# CLCH
# QUALITY ACCOUNT 2014/15

## Voices of our patients...

Central London Community Healthcare NHS
NHS Trust

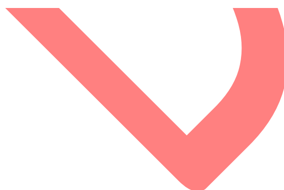
Barnet | Hammersmith and Fulham | Kensington and Chelsea | Westminster

"I found it useful to have someone to ask questions to, who made me feel comfortable and gave me the time I needed for the questions I was asking. At no point did I feel rushed."
**Community Nursing, CHD**

"I would say that the service should just carry on as it is, because it's working. I can't tell you how much it's helped me. I couldn't see the wood for the trees before coming here... [but] I felt like I wasn't being judged"
**Psychological Therapies, APCS**

"When I come here I get so much attention, and it's a treat to come... I am now walking about in my house without my walking stick, which I have never done, so that's a big improvement"
**Barnet COPD Service, BCSS**

"I feel like I've been having a top service. [CLCH staff] came one day, ordered the things, and they were here the next day. Then they said they didn't know how long the physiotherapist would take but she came within 2 weeks... Remarkable!"
**Community Independence Services, NCNR**



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## 1. ABOUT OUR QUALITY ACCOUNT 2014/15

Welcome to the Central London Community Healthcare NHS Trust (CLCH) Quality Account for 2014/15. 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 a number of patient stories this year explaining the impact of our care on their lives.

### 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?

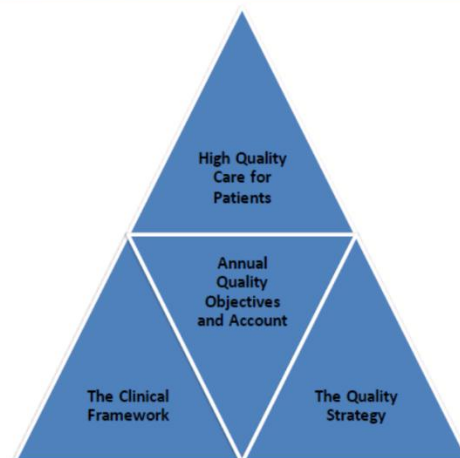
CLCH is a community healthcare provider, providing healthcare to people in their homes and the local community and therefore we are statutorily required to publish a Quality Account.

### 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 (2014/15) and to identify where we could improve over the next year, and we have defined six main priorities for improvement.

### Developing the Quality Priorities 2015/16

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 commissioners 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 2015/16. Our clinical framework, quality strategy and quality account fit together, the clinical framework is our overarching direction, our quality strategy is a 3 year plan and our quality account is annual setting our quality priorities to compliment our strategy.



**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 **communications@clch.nhs.uk** or telephone **020 7798 1420**

## 2. ABOUT CLCH

We provide health care in people's own home and in over 400 community settings including GP Practices, school and early years' centres.

**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.
- 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 please visit our website www.clch.nhs.uk

*insert CLCH map here*

## 3. STATEMENTS

### CHIEF EXECUTIVE'S STATEMENT

I am pleased to present the quality account for the year ending March 2015; it has been a busy year for CLCH especially as we were preparing for our CQC inspection which took place in April 2015.

We welcomed the opportunity to highlight the work our clinical services deliver; during the three day visit the CQC inspected our four core services:

1. Community health services for adults
2. Community health services for children, young people and families
3. Community health inpatient services
4. Community end of life care

Another exceptional event occupying us this year has been the switch over from Rio to SystmOne being completed in Adult Services, walk in and urgent care centres. I was encouraged to hear, in two recent sessions I had with community nursing staff in Westminster and Hammersmith & Fulham, that they were already experiencing some of the benefits of the new system – saving them time in entering data and in interacting with key partners, particularly GPs.

SystmOne is a significant step forward towards our patients having a single care record and joint care plans for our patients to enable more positive multi -disciplinary working. I look forward to the summer when we will have completed to roll out to all the remaining services in the Trust.

This year we have rolled out a number of projects and initiatives to improve quality which our outlined in section 4.3 of the account. I would like to extend my thanks to our users, memebrs of the public and staff who played a significant role in making these such a success.

I'm also pleased to report that this year's audit of clinical record keeping has shown a clear improvement over what was already considered a good performance last year. Keeping up-to-date and accurate records is one of the hallmarks of a good professional and is vital for safe and effective patient care. Good record keeping is also essential in demonstrating that we are delivering our contractual requirements. Whilst we can be encouraged by the progress we have made in this area, we must all continue to work to create timely, accurate records within our teams.

In the next 18 months we will  undergo a range of different assessments by the Trust Development Agency and Monitor. Also crucial to our success will be continued support from commissioners for our plans.

***I confirm that the information contained in this document is an accurate reflection of our performance for the period covered by the report.***

*Electronic signature to be inserted*

James Reilly, Chief Executive

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**STATEMENT OF THE CHAIR OF THE QUALITY COMMITTEE**

2014 saw the introduction of the Associate Director of Quality posts in each clinical division, The purpose of this role is to provide leadership within the division in order to ensure and consistently develop a high quality efficient service for patients and service users. The post holders support the Divisional Directors to deliver the quality agenda.

The Trust Quality Committee has continued to review progress against both our quality strategy and our quality account and we have made improvements in a number of areas including:

- a reduction in medication errors that caused harm,
- a reduction in falls that caused harm,
- the proportion of patients who rated their care as excellent or good increased,

We continued to concentrate of the reduction of pressure ulcers in the community and the committee reviewed a no. of actions that the Chief Nurse and her team have put in place this year to reduce the overall incidence – this includes working with other providers of care to support their education and knowledge regarding pressure damage.

We also had our external Monitor quality governance assurance framework (QGAF) assessment in September 2014 as part of the application for Foundation Trust status. The Trust was required to achieve a score of 3.5 in the assessment. I'm pleased to say that the external assessment scored the Trust as 3.0.

In 2015/16 the Quality Committee will continue to monitor progress against the objectives set in year three of the Quality Strategy as well as developing our new Three Year Quality Strategy (2016/17 - 2019/20).

*Electronic signature to be inserted*

*Julia Bond, Non-Executive Director, Chair: Quality Committee*

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**PATIENT STORY - Continuing Care Team**

Patient X is a 3 year old boy with a congenital condition. He lives with his parents and older sister. This is his mother's story.

`My son was born in 2011. He was in hospital for about ten months. I was introduced to the Continuing Care Team just before I was due to go home. I was introduced to C first. She came to meet my son and she introduced me to the Health Visitor. C also gave me a rough idea of how things would be when my son came home.

My son was supposed to come home and then it was delayed for a month or a month and a half. Before he came home what I found helpful was that C came to the house. X came home on oxygen, so she helped me with the oxygen, the feeding pump and everything that we needed to know about bringing him home, so that made it quite easy. She came a few times before he came home to help me set things up. C helped with his discharge home, with a couple of nurses from the Whittington Hospital, so that was helpful.

When he came home at ten months we did have a lot of help from the carers, because I have another child, a daughter and she needed to be taken to school. X was very susceptible to the bad weather and we had to be very careful with him. There were also very few people who actually look after him, so we had help from the community.

Whenever I needed anything I would call C and she would get what I needed, whether it was things for the suction machine or anything to do with his feed. Gradually, as he got older, I was introduced to the Dietician, the Paediatrician, Speech and Language Therapist and Physiotherapist, so there were a lot of people in the community who played a big role. As he got older he got stronger. Since he turned one and a half or so we don't have carers because we are more used to what happens and how to take care of him. Most of the time people are available for advice. For example when he has problems with his stoma I have called for help. The nurses, physios and dieticians are quite easy to reach for advice but it would be great if people were available at weekends as well.

Other than that, the team has been very helpful. My son got to know and like the carers. It was good having them around and it was really helpful at a crucial time for us. C is still always around if we need anything, whether it was help getting him to nursery, which he now attends, or advice when we needed to get things rolling.'

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## 4. LOOKING BACK - QUALITY IN 2014-15

### 4.1 Progress against our Quality 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 along with clear three year objectives, to focus the quality improvements the Trust wished to make. The three campaigns were:

- Campaign one: Positive patient experience;
- Campaign two: Preventing harm;
- Campaign three: Smart, effective care

Each of the campaigns was divided into two key components; gathering feedback and improving services, and all have clear high level vision statements of where we aim to be as a Trust in year one, two and three.

For year 2 (2014/15) the **Quality Strategy** objectives were as follows:

**QUALITY STRATEGY CAMPAIGN: Positive Patient Experience**

**Objective**
Teams analyse the data from their reports and are able to demonstrate simple, effective action plans to improve the patient experience.

**Progress**
Feedback and data is collated by our team of Patient Experience Facilitators into a monthly Divisional and Clinical Business Unit report. The report is presented at monthly quality meetings and each team can use any of this data to develop local action plans.

In some areas we have introduced 'You said – We did' type boards to show what patients have told us and the changes we are making if necessary. We also learn from positive feedback and make sure we capture compliments to boost staff morale. The monthly patient experience report, collated by the patient experience team, includes a section on 'You said – We did' to share best practice and capture the changes and improvements.

Examples of the many improvements from what patients told us (*You Said)* included the following:

- Training has been implemented for night staff within the district nursing team to ensure that they have the required skills
- The process for cancelling a rehabilitation clinic was tightened to ensure it does not happen unless absolutely necessary.
- The Falls CLCH transport contract was re-negotiated with an alternative provider to ensure there was sufficient support to assists clients to get on and off the transport vehicle safely.
- Magazines and a water machine were provided at Edgeware hospital

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**Objective**

Each Division will be able to demonstrate improvements in the patient experience based on the achievement of their objectives.

**Progress**

Each Division has a Quality Committee structure in place where each of the indicators or quality is discussed. Managers review the feedback they have received, from all the sources including patient stories, 15 step Challenge visits, patient focus groups, and discuss the improvements they have put in place as a result. The Trust Patient Experience Group monitors divisional progress against engagement plans. Additionally there are in depth reports from the divisions at every meeting.

**Objective**

Each individual member of staff will be able to demonstrate at least one improvement they have made to their patients'' experience.

**Progress**

Each member of staff will discuss service improvements they have been involved in throughout the year, and in summary at their annual staff appraisal.

The appraisal process requires each person to review their contribution to the Trust values and specifically asks the question: *'I use best practice and feedback to innovate and constantly improve my service'*. This rating against this question will inform the overall performance rating for that year.

