CLCH QUALITY ACCOUNT 2015 – 16

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PATIENT STORY
Offender Health – Seacole Service

When I first came to Seacole*, I was unsure about the activities. They gave me a list of all the activities and I chose all of them, just to get out of the cell. I got very fond of the lead girl from the 'Only Connect' charity at Seacole. She was an inspiration as I am interested in carry on doing the same charity when I leave prison. They allow me to express myself. The activity they do was new to me and I very much enjoyed it. It made me come out of myself as a person.

As a criminal person I will never be in front of the camera. It was hard for me to speak in front of other people, but they encouraged me to take centre stage to properly express myself. In the group, I was taught presentation skills and acting skills, things that I was always wanted to do but was too shy. The highlight of the course was to give a presentation in front of audience. They arranged executives from John Lewis to come and watch me as I give my presentation. Their reaction was very good and I felt elated and overwhelmed. I have achieved something that was foreign to me. It was an amazing experience.

I always led my life by my own moral code and not the codes set by society, but the experience with the centre made me feel positive about joining society. Therefore, I decided to stay in touch with the charity and carry on working with Only Connect. In my opinion, 'the devil finds time for idle themes'. The few hours I spent in the centre, made me forget that I am in prison. I regret the time was limited here. I hope it will expand and be promoted for a longer time for other prisoners. The classes are now getting bigger and prisoners are spreading the word around. I suggest spreading the word among prisoners and improving communication between governors and prisoners to encourage them to join the Seacole centre. And to put more leaflets, so people can learn more about the activities at Seacole.
The team were very professionals and welcoming and I felt like in 'my true comfort zone'. I was laughing constantly. The way that the class is set up was amazing. I was exposing more of myself and I discovered more skills I didn't know I had before.

Leaning from this story
This story illustrates the positive difference that the Seacole service can make and suggests that there is a need for more awareness about this service within the prison environment.
In response to this feedback, a leaflet has been developed by the staff within offender health, so people can learn more about the role of the Seacole service and the sort of activities that are offered.

*The Seacole centre is based within HMP Wormwood scrubs; interventions and therapies are run from the centre with the aim of improving prisoners' awareness, life planning skills and self-esteem.

ABOUT OUR QUALITY ACCOUNT

Welcome to the Central London Community Healthcare NHS Trust (CLCH) Quality Account for 2015/16. The Quality Account is a summary of our performance in the last year in relation to our quality priorities and national requirements. We have incorporated feedback from our clinical teams this year showing how they have changed the way they deliver care in order to improve the quality of our services.

What is a Quality Account?

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

Why has CLCH produced a Quality Account?

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

What does the CLCH Quality Account include?

Over the last year we have collected a lot of information on the quality of all of our services within the three areas of quality defined by the Department of Health: safety, clinical effectiveness and patient experience. We have used the information to look at how well we have performed over the past year (2015/16) and to identify where we could improve over the next year, and we have defined three main priorities for improvement.

Patient stories have been interspersed throughout the account to demonstrate how quality makes a difference to them as well as informing us of what we do well and where we might improve. Also incorporated into the account are examples of quality put into practice within our services.

Developing the Quality Priorities 2016/17

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 2016/17.

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

ABOUT CLCH

We provide health care in people's own home and in over 400 community settings including GP practices, walk in centres (WiCs), 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, osteopathy
- End of life care – for people with complex, substantial, ongoing needs caused by disability or chronic illness
- Specialist services including 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

CLCH map to be inserted

CHIEF EXECUTIVE'S STATEMENT

It gives me great pleasure to introduce the Central London Community Healthcare NHS Trust Quality Account. Over the year we have continued to strive to provide the highest standard of clinical care and ensure that our patients remain central to everything we do. The Quality Account contains many examples of our approach to quality and we will continue to focus on providing high quality services in the year ahead.

At CLCH we have made a firm commitment through our quality strategy and patient and public engagement (PPE) strategy to keep patients at the heart of everything we do. Our three-year quality strategy entered its final year in 2015/16 and with the publication of our Quality Account this year we will also be publishing our new three-year quality strategy. Our board and staff are committed to providing quality healthcare for our patients and their families.

Patients continue to tell us what they think of our services by taking part in our regular surveys. The results allow us to see if we are improving by comparing results to survey findings from previous years and also allowing us to compare our progress against other NHS Trusts. We want our patients and the public to play an active role in shaping their own care and treatment and in developing and redesigning our services especially as we develop our membership strategy.

This year we were pleased to be one of a minority of trusts rated as good by the Care Quality Commission (CQC) and welcomed the feedback we received in relation to how we are improving. Our progress against the CQC recommendations is contained in the account. I was also pleased to see that the Trust was one of only 18 Trusts to receive an outstanding rating for learning from incidents in the NHSI league table. This is the first year Trusts have been measured in this way and it will be a key objective for the Trust to remain in the top group of NHS Trusts.

We also welcomed a number of new services to the Trust this year and in 2016 community services in both Harrow and Merton join us.

Finally, I would also like to take this opportunity to thank our staff, who strive to continue to improve the quality of care they deliver, our patients for taking the time to give us feedback and our colleagues across health and social care for working with us to provide a comprehensive local service.

The information contained in this document is an accurate reflection of our performance for the period covered by the report. In particular I certify that the following mandatory data quality statements within the CLCH Quality account are accurate:

The use of the NHS number (which measures the completeness of the data held on patients);

The clinical coding error rate (which measures the accuracy of data recording)

The use of the GP medical practice code and;

The information quality and records management score (covering the quality of data systems and process within the organization)

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STATEMENT OF THE CHAIR OF THE QUALITY COMMITTEE

As the Chair of the trust Quality Committee I am pleased with the progress the trust has made this year in relation to Quality and also our achievements against the objectives we set ourselves in the Quality Strategy.

As well as gaining assurance through review and scrutiny of our key performance indicators; the Quality Committee has continued to receive a presentation each month from our clinical services which has included both staff and patients.

The Care Quality Commission (CQC) inspected Central London Community Healthcare NHS Trust from 7–10 April 2015 and undertook an unannounced inspection on 29 April 2015. This was carried out as part of the CQC's comprehensive inspection programme and included the following core services:

- Community health inpatient services
- Community adult and long-term conditions
- Community end of life care
- Community health services for children, young people and families
- Urgent care centres.
- Dentists

We were pleased to be awarded a rating of "good" and as our Chief Executive has already said, are committed to improving in the areas the CQC highlighted and have already made substantial progress against their recommendations.

The Quality Committee will monitor the Trusts new quality goals outlined in the quality strategy and the new priorities laid out in this account; we will also be ensuring that as the organisation expands that we maintain our track record on quality and safety.

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

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PATIENT STORY - Ruby Ward Inpatient Rehabilitation

I came to Ruby Ward for rehabilitation from Northwick Park hospital after I had a stroke. I found my stay on Ruby ward was excellent and the attitude was excellent. I was there over Christmas and it was one of the most sociable events without me having to do any work. They arranged all these presents for every patient on the ward. They had cooked breakfast. They couldn't have worked harder to make it a lovely day; naturally they must have been short staffed over Christmas. I was disappointed not to be at home as it was my granddaughter's 21st birthday. They allowed us to have a celebration on the ward with no problems in the day room. On Christmas my family came and I used the day room to have a celebration. They installed a TV on the ward before Christmas, it was on most of the time, but it was a disturbance most of the time. It would be good if people had headphones. All were able to watch the Queen's speech.

I found the staff on the ward sympathetic and encouraging, particularly the physios. I didn't think it was enough physio, however from what there was it was good. For visitors it did take a very long time to get into the wards. Sometimes you can stand waiting, waiting outside the door and no one opens the door. There was an altercation with a patient and staff on the bay however, it didn't affect me, I became the spokesperson as I would press the bell for everyone as my bell was the only one working on the bay. Staff were accommodating and didn't brush us off as amateurs. They took note of the fact that I found it hard to sit in the wheelchair, so they did change the timings for my seating. Food however was an issue as I am lactose intolerant. The person in charge of the kitchen on the ward used to go to great lengths to try and find something. Sometimes she found it hard to get things in, so sometimes I had to ask family to bring in food from home.

I would definitely recommend this service to friends and family. I think my daughter has already done so, her friend was offered rehab and recommended she went to Edgware Community hospital, she said, "my Mother's experience was really good there I would go if I were you".

I would speed up the change over from day staff to night staff on the ward. A couple of times I was on the chair and I had to wait a while before I saw anyone from the night staff. I was ringing my bell and nothing happened. I would put more staff on, as nurses were rushing and rushing all day. There are not enough nurses. A 12-hour shift is a long time and they definitely need more staff. Training for my husband on how to use a rota stand would have been useful; He was there all day using it with no problem but were then told he couldn't due to manual handling. I understand you can't do this because of health and safety however it ignores the reality as we need to do it at home anyway. My husband visited in the afternoon and in the evening for four months. He could have helped many times.

Learning from this story

The learning from this story has led us to recruit an additional ward receptionist so that the doorbell can be answered more promptly reducing the time that people have to wait outside the ward when visiting. An audit of patient call bell response is taking place each week. Additional rehabilitation support workers have been recruited to the service so that more groups and activities can be provided for patients within the ward. A lactose free menu has been developed and menus will be laminated for patients to use. Staff are monitoring the sound level of the TV to ensure that it does not disturb others and the provision of earphones is being explored.

LOOKING BACK - QUALITY IN 2015-16

Progress against our 3-year (2013 – 2016) 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

Within each of the campaigns a number of key work streams were put in place. Progress against the priorities is described in the score card and explanation below.

Quality Campaign	Key Performance Indicator	End of Year Target	Year End Actual
A Positive Patient Experience Patients' Experience **Caring & Responsive Services**	Proportion of patients who were treated with respect and dignity	95.0 %	93.9 %
	Friends and family test - net promoter score	85.0	82.5
	Proportion of patients whose care was explained in an understandable way	90.0 %	91.2 %
	Proportion of patients who were involved in planning their care	80.0 %	80.3 %
	Proportion of patients rating their overall experience as good or excellent	80.0 %	90.7 %
	Number of PREMS responses	1,600	1,759
	20% reduction in complaints related to poor communication and attitude from 2012/13 baseline	35	38
A Positive Patient Experience Patients' Complaints, Concerns & Compliments **Caring & Responsive Services**	Number of compliments	-	492
	Proportion of patients' concerns (PALS) responded to within 5 working days	90.0 %	94.8 %
	Number of complaints received	-	148
	Proportion of complaints responded to within 25 days	90.0 %	100.0 %
	Proportion of complaints responded to within agreed deadline	100.0 %	100.0 %
	Proportion of complaints acknowledged within 3 working days	100.0 %	100.0 %
Preventing Harm Incidents & Risk **Safe Services**	Proportion of patient-related incidents that were harm free	54.0 %	73.8 %
	30% increase in harm free incidents from 2012/13 baseline	1,970	3,347
	50% reduction in medication incidents that caused harm from 2012/13 baseline	73	36
	50% reduction in falls incidents that caused harm from 2012/13 baseline	97	85

	50% reduction in CLCH acquired category 2-4 pressure ulcers from 2012/13 baseline	212	416
	Zero tolerance of new (CLCH acquired) category 3 & 4 pressure ulcers in bedded units	0	8
	Proportion of external SIs with reports completed within deadline	100.0 %	93.2 %
	Percentage of time bedded units achieving minimum staffing each month	100 %	108 %
	Statutory and mandatory training compliance	90.00 %	88.28%
Preventing Harm Prevalence (NHS Safety Thermometer) **Safe Services**	Proportion of patients with harm free care	98.0 %	92.4 %
	Proportion of patients who did not have any NEW harms	98.0 %	97.5 %
	Proportion of patients who did not have a pressure ulcer	98.0 %	93.7 %
	Proportion of patients with Category 2 pressure ulcers (old)	2.0 %	2.7 %
	Proportion of patients with Category 3 pressure ulcers (old)	2.0 %	0.9 %
	Proportion of patients with Category 4 pressure ulcers (old)	2.0 %	1.6 %
	Proportion of patients with Category 2 pressure ulcers (new)	2.0 %	0.8 %
	Proportion of patients with Category 3 pressure ulcers (new)	2.0 %	0.2 %
	Proportion of patients with Category 4 pressure ulcers (new)	2.0 %	0.2 %
	Proportion of patients who did not have a fall	98.0 %	98.7 %
	Proportion of patients with no harm - falls	2.0 %	0.6 %
	Proportion of patients with low harm - falls	2.0 %	0.5 %
	Proportion of patients with moderate harm - falls	2.0 %	0.2 %
	Proportion of patients with severe harm - falls	2.0 %	0.0 %
	Proportion of patients who died - falls	2.0 %	0.0 %
	Proportion of patients who did not have a catheter associated UTI	98.0 %	99.4 %
	Proportion of patients with a catheter associated UTI (old)	2.0 %	0.3 %
	Proportion of patients with a catheter associated UTI (new)	2.0 %	0.3 %
	Proportion of patients who did not have a venous thromboembolism	98.0 %	99.8 %
Smart, Effective Care **Effective Services**	Standardised mortality ratio in bedded units	3.8 %	0.1 %
	Proportion of services capturing patients' clinical outcomes	100.0 %	100.0 %
	Proportion of patients who were satisfied with the wait for treatment	80.0 %	78.1 %
	Proportion of patients reporting a positive Goal Attainment Score	90.0 %	86.7 %
	Proportion of safety alerts due, and responded to, within deadline	100.0 %	97.1 %

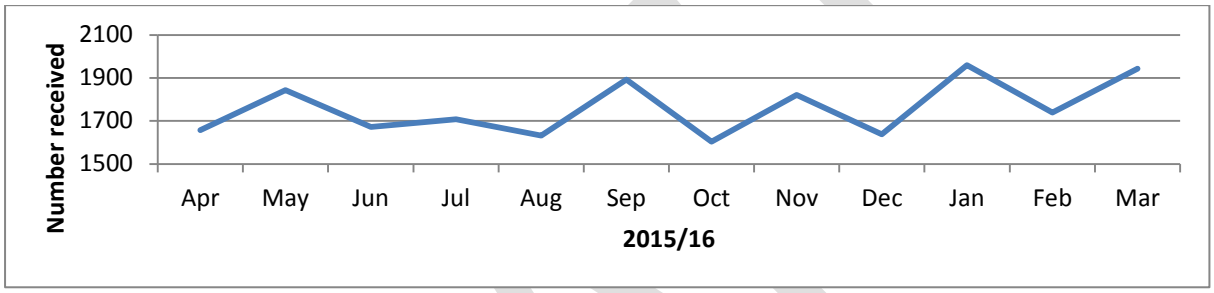
POSITIVE PATIENT EXPERIENCE

Patient Reported Experience Measures (PREMS)

The Trust is committed to receiving feedback from as many patients as possible and from all groups that represent our patients' diversity; to this end we use PREMS. We collect PREMS using a range of methods including electronic tablets, paper surveys, kiosks, comment cards and telephone interviews. We have tested a redesigned survey for people with learning disabilities. Each service has a patient experience engagement plan outlining how they will collect this data and how they will increase patient feedback. In areas where it is hard to garner feedback; the Trust is developing volunteers to support the process. The Trust is also adding a new question to the PREMs survey asking if patients were told how to complain and raise concerns.

The Trust has consistently collected over 1600 surveys per month in 2015/16.

