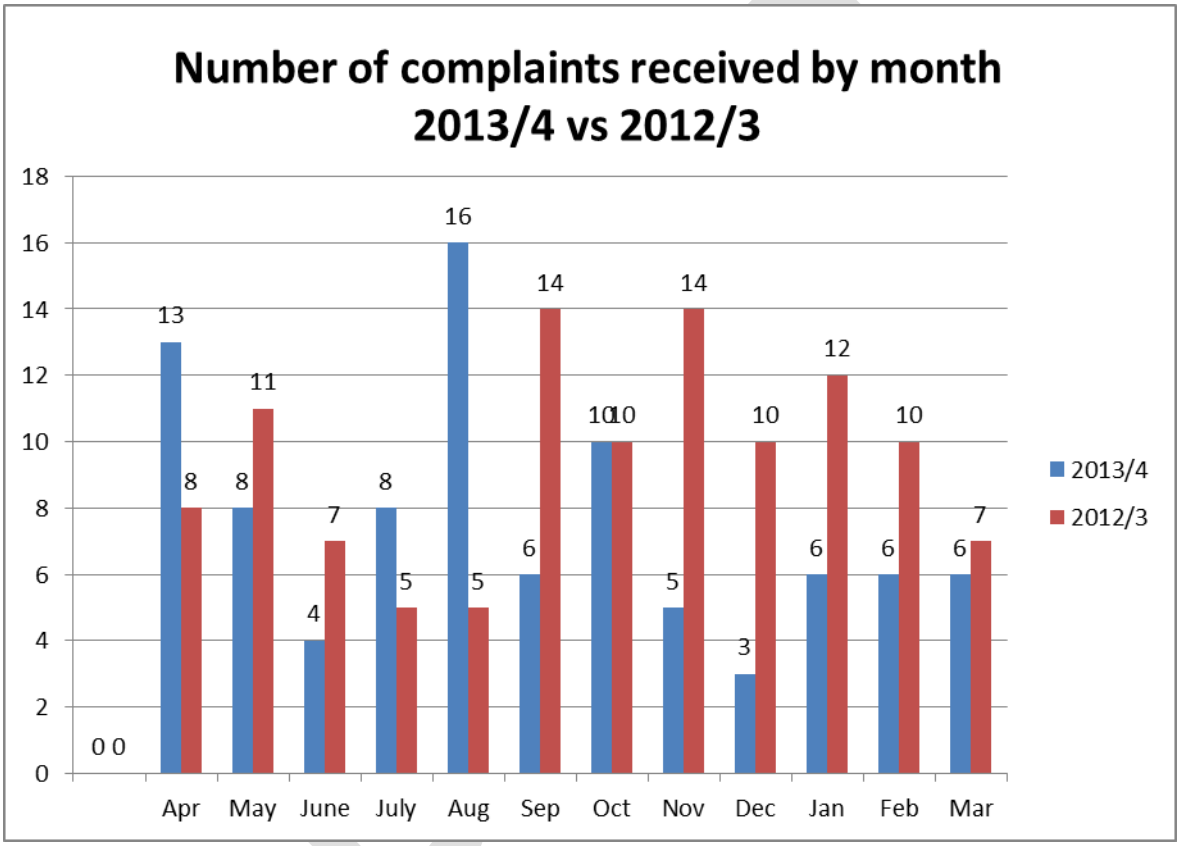
2.0 Complaints received

2.1. A total of 92 formal complaints were received by the Trust during 2013/2014. This is a decrease of 20 (19%) complaints on the previous year.

2.2. Complaints received by month.

The following chart illustrates the number of complaints received by month in 2013-4 vs. 2012-3.

Chart 1



2.3. Complaints received by Clinical Commissioning Groups (CCGs)

The following table illustrates the number of complaints received by CCG. A reduction of 62% in the number of complaints received regarding services provided in the Barnet CCG is the driver for the overall reduction in complaints received Trustwide this year versus last year.

Table 1

Borough	Number of complaints received	
	2013/14	2012/13
Barnet CCG	**27**	**43**
Hammersmith and Fulham CCG	**17**	**20**
West London CCG	**19**	**22**
Central London Health CCG	**28**	**26**
Corporate	**1**	**2**
Total	**92**	**113**

3.0 Analysis of complaints received.

3.1 Complaints received by Division.

The following table illustrates the number of complaints received by Division.