**Objective**

There will be a 10% (against 2012/13 data) reduction in complaints and incidents relating to poor communication and attitude.

**Progress**

In 2012/13 the Trust received 44 complaints regarding communication/staff attitude which reduced to 29 complaints for the 2014/15. This represents a decrease of 34.1% for complaints regarding communication/staff attitude and so this target was met.

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**PATIENT STORY- District Nursing**

`I am 56 years old and have been receiving District Nursing care for over 2 years. I've always been extremely happy with the care I receive from the District Nurses and feel that they go out of their way for me. I'm visited twice a day to help me with my Nebulisers. On every occasion I feel like I'm respected and treated as an individual. The Nurses are always very kind, considerate and compassionate and always communicate with me very well. They always explain what they are doing and ensure that I understand what is happening. Often the District Nurses will pop down to the shops for me and take my rubbish down to save me having to walk down a flight of stairs. They always ensure that I have everything I need before they leave and often make me a drink and sandwich. It's very easy to contact the District Nurses (DNs) though I haven't had to very often. In the past I've left a message and been called back within 30 minutes. Sometimes I think it's a shame when people leave – I don't like high turnover or when I get used to someone, and then they're gone. The nurses who see me though are so professional and pleasant. They are happy to refer me to other services in the community and suggest ways in which I can be supported. I can't really fault the DNs and I'm very happy with the service I receive'.

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**QUALITY STRATEGY CAMPAIGN - Preventing Harm**

**Objective**
Risk registers will be mature and will be used as a service improvement tool from team level to board and teams will be able to demonstrate service improvements based on analysis of risk factors.

**Progress**
Risk registers are discussed at all levels of the organization and there is a comprehensive system of reporting risks upwards and ultimately to the board as appropriate. The registers have been in place for several years and are embedded throughout CLCH.

Using the registers has led to improvements for example in information technology (IT) at school nursing and 0-19 service at Normand Croft School This was the case as the register picked up ongoing issues around connectivity and staff ability to use the IT to access patient records. Another example was the issue of faulty call bells at Jade and Marjorie Warren wards. Using the register highlighted the issue; the risk was referred up through the governance structure leading to a new system being introduced.

**Objective**
95% of incidents will be reviewed by the handler within 7 days, 100% within 14 days.

**Progress**
This target was partially achieved with 91.4% incidents reviewed by the handler in 7 days and 99.6% within 14 days.

**Objective**
Level of harm is reduced by 20% (against 2012/13 data).

**Progress**
This was only partially achieved as the level of harm was reduced against 2013 data by c.15%.

**Objective**
Incidents reported with no harm increased by 20% (against 2012/13 data).

**Progress**
This was fully achieved with the number of no harm incidents increased by 51%. In 2013 40.8% of incidents were no harm and in 2014/14 54.5% were no harm.

**Objective**
Being Open (Duty of Candour) contractual requirements to be achieved for all incidents directly affecting patients where the harm was moderate or above. All serious incident reports will be completed and returned to the commissioners within the required timescales (currently 45 /60 days)

**Progress**

**(AW DATA) – full reporting on compliance available May 2015**

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**Objective**

The trust will continue to meet the 100% data collection target for the NHS Safety Thermometer.

**Progress**

This target has been met. Of the teams that participate in the NHS Safety Thermometer, there has been a 100% collection of the data.

**Objective**

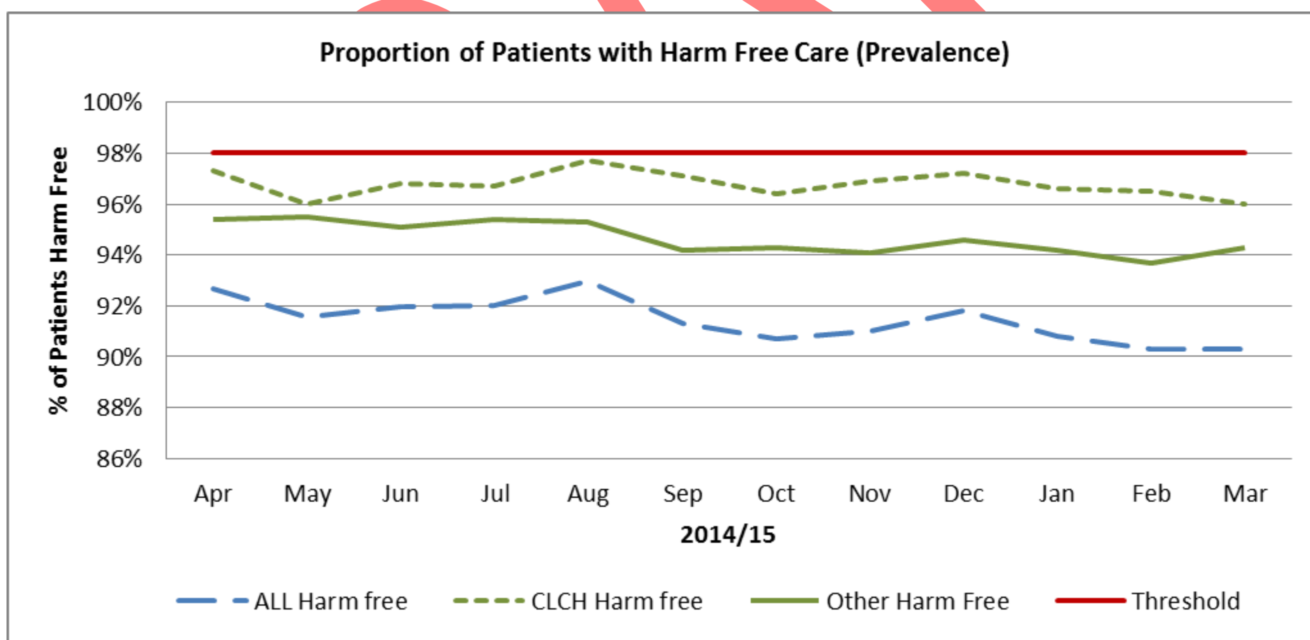
There will be a 40% reduction in harm against all 4 areas (as measured by NHS Safety Thermometer) (against 2012/13 data).

The NHS safety thermometer is a national prevalence survey. On one, nationally determined, day each month all relevant patients in the Trust are reviewed to determine if they have suffered any harm as a result of their healthcare. The categories include pressure ulcers, falls, catheter associated urinary tract infections (CAUTIs) and venous thromboembolism (VTE). The data is collected by the nursing staff caring for patients on that day and fed back to a national data base which is used for comparison and benchmarking. All data is presented at www.safetythermometer.nhs.uk as well as being used locally for quality improvement. A national target has been set that 96% of patients should be harm free; this applies to the overall scores and the individual categories.

**Progress**

Our prevalence of harms as measured by the NHS safety Thermometer was 96.75% harm free against the national threshold of 96%. We narrowly missed the Trust target to have 98% harm free care.

The following shows our rate of new harms (those caused under our care), All harms (all patients in our care) and the national average for harm free care.



**PATIENT STORY– Homeless Outreach Team**

`I met the Homeless Outreach Team and they told me about all of the services they have here. That was 14 years ago. The services here helped me. I volunteer here now.

The health team have always been very helpful. It's good to have a good receptionist who comes out and gets everyone's names. They get on with the guys, and the nurses have always been more than helpful here. I think it's a good service compared to going to an outside service, like a normal surgery. When you're homeless, I found that other services look down their nose at you. The medical staff here are very understanding of homelessness, and I think that's what places like this need. In other surgeries I've felt that people are thinking "you're homeless, why are you in my surgery?"

I've used the service a lot over the years. They keep monitoring my health problems. They wait for me to get in touch with them but might ask me to come back in a few days or something. If something needs to be followed up, they remember and will walk down the passageway and see you, and they might say "What's happened? Any progress?" They help me physically and emotionally.

You get your name down on a list if you want to see a nurse or doctor that day. It's done fairly. I do think that sometimes people expect miracles, and want to see a doctor and they want to see them now, but it's not a doctor's surgery; they get here at specific times when they're due, then you have to wait. The doctors I've seen here have been fine and I'm fine with waiting.

I believe that I'm part of the decision making myself. They're not saying "this is what you need to do". They just advise you. They keep me involved with what is happening, and they'll always go to somebody else and ask if they don't know the answer to something.

I think it breaks down barriers with the clients here, that the medical staff walk up and down and people can ask them questions. Even though the receptionist walks up and down and asks who wants to see the nurse, if the nurse is visual, and they see that the nurse is there, they may be more likely to say 'can I see you?' than talking to somebody coming round with a clipboard.

I've never worried about anything I've seen. I just think that everything needs to be more accessible. There are no notices for where the medical team is. Hopefully when the refurbishment work is finished this'll be better and there'll be more signs showing where everything is'.

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**QUALITY STRATEGY CAMPAIGN – Smart Effective Care**

**Objective**

There is a NICE programme in place to identify new NICE clinical guidance and ensure services are reviewing and adopting those that are relevant.

The process measures are;

*100% of NICE guidance is assessed by a multi-disciplinary team.*

*80% of services have completed the assessment of relevant guidance.*

**Progress**

During 2014/15 NICE guidance was reviewed systematically for relevance through the NICE Core Group meetings, chaired by the Medical Director and consisting of a panel of quality and professional clinical leads. Specialty teams have been tasked with reviewing the guidance and implementing where appropriate.

The NICE process and policy has been reviewed and redesigned during 2014/15, and as a result quantitative recording measures were established.

**Objective**

A Clinical audit programme will be in place to ensure all services are conducting regular reviews of clinical practice. Additionally, stringent monitoring processes are in place to track progress of clinical audits.

The process measures are;

*100% of agreed audits are completed annually*

*100% of audits have SMART action plans*

**Progress**

The Trust has achieved a compliance level of 72% ('*moderate assurance*') with regard to clinical audits in 2014/15. The audit programme opened with 58 audits at the beginning of the year, including local, national and Trust-wide audits, and 42 audits were completed. This represents an increase of 9 audits on the previous year.

All audits have an associated action plan and there is an action log where the actions and their completion are monitored.

**Objective**

There is a programme in place to ensure services are measuring the outcomes of their practice and using the data to drive improvement.