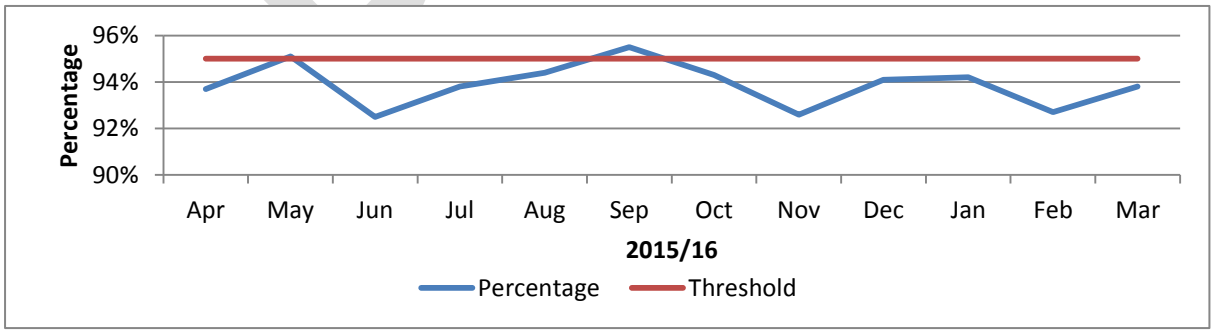
Graph 1: Number of PREMS received



Dignity & Respect

Patients are asked if they feel they were treated with dignity and respect. The data described in graph 2 shows the proportion of patients who responded "yes definitely". We have not met the target for the last quarter and continue to work with the Compassion in Care lead to improve this. Having analysed the narrative from patient feedback, there are no specific comments relating to privacy and dignity. However, there are some comments about patients feeling that there is a lack of continuity in care and a lack of information regarding who is caring for them which may be contributing to the score. This has been fedback to staff.

Graph 2: Proportion of patients who reported that they were treated with dignity and respect.



Friends & Family Test (FFT)

In the FFT we ask patients how likely they would be to recommend our services to their friends and family. The score is calculated by subtracting the number of people who would not recommend the service from the number who would recommend it. This is measured according to national guidelines against a board target of 85. This was not met in February and March largely due to a high proportion of negative comments about the Walk in Centres; specifically waiting times and accessibility. The service is taking forward a number of actions to address this including a review of staffing levels to assist with the demand at peak times.

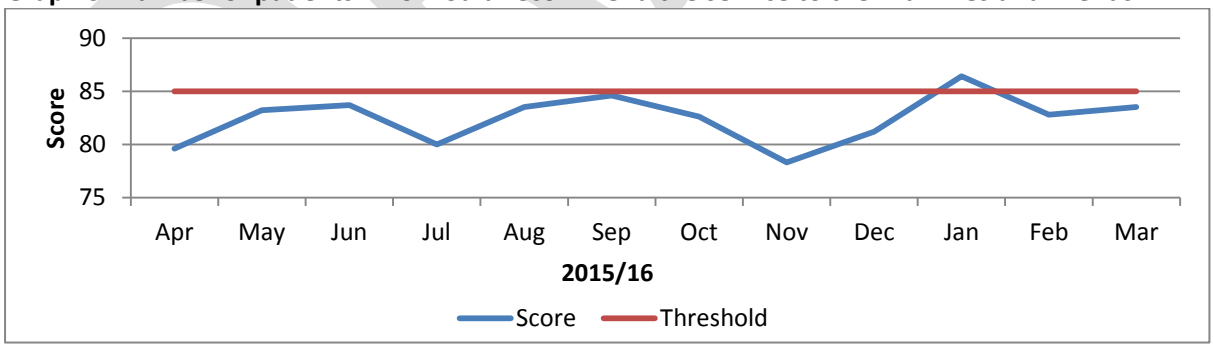
NHS England (NHSE) now presents the percentage of people that would recommend the service (extremely likely and likely responses), and the percentage of people that would not recommend the service (unlikely and extremely unlikely responses) rather than using the net promoter score. NHSE considers this easier for patients to understand and fairer as it includes 'likely' responses which were previously excluded. The table below outlines how the Trust is performing using this approach. This method will be used in our 2016/17 reports.

NHSE FFT presentation

FFT	Base size	Recommend %	Not Recommend %
February 2016	**n=1929**	**90.2%**	**5.0%**
January 2016	n=1725	90.4%	5.3%
December 2015	n=1939	91.2%	4.1%
November 2015	n=1625	89.0%	5.7%
October 2015	n=1804	87.1%	7.2%

(Please note that February 2016 is the most up to date data available from NHSE at the time of writing the account).

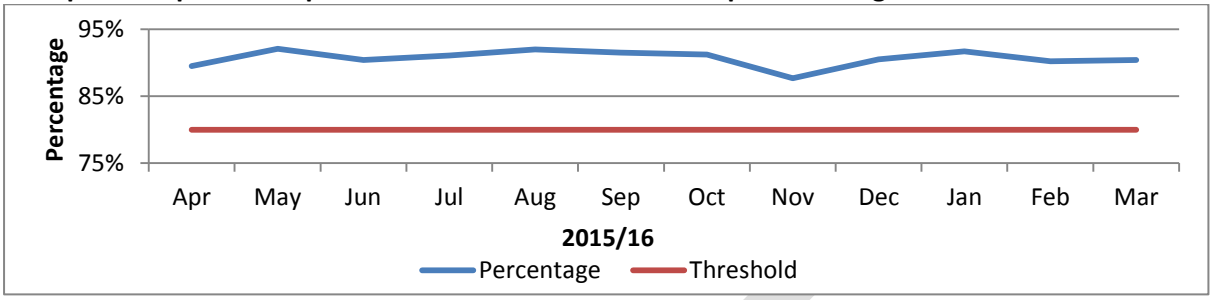
Graph 3: Number of patients who would recommend the service to their families and friends



Overall Experience

We ask patients to rate their overall experience of care. Graph 4 shows patients who said that their care was good or excellent. We have consistently and significantly exceeded the target.

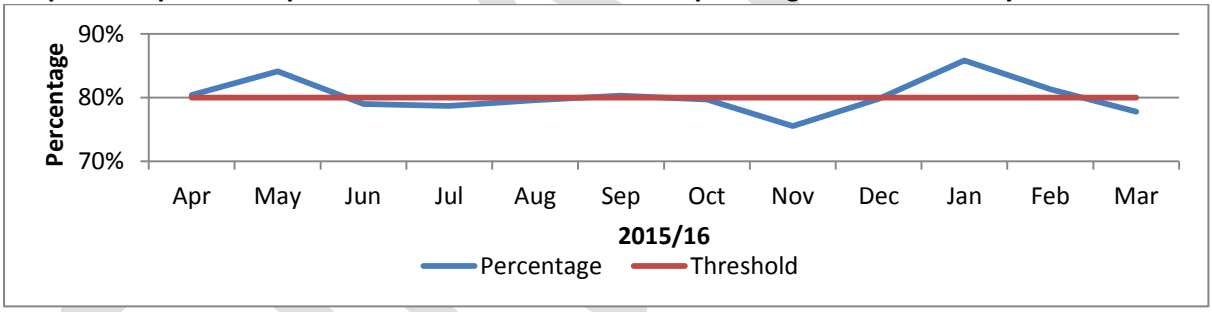
Graph 4: Proportion of patients who rated their overall experience as good or excellent



Involvement in care

We ask our patients how involved they have been in planning their own care. Graph 5 represents those patients who said that they were as involved as they wanted to be. This target has been achieved for most of the year. However, there has been a decline in positive responses in the last quarter. Mobile devices are being rolled out and it is hoped that this will facilitate collaborative care planning in patients' homes. The Patient Experience Group will also work with users to find out how they think this can be improved.

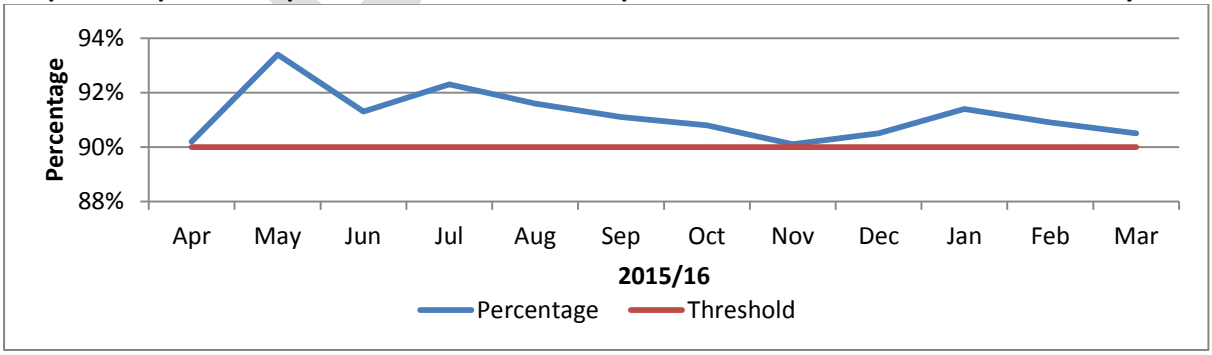
Graph 5: Proportion of patients who were as involved in planning their care as they would like.



Explaining Care

We ask patients if their care was explained to them in a way they could understand, graph 6 shows those patients who said that it was. We have achieved or exceeded the target all year.

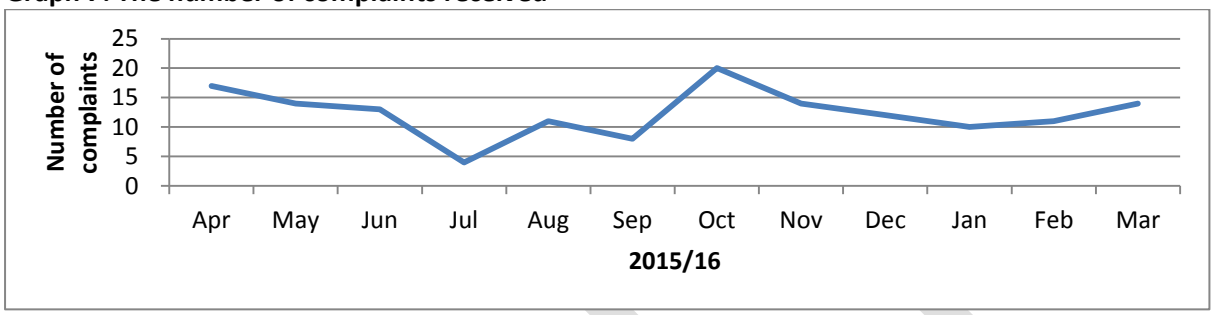
Graph 6: Proportion of patients whose care was explained to them in an understandable way.



Complaints

We categorise complaints as either simple or complex. This decision depends on the nature of the complaint and how difficult it is to investigate. The national target requires NHS Trusts to respond to all complaints within a time limit agreed with the complainant. To drive quality, the CLCH Board has set the Trust a more challenging target of responding to 90% of simple complaints in 25 working day and 100% of complex complaints within the agreed timescale. All complaint targets have been achieved this month and all simple complaints have been responded to within 25 days for the whole of 2015/16.

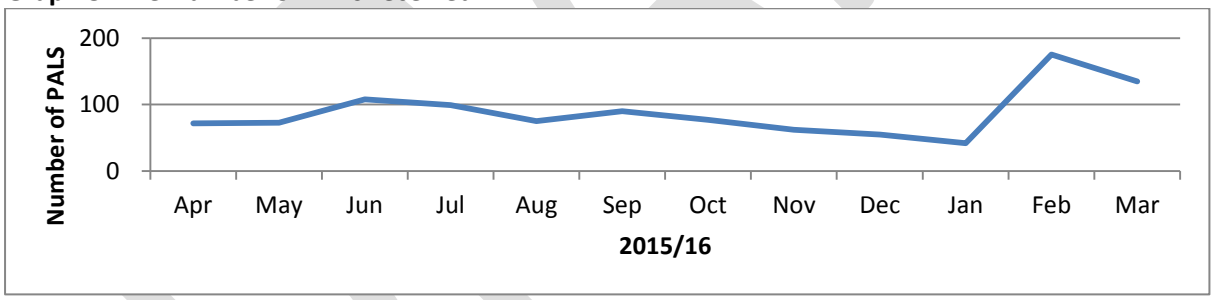
Graph 7: The number of complaints received



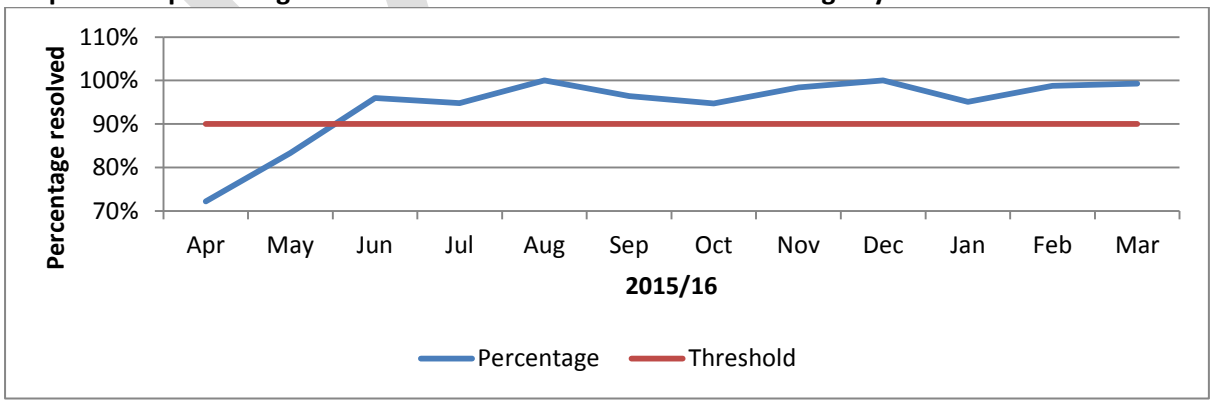
Patient Advice & Liaison Service (PALS)

We aim to resolve 90% of all PALS issues within 5 working days. This has been achieved for most of the year.

Graph 8: The Number of PALs received



Graph 9: The percentage of PALS issues resolved within five working days



PREVENTING HARM

NHS Safety Thermometer

The NHS safety thermometer is a national prevalence survey. It is conducted on one day each month when our nurses review all relevant patients to determine if they have suffered any harm as a result of their healthcare. The categories they review include VTE, catheter associated urinary tract infections (CAUTIs), falls, venous thromboembolism (VTE) and pressure ulcers. Their data is fed back to a national data base, which is used for comparison and benchmarking. All data can be reviewed at www.safetythermometer.nhs.uk. The national target is that 96% of patients are harm free; this applies to the overall score as well as each individual category. The CLCH Board has set a more challenging target that 98% of patients are harm free.

