Quality Campaign	Key Performance Indicator	Target	Performance Current Year		Previous Year	Performance Improved or maintained
			Mar-17	Year End		Y/N
A Positive Patient Experience Patients' Experience **Caring & Responsive Services**	Proportion of patients who were treated with respect and dignity	95.0 %	96.2 %	94.5 %	93.9%	Y
	Friends and family test - percentage of people that would recommend the service	90.0 %	92.2 %	91.3 %	82.5%	Y
	Proportion of patients whose care was explained in an understandable way	90.0 %	91.8 %	90.1 %	90.5%	Y
	Proportion of patients who were involved in planning their care	85.0 %	81.2 %	81.8 %	77%	Y
	Proportion of patients rating their overall experience as good or excellent	90.0 %	93.5 %	91.8 %	90.4%	Y
	Number of PREMS responses	1,700	2,479	2,232	1943	Y
	Percentage of patients who have been informed of how to complain or raise a concern	-	49.6 %	52.0 %	-	New measure 2016/17
A Positive Patient Experience Patients' Complaints, Concerns & Compliments **Caring & Responsive Services**	Number of complaints received this month	-	6	153	148	-
	Proportion of patients' concerns (PALS) responded to within 5 working days	95.0 %	100.0 %	99.0 %	94.8%	Y
	Proportion of complaints responded to within 25 days	95.0 %	100.0 %	100.0 %	100%	-
	Proportion of complaints responded to within agreed deadline	100.0 %	100.0 %	100.0 %	100%	Y
	Proportion of complaints acknowledged within 3 working days	100.0 %	100.0 %	100.0 %	100%	Y
Preventing Harm Incidents & Risk **Safe Services**	Proportion of clinical incidents that did not cause harm (moderate to catastrophic categories)	96.0 %	96.9 %	95.0 %	-	New measure 2016/17
	Zero tolerance to falls in bedded units with harm (moderate or above)	0	0	8	9	Y
	Incidence of new (CLCH acquired) pressure ulcers (category 3-4)	-	14	156	64*	-
	Zero tolerance of new (CLCH acquired) category 3 & 4 pressure ulcers in bedded units	0	1	4	8	Y
	Proportion of external SIs with reports completed within deadline	100.0 %	100.0 %	99.4 %	92.4%	Y
	Percentage of time bedded units achieving minimum staffing each month	100 %	107 %	105 %	101%	Y
	Statutory and mandatory training compliance	90.00 %	91.95 %	91.95 %	88%	Y
Preventing Harm Prevalence (NHS Safety Thermometer)	Proportion of patients with harm free care **(non CLCH attributed harms)**	98.0 %	93.0 %	93.6 %	92.4%	Y
	Proportion of patients who did not have any NEW harms	98.0 %	98.9 %	98.6 %	97.7%	Y

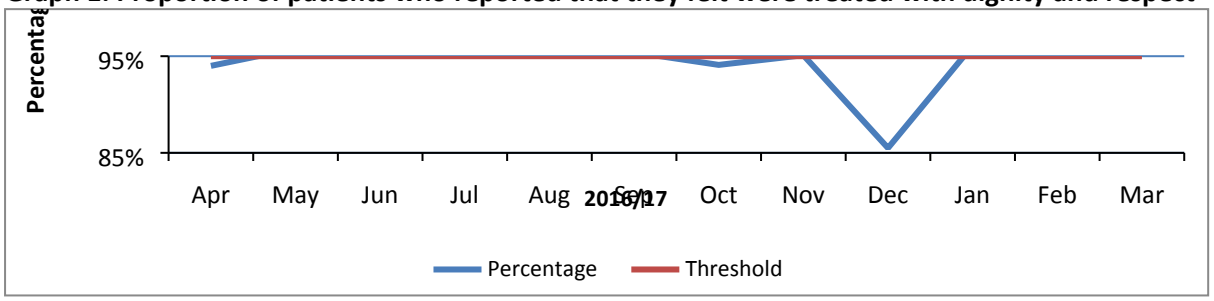
Safe Services	Proportion of patients who did not have a NEW (CLCH acquired) pressure ulcer	98.0 %	99.4 %	99.3 %	98.8%	Y
	Proportion of patients who did not have an OLD (non-CLCH acquired) pressure ulcer	98.0 %	93.9 %	95.0 %	94.8%	Y
	Proportion of patients who did not have a fall	98.0 %	99.5 %	99.3 %	98.7%	Y
	Proportion of patients who did not have a catheter associated urinary tract infection	98.0 %	99.6 %	99.4 %	99.4%	Y
	Proportion of patients who did not have a venous thromboembolism	98.0 %	99.7 %	99.8 %	99.8%	Y
	Percentage of deaths in community hospitals (expected and unexpected) compared to all discharges (excluding palliative and end of life care)	3.8 %	0.0 %	0.4 %	0.1%	
Smart, Effective Care	Percentage of CI programme graduates who have participated in an improvement project in the past 12 months	-	53.3 %	55.0 %	-	New measure 2016/17
Effective Services	Proportion of patients who were satisfied with the wait for treatment	80.0 %	82.9 %	79.1 %	78%	Y
	Proportion of patients reporting a positive Goal Attainment Score	87.0 %	Ÿ-	Ÿ -		
	Proportion of safety alerts due, and responded to, within deadline	100.0 %	100.0 %	99.1 %	97%	Y
	Percentage of hand hygiene episodes observed across CLCH services (excluding bedded areas) that are compliant with policy	97.0 %	100.0 %	99.3 %	99.3%	-