The process measures are;

*66% of services have defined a set of 3 or more clinical outcomes, with associated electronic data collection, to monitor the effectiveness of their clinical practice*

**Progress**

- All services have been tasked to identify at least three clinical outcomes to evidence the effectiveness of their clinical interventions. To date 75% have identified 3 clinical outcomes with associated electronic data collection.
- National benchmarks for clinical outcomes in community services are being developed but progress is slow.
- In the absence of nationally agreed metrics, services are testing 'good enough' indicators to enable them to drive improvements in service quality.
- A clinical outcomes reporting system is being developed to allow teams to easily access their outcomes data and to enable effective analysis/interpretation.
- Services will set improvement goals for their service based on current performance.
- Monthly data will be reported back to clinical teams, operational managers and assurance groups enabling ongoing monitoring of clinical effectiveness and evaluation of improvement efforts.

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- As nationally agreed metrics are developed, they will be incorporated into the local frameworks.

**PATIENT STORY– Dietetics services**

`It started off when my son was 2-3 months when he started having reflux and in the afternoon he was having cramps and feeling unsettled. I was breastfeeding at the time. I went to the GP and he referred me to see the dietician. And then what I started to do myself was, I read about things on the internet- the causes for reflux and one of the reasons was dairy. I don't have much dairy anyway, but I cut it out completely and it got a lot better. The dietician said it was important that I am taking calcium myself, especially when I started weaning, I really needed the support.

When he was 5 months old my son had another episode because my daughter put some food into his mouth, it was something dairy. And he started to get this mad rash on his face which proved to me that he is intolerant. The dietician had given me some formula to try. I continued to breastfeed longer than usual. And they really supported me through the weaning process.

I somehow felt during this, that he was not as sensitive anymore and I was keen on giving him some dairy products. And then we thought let's see if we can try and reintroduce the foods and she gave me a good guideline of what sort of foods to try first. And he was tolerating it all fine. She taught me how to try things and what time to. And she explained how other foods can cause a reaction like soya and fish. And she was giving me lots of advice on paper. I didn't know what the typical foods were that cause allergy, because my other child was normal. And she said it could happen with other things, which she explained to me well.

I saw the dietician about 4-5 times. I saw her every two months. And that was really useful. I didn't think I needed to see her more than that because in my case, it wasn't that serious. And she timed it perfectly so she saw me just before weaning and then after. At the times it was important for me to get the support. The overall booking process was good. The GP referred me and then someone called from the centre, it was all really straight forward. I had a choice in what times I wanted to see the dietician. If someone else has a similar case to ours, I would recommend your service'.

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## 4.2 OUR QUALITY IMPROVEMENTS 2014/15 - QUALITY ACCOUNT PRIORITIES

This section describes how we performed against the six quality priorities we set ourselves last year. Where we have not achieved a priority we will continue to progress this work into the coming year. Where we have achieved a priority we will continue to monitor progress in order to ensure improvements are sustained.

### QUALITY ACCOUNT PRIORITY – Positive Patient Experience

Our priorities for improving the patient experience in 2014/15 were:

**Priority: We will improve user involvement and participation in developing and improving services at the trust**

**Progress:**
Listening to our patients is vital for us to improve services so ensure our staff encourage patients and service users to provide feedback on a regular basis. We are very keen that we use a wide variety of other methods to get feedback, rather than just surveys. We also collect patient stories, where we can hear the real experiences of individuals that we care for, within our teams. Teams have the ability to look up patient experience feedback data through the Trust's intranet and use this to improve the patient experience.

We also carry out 15 Step Challenge visits to services. The 15 Step Challenge team, including Non-Executive Directors, Directors and patient representatives, will visit a service and explore the quality of care under four categories; Is the service well prepared, do patients feel safe and cared for, are patients and carers involved, and is there good communication? They use structured questions and talk to patients but are focused on 'First Impressions'.

To further understand patient views, some services also run patient groups. This can give us much richer feedback. It is so important that we also learn from when things have not gone well, through complaints and any feedback through the PALs service. People need to know that we have listened, responded and made changes as a result.

CLCH wants to hear from all our service users and their about any concerns you they have as well as ideas as to how we can shape our services going forward. To do this we developed a programme of *Listening Events*, these were held in all four Boroughs starting in February 2015. Additionally CLCH has signed up to the national campaign '*Sign up to Safety'* where we have joined a range of acute and community trusts to 'establish and deliver a single vision for the whole NHS to become the safest healthcare system in the world'. Our approach to this campaign is rooted in involvment and participation. Amongst other things, the events in February 2015 were designed for patients, members and the public to advise us on the best ways to communicate messages about safety.

The Trust holds a Quality Stakeholder Reference Group where patients and representatives meet regularly throughout the year to help us test new ideas, develop new methods and learn from feedback. The group and its members are a vital source of feedback and guidance to develop and improve our services.

Each Clinical Business Unit has developed their own Engagement Plan to ensure that CLCH is involving patients, members and the public in improving services across the trust. We are pleased that involvement and participation is being developed in local services and look to continue this next year.

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**Priority: All services will actively use patient feedback for improvement, including using new feedback through the Family and Friends Test (FFT).**

**Progress:**

The FFT asks the question: *How likely are you to recommend our service to friends and family if they needed similar care or treatment?*

Each service has the ability to seek feedback from their patients using a Patient Reported Experience Measure (PREM) Survey. Each service can decide how they go about this and some services are using a kiosk, a tablet device, or a paper survey. In addition to this we carry out a sample (800) of telephone surveys every month from patients across the whole trust. The FFT question is asked of our patients and the results are collated with all our other feedback, and presented to our Divisions and Business Units. 75 of our services have provided PREMs feedback, including the Friends and Family Test question, with 15,762 surveys being completed between March 2014 and February 2015. The majority of these (10,021) were collected via telephone interviews with patients.

The results of this feedback show that 80% of patients would be extremely likely or likely to recommend our services to friends or family members, with 91% of patients rating their care as excellent or good. 96% of people felt they were treated with dignity and respect (February 2015). Most positive comments received were about our staff, and the treatment, care and efficiency of the service. Most negative comments were about waiting times.

**PATIENT STORY – STOMA NURSES**

`I was temporarily in the care of District Nurses post-operatively before hand over to stoma nurses. The hand over process was smooth and hassle-free. Everyone involved seemed fully aware of past and current medical history. The administrative side of the clinic was very efficient. Patients could always get an appointment in a reasonable timeframe. The issues with the stoma kit were dealt with quickly and compassionately. I was told that even if I did not have an appointment, I should still make contact (with the service) and the stoma nurses will fit me in somewhere.

The stoma nurses were very professional, very kind, warm hearted and very well informed about all matters stoma. The treatment was very much personalised/tailored to them, which helped me relax and have trust in the nurses. The standard of care was uniform and very high, and I felt very fortunate to receive such care. The nurses took personal responsible for me. There were no oversights in the treatment, which was meticulous and precise throughout and I had absolute confidence in the approach taken by the nurses. The service was like a well-oiled machine and there was not a single thing that I could suggest they could do differently'.

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**QUALITY ACCOUNT PRIORITY - Preventing harm**

Our priorities for improving the prevention of harm in 2014/15 were:

**Priority : We will continue to demonstrate an increase in the reporting of incidents across the trust whilst reducing the level of harm caused to patients**

**Progress:**
There was a 12% increase in the total number of incidents reported across the Trust (from 2012/13) but there has been a 15% reduction in the levels of harm. However from 13/14 to 14/15 there was a small reduction in the number of incidents that were reported. We are pleased that overall incident reporting is now embedded throughout CLCH.

**Priority: We will reduce the incidence of medication errors across the Trust by a minimum of 10% (from 177 per annum to 159 or fewer)**

**Progress:**
We achieved this target with the number of medication errors reduced to a total of 93, representing a 49% reduction. Medication errors were recorded last year so that **actual harm** was recorded and not **potential harm** as was the case previously.

**PATIENT STORY– Community Nursing**
`I ended up in hospital after I had a bad chest infection which was affecting my breathing. My oxygen had gone down. I was in hospital for 5 days. It freaked me out being in hospital. I was saying to myself what was I doing in here and it felt like I was having a nightmare.
A gentleman in hospital by the name of Richard was worried about me and I think he set up the nurses to see me at home. The first nurses (*rapid response nurses)* came to see me initially after coming out of hospital and they helped me with oxygen, my diabetes, check me over and checked my chest was alright. They would sit down and talk to me. Make me feel more confident. It was nice and they didn't make me feel rushed. They helped me with my inhaler as well because I was doing it wrong and my breathing since has been better.
Then the virtual ward case manager came to see me and she initially did the same. She would sit down and chat with me. If I had concerns I was able to speak to her about my health. I felt easy around her and she showed that she was concerned about me. She also got the Respiratory Nurses to come and see me at home which was also a help.
I can't complain with this treatment cause I have come out of hospital before and been forgotten. When I had my open heart surgery, it was around a Christmas time and the hospital sent me home with no one. I really lost confidence at that time but now I feel more comfortable coming home since having this service'.

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**QUALITY ACCOUNT PRIORITY – Smart Effective Care**

Our priorities for improving smart effective care in 2014/15 were:

**Priority: 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.**

**Progress:**
All our community nursing teams are now using SystmOne as the main electronic based patient care record. SystmOne is the same electronic care record as our local GP colleagues. This allows us to work within one patient one record, for the benefit of our patients. The progression of SystmOne alongside the use of mobile working devices allows for patient care to be visible in the right place at the right time and accessible to the most appropriate health care professional. This is the first time that patient care provided can be shared between community nurses and general practice in real time. When our community nursing teams have successfully completed delivering patient care, SystmOne allows us to inform general practice immediately of their discharge from our care. The benefit of one patient, one record also ensures that patient's care is not fragmented when e.g. they are discharged from a service, as the care that was successfully delivered is still available for the most appropriate health care professional.

Additionally, Barnet District Nursing (DN) service reconfigured in 2014 in order to organise their work into 3 localities. Each locality is now managed by a clinical locality manager, who is responsible for attending locality General Practice (GP) meetings and for liaising with the GP groups. The realignment confirming which GP practices are attached to each DN team. District nursing team leads attend 'Gold Standard Framework' meetings relating to advances care planning for patients reaching end of life care. GP referrals are sent to a single point (SPA) where triage and allocation to the team occurs. Standardised communication back to the GP following an initial assessment is under development with the implementation of a new clinical recording system.

**Priority: We will ensure that, where national clinical guidelines have been produced by the National Institute for Health and Care Excellence (NICE) which are relevant to the care we provide, we will demonstrate we are using them in everyday practice**

**Progress:**
In order to ensure that the implementation of national clinical guidelines is clinically effective, the trust uses a system of clinical standards, clinical audit and clinical outcomes measurement, as listed below, to ensure that care is safe and effective.