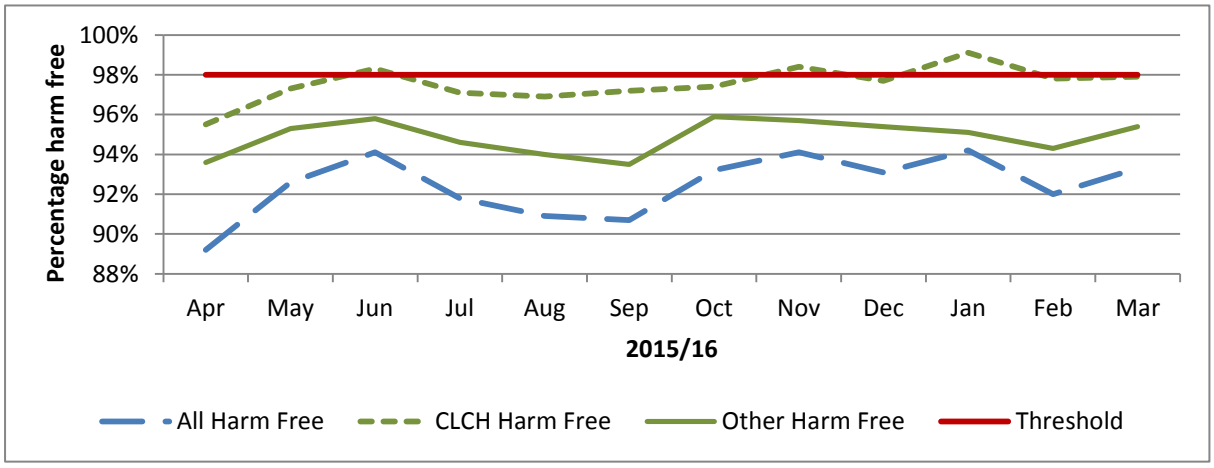
The limitations of prevalence data are well known, one day each month is unlikely to capture normal variations in occupancy, dependency and a variety of other factors, but it acts as a starting point for a more in depth analysis. A more reliable and robust picture can be gained by reviewing the incidence of harm over time. CLCH collects both types of data and uses the incidence analysis as necessary. Incidence data is collected as reports on the DATIX system.

Harm Free Care

We calculate the percentage of patients on the survey day that did not have any of the harms being monitored. This includes harms which occurred within CLCH (new harm) and those that occurred with other providers (old harms). The vast majority of patients suffer no harm at all. For the whole of 2015/16 more than 96% of patients were free from any CLCH acquired harm. At the end of 2015/16 more than 93% of our patients were free from any harm (including harms acquired with other providers).

It is important to differentiate between all harms and new harms. New harms are those which occurred whilst the patient was under CLCH care and exclude harms that the patient had already sustained when they arrived in our care, for example a patient discharged from an acute hospital to the district nursing service with a pressure ulcer. We exceeded the national target for new harms in all bar one month last year. The board target was exceeded three times during the year. At the end of 2015/16 the Trust was just 0.1% shy of achieving the board target.

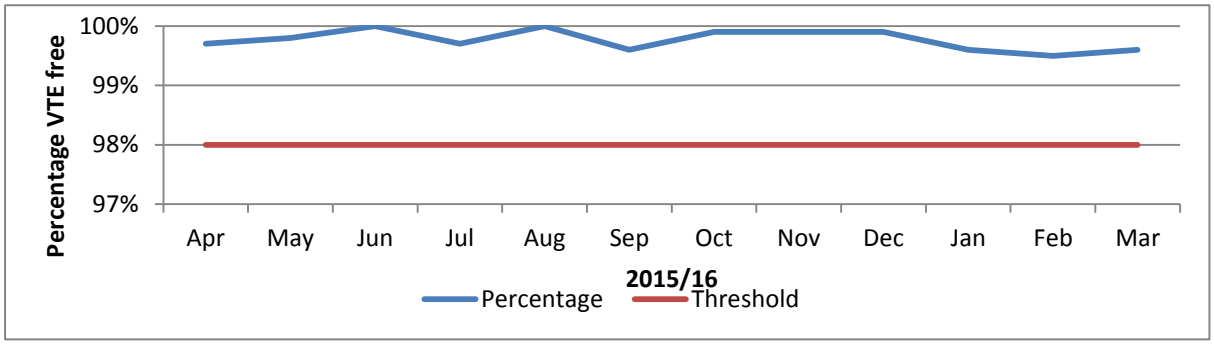
Graph 10: The proportion of patients whose care was harm free



Patients free from venous thromboembolism (VTE)

We count the number of patients on the survey day who have a VTE, such as a deep vein thrombosis (DVT). We have exceeded this target all year.

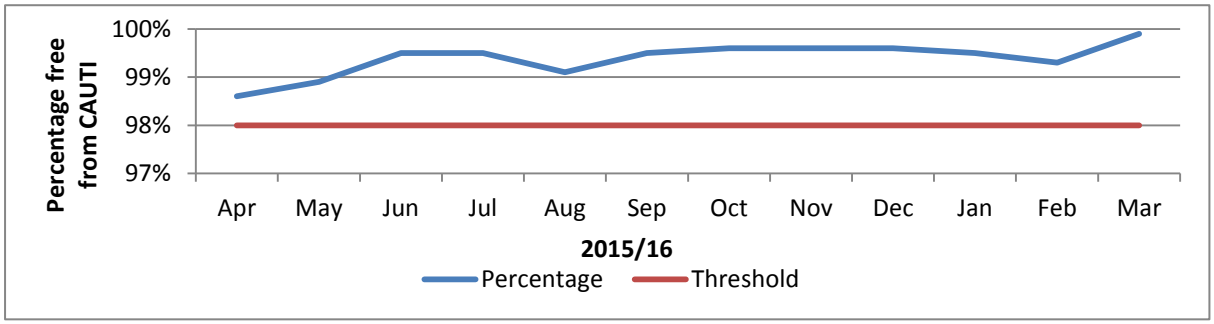
Graph 11: The proportion of patients free from VTE.



Patients free from catheter associated urinary tract infections (CAUTIs)

This category of harm counts the number of patients on the survey day who have a CAUTI. We have exceeded this target all year.

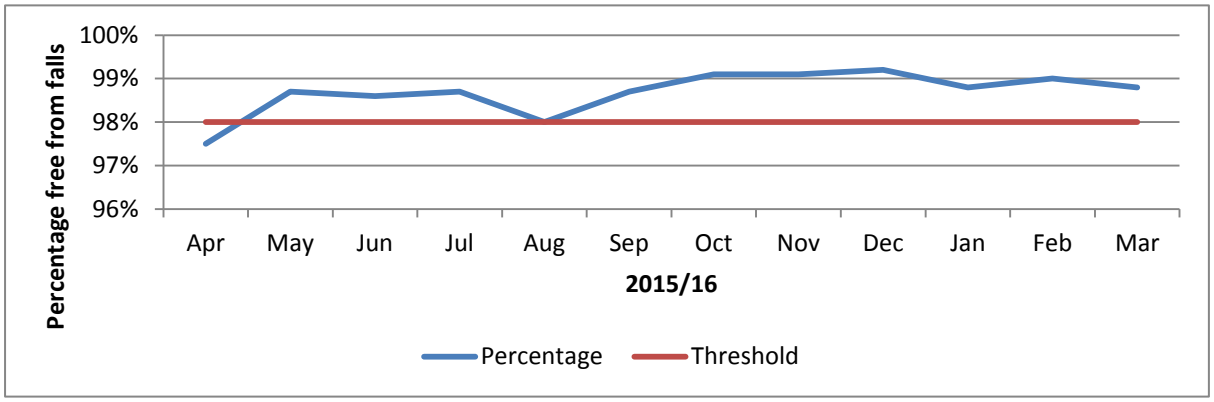
Graph 12: The proportion of patients free from CAUTI.



Patients who did not fall

On the survey day, we count the number of patients who fell in the previous 3 days. This target gas been achieved since May 2015 as demonstrated in Graph 13. Graph 13 is prevalence data, whereas graphs 14 and 15 show the incidence of falls in Q4 2015/16.

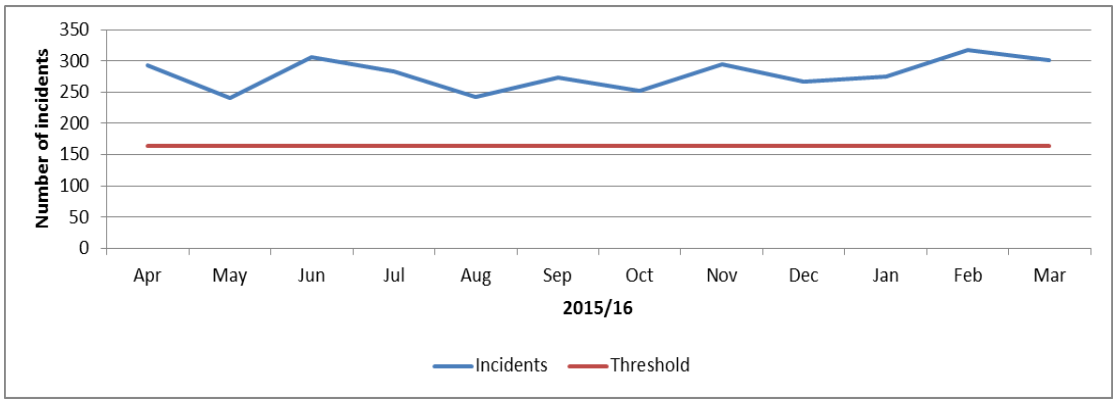
Graph 13: Proportion of patients who did not fall



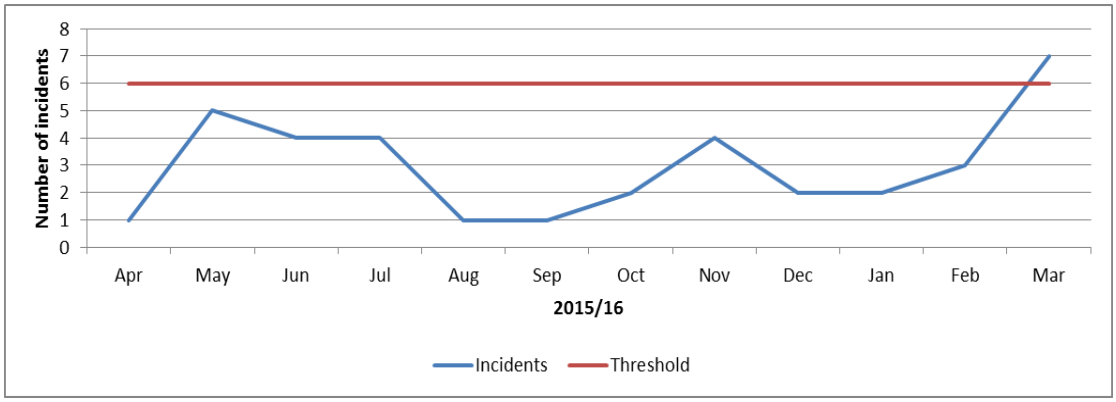
Safety Indicators by Incidence

We continue to meet our target of a 30% increase in harm free care as measured by incidence.

Graph 14. 30% increase in harm free incidents from 2012/13 baseline



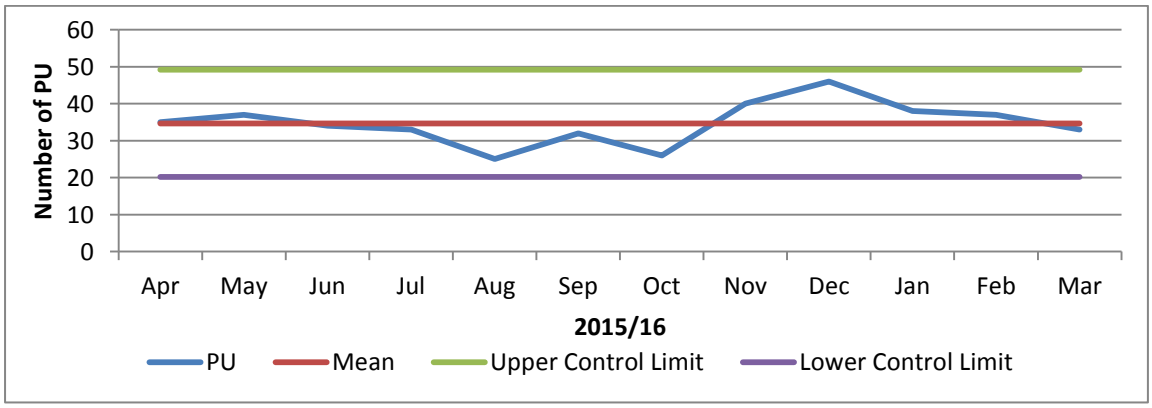
Graph 15: 50% reduction in medication incidents that caused harm from 2012/13 baseline



Pressure ulcers

Graph 16: Incidence of CLCH acquired (i.e. acquired in our care) pressure ulcers

The number of new ulcers has remained stable with no statistically significant changes.



Pressure ulcer cases are reviewed by serious incident panels. The reports from these panels are submitted to our commissioners. All cases have agreed action plans, which are monitored through the SI process. The lessons learned are discussed and shared in a number of ways:

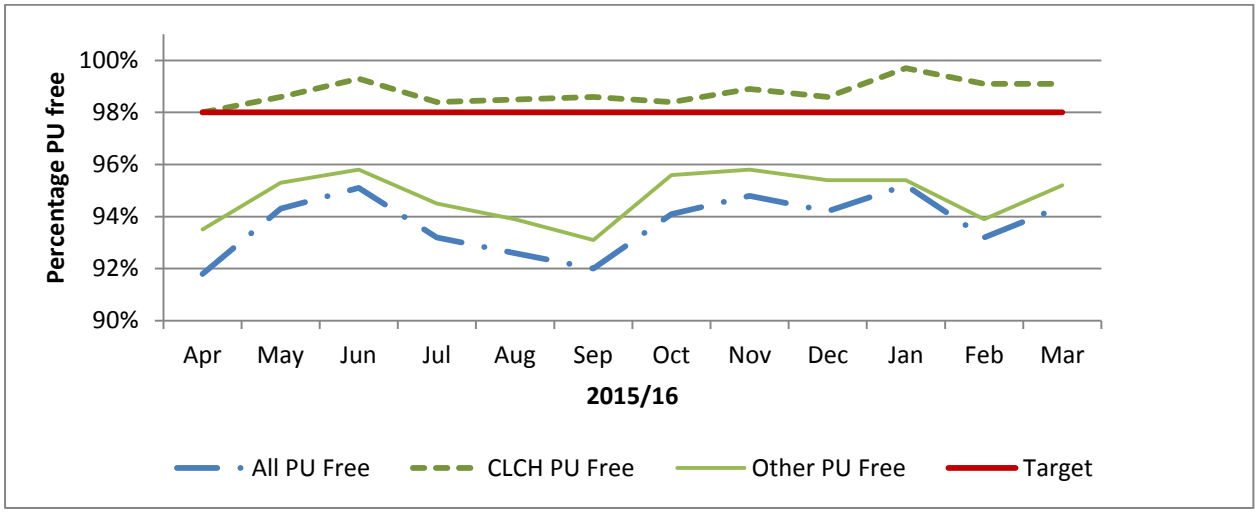
- Back to the staff/team directly involved in the case
- At the local and Trust wide complaints, litigation, incident and pals (CLIPS) meetings
- At the Pressure Ulcer Working Group

When key messages are identified they are included in the *Spotlight on Quality Newsletter*.