Table 2

Division	Number of complaints received
Allied Primary Care Services	**37**
Child Health and Development	**8**
Corporate Services	**2**
Networked Community Nursing and Rehabilitation	**10**
Specialist Community Nursing	**35**
Total	**92**

3.2. 21 of complaints received by Allied Primary Care Services were regarding the Urgent Care and Walk-in Centres.

3.3. 4 of the complaints received by the Child Development Service were regarding the Health Visiting Service.

3.4. 5 of the complaints received by the Networked Community Nursing and Rehabilitation Service were regarding the District / Community Nursing Service.

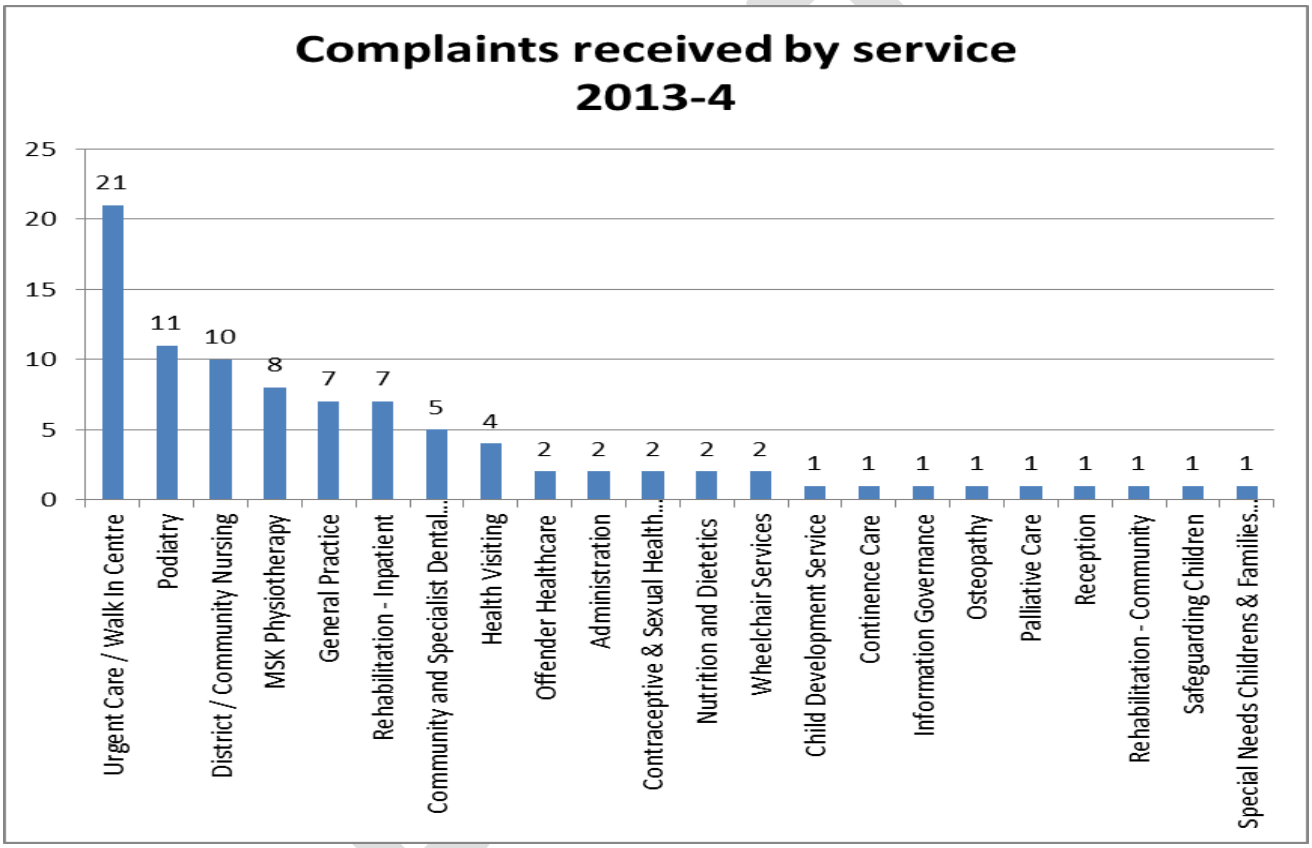
3.5. 11 of the complaints received by the Specialist Community Nursing Service were regarding the Podiatry Service 8 about the Musculoskeletal Service.