**Clinical standards**

- An evaluation of the clinical standards programme is currently under way. The NICE clinical standards relate directly to the NICE published guidance, which are not always relevant to clinical services at CLCH. Individual clinical teams also use standards which are more relevant to their clinical areas, and these may be produced by their own professional bodies or other recognised national organisations.

**Clinical audit**

- There have been 18 audits of NICE clinical guidelines included in the audit projects in 2014/15.
- The Key Performance Indicators established for 2015/16 include the auditing of two NICE guidelines in each Clinical Business Unit during the course of the year.

**Clinical outcomes**

- All services have been tasked to identify at least three clinical outcomes to evidence the effectiveness of their clinical interventions. To date 75% have identified 3 clinical outcomes with associated electronic data collection.
- National benchmarks for clinical outcomes in community services are being developed

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- In the absence of nationally agreed metrics, services are testing ‘good enough’ indicators to enable them to drive improvements in service quality.
- A clinical outcomes reporting system is being developed to allow teams to easily access their outcomes data and to enable effective analysis/interpretation.
- Services will set improvement goals for their service based on current performance.
- Monthly data will be reported back to clinical teams, operational managers and assurance groups enabling ongoing monitoring of clinical effectiveness and evaluation of improvement efforts.
- As nationally agreed metrics are developed, they will be incorporated into the local frameworks.

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**PATIENT STORY– Primary Care Psychological Health (PCPH)**

`I got to a point where I wasn't in a great place at all. It's just not like me to think about getting help, and it was probes from my mum and dad and family and friends saying that something's not quite right that made me go to my GP. I felt that I needed something extra. I had got to a point where I felt I couldn't even control my own emotions, and found it difficult to decide what was right and what was wrong. I needed some sort of support and I knew that my family couldn't help me with that, so I needed someone outside the box who I could talk to freely about how things have been. That's why I said yes to being referred, and came here. The GP suggested that I had a referral and that I should take some medication, but I refused the medication.

I had no idea at all what it would be like here [PCPH] and what to expect. I knew I'd be talking to someone about my problems. I didn't realise that there'd be different aspects of the meetings that would be able to point me in the right direction, not having had any counselling or self-help sessions before.

I had a phone call from the service before I started my sessions. I think it was really fair and right to have that. I think it was a stepping stone to suddenly coming here and talking to somebody. I think it was really helpful to speak to someone initially about my problem and having a designated time for it as well, rather than someone just ringing me at any point in the day; having an actual slot to raise concerns about how I had been feeling, as I could then have a list in front of me of things that I needed to say that I thought needed to be picked up on. It was very clear who I was talking to on the phone and they made their role clear. I never felt that I was rushed or needed to stop talking – 100%. I spilled a whole load of information about everything, and we worked together about which direction would probably be the best to go down. [The triager] gave me the options and we worked out that low intensity cognitive behavioural therapy (CBT) would be probably the best.

To a certain extent, seeking support was quite daunting at first because I've never needed support. Even my physical health has always been brilliant. I have a sister who has all the support in the world, and me being the one who needs a little bit of help has been a bit bizarre, so actually having that initial conversation about what it involves really helped.

I don't think I'd change anything about the service. I think it's really good to have the first telephone appointment because then you can determine what's best for that person, and the first face to face session was more about me just talking about my issues. That helps the practitioner understand what I'm talking about.

When I begin talking I can think of loads of things to say because I think so much, but I've never felt overly restricted as I know that we can talk about it more next session if we don't have the time. I think the sessions have taken the right length of time for me too, so that's ok. It's been really helpful having someone to talk to about things, and I wouldn't have been able to talk to anyone at home about half the stuff I've been able to talk about, just because I wouldn't want to upset anyone or feel a burden so it's been really helpful having a set time to bring up things. It's been really good and very supportive'.

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### 4.3 TRUST QUALITY PROJECTS AND INITIATIVES

**Achieving Excellence Together**

Five groups have been established to take forward the Achieving Excellence Together Campaign which focusses on improving the morale of staff and the quality of care within our district nursing teams. Each group has a range of representation and is taking forward a plan focussed on the following themes; staff morale, recruitment and retention, competence of staff and confident in their role, community nursing models and clinical leadership. The progress of each group is reported to our steering group which meets every 2 months

**Compassion in Care**

The Compassion in Care project aims to promote dignified and compassionate care through appreciative, evidence-based, and relationship-centred-methods that focus on making a difference to the lived experience of service users and carers (both paid and unpaid). The Project Lead is working directly with frontline staff, in a range of different clinical contexts, to support local change projects, that promote the 6Cs (care, compassion, competence, communication, courage and commitment) in line with the NHS England Compassion in Practice vision and strategy (http://www.6cs.england.nhs.uk/pg/dashboard). She is also taking a whole systems approach to ensure compassionate care is embedded across the whole of CLCH.

Examples of outcomes achieved include:

- Appointment of a Compassion in Care Co-ordinator to lead transformational change across the Trust using appreciative, evidence-based and relationship-centred approaches that are focused on making a difference.
- Development of 50 named Compassion in Care Champions (CCCs) who are actively engaged in implementing and evaluating local Compassion in Care change projects at CLCH, across all of the Trust.
- Attracting the interest of senior staff from the Department of the Health who visited the Trust in November 2013 and again in May 2014. In particular, they were interested in the Compassion in Care Compass Model and the development of evidence-based outcomes to measure success in compassionate care.
- A visit by Jane Cummings (Chief Nurse for England) visited the Trust on International Nurses' Day (12th May 2014) as a guest speaker at a celebratory event where many Compassion in Care Champions (CCCs) presented their various projects, and where she presented the CCCs with awards for their work.

**End of Life Care**

CLCH is committed to the delivery of high quality, compassionate care and the involvement and engagement of all key stakeholders in decisions about end of life care. Our End of Life Care Strategy (2015-2018), through the End of Life Care Model of Care and work programmes aims to ensure the continued delivery of holistic, competent, compassionate care for the dying and their families regardless of where they are cared for. It includes the provision of end of life care for children and adults with any advanced, progressive or chronic illness regardless of diagnosis.

In order to achieve the aims of the Strategy the Adults work programme will focus on six objectives as follows:

- High quality, relationship centred, compassionate care
- Advanced care planning/risk stratification
- Assessment and care planning
- Symptom management, comfort and well being
- Support for families including bereavement care
- Education and training

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**Sign up to Safety -** Central London Community Healthcare Trust's Sign up to Safety Plan 2014 - 2018

**The aim of the trust's service improvement plan**

To embed the Sign up to Safety campaign's five pledges (see Appendix 1) into a plan to engage the ambition of staff by identifying the changes in their practice that are required to identify, implement and evaluate one change in their service that will improve its quality.

**Reason for focus on frontline staff engagement**

Historically, the trust's safety campaigns have not affected all of its dispersed and diverse services as they have focussed on the outcome of reducing pressure ulcers, falls, catheter associated UTIs and VTE. It is hoped that by focussing on the process of engagement and learning, this campaign will encompass those services who traditionally have not had involvement in patient safety initiatives and support them to identify and resolve safety issues relevant to their particular context.

**Objectives**

1. To engage a wide range of people in a series of conversations about what can support their leadership for improvement in their service.

2. To offer local champions the opportunity to review, evaluate, develop and share their skills and experience about how to lead improvement projects.

3. To organize resources around the requirements of each project to enable the local leadership of improvement.

4. To gather data to evaluate what works in particular contexts and spread the results throughout the trust, using them specifically to develop the trust wide approach set out here.

5. To align the work of the trust service improvement plan with the wider trust quality improvement initiatives.

The trust has worked hard at developing and implementing its quality strategy and preventing harm campaign. The focus remains on improvement in reporting incidents whilst reducing harm caused to patients. However, the trust wants to continue to learn more about how to intervene to improve things for patients. In particular, how to lead and resource improvements in an organization characterized by geographic spread; diverse service cultures; lead by a variety of professions; in a governance framework that must reflect a range of contractual relationships with commissioners and providers.

The two questions we have asked ourselves developing the service improvement plan are:

1. *If our organisation's quality and safety culture depends on our staff focusing on how they learn about how to improve things for patients and service users; how do we help our local leaders develop their skills to facilitate this learning*
2. *If our current approach to quality and safety does not exhaust what is possible in terms of local leadership, how do we now need to behave, think and organize as the leaders of the SIP project in the Trust?*

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The approach we have designed to guide the set up phase of the service improvement plan is based on practical engagement. Simply put, we will 'reach out' to local champions within services to have a conversation to identify what it is they want to improve; the resources they may need; how they can measure progress; how they wish to report progress centrally; and what they may need from those to whom they report. In having these conversations we will be mindful that some frontline staff will not have had the opportunity to lead service improvement before. It is the reliance on centrally set priorities that we are interested in changing to see if it increases frontline staff engagement and consequently local improvement and spread.

**Support to local projects**

In parallel, we will engage those who have a designated quality and safety role in the trust. We will require the central quality team to explicitly deploy their expertise in support of local leaders; their teams and service users. Key to this work will be the development of local action plans.

**Local action plans**

The local action plans will be developed at the service improvement workshops. Frontline staff will consider the following sorts of questions prior to the workshop:

1. What needs to be different in my service now?
2. What would patients and others notice if I helped make these changes?
3. What needs to be measured and who can help me?
4. What methods are available to present my findings and how would I report this in the clearest manner?
5. Who has a view that I need to take into account?
6. What resources would help me and my team to be successful?
7. What do I need from others?
8. What are the implications for my leadership ability; do I have the right skills, knowledge and experience to achieve what I want to achieve?
9. What could undermine the work and what can I do to reduce this risk?

**Patient Experience**

We will also 'reach out' to patients to discuss how they think their safety could be improved. We will work alongside the patient experience team to achieve this. As part of The Patient and Public Engagement Strategy, listening events were run during February, May and November in each of the boroughs in which CLCH is the primary community care provider: Kensington and Chelsea, Hammersmith and Fulham, Westminster and Barnet. The overarching objectives of these events was to:

1. Share information about health related issues and CLCH
2. Ask what matters to patients most
3. Listen to feedback about what is working well and what could be improved
4. Open up the discussion about health matters and services to as wide an audience as possible to contribute

A link to our listening events for patients and users this year:
http://www.clchlistening.citizenscape.net/core/portal/home

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## 5. LOOKING FORWARD - OUR PRIORITIES FOR IMPROVEMENT 2015/16

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

**Positive Patient Experience**

- We will improve patient engagement in relation to working together in partnership to change/improve quality
- We will work to support a single point of access for patients with long term conditions

**Preventing Harm**

- We will improve service users involvement in service improvement projects and safety campaigns
- We will continue to reduce medication errors in practice

**Smart Effective Care**

- The Trust will work to provide improved information publically for people to be able to make an assessment about how Central London Community Healthcare NHS Trust performs on quality
- We will improve % of relevant NICE clinical guidance that have been assessed by eligible clinical teams

**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 patients, their safety and the effectiveness. The progress on all planned quality improvements will be monitored monthly by the Trust Quality Committee. This committee will report at least quarterly to the Trust Board.