Prevalence of pressure ulcers

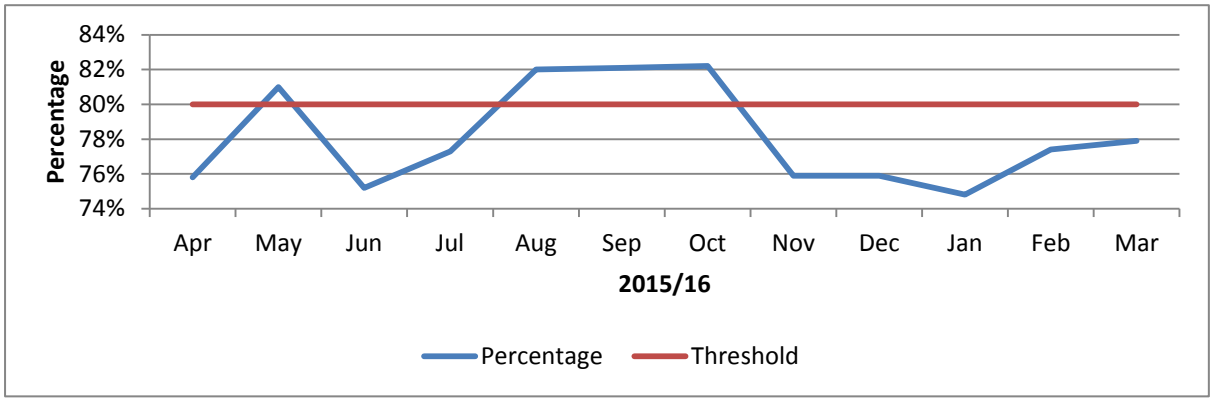
For the last 12 months more than 98% of patients were free from CLCH acquired pressure ulcers, consistently exceeding the national target.

Graph 17: The proportion of patients who did not have pressure ulcers.

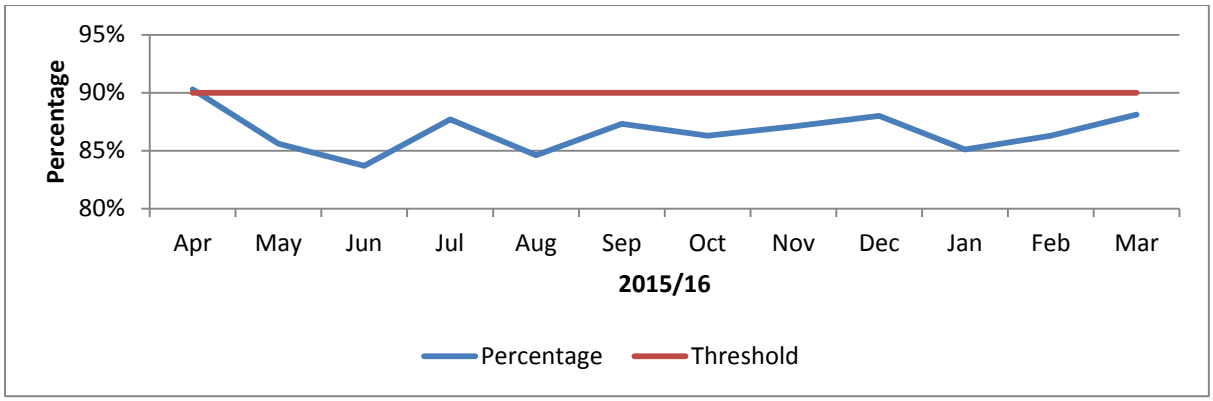


SMART, EFFECTIVE CARE.

Graph 18: The percentage of patients who were satisfied with their wait for treatment



Graph 19: The percentage of patients reporting a positive goal attainment score (GAS)*



*** This is a way of measuring whether a patient's individual goals are met.**

PATIENT STORY - Sickle Cell Service

I was first aware of the service for sickle cell at Richford Gate in 2004 when my twins were diagnosed with the condition. I met a lady called 'Y' who came round to visit me and gave me a book on sickle cell to read which was very scary because I had no clue how bad it really was.

Then 'Y' retired and another lady took over the service. She was there for about six months before she made contact with me and by then I had kind of given up with Richford Gate because the time had lapsed. Then I started receiving phone calls from a lady called 'Z' but I was too stubborn to return the calls because what was the point? She was probably only going to be there for six months and then leave as well. One day I went to St Mary's Hospital and this lady came up to me and introduced herself as 'Z'. She reassured me that she would always message or call me back if I sent her an email or text and if she was unable to do so that day somebody else would, and usually within 24 hours.

We then built up a kind of friendship which put some of my faith and trust back into Richford Gate. She made some home visits just to see how I was doing generally and how the kids were doing. 'Z' has become like part of the family I suppose. If I cannot speak to 'Z' I talk to her colleague called X who has been a great help as well.

I think that the service could arrange meetings locally where children with sickle cell could get together because my children feel very alone because there are not many children locally who have it. Maybe if they were to provide counselling sessions for children with sickle because when you miss time off school your confidence deteriorates because you have missed out on so much learning. Also with parents who have to spend time in hospital with one child if they could provide hotel type accommodation near the hospital with room for the parent with the other children, and keep the family together.

I think we need a parent's forum where we can get together and talk it would be beneficial. An online forum would also be good, for older children as well as parents. Maybe if the local hospitals do not have the facilities that they have at St Marys they should be aware that if someone does come in with a child with sickle cell it makes more sense to send the child straight to the specialist hospital instead of delaying the process by doing blood tests.

A good thing would be an out of hours Haematology Helpline where you could get professional advice instead of rushing to the hospital because sometimes you go to the GP and the Doctor doesn't always know what Sickle Cell is. A sickle cell youth club would also be a good idea where children with the same condition could meet, say once a month, and do fun things together at small cost. Parents could volunteer for some hours each with some professionals too.

I feel they should do more in the way of information and let School Nurses know that when they are doing school staff training allergies they should include sickle cell

Learning from this story

From this story, a number of actions are being taken forward by the Sickle Cell service. A blog will be developed with the help of a local support group whilst the service will also develop a peer support group and enable access to an existing youth group. So that more professionals are confident in caring for children and adults with the condition, the service will provide additional training for staff groups whist also informing patients about urgent care facilities to enable fast track to specialist care.

LOOKING BACK – TRUST QUALITY PROJECTS AND INITIATIVES

As well as the implementation of the Quality Strategy described above, the trust was involved in a number of other quality projects and initiatives and several of these are described below:

TRUST PROJECTS - POSITIVE PATIENT EXPERIENCE

ACHIEVING EXCELLENCE TOGETHER

This is a campaign focussed in improving the quality of district nursing services across our organisation whilst also improving the morale of our staff working in these services. Our campaign lead supported staff and teams in taking forward the following campaign priorities;

Lifting the mood: We have initiated a newsletter 'by district nurses, for district nurses' which is sent to all district nursing teams monthly. This newsletter highlights exciting news, includes staff and patient stories and keeps community nurses up to date with the ongoing work of the campaign and other programmes such as our continuous improvement programme. Team building events have been organised for each borough for community nurses and we held a celebration event for staff in November 2015

Fit for practice: We have appointed practice development nurses for each borough who work with new and less experienced community nurses, enabling their competence and wider personal / professional development

Filling the gaps: We have developed a range of approaches to support recruitment including the mapping of career pathways. A fast-track programme has been developed for less experienced staff which will now be piloted. This is a 12 month work-based programme that will support their succession into deputy team leader roles and is attracting nurse recruitment and we envisage that it will also support staff retention.

Modelling the way: We are focussing on safer staffing and defining team structures, numbers and skill mix

Leading the way: We have developed a 12 month clinical leadership programme for our district nursing team leaders, a programme for deputy team leaders as well as leadership development for our clinical business unit managers and clinical leads within district nursing services.

DEMENTIA CHAMPIONS PROGRAMME

We aim to develop an informed and effective workforce for people with dementia and to this end we were successful in gaining funding from Health Education North West London to develop and host an innovative Dementia Champions Programme for staff working closely with those who have dementia. The programme was developed collaboratively with a range of stakeholders and Buckinghamshire New University and it is open to staff from differing professions who work in CLCH and other care organisations in North West London. Champions may work in hospitals, care homes, hospices, clinics or community teams providing a range of differing services for those with dementia.

The purpose is to provide practical, needs led and accessible approach to developing people's knowledge and skills in dementia care and also to enable them in taking forward a range of service improvements.

DEMENTIA ENGAGEMENT PROJECT

We are hosting an innovative 18 month project in collaboration with the Point of Care Foundation and Health Education North West London. The purpose of this work is to engage with people with dementia and their carers across North West London to create an effective, inclusive process to involve people with dementia and their carers in the design, planning and implementation of locally relevant training to change the culture in dementia care.

COMPASSION IN CARE:

We have continued to implement our Compassion in Care project which aims to promote dignified and compassionate care through making a difference to the experience of service users and carers. Through this project we aim to embed the 6Cs across the whole of CLCH (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).

We have received funding from Health Education North West London to further implement the Compassion in Care model with partner organisations and to develop a Compassion in Care Community Provider network. This will enable staff to contribute to the promotion of compassion in practice where they work, and promote a consistent culture of compassion through the patient journey, through the attainment of Compassion in Care competencies.

END OF LIFE CARE:

We have taken forward work to develop and embed our End of Life Care Strategy (2015 – 2018) through our End of Life Care Model to ensure the delivery of holistic, competent, compassionate care for the dying and their families regardless of where they are cared for. The strategy encompasses improving access to end of life care services, improving choice and the coordination of services to reduce inequalities of service provision. It aims to increase the proportion of patients who are cared for and die in their preferred place of care.

The strategy is actioned through a number of work-streams including the following:

Advance Care Planning: We are implementing Advance Care Planning documentation which has been incorporated into our electronic care records. Advance care planning master classes have taken place in each of the boroughs facilitated by the Royal Marsden Hospital and further classes are planned.

Assessment and Care Planning: An individual plan of care and support for the dying person in their last days and hours has been developed. This is used to record individualised tailored care provided to the person whilst also supporting their families, carers and others close to them.

Education and Training: Core education standards for the care and support of the dying person in their last days and hours have been developed for all staff. An education programme has also been developed to support the core education standards and implementation of an Individual Plan of care and support.

Bereavement information: We have held focus groups to consider our bereavement information and this has now been updated for staff, families and carers whilst we also plan to implement Schwartz rounds.

Symptom Management: We have reviewed our symptom management guidelines and our administration of the subcutaneous medicines policy.

LEARNING DISABILITIES

Traditionally, whilst people with Learning Disabilities often have complex health needs, their outcomes have been poorer than the general population. CLCH is committed to eliminating this inequality and believe that people with a Learning Disability have the right to the same level of healthcare as that provided to the general population. To this end we have worked collaboratively with the Local Authority to provide services to people with Learning Disabilities. These specialist services are expert in assessing and meeting the needs of this client group. People with learning disabilities may also access our general services such as walk in centres, community nursing and dentistry, so it is essential that the care we provide in such areas also meets the needs of this client group.

PATIENT STORY – Learning Disabilities

I have been receiving services from Hammersmith and Fulham Learning Disability team for over twenty years. A lot has changed over these years, including moving buildings three times. I have seen nurses, counsellors, social workers, and psychologists over this time; they have helped me with my emotional problems, my diabetes, my medication, and other doctor and hospital appointments. My experience of most of the service has been very good. I have always got on with the staff here; particularly my nurse and psychologist because I can have a laugh and a joke with them and they are all nice people. I feel comfortable talking about my problems with them because I know that they will help me. With some staff I feel that they are like family to me; it is like having lots of other sisters and brothers!

It is important to me that I can get hold of staff easily by calling them. I find this very helpful with my nurse who always answers their phone and who I am in regular contact with. However, I get frustrated when I cannot get hold of other staff- like my social worker- and it makes me think that they do not do their job properly and that they do not want to help.

The services I have received have made my life much better by helping me with a lot of things. In my psychology sessions, for example, I learnt a lot of skills to help me manage my anger and feel calmer. I have also been helped with my diabetes and other physical problems and the nurses remind me when to take my medication which has also helped a lot. Another thing they help me with is supporting me to meet new people and attend new things; without this support I would not go to first appointments because I need to know that I can trust people before I spend time getting to know them.

I have always felt involved in the decisions made about my care and know that I can ask questions and refuse or agree to different types of care if I want- it is always my choice. I feel that all staff communicate well with me; they listen to my problems, ask me questions, and have a laugh and a joke with me. When I come to appointments here I normally get here early because I like to chat with staff. This is also my favourite building over the years because it is the biggest. However, it frustrates me when there are no staff on reception who know about the learning disabilities team.

As well as having good reception staff, I think that appointments should be quicker and everything should be on time. I would suggest that the staff start earlier and that the service maybe opens at 8am rather than 9am to make sure that everything runs quicker. For most of my sessions I am seen on time but there are some where people tell me to wait ten minutes and this frustrates me.

If I had a friend who needed help I would recommend the service because of the staff. My one message to new staff is to just look after people. If you do this you will be doing a good job!

Learning from this story

A key message from this person's story is about staff being aware of the needs of those with learning disabilities and planning to meet their individual needs. We have developed a 'flag' within the electronic patient record so that those with a learning disability can be easily identified. We are planning to implement mandatory training for all staff to raise awareness of the needs of those with learning disabilities whilst also implementing specific training for staff who work in the Single Point of Access and Single Point of Referral services so that appointment times can be tailored to people's needs.

TRUST PROJECTS - PREVENTING HARM

SIGN UP TO SAFETY

Sign up to Safety is a national patient safety campaign, one of a set of national initiatives to help the NHS improve the safety of patient care. Collectively and cumulatively these initiatives aim to reduce avoidable harm by 50% and support the ambition to save 6,000 lives.
The campaign has five safety pledges:

1. Putting safety first
2. Continually learn
3. Being honest
4. Collaborate
5. Being supportive

We joined the national Sign up to Safety campaign in September 2014 and in response to the pledges, we set out a number of actions that we would undertake to form the basis of our patient safety improvements. In February and March 2015 four listening events were held for patients and members in the four principal boroughs in which CLCH deliver care; Barnet, Hammersmith and Fulham, Kensington and Chelsea and Westminster. Five themes emerged from these events - Supporting and signposting patients and carers; raising awareness to raise standards of care; working together within the community; better use of information and technology and treating the person as an individual.

These themes were shared at a staff conference where staff were asked to identify safety improvement measures for their specialist areas of care and from this to develop service improvement projects to address these issues. These themes included: educating and signposting patients, their families and carers in pressure ulcer care through using new technology; improving knowledge of specialist formulae with GPs; ensuring joined up working between hospital and community care; fully utilising information and technology within the dental service and improving communication between district nurses and patients in Hammersmith and Fulham. Each project is led by a member of our frontline staff who is supported to implement and monitor their projects through workshops, training and the provision of expert advice.

From the outset of the campaign, CLCH has been clear that clinical staff should lead their own safety projects. This fundamental belief has not changed and therefore the aim remains *'to engage the ambition of staff by identifying the changes to their practice that are required to identify, implement and evaluate change in their service that will improve its quality'*.

The next stage of our campaign will now be to integrate sign up to safety into the safety groups using the shared governance approach set out in our Quality Strategy 2016 – 2019.

More detailed information about the Trust's *Sign up to Safety* plan can be found on the following link: https://www.england.nhs.uk/signuptosafety/whos-signed-up/clch/

DUTY OF CANDOUR

Since November 2015 the *duty of candour became* a statutory requirement. This duty focuses on prompt notification, together with an apology, explanation and reasonable support for patients, or those acting on their behalf, who have been harmed. In practice this means that as soon as practicable after being made aware of an incident that has caused harm, the trust must conduct an investigation and notify the relevant person within ten days. Compliance with the duty is monitored via the trust's DATIX incident reporting system. Additionally the patient safety managers review and support staff to ensure our duty is met. Compliance is reported via the serious incident reports which are presented to the trust board and serious incident reports which are submitted and presented to the CCG clinical quality review groups. Within 2015/16 we reviewed our Being Open policy (which incorporates the duty of candour); this helped lead the compliance with the duty to 100% from November 2015 onwards.