Further analysis is provided under section 3.2 of this report.

3.6. Complaints by service

The following chart illustrates the number of complaints received by service.

Chart 2



The following trends and themes emerged from complaints received were:

3.7. Urgent Care and Walk-in Centres (21)

Clinical care and treatment 13

3 of the complaints were regarding misdiagnosis.

Rudeness or conduct of staff 7

There were 3 complaints regarding different staff members at St Charles UCC.

3.8. District /Community Nursing (10)

Clinical care and treatment 8

No trends in clinical themes although communication between patients and staff was a factor in 6 of the complaints.

3.9. Podiatry (11)

Clinical care and treatment 6

The management of the patients' expectations regarding the possibility of bleeding during or after treatment was a factor in three of these complaints.

3.10. In-patient rehabilitation (7)

Clinical care and treatment 7

3.11. Three of the complaints were regarding falls or other harm caused to patients during their stay on at Finchley Memorial Hospital. Two complaints were regarding care and treatment provided at Athlone House.

3.12. Musculoskeletal Physiotherapy (8)

Three of these complaints were regarding the appointments or referral process.

3.13. GP Services (7)

Clinical care and treatment 5

3.14. Three of these complaints were regarding the treatment and behaviour of a particular GP.

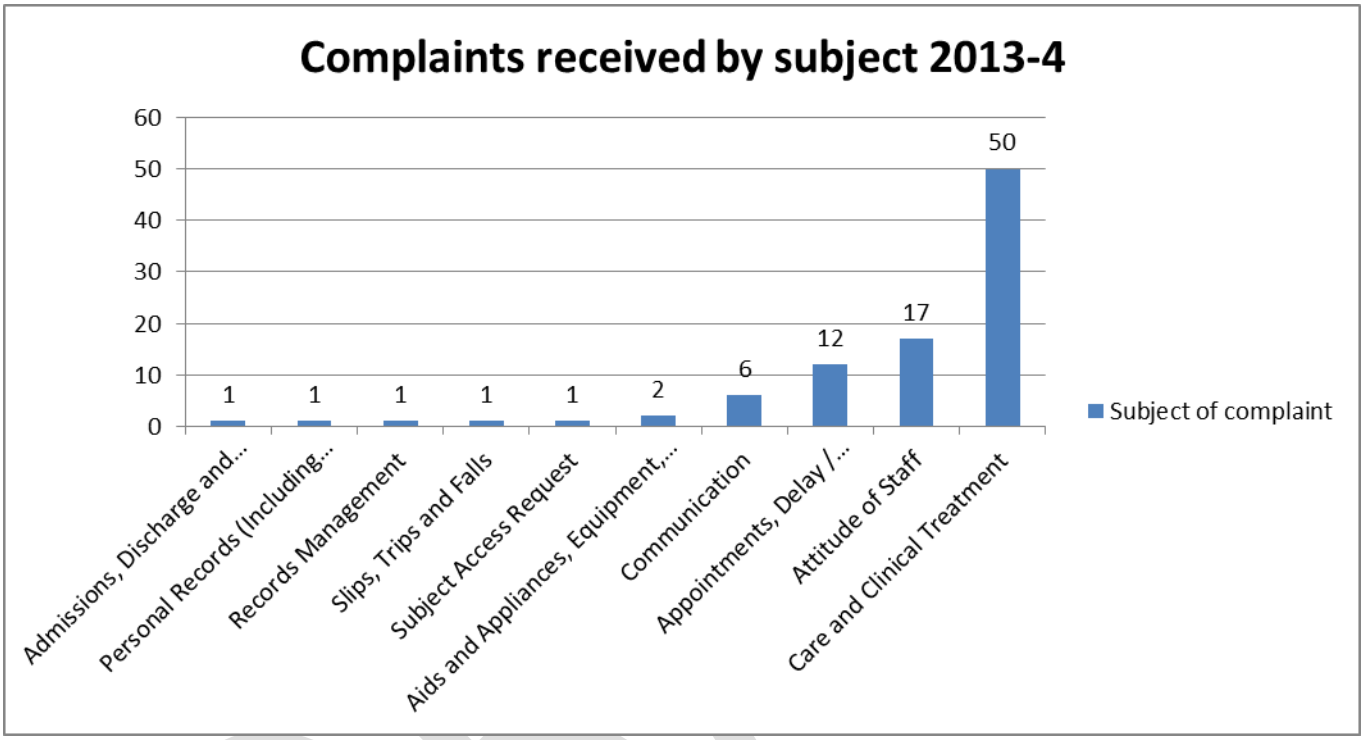
3.15. Health Visiting

Two of these complaints were regarding the vaccination process.