CLCH will continue to involve our service users in monitoring aspects of quality improvement. For example we will continue to involve our service users in the 15 Step Challenge. We will also continue to engage with our service users via the Trust's governance structure and in particular via the Quality, Safety Reference Group (QSRG) and Patient Experience Groups.

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**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 Senior Clinical and Quality Staff 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 Clinical Commissioning Group (CCG) Chairs asking for suggestions to be included in the account and we also reviewed the proposed quality priorities with the Quality Stakeholder Reference Group (QSRG) as part of the consultation on the draft Quality Account.

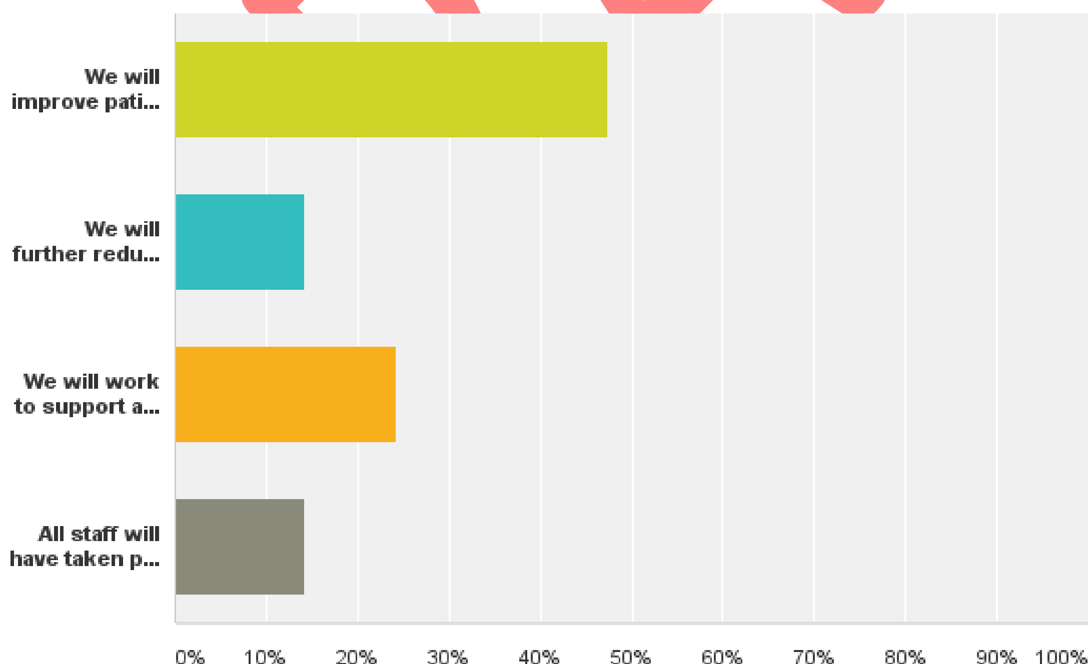
Based on this we chose our list of quality priorities for 2015/16

The following information shows how, following consultation, our proposed quality priorities were ranked by the 104 who responded to our consultation.

**POSITIVE PATIENT EXPERIENCE**

99 people responded to this question

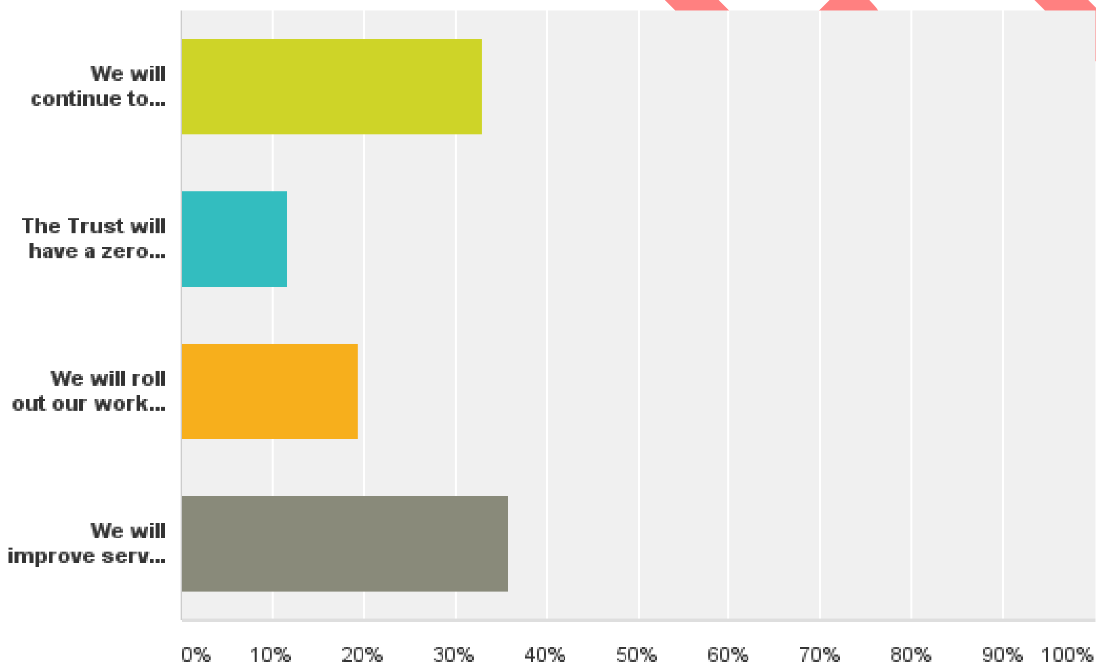
| Answer Choices | Responses | |
|---|---|---|
| We will improve patient engagement in relation to working together in partnership to change/improve quality | **47.47%** | 47 |
| We will further reduce comments, concerns and complaints about staff attitude | **14.14%** | 14 |
| We will work to support a single point of access for patients with long term conditions | **24.24%** | 24 |
| All staff will have taken part in dementia awareness training | **14.14%** | 14 |
| **Total** | | **99** |



**PREVENTING HARM**

103 people responded to this question

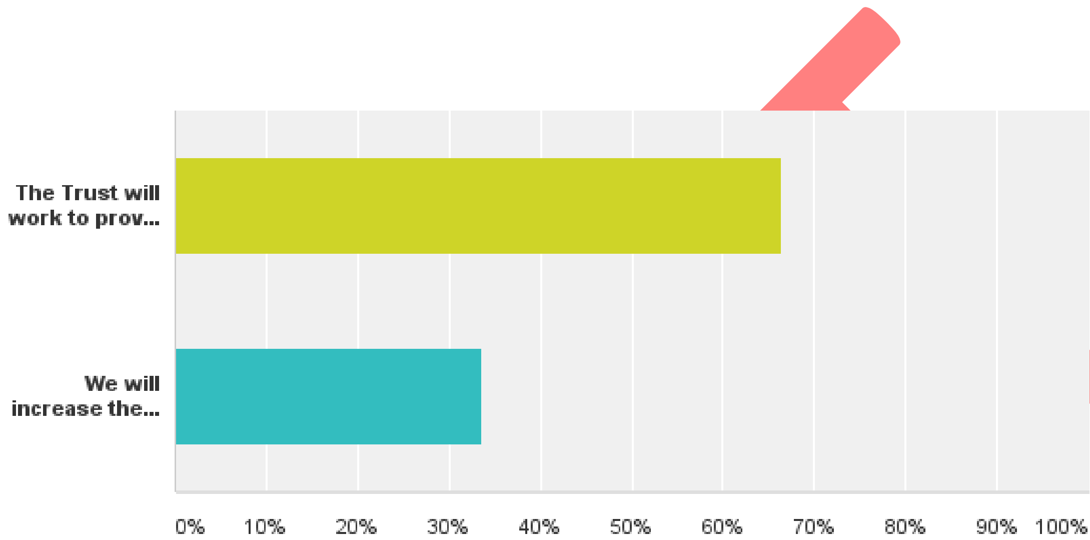
| Answer Choices | Responses | |
|---|---|---|
| We will continue to reduce medication errors in practice | 33.01% | 34 |
| The Trust will have a zero tolerance target for immunisation errors | 11.65% | 12 |
| We will roll out our work on the national sign up to safety campaign implementing safety improvement plans click here | 19.42% | 20 |
| We will improve service users involvement in service improvement projects and safety campaigns | 35.92% | 37 |
| **Total** | | **103** |



**SMART EFFECTIVE CARE**

98 people responded to this question

| Answer Choices | Responses | |
|---|---|---|
| The Trust will work to provide improved information publicly for people to be able to make an assessment about how Central London Community Healthcare NHS Trust performs on quality | 66.33% | 65 |
| We will increase the number of relevant NICE clinical guidance that has been assessed by eligible clinical teams | 33.67% | 33 |
| **Total** | | **98** |

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**PATIENT STORY - PODIATRY**

`Today I came to see the biomechanics specialist to whom I was referred by another podiatrist. I have some problems with the skin on my feet and various [foot pains] that I had been to see my GP about and that's how I was originally referred. Because I didn't know anything about podiatry before I came, I admit I was a bit sceptical as I didn't really understand was you did and how you could help but now that I've had my appointment I feel it was worthwhile and very interesting. Now that my treatment plan has got started I'm very confident that it will help my [foot pains] and that the situation is in hand.

With regards to booking my appointments, compared to my recent experience, which was awful, I'd say that this is a model service, my best NHS experience so far. I was seen punctually without any problems.

My only slight negative is that I'd like to know more about the findings and thinking around my biomechanical assessment. Today the specialist had a student with her, which she asked about if this was okay and I didn't mind at-all, and when they were analysing the way I walked I could hear the specialist explaining things to the student. I understood that this was part of the teaching process but I was interested to know more about what they were seeing. It wasn't a big deal, I'm just very intrigued.