INCIDENT REPORTING

Learning from serious incidents

Serious incidents can be described as events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

Within the Trust we use Root Cause Analysis (RCA) methodologies to investigate every serious incident to enable lessons to be learnt and disseminated across the organisation. Following the RCAs actions plans are created, monitored and key messages shared widely.

Within the year, we have achieved some improvements on incident reporting indicators, for example those measured within the NHS 2015 staff survey published on 23rd February 2016 which indicated that we are better than average in the following two key indicators:

- Percentage of staff reporting errors, near misses or incidents witnessed in the last month
  Our score for 2015 was 94% compared to the national 2015 average for community trusts which at 90%.
- Staff confidence and security in reporting unsafe clinical practice
  There has been a statistically significant positive change in this finding since the 2014 survey, and we are ranked above average compared with all community Trusts in 2015.

We were also ranked 'Outstanding' in first annual 'Learning from Mistakes' league which was published in March 2016. We are one of only eighteen providers in the country that has achieved this ranking in one of the latest quality initiatives launched by NHS Improvement.

To further the quality of our services, we have taken the following actions to improve learning from incidents:

- 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 and updating of the Datix (and incident reporting system) to improve the integrity of the data.

- Established feedback notifications on Datix so that incident reporters receive the lessons learnt and action taken as a result of the incident that they reported, upon final approval of the incident.

- Regularly included articles in the 'Spotlight on Quality' monthly publication from the Complaints, Litigation, Incidents, PALS and Serious Incidents (CLIPS) group, for example Pressure Ulcers in August/September, Falls in November 2015, Information Governance in December 2015 and January 2016.

- Held a cold chain summit in October 2015 following a number of Cold Chain serious incidents. The event, which 32 clinical staff attended, focussed on presentations outlining the background, events and learning surrounding the cold chain incidents, followed by group work looking at the reasons why these incidents occurred, with particular reference to the human factor elements on adherence to policies and clinical practice.

- Developed a Datix / Incidents discussion board on our Intranet; The Hub, to enable staff to report any issues they have with reporting incidents or using the system. The Patient Safety Team monitors and responds to all posts.

- Maintained a database of Complaints, Litigation, Incidents, PALS and Serious Incidents (CLIPS) Groups to share the learning from serious event.

During 2015/16 the total number of incidents reported on the Datix system was 6,328. This is a 1.7% decrease from 2014/15 when a total of 6,436 incidents were reported. The Patient Safety Managers continue to work closely with clinical colleagues to raise awareness about the types of incidents that should be recorded on the incident reporting system. In addition, as part of the Trust induction, an e-learning package was launched in March 2015 which was made available to all staff during the year via the ESR Learning portal and publicised through Communications including Spotlight on Quality.

INCIDENT REPORTING - NHS ENGLAND PRESCRIBED INFORMATION

The following two questions were asked of all trusts.

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.

The national and reporting learning system (NRLS) reported 1,154 incidents during the first half of 2015. This equates to 38.22 per 1,000 bed days. This puts us in the lowest 25% of reporters, within a cluster of other NHS Community Organisations, and below the median reporting rate for this cluster of 146.03 incidents per 1,000 bed days.

During this period, we reported 58 incidents (5.0%) resulting in severe harm, which was higher than the cluster rate of 0.7%. There was one incident which resulted in the death of a patient.

This was 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 we reported were grade 3 and 4 pressure ulcers and three falls.

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.

This metric is normally only applied to acute units where the measure is an indication of inappropriate early discharge. As such, it is not reported by community trusts and so has not been responded to.

PATIENT STORY – Psychological Health

I originally went to the GP to talk about my perceived issue of aggression. The GP asked me to complete an assessment, which revealed high levels of anxiety it felt as though I was contacted very quickly to have the initial phone assessment. I found the assessment a little repetitive. I felt I got asked the same questions as I had from the GP. I felt that for some, this might be the opportunity to answer questions differently, if they still weren't sure about having therapy and admitting to their problems.

I knew my GP pretty well so it was easy to bring up problems especially as it was face to face, but I had to answer these questions [the triage] when stood outside McDonalds on a busy road and that was hard. However, the therapist I spoke with was empathetic and non-judgemental. This was different to other experiences I've had with hospitals where no one has done that. As I walked in the door of the service I felt it was perfectly welcoming. Everyone was perfectly friendly, informative, asked me to fill in the forms and sign in with just my initials, so there was privacy. I wasn't made to wait, which is what people don't like. There was good information around on keeping fit, stopping drinking and smoking, which was helpful. I couldn't think of anything to improve it!

The initial meeting with my therapist was good. At the time I didn't know my problem was a problem so it was good to hear someone else's side and their understanding of what you described and what might have been causing it. I knew it would never be a case of someone rolling their eyes and saying you don't have a problem with that, but they immediately understood and were empathetic. As the sessions went on I could actually see myself changing as I filled in the questionnaires. Conversation was free flowing and not too structured, which I liked. My therapist was a good interrogator; I felt able to voice any concerns!

In my last session the therapist said that everything was going very well and improvement had been made over the course of treatment. We didn't complete a firm staying well plan but they said they would be happy for me to come back if I needed further help. I felt by this session ready to finish as I hadn't had anything to write down that week in terms of negative thoughts. If I was the manager of the service, there's not much I would change, it was great from my experience. I suppose the only thing might be increasing awareness; awareness of the problems that you can help with, not just depression and anxiety but post-accident difficulties as well.

Learning from this story

Some people may not be aware of our self-referral process. We now cover this in community outreach sessions. We have also raised awareness about the alternatives of telephone sessions if people can't attend in person. Our website has been revised and we have added this information. We also intend to develop electronic leaflets and add our web site details to our letter templates. People may be uncertain about the purpose of the triage, so are sometimes not in an appropriate place to discuss sensitive issues when contacted. The team has had a lot of new members so we explained to all new members how to appropriately describe a triage appointment to a patient. We also identified that people may not be sure about the number of sessions to expect. Clinicians now set up a treatment contract with the client in their initial assessment/follow-up

TRUST PROJECTS - SMART EFFECTIVE CARE

CLINICAL OUTCOMES

Over the past 2 years the Trust has worked extensively with clinical teams to identify appropriate electronic measures for clinical outcomes using a consistently applied methodology. Discussion with teams has identified that focusing on the management of variation across the three outcomes is the next developmental step aligning with the Trusts intent to develop continuous improvement leaders and organisational capability.

Clinical outcomes are a key strand of clinical effectiveness at CLCH and, alongside patient safety and patient experience, are an important component in the assurance and improvement of quality in clinical practice.

The aim for 2015/16 was to ensure that all CLCH clinical services were competent in the basic use of outcomes measures i.e. that they understand what outcomes should be expected from their interventions, have identified a minimum of three outcomes which they are able to demonstrate performance against on a continuing basis, and have established an aspirational goal for improving performance.

Going forward, services are now being asked to review and analyse the variation in their outcomes each month to establish a 'normal' level of performance and to understand the amount of variation that results within current service delivery. Once the normal level has been established and the common causes of variation have been identified, services should be able to identify a goal for improvement.

Discussions with commissioners are commencing to explore how to incorporate this work into contracts and schedules.

PARTICIPATION IN CLINICAL AUDITS

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 forward clinical audit plan was approved and agreed for 2015-16.

National confidential enquiries

During 2015-16 the Trust was not eligible for participation in any national confidential enquiries but was registered for the following six national audits.

(Information awaited)

National Clinical Audits	Participation	Number of cases submitted or reason for non-participation
Sentinel Stroke National Audit Programme (SSNAP)		
BTS Pulmonary Rehabilitation Audit (part of the national COPD audit)		
Audit of Imperial's Laser Books		
National Audit of Intermediate Care (NAIC) 2015		

National Audits

UNICEF Baby Friendly Initiative audit		
National Parkinson's Audit 2015		

Local and Trust-wide audits

No	Item	Division	Service	Outcome and Actions 2015/16
1.	Re-audit of intervals of taking Bitewing radiographs in children	APC	Dental	The aim of the audit was to ascertain appropriate use of Bitewing radiographs in children in line with national guidelines and if the service had made an improvement on the 73% compliance from the previous cycle. The compliance of the re-audit was 93%. The mandatory requirement for recording the radiograph reports was 100% compliance. To action is to continue to reinforce the guidelines and mandatory requirements.
2.	Audit on Bitewing radiograph for new Paediatric dental patients	APC	Dental	The aim of the audit was to establish if radiographs were taken at the initial assessment appointment of all new patients. 100% patients were considered for radiographs. 64% patients were given a radiograph. 36% were not given a radiograph as on the day the child was unable to co-operate. Request for radiographs has been incorporated in the new referral forms.
3.	Audit of appropriateness of radiographs taken for adult patients across CLCH - Inner	APC	Dental	The aim of this audit was to ascertain if adult patients within the dental service had radiographs taken where there was clinical justification and had a film full report. 100% radiographs taken were clinically justified and all of them had reports. Action is to continue maintaining the compliance.
4.	Audit on frequency of taking Radiographs in adults in Barnet Dental Services (CLCH)	APC	Dental	The aim of the audit was to determine if the radiographs were taken at the set frequencies stated in the Faculty of General Dental Practice guidelines. 73% compliance was noted. The actions identified were to re-audit after one year and to reiterate the guidelines to the clinicians.
5.	Re-audit of dental Recall Process	APC	Dental	The aim of the audit was to establish if dentists were recording the next oral health review appointment after completing the treatment as per NICE guidelines CG19 and to observe if compliance had increased since the first audit. 95% compliance was noted. The compliance had increased from 79% to 95%.The action remains to

				reinforce that all patients should have a recorded agreed interval for routine dental examination.
6.	Blood Borne Virus (BBV) Screening & Vaccination Audit	APC	Homeless Health	Aim of the audit was to establish the current practice after the implementation of BBV Screening & Vaccination Protocol supported by NICE guidelines (PH43). 41% new patients referred to the service were offered BBV screening and 14% were offered 1st dose of Hepatitis B vaccination. The actions include offering health check and screening as standard practice, improve patient information and update the protocol.
7.	Generalised Anxiety Disorder	APC	Primary Care Psychological Health	Aim of the audit was to measure current practice for treating generalized anxiety disorder in adults against the recommendations in the NICE CG113 (Steps 2a, 3a & 3b). 68% met the recommendations in the guidelines. The main actions are to improve the documentation at the point of triage and provide patient information by the practitioners.
8.	Audit of intra uterine device insertions (IUDs) in the Contraception and Sexual Health Service. (CASH)	APC	Sexual Health	The aim of the audit was to assess the performance of clinician inserting the IUD against three Faculty of Sexual & Reproductive Healthcare guidelines namely to insert copper device TCu380 with banded copper on the arms and recording uterine version and length. Compliance for choice of device was 54%, recording uterine version was 99% and for length was 95%. The action is to increase the number of TCu380 IUD to reduce the number of devices replaced early and prevent untoward events.
9.	DAT Scan requests and management outcomes for patients attending Edgware Parkinson's service	BCSS	Parkinson's Service: Barnet	The aim was to ascertain the number of DAT scan requests for the year and to evaluate how the results influenced the management outcome for the patients. 47 DAT scans were requested in the year. DAT scans ruled out Parkinson for 46% cases and helped to provide clearer clinical understanding in uncertain cases, improving management and outcomes for patients.

10.	Safety indicators for patients starting oral anticoagulant treatment	BCSS	Specialist Nursing/ Anticoagulation	The aim of the audit was ensure regular monitoring of safety indicators for the anticoagulant service supporting the British Committee for Standards in Haematology. 100% compliance in following the appropriate loading doses. 15% new referrals were incomplete and were from GP surgeries. All the patients were provided information, written dose instructions and next INR measurement appointment No patients suffered major bleeding in the first month and whilst using INR. No patients had sub-therapeutic INR after stopping heparin. The action identified is improving the quality of new referrals from GPs.
11.	Antimuscarinics prescription by continence specialist nurses for overactive bladder syndrome treatment	BCSS	Specialist Nursing/ Continence Service	The aim of the audit was to assess if NICE Guidelines (CG171)2013 were met in relation to prescribing antimuscarinics in overactive bladder syndrome. There was 100% compliance
12.	Nutritional Care Audit Tool	BCSS	Community Nursing Services – Barnet/Inpatient Rehab: Barnet	Aim of the audit was to ascertain whether malnutrition audit tool, MUST, and dehydration tool, AGULP, were being used in line with the local policy and effectively in care of patients as per NICE (2006) Nutritional Support in Adults. The findings were that use of MUST was complied with and appropriate care plans were being put in place. However, it did not fully comply with NICE guidance as not all patients were assessed on arrival. AGULP tool was not being used and the appropriate care plan was not in place. Actions identified were to ensure MUST assessment was carried out on arrival. AGULP, which was identified as unsafe tool, would be replaced with FURST and appropriate training and practice would be put in place.
13.	Splinting for the prevention and correction of contractures in adults with neurological dysfunction	BCSS	Inpatient Rehabilitation (Barnet)/Inpatient Rehab: Barnet	The aim of this audit is to ensure correct assessment, treatment and management of patients needing and using splints to prevent or correct contractures after a neurological dysfunction as per COT and ASPIN guidelines 2015. WAITING FOR RESPONSE TO QUERY

14.	Audit of MSK clinical staff against NICE guidance of behaviour change: individual approaches PH49	BCSS	Specialist Therapies/MSK	
15.	Management of Osteoarthritis in Adults within the Musculoskeletal Service: adherence to NICE Guideline CG177	BCSS	Specialist Therapies/MSK	The aim of this audit was to ensure the compliance of the musculoskeletal service in accordance with NICE guideline CG177. The service was 80% compliant. The actions include improving the holistic approach to supporting the patient with osteoarthritis of the knee and providing patients with more information regarding any surgical options.
16.	No. of patients with reduced HbA1c within 6 months of treatment from the community diabetes team	BCSS	Diabetes: Barnet & West Herts	
17.	COPD “Hospital at Home" project.	BCSS	Respiratory (Barnet and West Herts)	
18.	Adult Home Enteral Feeding Audit Team Compliance with NICE guidelines CG32	BCSS	Dietetics (Nutrition Support Team)	The aim of the audit was establish that the service was complying with the NICE guidelines CG32. 2 out of 5 criteria met 100% compliance, 93% met the provision of contact details of the healthcare professional and homecare company and 88% records were completed with updated feeding regime. Actions taken have been to produce Patient Information Leaflet which includes all contact details and the assessment form has been updated to include a prompt for ‘updated feeding regime’.
19.	Incidence and management of oedematous wet legs in community setting	BCSS	Community Nursing Barnet	The aim of the audit was ascertain if patients with oedematous wet legs were managed as per NICE guidelines D007871. 61% of patients underwent Doppler Ultrasound assessment and 25% of patients were put in compression bandaging.
20.	Preferred place of death (PPD) in end of life patients	BCSS	Community Nursing/ Community Nursing Barnet	Aim of the audit was to identify the preferred place of death for end of life patients and if the preference was met. 94% patients died in their preferred place. In 4% of the records PPD was not recorded. The action identified is to ensure PPD is stated in 100% records.