4.0 Complaints received by subject

4.1. The following chart illustrates the number of complaints received by subject.

Chart 3



NB: The subjects of complaints are classified by the main theme of the complaint, as required by the annual submission of complaints data to the Health and Social Care Information Centre.

4.2. The top three subjects remain the same as the previous year; unhappy about aspects of their clinical treatment, staff attitude (also taken to mean rude) delays and/ or process regarding appointments.

Table 3

Top three complaint themes	Total Number of Complaints Received (2013 / 2014)	Total Number of Complaints Received (2012 / 2013)
Unhappy with Treatment	50	50
Staff Attitude	17	19
Appointments	12	10

4.3. Unhappy with Treatment. The category 'unhappy with treatment' covers a wide spectrum. In 4 cases, complainants reported that their treatment and/or side effects were not fully explained. In addition to the themes reported in section 3 of this report the following trends were found:

Table 4

Subject	Total Number of Complaints Received
Discharge	3
Misdiagnosis	6
Catheter	2
Infection control	1
Medication	5

4.4. Staff attitude can often be the complainant's perception of the way they were addressed or treated by staff. When describing their perception of some staff, rudeness, insensitivity and a general lack of concern were the most common themes.

4.5. A target was set to achieve a 5% year on year reduction in complaints and incidents related to poor communication and attitude. This year saw 18% of complaints regarding this subject, an increase of 1%.

4.6. As a means of addressing this issue, the appropriate members of staff have received further Customer Service Training as well as enhanced supervision. The Trust has also set out values and standards of behaviour expected. Any members of staff who do not reach these standards will undertake a customer care training workshop and will be monitored closely under supervision.

4.7. There were no trends in the 12 complaints received regarding appointments in terms of the service affected.

5.Response times to complaints

5.1. All complaints were investigated within the timescales agreed with the complainant. It should be noted that in some cases the timescale initially agreed with the complainant was extended after it had been explained why and re-agreed with them.

5.2. 17 (18%) of complaints received were in investigated within 25 working days.

The majority of the complaints closed outside of the agreed timescales were either due to the complexities of the investigation. Other reasons, although to a lesser degree, included staff that were the subject of the complaint not being available due to sickness or leave. Additionally there were delays awaiting contact from complainant to clarify their complaint or awaiting proof of consent where required. One of the Trust's aims for 2013/14 is to build on the considerable work already undertaken to improve response timescales.

6.0 Local resolution meetings

6.1. Two meetings took place of which one resulted in a positive outcome. Another meeting with a patient was did not take place due to the patient being unwell.

7.0 Complaints referred to the Parliamentary & Health Service Ombudsman (PHSO).

7.1. Under the current complaints legislation, Trusts have six months in which to endeavour to resolve a complaint to the complainant's satisfaction. If the complainant remains dissatisfied with the response they receive, they can ask the Ombudsman to independently review their complaint.

7.2. From April 2013, the Ombudsman's office advised that they would begin investigating and sharing reports on more of the complaints. This is part of their new strategy 'More Impact for More People'. They stated that they will be investigating thousands rather than hundreds of complaints each year. The Ombudsman will continue to publish figures for the number of complaints they investigate about each organisation in their jurisdiction, but will be explicit that their change of process is a reason for the significant increase in the number of investigations they will undertake during 2013/14.

7.3. During 2013/14 the PHSO did not request case files or a formal review of any complaints made against CLCH.

8.0 Reopened complaints

8.1. Complainants who were unhappy with their responses felt that there were discrepancies between what was said in the response and their recollection of events. Some complainants felt that the investigation had been superficial and had not addressed the concerns raised. Others identified that they were unhappy with the tone of the response and that the Trust had failed to offer a sincere apology. A number of complainants wanted further information in order to help them understand the decisions made about their care. Of the complaints that were re-opened 17 were resolved through further responses.