I really am very happy, my only suggestion would be to try and supply a little more information about the biomechanics service before people attend so they know more about what to expect. Maybe a leaflet or a web link. I have been prescribed orthotics That I'll need to come back to have fitted so I don't know if all my problems have been solved yet but I'd be happy to talk with you again to continue my experience. Yes, I would certainly recommend this service to my family and friends'.

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## 6. 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 2014/15 and CLCH has not participated in any special reviews or investigations by the CQC during the reporting period.

**Summary of inspections**

During 2014/15 the CQC undertook 3 unannounced inspections at 3 of the trusts registered locations.

**HMP Wormwood Scrubs – Inspection Date: 12th/13th May 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 6 – Co-operating with other providers
Outcome 7 – Safeguarding people who use services from abuse
Outcome 9 – Management of medicines
Outcome 14 – Supporting workers
Outcome 16 – Assessing and monitoring the quality of service provision

**Garside House Nursing Home – Inspection Date: 7th August 2014**

The Trust was found to be meeting the following standards
Outcome 4 – Care and welfare of people who use services
Outcome 16 – Assessing and monitoring the quality of service provision

**Princess Louise Nursing Home – Inspection Date: 16th March 2015**

The report from the inspection has not yet been published.

If you would like further information about the Trust's registration and the CQQ's inspection reports, please see the following website http://www.cqc.org.uk.

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**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 Clinical Commissioning Group (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:

| CQUIN | Goal | Plan TOTAL £ | Forecast 13/14 £ |
|---|---|---|---|
| Friends & family test | Implementation of staff and patient friends and family tests | 191,495 | 191,495 |
| NHS safety thermometer | 25% reduction in prevalence of pressure ulcers, including those acquired within CLCH and those acquired under the care of other providers. | 191,495 | tbc |
| Shared patient record and real time information system | Access to and two way information exchange within a common clinical IT system / shared electronic record between GP & care provider. | 765,837 | 765,837 |
| Improving the emergency care pathway | Reduce emergency patient referrals and re-attendances at hospitals. | 382,918 | 306,335 |
| Improving the planned care pathway | To reduce the number of patients with long term conditions attending hospital through supporting self-management and long term condition management in the community. | 382,918 | 306,335 |
| **INWL TOTAL** | | **1,914,592** | **1,569,965** |

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| Friends & family test | Implementation of the friends and family tests for staff and patients. | 73,913 | 73,913 |
|---|---|---|---|
| NHS safety thermometer | 35% reduction in prevalence of pressure ulcers, including those acquired within CLCH and those acquired under the care of other providers. | 73,913 | tbc |
| Value based commissioning (Long term condition management) | Reduce unplanned admissions into hospital or attendances at A&E for patients over 65 | 177,390 | 177,390 |
| Integrating Care | Increased effectiveness of multidisciplinary meetings, improve patient care using rapid care and integrated care services, improve shared decision making with patients. | 206,955 | 110,869 |
| Prevention – smoking / alcohol | Improvement in stop smoking offers in community health services and referrals to stop smoking services and increase screening for patients at risk from alcohol use. | 110,869 | 84,930 |
| Pressure ulcer stretch | Reduce the number of pressure ulcers in residential homes through training their staff. | 96,086 | 96,086 |
| **NCL TOTAL** | | **739,126** | **543,188** |

| Diabetic retinopathy screening – smoking cessation | Increase screening for smoking cessation | 2,647 | 2,647 |
|---|---|---|---|
| Diabetic retinopathy – uptake of screening services | Increase uptake of screening services | 10,590 | 10,590 |
| Early years – smoking cessation | To train 80% of staff to give smoking cessation education. For health visitors to record that smoking cessation advice had been given on the patient electronic record. | 74,165 | 74,165 |
| Early years – CHIS to CHIS | To create an interoperable Child Health Information System (CHIS) across London and improve documentation of Hep B vaccinations for all children and of all immunisations for looked after children (LAC) | 296,659 | 296,660 |
| Offender health – staff vacancies | To decrease staff shortages. | 53,166 | 53,166 |
| Offender health – TB screening | To increase screening and treatment for TB. | 53,166 | 53,166 |
| Offender health – Hep B vaccination | To increase the uptake of the Hepatitis B vaccination. | 53,166 | 53,166 |
| Offender health – mental health screening | Improve access to mental health screening. | 53,166 | 53,166 |
| **NHSE TOTAL** | | 596,724 | 596,725 |
| **TOTAL** | | **3,250,442** | **2,709,878** |

**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 implementation plan was revised, improved and implemented during 2014-15.
- A data quality manager was appointed on a substantive basis. A key responsibility of the role is to liaise closely with operational staff in order to drive improvements in the level of data recording on the Trust's patient information systems, as well as raising awareness of specific data quality issues and developing the Trust's data quality culture in general.
- A data quality assurance framework (DQAF) was established.
- A dedicated online data quality training course was rolled out to all attendees of the Trust's information systems training courses
- Members of the Business Intelligence, Performance and Analytics (BIPA) team liaised with the SystemOne project team to effect improvements to the system to optimise data entry, and raise levels of data recording and data quality.

CLCH will continue to improve the quality of its data during 2014-15 by:

- Extending the DQAF to the assessment and audit of patient activity based key performance indicators.
- Investigating the possibility of submitting both admitted patient and outpatient records to the SUS for inclusion in the Hospital Episode Statistics during 2014-15 (see below), and continuing to work to improve the quality of the data submitted across all treatment pathways.
- Provision of a comprehensive list of data quality reports for service validation on the new patient information system (SystemOne)

**NHS number and General Medical Practice Code Validity**

CLCH submitted records during 2014-15 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was: **95.4%** for accident and emergency care. The percentage of records in the published data which included the patient's valid General Medical Practice code was: **99.9%** for accident and emergency care.

CLCH did not submit records during to the Secondary Uses service for inclusion in the Hospital Episode Statistics for either admitted patient care, or for outpatient care.

**Clinical coding error rate**

CLCH was not subject to the Payment by Results clinical coding audit during 2014/15.

**Information Governance Toolkit Attainment Levels**

The Trust achieved a score of 77% against the toolkit. This represents overall satisfactory compliance.

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**PARTICIPATION IN RESEARCH 2014/15**

CLCH remains committed to research as a driver for improving the quality of care and patient experience.Our Research strategy approved by the Board in May 2014 signaled CLCHs commitment to research. The Director responsible for research is the Medical Director; and research activity is monitored through the Clinical Effectiveness Steering Group, overseen by the Quality Committee (a subcommittee of the Board).

The current research goals are to:

- Develop a Robust Research Governance Framework
- Develop a Research Culture within CLCH
- Establish Communication about research activity and support internally & externally
- Demonstrate visible research leadership: identifying research opportunities, offering research support and supervision, research training
- Increase the amount of research funding and resources for research
- Improve research partnerships and collaborative working
- Support the implementation of research into practice
- Promote CLCH and its strengths as an essential research partner.

Participation in clinical research demonstrates CLCH's commitment in improving the quality of care we offer and making our contribution to wider health improvements. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to the successful patient outcomes. Our focus on patient health outcomes in CLCH underpins our commitment and understanding that clinical research leads to better treatments for patients.

The number of patients receiving NHS services provided or sub-contracted by CLCH from 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 104.

CLCH was involved in 25 clinical research studies in a number of specialities during 2014/15 including; Diabetes, Offender Health, Children's health, COPD, Stroke, Ulcer care, Dementia and Compassionate Care.

There were over 50 (5 CLCH) clinical staff participating in research approved by a research ethics committee during 2014/15, these staff participated in research covering 8 specialities.

This year our key achievements included:

- Board approval for a Trust Research Strategy and a Trust Research Governance Policy
- Successful applications fora Research Fellowship to the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Northwest London
- Successful application for funding for a research nurse

The following are examples of studies that CLCH is currently involved in:

- So what sort of nurse are you? Nursing in a social care setting: Looked after children's views and stories.
- Survey study for patients with Type 2 diabetes and atrial fibrillation on the risks and benefits of medication
- The delivery of compassionate care: the role of the middle manager
- Experience of intravenous drug users with leg ulceration

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**PARTICIPATON IN CLINICAL AUDIT**

During 2014-15, the Trust undertook extensive work towards achieving the key performance indicators set for clinical audit; namely, ensuring a proportion of clinical audits and key actions are completed within specified timeframes and that information and data from a proportion of the national clinical audits the Trust is committed are delivered within stated deadlines.

The start of the financial year saw the launch of a comprehensive clinical audit programme based on national and mandatory requirements as well as locally driven priorities specifically identified by Trust divisions and services. In addition, CLCH undertook Trust-wide audits incorporating areas of high risk and concern affecting the entire organisation. Further to peer review by the Clinical Effectiveness Steering Group and ratification by the Quality Committee, a sub-Committee of the Trust Board, a forward clinical audit plan was approved and agreed for 2014-15.

During 2014/15, the Trust was not eligible for participation in any national confidential enquiries; we were however registered for 2 national clinical audits.

| National Clinical Audits | Participation | Number of cases submitted or reason for non-participation |
|---|---|---|
| Chronic Obstructive Pulmonary Disease (COPD) | Yes | Data collection phase<br>Data collection for the pulmonary rehabilitation work stream is underway. The publication of the national organisational audit report is expected in November 2015. |
| SSNAP (Sentinel Stroke National Audit Programme) (Previously known as the National Stroke Audit). | Yes | Data collection phase<br>The 2014 acute organisational audit measured stroke service organisation in acute hospital settings. The audit now is now focusing on post-acute organisations and measures the extent to which specialist stroke rehabilitation is being organised and benchmarks the quality of community services, regionally and nationally. |
| Intermediate Care National Clinical Audit | No | Due to unforeseen circumstances that included the merging of services and staff shortages, the Trust did not register no participate in this audit. |

**Local and Trust-wide audits**

| No | Item | Division | Service | Outcome and Actions 2014/15 |
|---|---|---|---|---|
| 1 | Audit of Intervals of Taking Bitewing Radiographs in Children | APC | Dental | Overall compliance level was 73%.<br>Recommendations: the dissemination of results to all clinicians to ensure 100% compliance on re-audit. |
|  | Diagnostic Quality of Radiographs Sent in by Referring Dentists | APC | Dental | Awaiting final report |