21.	Audit of pulmonary rehabilitation uptake after hospitalised acute exacerbations of COPD discharge	BCSS	Integrated Long Term Conditions – Barnet & West Herts /Respiratory (Barnet and West Herts)	
22.	Self- management in COPD in the respiratory service	BCSS	Integrated Long Term Conditions Inner Boroughs/Respiratory Inner London	
23.	Biopsychosocial components of Respiratory admissions within Charing Cross Hospital	BCSS	Integrated Long Term Conditions Inner Boroughs/ Respiratory Inner London	
24.	Venous Leg Ulcer Assessment and Management	BCSS	Community Nursing/Tissue Viability	The aim of the audit was to establish if the current practice of leg ulcer and management aligned with NICE guidance 2012. There was overall 89.5% compliance. A re-audit is recommended.
25.	Pain Tool Audit (re-audit)	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/IPU (doctors)	The aim of the re-audit was to ascertain if there had been an improvement in the use of pain charts for appropriate patients. The compliance for use of the charts in appropriate patients was 87% (58% improvement) and 50% completed regularly for ongoing use. The action is to continue improving.
26.	Slip, Trips & Falls Audit	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care /IPU (nurses & OT)	The aim of the audit was to establish adherence to the CLCH slips, trips and falls policy and practice guidelines on the prevention of falls (NICE, 2013). 100% patients had their falls risk discussed at MDT. 75% had continence assessment and postural BP recorded. MEFRA was completed within four hours for 25% fall patient. The actions include recording time and date when MEFRA completed and where assessments cannot be done, follow up process to be put in place.
27.	Weekend Admissions to Hospital Audit	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/Community	

			Team	
28.	Opiate Audit	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/Community Team	The aim of this audit was ascertain the current practice for prescribing analgesia against Palliative Adult National and NICE guidelines. QUERY
29.	Steroids Audit	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/Pharmacy	The aim of the audit was to ascertain the collection and recording of the information of the steroid use for patients on steroids on admission to the inpatient unit. 45% had an indication recorded and 45% had a plan for the steroids on admission. The action is to ensure that name of steroid, dose, indication and management plan are recorded at time of admission and if the information is not available within 72hours.
30.	Review of Residents' Medical Records and Care Plans	BCSS	Continuing Care Nursing Homes/Athlone House, Garside House, PLK	
31.	Management of Frozen Shoulders	BCSS	Specialist Therapies/MSK	
32.	Effectiveness of the STarT Back allocating patients to different treatment pathways based on their prognosis with current best practice	BCSS	Specialist Therapies/MSK	
33.	Pneumococcal Treatment Compliance	CHD	0-19 Services H&F/Children's Community Nursing	
34.	Paediatric nasogastric tube feeding management (re-audit)	CHD	Children's Therapies/Dietetics	
35.	Giving of Buccal Midazolam by care workers during Seizure management	CHD	0-19 Services H&F/Children's Community Nursing	

36.	Compliance with the Hepatitis B Clinical Practice Standard: for health visitors and Children's Nursing teams working with parents/carers and babies	CHD	0-19 Services H&F/Health Visiting: H&F 0-19 Services K&C/Health Visiting: Westm.	
37.	Rating effectiveness of physiotherapy interventions within Employee Health	Corporate/ Employee Health	Employee Health	
38.	Stress reduction of CLCH employees	Corporate/ Employee Health	Employee Health	
39.	Aseptic Non Touch Technique (ANTT)	Medical Directorate/ Trust wide	Infection Prevention	
40.	Mealtime Mantra audits - bedded services	Medical Directorate/ Trust wide	Infection Prevention	
41.	Urinary Catheter Care Documentation Audit	Medical Directorate/ Trust wide	Infection Prevention	
42.	Dental audits	Medical Directorate/ Trust wide	Infection Prevention	
43.	Hand Hygiene audits - Community Services	Medical Directorate/ Trust wide	Infection Prevention	
44.	Hand Hygiene audits - bedded services	Medical Directorate/ Trust wide	Infection Prevention	
45.	Safe and Secure Handling of Medicines & Cold Chain - Bedded Areas	Medical Directorate/ Trust wide	Medicines Management	
46.	Security of Prescriptions	Medical Directorate/ Trust wide	Medicines Management	

47.	Safe Management and Use of controlled Drugs - Clinics	Medical Directorate/ Trust wide	Medicines Management	
48.	5 Patient Audit on transfer and discharges	Medical Directorate/ Trust wide	Medicines Management	
49.	Safe and Secure Handling of Medicines & Cold Chain - Clinics	Medical Directorate/ Trust wide	Medicines Management	
50.	Use of Antimicrobials	Medical Directorate/ Trust wide	Medicines Management	
51.	Omitted Medicines	Medical Directorate/ Trust wide	Medicines Management	
52.	Safe Management and Use of Controlled Drugs - Bedded Areas	Medical Directorate/ Trust wide	Medicines Management	
53.	Safe Management and Use of Controlled Drugs - Bedded Areas	Medical Directorate/ Trust wide	Medicines Management	
54.	Health Records Keeping Clinical Audit – Re-audit	Medical Directorate/ Trust wide	Clinical Effectiveness Team	
55.	Health Records Keeping Clinical Audit	Medical Directorate/ Trust wide	Clinical Effectiveness Team	
56.	Falls assessment and management in-patient rehabilitation	BCSS	Inpatient Rehabilitation Barnet/ Inpatient Rehabilitation Barnet	
57.	Audit of clinical practice against NICE Falls in older people: assessment after a fall and preventing further falls (2015) Quality standard 86	NCNR	Community Independence Service/Falls Prevention Service	

58.	Re-audit of Dysphagia Outcome Measure (DOM)	CHD	Speech and Language Therapy (Adults)	
59.	Adult Community Nursing Medicines Management	NCNR/ Quality & Learning Division	Community Nursing Service Central London/District Nursing: Central London	
60.	Community Nursing NICE Guidance Pressure Ulcer CG029 2014 - 15	NCNR/ Quality & Learning Division	Community Nursing/District Nursing: Central London	
61.	Falls assessment in the Falls Clinic at Finchley Memorial Hospital	BCSS	Falls prevention service / Intermediate Care Services	
62.	PACE/Rapid Response Assessment Pack Documentation	BCSS	PACE/Rapid Response - Intermediate Care Services	

Service Evaluations

1.	The use of telehealth for patients with long term conditions	BCSS	Integrated Long Term Conditions – Barnet & West Herts /Respiratory (Barnet and West Herts)	
2.	Morning Handover Audit	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/IPU (doctors)	
3.	DNAR Audit	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/IPU (doctors)	
6.	Service Evaluation of the Cross Care System at CLCH with Version 12 of the Liverpool Care Pathway (LCP)	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/IPU (doctors)	
7.	Inpatient Admissions Audit	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/IPU (doctors)	
8.	Out of Hours Telephone Calls Audit	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/IPU (nurses)	
9.	Admissions Audit	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/IPU (nurses)	
10.	Missing Information of Referral Forms Audit	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/Community Team	

11.	Response Times Audit	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/Community Team	
12.	Syringe Drive Monitoring Charts	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/Pharmacy	
13.	Social Work Response Rate – Community and IPU Referrals	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/Social Work	
14.	Implementation of the Ages and Stages Questionnaire [ASQ- 3]	CHD	0-19 Services Westminster/ Health Visiting: Westminster	
15.	Weighing and Measuring Service Evaluation	CHD	0-19 Services Westminster/ Health Visiting: Westminster	
16.	Audit of the movement in process	CHD	0-19 Services Barnet/Health Visiting: H&F and 0-19 Services H&F/Health Visiting H&F	
17.	Effectiveness of Employee Health consultations	Corporate/ Employee Health	Employee Health	
18.	Audit of research governance compliance	Medical Directorate	Research and Development	
19.	Audit to determine compliance to the Trust's Policy on consent to examination, treatment or therapy	Medical Directorate	Research and Development	
20.	Audit of implementation of MCA (Mental Capacity Act 2005) across services	Quality & Learning Division/Safeguarding	Safeguarding Adults	

21.	Audit of supervision record - safeguarding	Quality & Learning Division/Safeguarding	Safeguarding Children	
22.	The impact of the Specialist Weight Management Services (SWMS) on GP practice appointments	BCSS	Specialist Therapies/Nutrition & Dietetics Specialist Weight Management Team	
23.	Panic alarm system in the Podiatry clinics of CLCH, Hammersmith and Fulham branch Audit 2014-15	BCSS	Safeguarding Children	
24.	WIC UCC Safeguarding Audit	Quality & Learning Division/Safeguarding	Specialist Therapies/Podiatry	
25.	Mouth Care Training for Health Care Assistants	CHD	Speech and Language Therapy (Adults)	

PARTICIPATION IN RESEARCH 2015/16

Participation in clinical research demonstrates CLCH's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. 'Clinical research' means research which has received a favourable opinion from a research ethics committee within the **National Research Ethics Service (NRES).**

Research activity is monitored through the Clinical Effectiveness steering group, overseen by the Quality Committee a subcommittee of the Board. It is an established fact that active research within organizations promotes the highest standards of care in its settings. Health research in community healthcare has a potential to create new knowledge which will benefit many NHS organizations. Our Trust is keen to adopt such innovative approaches and practices, improving care and outcomes for our patients.

CLCH offers great potential for research opportunities with its broad range of community services across the whole age spectrum, including: adult community nursing services, children and family services, specialist services to help manage long term conditions, rehabilitation and therapies, palliative care services, NHS walk-in and urgent care Centre's. Future research opportunities for growth within the Trust are focussed on four main disease/service areas: Parkinson's disease, Stroke, Diabetes, Sexual Health and commercial studies.

The Trust Research Strategy (2014-2017) sets out eight key objectives aimed collectively at extending and enhancing the research profile of the organisation.

The research goals are as follows and are intended to be implemented during the period 2014-17. Each goal translates into several actions that are taken forward via an annual implementation plan.

- 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.

These objectives map onto all areas of research activity within the Trust and will be achieved by working in collaboration with partners. We are making steady progress to both promote research activity and develop a research culture in the Trust; this is demonstrated by the achievement of exceeding our recruitment target for 2015/2016 and our annual Trust Research conference. We are ambitious to develop a supporting environment for health research by encouraging and facilitating researchers and to make effective partnerships with clinical research networks, other NHS Trusts, academic and industry sector.

CLCH was involved in 24 clinical research studies in a number of specialities during 2015/16 either as a Participant Identification Centre (PIC) or a host site including; Diabetes, Children's health, Stroke, Sexual Health and Parkinson's. The number of patients receiving relevant health services provided by Central London Community Healthcare NHS Trust during 2015-16 that were recruited during that period to participate in research approved by a research ethics committee was 150. These patients were recruited into a clinical trial research project within the Sexual Health service.

In 2015/2016, there were over 40 clinical staff participating in research covering 4 specialities approved by a research ethics committee. CLCH is a host site for approximately one third of studies, for a further third, CLCH acts as a Participation Identification Site (PIC) and the remaining studies are educational projects either self-funded by students or funded by the Trust for educational purposes such as MSc or PhD qualifications.

The following are a few examples of current studies that CLCH is involved in:

- Health visitors' knowledge about pre-term infants care within the community
- A cross-sectional study of young-onset diabetes in 2 UK ethnic groups
- Patient-consented samples for STI diagnostic development & evaluation
- Exploring the training needs of health visitors working with children with Down syndrome:
- Working Memory Training in Type 2 Diabetes

PATIENT STORY – Parkinson's Service

I came to the Parkinson's Unit through the Manager in my Doctors surgery, she referred me. I received a letter from the Parkinson's Unit with an appointment date to see a doctor. I saw her a few months ago. My walking wasn't so good then and she said it was Parkinson's.

They asked me to see the nurse next door. I am no good at drawing or maths and couldn't get the figures right. The nurse may have thought I had something wrong with me as I couldn't do it. It was nothing to do with my memory. The only thing that surprised or concerned me was the nurse was asking me maths questions I am not good at. They did not explain why they were doing it. It may have been good to explain why they were doing the test. The doctor organised to see me in 6 months time.

A therapist told me they would like me to go on a 6 week course. It would have been difficult for me as I have to get 2 buses to Edgware so they organised the hospital transport. They organised everything. I found the course extremely helpful. The therapist also came to my home. She arranged for someone to put a handrail under my mattress. I find it a big help. She also felt my coffee should be moved. She said my toilet frame should be raised but I felt it wasn't necessary, she respected my decision. The Physio was excellent and Occupational Therapist was very good. Even the woman who does the tea was lovely. I phoned the helpline the other day. I spoke to a man who put me straight through to a Nurse who spent 30mins speaking with me. This was very helpful.

When I saw the doctor she wanted to up my dose of Parkinson's medication more and I said no. I don't know if I need to up it now, but she respected my decision. I was worried the medication would need to keep going up. The Occupational Therapist involved me in everything. She left a couple of magazines with things I can buy. This was very helpful.

To be honest, I do not like being a patient with Parkinson's, but I must say the Parkinson's Unit down to the receptionist, Occupational Therapist and Physiotherapist were all very kind, caring and nice. There are always staff around and the receptionist if there are any problems. I am still trying to come to terms with my Parkinson's. I have accepted it as I have been told by 2 Doctors. It's like anything I wish I didn't have it as I get very tired in the afternoons and don't sleep well at night.

If people didn't know the staff, it would be helpful if people said who they are, when they come into the waiting room. It may also be helpful to introduce the patients to each other.

Learning from this story

This person tells us a very positive story about their experience within the Parkinson's service. We learn, however about the importance of staff introducing themselves and providing explanation. The trust joined a national campaign in March 2015; 'Hello my name is'. This reminds staff to introduce themselves to patients as the start of making a vital human connection, beginning a therapeutic relationship and building trust between patients and healthcare staff. Patients are asked in our feedback surveys if care and treatment was explained in a way they could understand, and teams are provided with this feedback to inform their future practice.

LOOKING BACK - PROGRESS AGAINST THE AGREED 2015-16 QUALITY PRIORITIES

AT A GLANCE SUMMARY OF PROGRESS AGAINST 2015 – 16 QUALITY PRIORITIES			
Quality domain	**Priority**	**Achieved**	**Further Action**
Patient experience	1. We will improve patient engagement in relation to working together in partnership to change/improve quality	YES	This work will be incorporated into the Trust Patient Experience Strategy
Patient experience	2. We will work to support a single point of access for patients with long term conditions	PARTIALLY	
Preventing harm	3. We will improve service users' involvement in service improvement projects and safety campaigns	YES	This work will be incorporated into the Trust Patient Experience Strategy
Preventing harm	4. We will continue to reduce medication errors in practice	YES	We will continue to monitor medication errors as part of our Quality Dashboard and act where errors are noted
Smart effective care	5. 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	PARTIALLY	We will ensure that more information is available on our improved internet site
Smart effective care	6. We will improve the percentage of relevant NICE clinical guidance that have been assessed by eligible clinical teams	YES	The Trust will continue to monitor as part of our clinical effectiveness group reporting to the Quality Committee.

PROGRESS AGAINST QUALITY ACCOUNT PRIORITY 1 - WE WILL IMPROVE PATIENT ENGAGEMENT IN RELATION TO WORKING TOGETHER IN PARTNERSHIP TO CHANGE/ IMPROVE QUALITY.

Our approach to patient engagement was informed by our engagement strategy which translated into local plans for each Clinical Business Unit. In reviewing our strategy we have used the Trust Development Authority Patient Experience Framework to assess our current position and to determine our objectives for the next three years. Feedback from listening events has also been used to help inform our approach.