9.0 Change of practice

9.1. A fundamental aspect of the complaints process is ensuring that the organisation learns and improves from the experience of receiving and managing complaints. Each complaint investigated

will have recorded, as a feature of the final outcome, the lessons learned and what action has been, or will be taken as a result of the investigation.

9.2. The resulting actions are currently monitored by the Patient Experience Group and the lessons learned disseminated throughout the organisation. The actions from those complaints risk graded as medium to high are monitored via the Trust's Risk Register.

9.3. The Customer Service Manager also presents emerging themes or trends to the Complaints, Litigation, Incidents, PALS, Serious Incidents (CLIPS) Group on a bi-monthly basis. The CLIPS Group provides the Trust's forum for discussing and sharing lessons in an open and supportive environment. Where required learning bulletins can be quickly disseminated via email or through the appropriate governance structure.

9.4. A quarterly cumulative thematic report is produced to enable the Trust to monitor any themes or trends arising from complaints throughout the year, so that any issues can be addressed accordingly.

9.5. The commissioners of CLCH's services also receive a monthly report on the lessons Actions and lessons learned from complaints originating from their specific geographical areas.

9.6. The table below highlights a selection of some of the changes and improvements made as a result of complaints received over the past year.

Table 5

Specialism	What we did…
GP Practice Milne House	In order to improve the patient experience the practice has recently installed a patient check-in machine which allows patients visiting the practice to check themselves in. Therefore patients contacting the practice by telephone will have their calls answered more promptly.
Podiatry Surgery	The podiatry nail surgery post-surgical advice sheet has been updated to more robust advice on accessing urgent care if the need arises.
Palliative Care Pembridge Unit	The unit has now obtained a further 11 beds which lower to the floor thereby reducing the risk of falls.
Ultrasound Scan and Biomechanics	Additional temporary staff were employed to help reduce a short term increase in waiting times.

Single Point of Access	All “Choose and Book” appointments are followed up with a confirmation letter which includes the address of the clinic. The SPA will inform “Choose and Book” callers of the clinic venue as well as the date and time of appointment.
Rehabilitation-In patient	The following recommendations have been identified and are being implemented by all wards: On admission, the ward staff will liaise with both patient and family to identify the patient's individual needs in relation to preference of health care worker. An induction program to be developed and implemented for use by agency staff on their first duty on the ward. When a patient is found to have poor core balance then guidance for managing this will be included in the patients care plan. Families of patients to be informed that they will be provided with clear outcomes from an incident and have an opportunity to respond. All ward staff will also undertake refresher training in effective communication which will include how to deal with concerns raised by relatives and carers in order to allay relatives' fears and anxieties with regards service delivery and patient safety.
MSK Physiotherapy Finchley Memorial Hospital	To help reduce caller waiting times that the service is now open at the earlier time of 8am.

We continue to review the lessons learned process and have introduced systems of robust trend analysis in order to enable the Trust to monitor and act upon any recurring themes. One of our corporate objectives this year will be to ensure that lessons learned are embedded into service delivery and that the process is included in the review of the Complaints Policy & Procedure.

10.0 Equality Data

10.1. When written complaints are received this information is not usually provided and an attempt to capture this is made at a later stage by way of a phone call, or by letter, if a contact number is

available. We gather this information and pass it on to the Equality & Diversity team to help assess whether we are providing equal access and treatment for different groups of people. The data requested is as follows: Ethnicity, Age, Sexual Orientation, Religion or beliefs.

11.0 Key achievements in 2012/2013

11.1. The team has attended a number of Operations Directorate team meetings to provide training in the management of complaints, concerns, comments and compliments for staff who undertake investigations or are involved in the process.

11.2. Implemented a new e-learning Complaints and PALS module, which will has replaced this section on the Corporate Induction Programme, and provide a more interactive experience for users.

11.3 Participated in NHS England's pilot of a new transparent patient feedback service with the working title of 'Care Connect'.

11.4. The Trust's Complaints Policy and Procedures have been reviewed in line with Department of Health guidelines and the recommendations from the Mid Staffordshire NHS Foundation Trust Public Inquiry (The Francis Report-Effective Complaints Handling) and the Report of handling of complaints by NHS hospitals in England by Ann Clwyd MP and Professor Tricia Hart.