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|---|---|---|---|---|
| 2 | X-ray interpretation acumen of clinicians working in the Finchley Walk in centre | APC | Walk-in centres | This audit found the overall percentage of abnormalities being missed by clinicians in the service remains low (< 2% of the total number of images taken) reflecting continuity of the good practice identified in 2013 audit. Recommendations: continued professional development to maintain clinicians' scanning skills. |
| 3 | Re-audit of patients presenting to the Finchley Walk in Centre with a complaint of chest pain | APC | Walk-in Centres | 71% of the patients who required secondary care follow up following a visit to the walk-in centre with non-traumatic chest pain either received drugs as recommended by NICE or a good rationale for why the drugs were not given. This represents a considerable improvement from the previous audit where compliance was less than 30%. |
| 4 | CASH (Contraception and Sexual Health Service) Notes Re-audit | APC | Sexual Health | This audit of the electronic record keeping system (EMIS WEB) indicated no change since the previous audit. |
| 5 | Clinical audit for service adherence to NICE guidelines for the treatment of depression | APC | Primary Care Psychological Health | Overall, this audit indicated unchanged similar scores when compared with 2013-14. Guidelines met scored 70-100%; percentage of guidelines partially met scored 10-70% while the unmet percentages were 0-10%. An action plan with February 2016 was implemented. |
| 6 | Maternal Mood Assessment Re-audit | CHD | Health Visiting | Postnatal depression [PND] is an important category of depression, with prevalence within the first few postnatal months of between 10% and 13%. Health visitors follow NICE guidance concerning maternal mood assessment. The compliance was found to be good regarding the questions asked by health visitors. Results were circulated for review and feedback. |
| 7 | 8-12/2-2.5 Year Health Review | CHD | Health Visiting | HPV Health Promotion Tools Audit |
| 8 | Food Allergy Clinical Assessment | CHD | Children's Therapies | HPV Health Promotion Tools Audit |
| 9 | HPV Health Promotion Tools Audit | CHD | Health Visiting | HPV Health Promotion Tools Audit |
| 10 | Paediatric Nasogastric Tube Feeding Management | CHD | Paediatric Dieticians | CLCH policy aims to support best practice in the management of nasogastric feeding. The need for guidance is based on the increased risk of tube displacement and thus accidental feeding into to the lungs resulting in aspiration pneumonia and potential fatality. This audit examined clinician compliance to this policy and found that overall, there was compliance of 3 out of the 5 key performance |

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|---|---|---|---|---|
| | | | | indicators set in the policy. Action plans included allowing other documentation to be used as risk assessment proof as well as a re-audit in 2015/16. |
| 11 | Baby Friendly Initiative - Mothers Audit (bottle Feeding and Breastfeeding) | CHD | Health Visiting | This audit is a continuation of the UNICEF Breastfeeding Audit and measures whether mothers were asked by health visitors about breast milk hand expressing including information on the importance and procedure. 82% of the mothers asked reported they had had this conversation. |
| 12 | Re-audit of Dysphagia Outcome Measure (DOM) | NCNR | Speech & Language Therapy (SLT) (adults) | The DOM is used by speech and language therapists to measure the safe management and progress of patients with dysphagia. All DOM graphs for the period March to May 2014 were audited to act as a direct comparison with previous audits. The audit concluded the DOM had been used consistently and that the service would continue to monitor outcomes and patient experience. |
| 13 | GAS (Goal Attainment Scaling) Goal Audit for Community Independence Services | NCNR | Community Independence Services | This audit, which aimed to evaluate the quality of GAS goals set with patients receiving therapy from the service, recognised that a proportion of patients struggled in identifying and setting goals and that additionally, a robust electronic system is required to document the goals. As a result, the service has worked closely with the Trust's IT department and is recommending all new staff complete GAS goal training as part of their local induction. |
| 14 | NICE Pressure Ulcer Prevention compliance to guidelines. Re audit | NNCR | District Nursing Community Independence Service (CIS) and Bedded Rehabilitation | This audit achieved an overall 85% response rate. 81% (of patients had a pressure ulcer risk assessment completed. Also indicated: there is variable adherence to NICE Guidance with regard to information and advice on pressure ulcer prevention given to patients and carer if applicable (63%), timely provision of pressure relieving equipment (52%) and updating of patient held records (74%). |

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| 15 | Use of stroke guidelines | NNCR | Community Rehab & Neuro | *Awaiting final report* |
|---|---|---|---|---|
| 16 | Use of compliance devices & transcribing for medication management | NNCR | District Nursing | *Awaiting final report* |
| 17 | Adult Home Enteral Feeding Audit Team Compliance with NICE guidelines | BCSS | Dietetics | *Awaiting final report* |
| 18 | Venous Leg Ulcer Assessment and Management | BCSS | Tissue Viability | Overall, the audit highlighted that both services are 90 % compliant with best practice standards in relation to venous leg ulcer assessment and management. Recommendations: development and implementation of Leg Ulcer Assessment & Management policy and re-audit in the next audit programme. |
| 19 | Hospital at Home (HaH) for patients with acute exacerbations of Chronic Obstructive Pulmonary Disease (COPD) | BCSS | Respiratory | This audit, aimed at reviewing performance against quality and standards of care which included NICE and British Thoracic guidelines provided for HaH COPD patients, found that there were improvements in elements such as quality of life although it although showed a slight increase in patient anxiety levels. Only 10% of patients were re-admitted after discharge within 30 days and there were no mortalities. This service was provided only during the winter. Although it was noted that COPD admissions were higher in winter, it was felt that service could be embedded into practice to allow preventative self-management care in preparation for winter. |
| 20 | Audit of CLCH anaphylaxis kits and face masks in the Podiatry Clinics of Hammersmith and Fulham | BCSS | Podiatry | This re-audit involved reviewing the adherence to current guidelines of access to anaphylaxis kits within Podiatry clinics. Two out of six clinic sites required new anaphylaxis kit to achieve 100% compliance. Action plan: delivering in new anaphylaxis kits to the appropriate clinics. |
| 21 | Introduction of SKIPP within the Pembridge Palliative Care Centre | BCSS | Pembridge Beds | SKIPP (St Christopher's Index of Patient Priorities) is an outcome measure which enables hospices/palliative care providers to assess the impact on patients of the care they deliver and show changes in symptoms over time. This audit, which aimed to assess SKIPP's benefits within the service, found that less than 50% of referrals had SKIPP completed, even partly. Recommendations: review on whether the service continued using the index. |

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| 22 | Endoscopy audit | Medical Directorate | Infection Control | This audit, aimed at decontamination, implemented an action plan which would ensure weekly AER validation was documented and accessible; appropriate space identified to store equipment and that surfaces were to be replaced. |
|---|---|---|---|---|
| 23 | Hand Hygiene Validation Audits – bedded services | Medical Directorate | Infection Control | CLCH is signed up to the ***cleanyourhands*** campaign and has a schedule of hand hygiene audits that is based on a risk assessment. 12 wards were re-audited during the period under review, out of these, 11 received 100% compliance scores, the remaining received 90% compliance. E-learning for Food Hygiene level 1 and 2 has been launched. Attendance compliance rolling programme including F:F 46.78%. |
| 24 | Hand Hygiene Audits – Community Services | Medical Directorate | Infection Control | *Awaiting final report* |
| 25 | Dental audits | Medical Directorate | Infection Control | Audits were carried out at all Community Dental Services (CDS) sites in 2014 to assess compliance with Health Technical Memorandum (HTM) 01-05 - *Essential Quality Requirements* and *Best Practice*. All CDS sites met the - Essential Quality Requirements and many areas also met the Best Practice requirements. Eleven out of the 16 services scored gold e.g. 98 – 100% compliance; and none of the services scored less than 93%. It was recommended that all teams ensure completion of all decontamination testing records and use of log books and a re-audit is planned for 2015/16. |
| 26 | Health centre audits (IC + environmental + waste) | Medical Directorate | Infection Control | *Awaiting final report* |
| 27 | Bedded services audits (IC + environmental + waste) | Medical Directorate | Infection Control | *Awaiting final report* |
| 28 | Aseptic Non - Touch Technique (ANTT) | Medical Directorate | Infection Control | *Awaiting final report* |
| 30 | Surveillance of MRSA wound infections, C diff diarrhoea, and urinary catheters in bedded areas | Medical Directorate | Infection Control | *Awaiting final report* |
| 31 | Mealtime mantra audits - bedded services | Medical Directorate | Infection Control | The aim of the audit was to monitor food service at meal times to ensure that the practice of food handlers in bedded areas is compliant with current best practice and |

|  |  |  |  |  |
|---|---|---|---|---|
|  |  |  |  | CLCH Food Hygiene Policy (IPC 13). All scores improved slightly and 4 areas reached 90% and above. Following each re-audit, the staff and managers on duty in the respective areas were provided with immediate verbal feedback. A re-audit report and action plan were sent to managers shortly after the audit. |
| 32 | Controlled Drugs Audit - Bedded areas | Medical Directorate | Medicines Management | *Awaiting final report* |

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| 33 | Controlled Drugs Audit - Sites | Medical Directorate | Medicines Management | *Awaiting final report* |
|---|---|---|---|---|
| 34 | Cold Chain Audit - Sites | Medical Directorate | Medicines Management | *Awaiting final report* |
| 35 | Safe and Secure Handling of Medicines Audit - Sites | Medical Directorate | Medicines Management | 187 audits at Community clinics have been conducted to demonstrate the Trust's compliance with CQC Outcome 9. All reports with recommendations will be sent to services by the end of March 2015. A full audit report is due to be presented to MMG in May 2015. |
| 36 | Antimicrobial Audit | Medical Directorate | Medicines Management | *Awaiting final report* |
| 37 | Omitted Medicines Audit | Medical Directorate | Medicines Management | *Awaiting final report* |
| 38 | Urinary Catheter Care Documentation | Medical Directorate | Infection Control | This audit aimed to evaluate whether all adult patients with a urinary catheter in situ were assessed and monitored regarding the reason and need for a catheter; and whether all catheter care was documented accurately as per urinary catheter policy. The audit found that 53% had a completed assessment form, and for 28%, there was no documented reason in the notes for the presence of the catheter. Key recommendations that were immediately implemented including ensuring all staff had the correct documentation and a re-audit in the next financial year to indicate service improvement. |
| 39 & 40 | Health Records Keeping Audit | Medical Directorate | TRUST-WIDE | Two audits were undertaken; the first between July and August 2014, where overall compliance achieved was 76% signifying 'Moderate Assurance'. The compliance level achieved for the re-audit, carried out in January-February 2015, and indicated very good improvement. The Trust achieved a 91% compliance level which indicated 'Significant Assurance'. |

***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.***

*TBC – AW Data*

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***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 percentage of patients aged—***
***(i) 0 to 15; and***
***(ii) 16 or over,***
***Readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.***

*TBC – AW Data*

***CLCH considers this data is as described for the following reasons:***
***CLCH has undertaken the following actions to improve the % / rate and so the quality of its services by:***

## 7. INCIDENT REPORTING

The National Reporting and Learning System (NRLS) reported 2,295 incidents during the first half of 2014. This equates to 58.5 per 1,000 bed days. This puts CLCH in the middle of reporters, within a cluster of similar NHS Community Organisations, and slightly below the median reporting rate for this cluster of 95.18 incidents per 1,000 bed days.
During this period, the Trust reported 89 incidents resulting in severe harm, which is higher than the cluster rate of 0.8%. There was one incident which resulted in the death of a patient lower than the cluster rate of 0.2%. Within the arena of patient safety it is considered that organisations that report more incidents usually have a better and more effective safety culture.
The severe harm cases were CLCH attributable grade 3 and 4 pressure ulcers.
*Learning from serious incidents*
A serious incident requiring investigation is defined as an incident that occurred in relation to NHS funded services and care resulting in unexpected or avoidable death or serious harm. Within CLCH a root cause analysis (RCA) was (and continues to be) undertaken for every serious incident to enable lessons to be learnt, and disseminated across the organisation. Following the RCAs actions plans were created, monitored and key messages were shared widely.
CLCH has taken the following actions to improve the learning from incidents and so the quality of its services.