We use a variety of approaches in capturing patient experience feedback to inform continuing service and quality improvement. These include the Friends and Family Test, Patient Reported Outcome Measures (PREM's), patient stories, 15 steps challenge visits and listening events. The Trust also uses formal and informal complaints (Patient Advice and Liaison Service, PALs) and has an active Quality Stakeholder Reference Group to support us in understanding the quality of our patient's experience.

During the year, we have held a number of listening events within several of the boroughs in which we deliver care; Barnet, Hammersmith and Fulham, Kensington and Chelsea and Westminster. The purpose of these was to engage with as wide an audience as possible to share information about services and health related issues, ask what matters to patients most and to identify what is working well and what could be improved. In May 2015 four listening events were held across our boroughs to explore a positive patient experience. We enabled wider participation through telephone interviews and an online survey. Our aim was to find out what aspects of the patient experience are so important that we should always get them right. In these discussions people identified what good care should look like and what we should always do. People also told us their views about involvement in care, health information and expectations of professional staff. Additionally, we sought people's views on what we do well and what we could do better.

From these discussions, the following themes emerged: the importance of consistency of healthcare professionals continuity of care and experienced front line staff), communication (Improvement in healthcare professionals communication skills and better training for telephone staff, being well-prepared (reading notes in advance and knowing about the patient), telephone access and response (not easy for people to leave messages or have their calls returned) and incorporating patient feedback (making sure people's feedback is used to improve what happens day to day).

This feedback will enable us to develop 'Always Events'; practices or behaviours that, when implemented reliably, ensure an optimal patient and family experience and improved outcomes. They provide clarity about what should happen for every person, every time they encounter our teams within CLCH. These Always Events will be incorporated into our new Quality Strategy and Engagement Strategy whilst each clinical division will develop local plans to embed these Always Events into their services.

In November 2015 a series of listening events were held to engage specifically with children and young people, their parents or guardians. The purpose was to explore what makes a good experience, how it could be better and whether information provided by healthcare professionals is easy to understand. Engagement in this discussion was widened through paper or online surveys.

Overall, it was seen that friendly, approachable and professional healthcare staff contribute to a good experience, and that information provided to them is largely clear and understandable. Areas for improvement related to poor communication or interaction with individual professionals at their appointment. In response to the feedback, local action plans have been developed in Children and Young Adult's services and these themes have informed the revision of our Engagement Strategy.

Our Continuous Improvement Programme (CIP) enabled our staff to take forward Rapid Improvement projects. The intensive 10 week course uses a combination of classroom teaching and practical work to provide our staff with the skills and confidence to apply methods to improve services and ultimately help provide better care for patients. A recent project focused on improving working practices between GPs and community nursing teams. A patient co-facilitated a training session for the programme participants and we have also had a patient participating in a Rapid Improvement Event for our staff.

PROGRESS AGAINST QUALITY ACCOUNT PRIORITY 2 - WE WILL WORK TO SUPPORT A SINGLE POINT OF ACCESS (SPA) FOR PATIENTS WITH LONG TERM CONDITIONS

All referrals come via the SPA. Referrals are then transferred in to the services for clinical triage every day. There is one phone number for patients to contact regarding appointments. Considerable work has taken place to improve communication between the SPA and our clinical services. This means that patient queries are signposted appropriately and promptly; there is now more integration between the SPA and our clinicians. Our Patient Advice and Liaison Service has been able to resolve appointments with callers promptly as a result of these changes and stakeholders, especially General Practitioners, find the system easier to use.

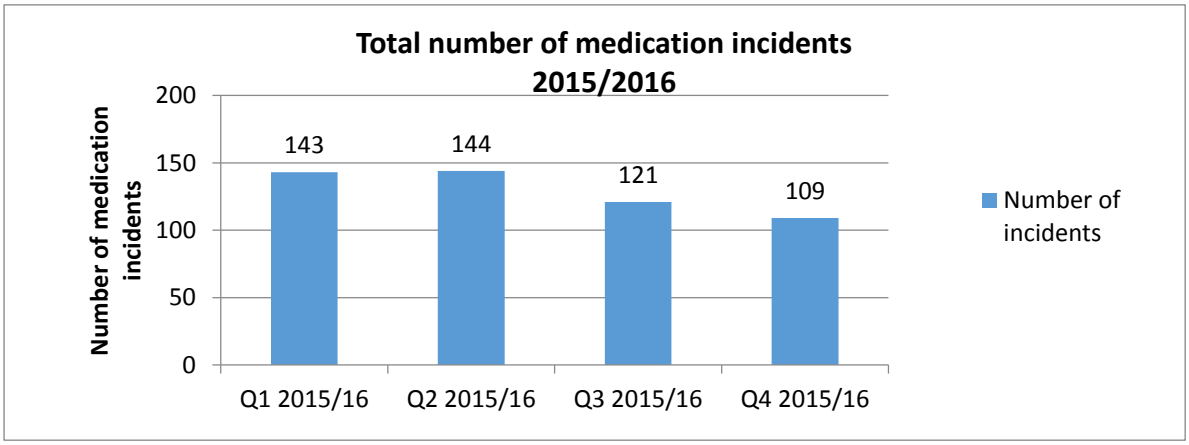
PROGRESS AGAINST QUALITY ACCOUNT PRIORITY 3 - WE WILL IMPROVE SERVICE USERS' INVOLVEMENT IN SERVICE IMPROVEMENT PROJECTS AND SAFETY CAMPAIGNS

As described elsewhere in detail in this account, CLCH joined the 'Sign up to Safety' campaign and was one of the first trusts to do so. We believe that listening to our patients, families, carers and staff is paramount and we want them to play an active and valued role in shaping and influencing how safety and improvement plans are developed. We know that the patient voice is a powerful force for change if listened to and learned from.

PROGRESS AGAINST QUALITY ACCOUNT PRIORITY 4 - WE WILL CONTINUE TO REDUCE MEDICATION ERRORS IN PRACTICE.

As can be seen in graph 15, there was a decline in the total number of reported medication errors in 2015 - 16 with a 24% reduction reported in Q4 compared to Q1.

Graph 15 – **Total number of medication incidents 2015-16**



Of the 517 reported incidents, 30 were categorised as having caused a level of harm in 2015/16. This is a significant reduction from the baseline in 2012/13 where 156 incidents were reported as having caused a level of harm.

During the year in question, there were a number of projects led by the medicine's management team that helped reduce the number of medication incidents. These included:

- The procurement and implementation of a remote fridge monitoring system and face to face cold-chain training sessions to tackle the cold chain incidents
- A review of the medicines management training packages for staff with a new programme ready for rollout in 2016/17
- A Medicines Optimisation Service (MOpS) service that was commissioned by Central and West London CCGs. This service helps to keep patients safe in their homes and prevent avoidable medicine-related hospital admissions by undertaking clinical medication reviews in patient's homes
- A continuation of the audit programme focussing on Safe and Secure Handling of Medicines at approximately 200 community clinics and bedded services, Omitted Doses and Antimicrobial Audits
- An increased reporting on errors on transfer from secondary to primary care with feedback to the relevant Acute Trusts
- A review of the Clinical Pharmacy services at bedded rehabilitation units with a change in the model at one unit and support on the roll out of a new drug chart at Barnet bedded services
- A review of Datix incident reporting and refining of categories within the medication field on Datix to help capture more accurate data

PROGRESS AGAINST QUALITY ACCOUT PRIORITIY 5 - 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 are awaiting the delivery of the new electronic dashboard. This is a quality dashboard which will be available on the Trust's intranet. One in-patient ward now has a quality board in place that gives members of the public information on patient experience and safety.

PROGRESS AGAINST QUALITY ACCOUNT PRIORITY 6 - WE WILL IMPROVE THE PERCENTAGE OF RELEVANT NICE CLINICAL GUIDANCE THAT HAVE BEEN ASSESSED BY ELIGIBLE CLINICAL TEAMS

During its monthly meetings, the NICE (explain?) Core Group, which is chaired by the Medical Director and consists of professional and clinical leads, systematically reviewed all NICE guidelines published in 2015/2016 while aiming to meet the Trust's key performance indicator that all specialities are fully compliant with relevant NICE guidelines within 6 months of publication.

In the process, 30 guidelines were considered relevant to the Trust and were subsequently circulated to specific clinical services for information or for assessment by means of a gap analysis tool using the NICE Baseline Assessment form (NBAF) electronic system. Where there was a gap, services were expected to develop action plans to ensure compliance with attention being paid to whether the services needed to work beyond the boundaries of their own service or required resources. Completion evidence was provided at NICE Core Group meetings.

PATIENT STORY - Health Visiting

I said to your Nursery Nurse that because we are a 2 mummy family we have found while people try to be inclusive and while I suppose it is a relatively new concept in terms of society, we have had a really relaxed experience at your clinic. There has been no stumbling over words or people second guessing or trying to include us as a separate entity. It has been a very natural inclusive experience and that is really important for us because it's really important for us that our little girl grows up in a society that doesn't treat her and her family any differently.

The Nursery Nurse has been totally invaluable to us. Actually we got ourselves into the habit after baby had her injections because she wouldn't settle on her own so she was sleeping between us and then we got stuck. We couldn't get her back to her cot and the Nursery Nurse advised us and we have got her back in her cot now. She has been really lovely.

The first time parents group has made a massive difference it has saved us so much 'googling' which is just a nightmare, just knowing that other people have the same situation as you. We are lucky we have a really supportive family but I would imagine for people that don't, we look at each other and say how do they do it on their own.

Because baby was premature it has been quite interesting coming to the baby clinics and next time we weigh her she will probably be about 5 stone!! because she has really caught up. But it has been important to us to track her progress perhaps more than someone else.

What is really good is that within the group all the mums have different experiences. A good example is when she was going for her injections - I said 'my baby has her injections tomorrow' and one mum said to me 'don't forget to buy the calpol and straight away another mum swooped in and said 'my doctor said don't do it unless she has got a fever'. So I was faced with 2 opinions and I said 'thanks I will just ask my nurse' and then I spoke to the Nursery Nurse because I thought she is a professional and I will take her guidance.

The only thing that frustrates me about the clinic is having to leave your buggy downstairs which I can understand but that is my only issue but they are making it accessible for people.

Learning from this story

This story identifies a positive experience of the service, but the person expressed their initial frustration as buggies need to be left downstairs at this clinic. The staff have recognised this concern and have put a system in place to provide locks so that these can be secured whilst people attend their appointment

LOOKING FORWARD - OUR QUALITY PRIORITIES FOR 2016-17

In this section we detail our quality improvement priorities for the coming year. Our Chief Nurse and Director of Quality Governance, Louise Ashley has overall responsibility for the development of our Quality Account. The priority leads within the account are as follows:

Positive Patient Experience: Ms Holly Ashforth, Director of Patient Experience
Preventing Harm: Professor Charlie Sheldon, Director of Patient Safety
Smart, Effective Care: Dr Joanne Medhurst, Medical Director

Progress against our priorities will be reported to the Quality Committee on a quarterly basis as part of our comprehensive quality report.

QUALITY PRIORITY 1 – POSITIVE PATIENT EXPERIENCE, PREVENTING HARM – DEVELOPING A QUALITY ALERT PROCESS FOR STAKEHOLDERS

We will develop a mechanism by which clinicians in other organisations can quickly alert CLCH to issues about our service; either those experienced themselves or issues reported to them by patients. We will establish a secure email system for these alerts and will set targets for reply and resolution of these issues.

What will success look like?

In quarter one we will communicate with referrers to our service regarding the process for using the alert system. The alert system will be implemented from quarter two. Alerts to the central inbox will be responded to by close of next working day. Logged and monitored.

A summary of the alerts received will be included in the weekly incident and complaint pack for the Executive Leadership team. A quarterly summary of quality alerts will be reported to the relevant CCG as part of the quality monitoring process.

QUALITY PRIORITY 2 – POSITIVE PATIENT EXPERIENCE, PREVENTING HARM - IMPLEMENTING A QUALITY EARLY WARNING SYSTEM

The Trust's quarterly Quality Report and monthly Quality Key Performance Indicator (KPI) analyse progress against all aspects of quality performance, including the Quality Strategy and Quality Account. The reports currently use funnel charts to identify outlying teams and the action being taken to support them. Within the report there are exception reports for any 'red' areas. Discussions at Trust Board and subcommittees look to triangulate information from performance reports and KPIs with professional judgement and insight from walkabouts and listening events. If there are ongoing concerns regarding any of the indicators, members of the Board can request further deep dives into areas of concern. An example of this is the community nursing teams in one of the Boroughs who had appeared as 'red' on several indicators for staffing, appraisals, pressure ulcers and falls.

In 2016/2017 we will develop a set of red flags to compliment this work and to provide an early warning system that will identify issues ahead of the reporting systems, therefore allowing very immediate actions to be taken prior to having to consider instigating a quality action team. This will allow us to maintain a spotlight on quality in the expanded organisation.

WHAT INDICATORS WILL WE USE?

Preventing Harm
A 10% increase in incidents causing harm (moderate or above)
Any new serious incidents reported

Positive Patient Experience
An increase in complaints
A drop in FFT score

Smart, Effective Care
Reduction in clinical outcome reporting
Any care/ clinical related internal serious incidents

Workforce
Absence of a team leader for >1 month
Vacancy rate above 12%

WHAT WILL SUCCESS LOOK LIKE?

How will the system work?
A red flag report will be triggered if:
i. a team has 2 flags or greater.
ii. A team has 1 indicator red > 2 months

How will we act upon Red Flags?
Departments/teams with a red flag will be asked to put a risk on the risk register and provide monthly progress as part of their report to the Patient Safety & Risk Group. The risk will be managed with an action plan in the usual way.

Support for Teams
It is expected that teams with a red flag will have assistance from the Divisional ADQ (explain) in drawing up plans. The appropriate Director (for example HR Director, Director of Patient Safety should ensure that the team lead has access to their specialist team).

Reporting of Red Flags
The red flag report will be reported to the Quality Committee monthly and will also be highlighted monthly at the Executive Leadership Team Meeting.

Commissioners will receive a report on relevant red flag teams as part of the monthly quality reporting and updates on action plans and progress as necessary.

QUALITY PRIORITY 3 – SMART, EFFECTIVE CARE - WE WILL ENSURE THE BALANCE BETWEEN ASSURING SAFE EFFECTIVE CARE AND ENABLING SYSTEMATIC IMPROVEMENT OF SERVICE QUALITY.

What indicators will we use?

- % new NICE guidance reviewed, assessed and implemented within 12 month deadline
- % completion of actions from Audits within deadline (TBC)
- % services reporting clinical outcomes (via reporting platform)
- Number of staff been trained via Continuous Improvement Programme
- % Continuous Improvement graduates participating in improvement in past 12 months

WHAT WILL SUCCESS LOOK LIKE?

Monitoring

- The Trust will monitor the adoption of best practice through the monthly assessment of new NICE guidance and its implementation.

- Every Clinical Business Unit (CBU) will undertake clinical audits to assess adherence to best practice standards.

- All services will monitor patient outcomes to understand the effectiveness of clinical interventions.

Development

- The Trust will develop capacity and capability for quality improvement through the delivery of the CLCH Continuous Improvement Training Programme.

- Graduates of the Continuous Improvement Programme will participate in improvement projects annually.

- Supporting services to identify improvement opportunities through effective analysis of quality data.