11.5 Participated in a number of public stakeholder events. For example, provided a stall at the 'Time of your Life Health Fair ' organised by Age UK Kensington & Chelsea and provided a key note speaker at the "How to Complain" community event organised by Healthwatch.

11.6 Provided support to Trust's 'Excellence in Customer Service' training programme.

12.0 Aims for 2013/4

12.1. The complaints regulations do not stipulate a specific time-scale for responding to complaints; the Trust has therefore determined three levels of response to complaints and a target for response to Low/Medium Risk complaints has been set at 25 working days.

12.2. Work with the Business Intelligence team to further develop its "QlikView" reporting function to enable the Directorates to access quality reports about complaints, comments, concerns and compliments received about their services.

12.3. Enhance the Customer Service section on the Trust Internet to provide, for example, transparency to the public in its management of complaints, the actions take and the lessons learned from them. A Compliments section will also be introduced.

12.4. Further develop the Customer Service Satisfaction Questionnaire to encourage service users to complete and return.

12.5. Build on the success of service team visits last year and providing further complaints training sessions across the Trust for staff who undertake investigations.

12.6. Provide further support to Trust's 'Excellence in Customer Service' training programme.

12.7. Work with local and national complaints networks to provide better benchmarking data with Trusts delivering comparable services.

12.8. Explore synergies and more integrated working with the Patient and Public Engagement Team with which the Customer Service Team has been integrated.

12.9. Evaluate the possible use of volunteers within the Customer Service Team.

13.0 Conclusion

13.1. The Trust continues to be proactive in its management of complaints and recognises that complaints provide invaluable feedback about the services we provide.

13.2. Work during 2014/15 will continue to build on that already undertaken this year, focusing on ensuring that lessons are learned from complaints and concerns. The Trust will continue to seek assurance that all actions have been undertaken and changes are made to service delivery where appropriate.

APPENDIX 2 - FRANCIS MATURITY MATRIX

Appendix 2: National report recommendations – Integrated Matrix (v4.1)

(v.4.1 updated January 2014)

	BASIC		BRONZE		SILVER	GOLD
	Starting off	Progress	Early Days	Progress	Good	Exemplar
	May 2013	July 2013	September 2013	Jan 2014	January 2014	April 2014
1. PREVENTING PROBLEMS	Quality strategy and Risk management Strategy approved by the Board Listening events held across Trust Quality Account developed in collaboration with patients, staff and key stakeholders	Completed Completed Completed	Quality Strategy and Risk Management Strategy launched across Trust Quality conference held to disseminate best practice Quality Account disseminated and objectives on track.	Completed Completed Completed	Quality Strategy and Risk Management Strategy Objectives clearly embedded across the Trust and Strategy targets on track.	Zero tolerance to culture of poor care Year One Quality Strategy and Risk Management Strategy Objectives being met. Engagement of all staff demonstrated through staff survey (Everyone's Business) Quality Account objectives met.
All actions this line cross ref to Berwick 3 / 8 Keogh 3	Patient stories presented to the Board and PPE strategy successfully rolled out across Divisions	Completed PPE strategy on track with expected outcomes.	PPE strategy refreshed and being implemented across divisions	Completed	15 Steps programme implemented and cycles of improvement identified	Patient stories used across all services Refreshed PPE objectives being met. Patient feedback actively used by all services to improve care
All actions this line cross ref to Berwick 7	Being Open Policy in place	In place.	Policy reviewed and awareness increased as part of Quality Strategy launch	Competed.	Wider programme of training in relation to Duty of Candour	Audit of SI investigations demonstrates Being Open policy is successful.
	Patient Safety Thermometer implemented	Completed	Review of policies and guidelines on intranet site Understanding of incidents by service.	Ongoing Completed	Reduction in incidents of avoidable harm	Embedded culture of patient safety demonstrated through achievement of Risk management Strategy Objectives
	Productive series used to help "release time to care"	Partial implementation in some teams/ units.	Complete capacity and capability review across community nursing Staffing levels are reviewed using evidence based tools Cross ref Keogh 6 Cavendish 17 Berwick 4	Completed Initial work / in progress	Reducing paperwork for front line staff (by 1/3) Staffing levels and training are reviewed using evidence based tools Trust Board will receive publish and endorse information on staffing	Creating time to Care by introducing electronic/ digital solutions to reduce paperwork Aligns Cavendish 12 Trust Board will receive, publish and endorse information on staffing at least twice per year
	CLCH working closely with TDA, CCGs and NHS England in relation to Quality measures and objectives	On-going	All CQUINs and quality performance information on track with afore mentioned.	Completed / On-going	Work with local commissioners to develop local quality incentives for 2014/15	Active engagement with Health and Wellbeing boards and achieve all commissioning quality objectives.