- A continued control on the quality of the data entry on incident reports to ensure accurate recording of degree of harm through quality checking by the patient safety managers.

- The maintenance of Complaints, Litigation, Incidents, PALS and Serious Incidents (CLIPS) Groups in each service/division and a Trust wide level to share the learning from serious event.

- The continuation of the CLIPS and TIPS Trust wide newsletter which cascades lessons learnt until January 2012, subsequently changed into the "Spotlight on Quality" newsletter.

- The Divisional Quality newsletters continued up until January 2015. In January 2015, a weekly newsletter, Spotlight on Quality was introduced, which highlights key quality messages across the Trust.

- On-going process around monitoring of action plans that are created in response to RCAs.

- The Quality and Learning Divisional restructure established four Patient Safety Manager Posts which have been recruited to in order to support the Divisions with incident and Risk Management.

During 2014/15 the total number of incidents reported for CLCH was 6, 441. This is 5.1% a decrease from 2013/14 when a total of 6, 788 were reported.  The Patient Safety Managers continue to work closely with clinical

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colleagues to raise awareness about the types of incidents that should be recorded on the incident reporting system and in addition as part of the Trust induction, an e-learning package was launched in March 2015.

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## 8. REVIEW OF SERVICES

During 2014/15 CLCH provided and or sub contracted 56 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 2014/15 represents 100 percent of the total income generated from the provision of NHS services by CLCH for 2014/15.

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

**These to be added in post the draft has been sent out**

## 10. 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 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: 020 8364 8400 x 218 or 219
www.healthwatchbarnet.co.uk

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**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 020 7150 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

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## GLOSSARY

**15 Steps Challenge**
This is a tool to help staff, service users and others to work together to identify improvements that can be made to enhance the service user experience. The idea is to see the ward through a service user's eyes. Members of the 15 step challenge team walk onto a ward or residential unit and take note of their first impressions.

**Baseline data**
This is the initial collection of data which serves as a basis for comparison with the subsequently acquired data.

**Being Open**
Being Open is a set of principles that healthcare staff should use when communicating with patients, their families and carers following a patient safety incident.

**Care Quality Commission (CQC)**
The CQC is the independent regulator of health and adult social care services in England. It ensures that the care provided by hospitals, dentists, ambulances, care homes and home-care agencies meets government standards of quality and safety.

**Catheter**
A catheter is a thin flexible tube which is inserted into the body, usually along the tube through which urine passes (the urethra) or through a hole in the abdomen. The catheter is then guided into the bladder, allowing urine to flow through it and into a drainage bag.

**Clinical commissioning groups (CCGs)**
CCGs are independent statutory bodies, governed by members who are the GP practices in their area. A CCG has control of a local health care budget and commissions healthcare services on behalf of the local population.

**Compassion in practice**
Compassion in practice is a three year vision and strategy for nursing, midwifery and care staff, drawn up by the Chief Nursing Officer for England and launched in December 2012.

**Commissioning**
This is the planning and purchasing of NHS services to meet the health needs of a local population. It involves deciding what services are needed, and ensuring that they are provided.

**Commissioning for quality and innovation payment framework (CQUIN)**
The CQUIN payment framework enables commissioners to reward excellence. It links a proportion of a healthcare provider's income to the achievement of local quality improvement goals.

**Exemplar ward**
These are wards where consistently high quality care and innovation in clinical practice has been demonstrated

**Francis report**
The Francis enquiry report was published in February 2013 and examined the causes of the failings in care at Mid Staffordshire NHS Foundation Trust between 2005-2009. The report made 290 recommendations

**Incident**
An event or circumstance that could have resulted, or did result, in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, visitors or members of the public.

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**Key performance indicators (KPIs)**
Key performance indicators help define and measure progress towards organisational goals. As the primary means of communicating performance across the organisation, KPIs focus on a range of areas. Once an organisation has analysed its mission, identified all its stakeholders and defined its goals, KPIs offer a way of measuring progress toward these goals

**National Institute for Health and Care Excellence (NICE)**
Nice provides independent, authoritative and evidence-based guidance on the most effective ways to prevent, diagnose and treat disease and ill health, reducing inequalities and variation.

**National Health Service Litigation Authority (NHSLA)**
The NHSLA manages negligence and other claims against the NHS in England on behalf of its member organizations.

**Never event**
These are are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place.  A list of incidents described as Never Events is published by the Department of Health.

**Palliative care**
Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with terminal illness. This is through the prevention and relief of suffering by means of early identification and excellent assessment and treatment of pain and other problems that could be physical, psychosocial or spiritual in nature.

**Patient led inspection of the care environment (PLACE)**
PLACE is the system for assessing the quality of the patient environment. PLACE assessments will see local people go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness and general building maintenance.

**Patient pathways**
The patient pathway gives an outline of what is likely to happen on the patient's journey and can be used both for patient information and for planning services as a template pathway can be created for common services and operations. You can think of it as a timeline, on which every event relating to treatment can be entered. Events such as consultations, diagnosis, treatment, medication, diet, assessment, teaching and preparing for discharge from the hospital can all be mapped on this timeline.

**Patient safety thermometer or NHS safety thermometer**
The NHS Safety Thermometer provides a 'temperature check' on harm. The tool measures four high-volume patient safety issues (pressure ulcers, falls, urinary tract infection - in patients with a catheter - and venous thromboembolism). The data is used at national, regional and local level (organisational as well as at ward and team level) to support quality improvements through ensuring harm free care.

**Patient reported experience measures (PREMS)**
These are more commonly known as patient surveys and can include paper based surveys; the use of electronic kiosks; hand held devices; and telephone surveys

**Patient reported outcomes measures (PROMs)**
Patient Reported Outcome Measures (PROMs) are a means of collecting information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves.

**Pressure ulcers**
A pressure ulcer is localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also

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associated with pressure ulcers.  Pressure ulcers are graded according to severity, with grade one being the least severe and grade four the most severe.

**Root cause analysis (RCA)**
A systematic investigation technique that looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened.

**Serious incident**
In summary these are incidents that occurred in NHS funded services and resulted in one or more of the following: unexpected or avoidable death; serious harm; allegations of abuse; a prevention of continuation of the provision of healthcare services; or a *never event*.

**Tissue viability**
The literal meaning of tissue viability refers to the preservation of tissue. The tissue viability service is a nurse-led specialist service whose aim is to promote the healing of compromised tissue.

**Venous thromboembolism (VTE)**
Venous thromboembolism is a condition in which a blood clot (thrombus) forms in a vein. It most commonly occurs in the deep veins of the legs; this is called deep vein thrombosis. The thrombus may dislodge from its site of origin to travel in the blood – a phenomenon called embolism.

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**APPENDIX 1 – COMPLAINTS ANNUAL REPORT**

**Not yet finalised**

**APPENDIX 2 - OUR WORK ON RESPONDING TO NATIONAL ENQUIRIES AND REPORTS**

During the year a number of external national reports were published. The following is a summary of how CLCH reacted to them and implemented their recommendations. Full reports with action plans were submitted to the Trust Board in respect of the recommendations.

**DEMENTIA**

The Prime Minister's 2012 *Dementia Challenge* was followed up by the Department of Health's November 2013 *Dementia: a state of the nation report*. In response to this report, CLCH is currently working with trusts across Inner North West London to deliver a *Dementia Champions Programme.* This three month programme will enable registered health professionals to develop their skills, knowledge and experience in dementia care, and to become future dementia champions within their established workplace. The programme will also focus on improving people's awareness and understanding of dementia, and supporting high quality care within the most appropriate environment. Additionally it will have a particular emphasis on engaging with patients, their carers and families in the provision of training for staff.

**REPORT ON *FREEDOM TO SPEAK UP* (WHISTLEBLOWING)**

In February 2015, Sir Robert Francis published the *Report on the Freedom to Speak Up.* CLCH's commitment to learning from whistleblowing can be seen in its Achieving Excellence Together campaign. The Trust has collaborated with Buckinghamshire New University, the Royal College of Nursing and the Queen's Nursing Institute to improve staff morale after a concern was raised. Additionally, CLCH's compliance with the new statutory Duty of Candour and Fit and Proper Person Test is encouraging staff to be open about issues and errors which could impact on patient care.

**REPORT OF THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY**

Work at CLCH is continuing to progress in response to Robert Francis' 2013 *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* and Department of Health update, *Culture change in the NHS: applying the lessons of the Francis Inquiries* (February 2015). The five areas for improvement identified in the report are as follows:

1. Preventing problems
2. Detecting problems quickly
3. Taking action promptly and ensuring robust accountability
4. Ensuring staff are trained and motivated

**SIGN UP TO SAFETY/DUTY OF CANDOUR**

During the year there was an updated focus on the creation of a more transparent healthcare system along the launch of a new national drive to improve safety in the NHS. In response to these initiatives, CLCH is implementing the Duty of Candour and is one of the twelve trusts in the vanguard of the *Sign up to Safety* campaign (the new safety improvement movement across England)

**FIT AND PROPER PERSON TEST FOR DIRECTORS**

In accordance with national guidelines, the '*fit and proper person'* test for directors was introduced at CLCH to ensure a more robust approach to accountability for the quality of care service users receive.

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