PATIENT STORY – District nursing case management

I left school when I was sixteen; I was brought up in the slums in Glasgow and joined the army, moved all over. I used to go to hospital a lot. I had 2 strokes, couldn't walk and couldn't talk. In 2004 I had a dislocated disk. It was a lot to deal with.

I started to see 'A' for the past 3 or 4 weeks I think. Before that it was different people. I like 'B' she is very nice, but she doesn't talk much. 'A' has more conversation with me. In the past people came to do a job, but now it feels like they care about me. 'A' cares about me more. I feel like she listens, she understands me better. I didn't want to attend the meeting at the hospital. Doctors and nurses don't listen to me in hospital so there is no point in me going. I was happy for 'A' to explain everything on my behalf as she understands me. I was able to tell her how I wanted my care to be given and 'A' listened and answered all the questions I had. I am able to tell her what I want in my care and I can also tell her if it's not working.

I've read the plan crisis plan and I agree with it. I have given the warden of the sheltered accommodation a copy of the plan and I know where my crisis plan is. The plan is very easy to understand. The staff are very committed and helpful. I still want to socialise and they are helping me, referring me to the groups at St Charles and other local groups.

The ambulance has come to see me, but I didn't want to go to hospital. With the plan I was happy to stay at home. I feel more confident talking but I get pain after talking for a long time my speech gets gibberish. I don't go to hospital anymore as I don't like hospitals, and staff in hospital bullied me. Having a Community Matron made my care more individualised. My confidence has increased and I feel more respected, not like in hospital. I feel I have better treatment now. The crisis plans are great and people care more. I can use the plan and now I have a rescue pack. The patch makes it very easy for my pain. I do it myself and change it every Friday at 3pm. It is very easy and they taught me.

Hospitals are not nice places to be, so the crisis care plan is good. I'm glad this is bringing change. Changes are for the better. I love change that is the secret to survival.

Learning from this story

We will aim to link the issues raised in this story around communication with the Trust's work on compassion (one of the 6cs) and `knowing you matter - see me, know me, connect with me'

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

This year we asked members of the public our users and staff to proposed areas for consideration under our 3 campaign headings. All the comments made are considered by the Trust and are taken forward where appropriate.

In response to this consultation we received 32 comments; not all of which proposed quality priorities. As might be expected from an open question, there was no single opinion as to which areas CLCH should take forward as their quality priorities. Responses were received about a number of issues ranging from the quality of reception staff and administration staff; the time it takes to get an appointment; medication errors, and staff training. All the issues raised (where relevant to CLCH) are looked at via the performance scorecard.

In some cases the replies referred to acute or mental health care trusts or the care that had been provided by a GP – all of which were not applicable to CLCH.

In addition, we wrote to the Chairs of Healthwatch, 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.

PATIENT STORY – Finchley Walk in Centre

I burnt my lower left leg on a motorbike exhaust whilst on holiday in Poland. I attended a local chemist who sold me an antiseptic cream which l applied. On my return home l had and abscess. I attended Barnet Hospital and was given a course of antibiotics. I was referred to your service by my GP for a review and change of dressing of my wound. I was informed by the GP twice that they do not do dressings at the surgery although there is a nurse at the surgery. I wondered why the nurse at the GP surgery could not review and change my dressing. I was not given any choice of a local Walk in Centre to attend but chose to come to the Finchley Walk in Centre.

I travelled there by bus and when l reached the main entrance I noticed the building was new. It had a car park facility which was free although l don't drive. The waiting room was packed with patients and I was informed the waiting time was 4 hours on my first visit, but then the total time from registering to being discharged was only two hours and today I was seen with 45 minutes.

My main concern is about the waiting time and too many people at times. I am lucky to be within the Finchley Walk in Centre catchment area and would highly recommend it. I am grateful and appreciative of the way I was treated by the staff. The care has been outstanding at every level from the receptionist to the nursing staff.

Learning from this story

The key issue for this person related to reliable information about waiting times within the Walk in Centre. To address this issue, we now have display screens which are updated regularly with information about current waiting times. We have introduced a new numbered queuing system for patients who arrive in the morning before opening time and a 'Triage and Treat' system has been introduced during busy times whilst doctors provide increased hours within the Walk in Centre.

REVIEW OF QUALITY PERFORMANCE - REQUIRED INFORMATION

The following is information that has not been reported on elsewhere in this account but that is required to be included by the Department of Health.

CARE QUALITY COMMISSION

The Trust was inspected by the Care Quality Commission in April 2015.

CQC findings – Good and Outstanding Practice to be replicated across the Trust

- The tissue viability service had developed innovative practice and had taken part in international research and the development of NICE guidance
- The nutrition and dietetics service provided excellent, patient centred care based on leading and setting standards in dietetics and nutrition including NICE guidance development and facilities for patients. The service participated in international research and publication
- In Adults services:

  The service responded proactively to reported incidences of pressure ulcers through training, Communication and distribution of resource packs to residential home staff

  Multi-disciplinary, patient centred care was evident and involved a range of specialist staff involved in joint visits to the patient. External partners included GPs, housing and social services, police, the prison service and mental health

  The turnaround work undertaken on Jade Ward was noted to have effected significant improvements in delivery of care

CQC findings – areas for improvement (must do's)

- End of Life Care services were caring and responsive although required improvement to safe, effective and well-led domains
- Children's services were caring, effective, responsive and well-led although required improvement in the safe domain
- Recruitment and retention of staff across a number of areas
- End of Life Care services were caring and responsive although required improvement to safe, effective and well-led domains
- Children's services were caring, effective, responsive and well-led although required improvement in the safe domain
- Recruitment and retention of staff across a number of areas

CareQuality Commission

Last rated
20 August 2015

Central London Community Healthcare NHS Trust

	Safe	Effective	Caring	Responsive	Well led	Overall
Community health services for children, young people and families	Requires improvement	Good	Good	Good	Good	Good
Urgent care services	Good	Good	Good	Good	Good	Good
Community health services for adults	Good	Good	Good	Good	Good	Good
Community health inpatient services	Good	Good	Good	Good	Good	Good
Community dental services	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Last rated
20 August 2015

Central London Community Healthcare NHS Trust

Are services

Safe?	Requires improvement
Effective?	Good
Caring?	Good
Responsive?	Good
Well led?	Good

The Care Quality Commission is the independent regulator of health and social care in England. You can read our inspection report at www.cqc.org.uk/provider/RYX

We would like to hear about your experience of the care you have received, whether good or bad.

Call us on 03000 61 61 61, e-mail enquiries@cqc.org.uk, or go to www.cqc.org.uk/share-your-experience-finder

As can be from the grid above, CLCH was rated as *requires improvement* in the *safe* domain. This was mainly due to vacancies in some services. Like most trusts in London, CLCH is affected by the shortage of available nursing staff. In response to this, CLCH has put in place a number of initiatives to address this – these include a recruitment summit, chaired by the CN to look at innovative ways of trying to recruit hard to reach groups and international recruitment.

CQUIN PAYMENT FRAMEWORK

A proportion of CLCH's income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between CLCH and the three CCGs which make up North West London (NWL) Clinical Commissioning Groups and Barnet Clinical Commissioning Group (CCG).
Our achievements against the CQUIN goals for 2015/16 are detailed in the following tables:

(NB these are currently still draft)

North West London (NWL)

CQUIN	Goal	Plan 15/16 £	Forecast 15/16 £
Dementia	Staff Training in CLCH and in Care Homes Carers' survey	£169,000	£118,000
Shared patient record and real time information system	Implementation and roll out of shared care records across all services- Year two of two year CQUIN- Emphasise full roll out and implementation- Interoperability is Key	£439,000	£439,000
Diagnostic Cloud across the NW London health economy	Introduction of the Diagnostic Cloud across CLCH services. This is an IT system enabling staff to view a patients diagnostic results across providers and to order diagnostic tests	£639,000	£639,000
Tissue Viability	To standardize and improve the quality and effectiveness of Tissue Viability services across Central London, West London and Hammersmith & Fulham CCGs	£217,000	£174,000
Supporting 7 Day Working	Analysis of current 7 day working requirements and plan for extending 7day working to support a 7 day health system and discharge from hospital	£150,000	£150,000
Continuous Improvement		£80,000	£80,000
NWL TOTAL		**1,914,592**	**1,425,700**

CQUIN	Goal	Plan 15/16 TOTAL £	Plan £TOTAL
Value based commissioning (Long term condition management)	Reduce unplanned admissions into hospital or attendances at A&E for patients over 65 through crisis care planning	206,966	157,294
Children's Safe Transition into Adult Services	Increased attendance at multidisciplinary /professional meetings. Increased patients with key transition planning evident within their care plan.	68,989	34,494
Dementia	Dementia awareness training (1) and screening (2)	(1) 41,393 (2) 27,595	(1) 31,046 (2) 24,837
Tissue Viability	Improved access to leg ulcer clinics	344,943	155,225
NCL TOTAL		**689,886**	**402,896**

NHS England

CQUIN	Goal	Plan 15/16 TOTAL £	Forecast 15/16 £
Diabetic retinopathy – uptake of screening services	Increase uptake of screening services (April 16 to Oct 16 only)	£7, 400	£7,400
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)	£6,100	£6,100
Child immunisations co-ordination	To co-ordinate immunisations across CLCH	£3,800	£3,800
Offender health – TB screening (Non digital)	TB screening; Escort and Bedwatch Audit; Ensuring adequate staffing levels	£195,000	£195,000
NHSE TOTAL		**£212,300**	**£212,300**
ALL TOTAL		**£2, 816,778**	**£2, 040 896**

DATA QUALITY

CLCH recognises that Information Governance which has as a component high quality data is essential for the effective delivery of patient care and to enable continuous improvements in care provision. This includes ensuring that personal data is treated in the strictest confidence, managed securely and is shared for the purposes of direct care in line with the Caldicott principles. The Trust is 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.

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 clinical and administrative 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 during the 2015/2016 year:

- The Data Quality Strategy was revised and re-issued in late 2015. This supports the already published Data Quality Policy
- A limited number of self-service data quality reports are now available on the CLCH Hub (intranet). These reports will increase in number during 2016/2017
- Additional reports covering specific areas of data quality are sent out on a weekly basis to service managers
- We have started to make use of third-party data quality reports from the Health and Social Care Information Centre (HSCIC) relating to submissions to the Secondary Uses Service (SUS)

In addition, a Performance and Information Data Quality Operations Group (PIDQOG) was established during the year, chaired by a Divisional Director of Operations. In the context of data quality this group has three specific aims:

- Support the Accountable Officer for Data Quality and Data Validation (the Chief Executive) and provide assurance that the quality of data within the Trust is of a high standard for accurate decision making and reporting
- To act as a central focal point for Data Quality matters within the Trust, from both a clinical and corporate services, including having ownership and responsibility for reviewing data quality issues and developing action plans to address those issues

To be responsible for supporting the development and implementation of corporate strategies, policies and procedures for data quality

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 94.6% for accident and emergency care. The percentage of records in the published data which included the patient's valid General Medical Practice code was 96.5% for accident and emergency care.

CLCH did not submit records during 2015/16 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 2015/16.

INFORMATION GOVERNANCE TOOLKIT AND REVIEW OF SERVICES

The Trust has maintained Level 2 compliance against the Information Governance Toolkit and achieved a score of 76%. This represents overall satisfactory compliance which has been confirmed by the Trust auditors.

REVIEW OF SERVICES

During 2015/16 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 2015/16 represents 100 percent of the total income generated from the provision of NHS services by CLCH for 2015/16.

STAFF SURVEY RESULTS[1]

Key Score 26 (KS19 in 2014 survey) – Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

2014 Score – 28%
2015 Score – 24%

This represents an improvement of 4% but it is still above the national average for community trusts which is 21%.

(The figure above combines results from two separate questions as follows:
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from:

Managers	88% said "never"	Community Trust average: 89%
Colleagues	82% said "never"	Community Trust average: 86%)

Key Score 27– Percentage of staff believing the trust provides equal opportunities for career progression or promotion

In 2015 **83**% said yes. Community Trust average: 89%
In 2014: 82% said yes.

Our Plans for improvement:
We have identified bullying and harassment hotspots by looking at staff survey data at service level and we are offering workshops to those teams with scores significantly higher than the trust average. This has proved useful in the past because it has helped team members develop effective working relationships.

[1] (results for indicators KS19 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) and KS27 (percentage believing that trust provides equal opportunities for career progression or promotion) for the Workforce Race Equality Standard

Additionally we are looking at options to prevent bullying and harassment at an early stage. These include developing the mediation service and raising its profile. We are also recruiting and training additional mediators and anticipate that four new mediators will be trained in May. We are also encouraging the use of the *restorative practice* approach within teams, which again aims to repair relationships as an alternative to using the formal bullying and harassment policy.

Finally we are building management capability through a range of management training options such as the clinical team leaders' development programme as well as a course designed specifically for managers who are new to management. We are also looking at how to provide training for managers to help them promote health and wellbeing in their teams, with a particular emphasis on how to spot and handle mental health issues. While none of this is specifically about reducing bullying and harassment, we believe that it will help develop a constructive and supportive team environment which provides a good basis resolving concerns at an early stage.

A workforce race equality standard has been completed by CLCH and shared with BME Staff. A board seminar is planned for April 2016 and a work plan will be formulated following the seminar.

STATEMENTS

HEALTHWATCH
COMMISIONERS
HEALTH OVERVIEW COMMITTEE

(These will be added when received).

FEEDBACK AND FURTHER INFORMATON

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 few 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, please call our communications team on 020 7798 1420.

Further advice and information
If you would like to talk to someone about your experiences of CLCH services or if you would like to discuss 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)
Email pals@clch.nhs.uk
Tel 0800 368 0412
Switchboard for service contacts Tel 020 7798 1300
Local Healthwatch

Central West London Healthwatch
For Hammersmith and Fulham, Kensington and Chelsea and Westminster Email healthwatchcwl@hestia.org Tel 020 8968 7049

Barnet Healthwatch
Tel 020 8364 8400 x218 or 219
www.healthwatchbarnet.co.uk

Local Clinical Commissioning Groups

Barnet CCG
Tel 020 8952 2381 www.barnetccg.nhs.uk
Central London CCG
Tel 020 3350 4321 www.centrallondonccg.nhs.uk

Hammersmith and Fulham CCG
Tel 020 7150 8000
www.hammersmithfulhamccg.nhs.uk

Harrow CCG
Tel 020 8422 6644
www.harrowccg.nhs.uk

Merton CCG
Tel 020 3668 1221
www. mertonccg.nhs.uk

West London CCG
Tel 020 7150 8000
www.westlondonccg.nhs.uk

Local councils

Barnet
Tel 020 8359 2000
www.barnet.gov.uk

Harrow
Tel: 020 8863 5611
www.harrow.gov.uk

Hammersmith and Fulham
Tel 020 8748 3020
www.lbhf.gov.uk

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

Merton
Tel: 020 8274 4901
www.merton.gov.uk

Westminster
Tel 020 7641 6000
www.westminster.gov.uk

Healthcare organisations

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

NHS Choices
www.nhs.uk

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.

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.

National reporting and learning system (NRLS)
The NRLS receives confidential reports of patient safety incidents from healthcare staff across England and Wales. Clinicians and safety experts analyse these reports to identify common risks to patients and opportunities to improve patient safety.

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.

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 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.

10. APPENDICES

APPENDIX 1 – COMPLAINTS ANNUAL REPORT

(This will be attached to final Quality Account).