	BASIC		BRONZE		SILVER	GOLD
	Starting off	Progress	Early Days	Progress	Good	Exemplar
	May 2013	July 2013	September 2013	Jan 2014	January 2014	April 2014
2. DETECTING PROBLEMS QUICKLY All actions this line cross ref to Berwick 3 / 8; and Keogh 3 Actions this line cross ref Keogh 2	PREMS in place Analysis of patient feedback being undertaken including friends and family test	Completed On-going	PREMs, complaints and other patient feedback disseminated at Quality conference Net Promoter Score in line with Quality Strategy Objectives.	Completed On track	Themes and outcomes of all complaints published monthly on the trust website.	Staff survey results / medical revalidation feedback used to complement patient feedback and plan developments for coming year.
	Performance scorecard includes key quality metrics by division	Completed	KPIs developed as part of quality and risk management strategies and published across all services Development of QlikView At least three key clinical outcomes for each service published on the trust website	Completed On-going Identified – not on website yet	Performance data published on trust website Communications team publish outcomes widely	Performance measures – open and transparent Scorecards demonstrate prompt action when concerns arise. Clinical Reference Group monitoring of CIPs has been successful in identifying any concerns quickly.
NEW ACTIONS Keogh 1			Trust Resuscitation Group reviewed Deteriorating Patient Policy	Completed	Implementation of National Early Warning Score (NEWS)	
	Incident reporting well established Serious Incident review – every case treated individually. 48 hr executive review. RCA panels for all SIs	In place - on-going Completed	Staff encouraged to speak up (whistleblowing) reinforced as part of Quality Strategy launch Risk Managers review SI process	Completed Completed	All incidents involving patients are discussed with the patient and their family	Internal Inspection programme to be established by the compliance team Candour and transparency fully understood by all staff
3. TAKING ACTION PROMPTLY	Board has established secondary set of standards for reporting related to patient care Intentional rounding in place in in-patient areas	Completed Completed	Standards for key areas of patient care established and disseminated through professional leads	On-going – in tandem with Compassion in care and skills project	Clear sets of fundamental standards in each service, backed by evidence. Where fundamental standards of care are being breached firm action will be taken until resolved.	Develop standards which demonstrate we want to exceed expectations and go beyond providing basic care. Achieve Exemplar Team status as outlined in the Quality Strategy
	Trust Learning from Experience (CLIPS) group established	CLIPS groups in place at Trust level and also at service level across divisions	CLIPS groups established in divisions to ensure learning from complaints/ incidents Learning from Experience Newsletter developed	Completed Completed	Clear examples demonstrated of improving practice following an incident or complaint.	Trust Quality Objectives for 2014/15 developed based on clear understanding of lessons learned form this year
	Never events reported and investigated as part of SI policy	On-going	Bespoke 'Never Events' developed within the Trust and targets set for reduction	Outstanding action	All Trust Never Events reported, investigated and lessons learned	Trust Never Events substantially reduced within the year.

4. ENSURING ROBUST ACCOUNT-ABILITY All actions this line cross ref to Keogh 4 / 5	Board Assurance Framework and Risks registers in place and reviewed by internal auditors	Completed	Board Assurance Framework and Corporate Risk Register regularly reviewed to ensure actions are being taken to reduce risks.	Completed	Accountability framework for managers to be devised with clear outcomes for actions when things go wrong. Cross refs to Berwick 9 / 10	Risk Registers and Board Assurance Framework together with Accountability Framework for Managers demonstrating clear lines of assurance and accountability.
	Medical Director and Chief Nurse complete weekly Quality Rounds. All NEDs and Executive Directors regularly undertake visits to clinical areas.	Log of NEDS visit being collated Chief Nurse "Clinical Fridays" on-going.	Strategy for all executive directors and NEDs clinical engagement agreed including plan for feedback and action	Partial – needs dissemination within Trust "Clinical Fridays" implement in January	Leaders at all levels to have agreed objectives with regard to engaging with patients (e.g. back to the floor activities). Cross Refs to Keogh 8	All staff (with the exception of some administrative posts) visit a clinical area and talk with at least one patient and members of staff at least once a week.
Actions this line cross ref to Cavendish 1 / 2 / 3	Some Healthcare Assistants have clear competency frameworks in place. Staff are referred to regulatory, professional bodies where appropriate. Re-validation process commenced for Doctors	On-going On-going as necessary. Process in place	Road shows to increase profile and understanding of fitness for practice requirements HCA competencies re-defined and discussed with staff. Doctors revalidation process continued	Outstanding action On-going On-going	Trust regulatory regime in place for all patient/client facing groups HCA competencies introduced, together with training and monitoring system - Cross ref to Cavendish 14 / 15 Berwick 9 / 10	Barring systems especially in relation to HCAs to be explicit Triggers for referral to professional regulators to be made explicit Year One Doctors revalidations complete. Prior to introduction of a national scheme of RN revalidation ensure that all RNs have support to be up-to-date and fit for purpose
	Questions asked to all staff regarding their specific values.	Completed.	All recruitment to patient/client facing positions to include a "values" assessment of the candidate Cross ref to Cavendish 6	Completed	Audit of recruitment processes demonstrate values questions asked and marry with Trust values. One culture campaign fully implemented with trust values understood by all staff	Work with HEI providers to ensure standards for pre-registration education have an emphasis on care and compassion. Cross refs to Cavendish 7 Staff demonstrate in the Staff survey high levels of understanding and commitment to Trust values.

5. ENSURING STAFF ARE TRAINED AND MOTIVATED Actions this line cross ref to Berwick 1 / 2 Keogh 5	Nursing supervisory ward managers (Band 7 Sisters appointed for in-patient areas in Barnet) in place District Nursing team leaders currently have 50% clinical caseloads Professional Leads attend monthly Clinical Reference Group Francis Listening Events well attended by staff	Ongoing implementation In place. part of Capacity and Demand project. On-going (good attendance) Completed	Review Trust Learning and Development Strategy to ensure training provided for staff meets patient need. Continue with staff listening events every month. Cross refs to Berwick 1 / 2 / 6	Outstanding action for new Dep Chief Nurse (education) Completed	Stronger voice for clinical staff expressed through a clinical leadership forum/ compassion council in each Division (? profession specific) Cross ref Keogh 7 / 8	Leadership development programme reviewed and developed. Fit for purpose learning and development activities well attended. Talent drawn from the clinical professions into management of the Trust where possible
Actions this line cross ref to Cavendish 1 /2/ 3 / 10 / 13	Competency framework established for support staff including record keeping, customer care, communication, confidentiality alongside clinical competencies. Generic JDs and PSs for bands 3 and 4.	Ongoing review of Competencies.	50% of band 3 staff (where needed) will have completed or are enrolled on a QCF	Partial – actual % not known	Continue work Pan-London to develop consistent bands 1-4 development alongside NHS London. Trust representation in bands 1-4 development group, with Bucks New University and London South Bank University	HCA workforce demonstrate high levels of skill and are receiving appropriate levels of training and supervision.
Actions cross ref to all Cavendish recommendations	Participation in the Cavendish Review.	Review considered				Respond to Cavendish Review
	Discussions underway with City University re commencement of Compassion in Care project.	Completed	Commence Compassion in Care project with City University (Barnet in-patient facilities)	Completed -	Full implementation of the national 6Cs (CNO campaign)	Implement and embed the principles in the 6Cs and demonstrate progress through Trust wide audit.
	Some staff have had specific dementia, mental health and learning disabilities training but this has not been undertaken consistently across the Trust.	Ongoing	Increase dementia, mental health and learning disability training and awareness to all staff working with vulnerable patients. Further develop the Trust Strategy for the Care of Vulnerable Adults based on new national guidance.	Outstanding action On-going	Complete a specific audit of dementia, mental health and learning disability care across the Trust based on recommendations from national strategies and guidance.	Work with HEIs to provide high quality clinical placements for students in relation to elderly, frail patients. Audit implementation of the Vulnerable Adults policy and review any associated incidents or complaints. Integrated roles developed between health and social care, in line with commissioning intentions and with a view of providing seamless transition of care