1.0 Positive Patient Experience

1.1 Dignity & Respect

The Trust asks patients if they feel they were treated with dignity and respect. Graph one shows the proportion of patients who responded "yes definitely". The target was achieved in Q4. The Trust Privacy and Dignity Policy has been approved and implemented. Key aspects were highlighted to staff at its launch.

Graph 1: Proportion of patients who reported that they felt were treated with dignity and respect



1.2 Friends & Family Test (FFT)

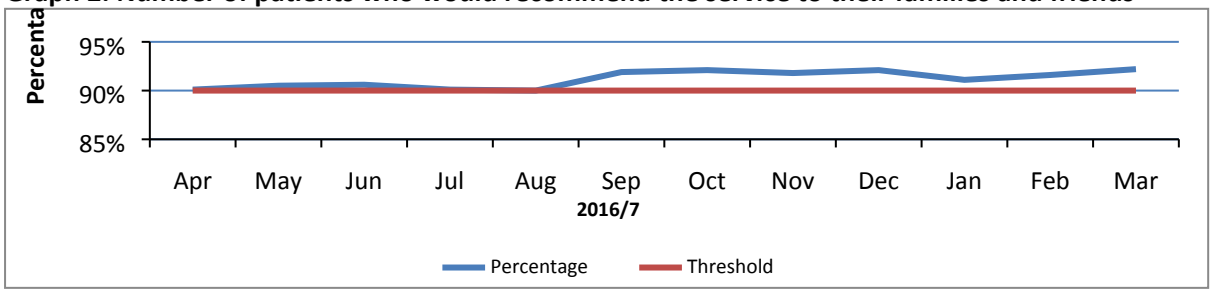
The Trust asks patients how likely they would be to recommend our services to their friends and family. The score is calculated by subtracting the number of people who would not recommend the service from the number who would. This is measured according to national guidelines against a board target of 90% which was achieved in Q4.

NHS England (NHSE) 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). Table 1 outlines how the Trust is performing using this approach. The NHSE target of 95% recommended was not met Q4. However there has been an improvement since Q2 where the aggregate performance was 91%.

Table 1: NHSE FFT presentation

FFT-	Base size	Recommend %	Not Recommend %
February 2017	**n=317**	**94.3%**	**2.5%**
January 2017	n=215	94.9%	2.3%
December 2016	n=230	96.5%	0.0%

Graph 2: Number of patients who would recommend the service to their families and friends

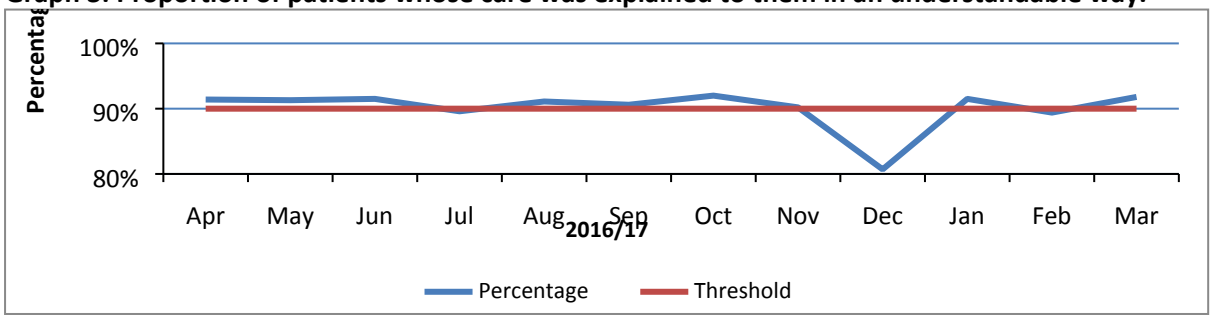


1.3 Explaining Care

The Trust asks patients if their care was explained to them in a way they could understand, graph 3 shows those patients who said that it was. Overall he target has been met in quarter 4.

The Trust *Always Event* project is progressing with the initial focus on *always* supporting patients, relatives and carers to be involved in the planning and delivery of their care. The project lead is developing, implementing and evaluating a*lways event*. The Trust has identified three pilot units with individuals identified to take part in the co-design of an *Always Event*. The approach to the co-design process has been agreed. This includes asking our patients to complete a survey around the topic of 'involvement in care'. This is being followed by in-depth filmed interviews with patients. A number of interviews have taken place and the themes emerging centre around introductions, understanding the service, explaining care, being listened to and being given a choice.

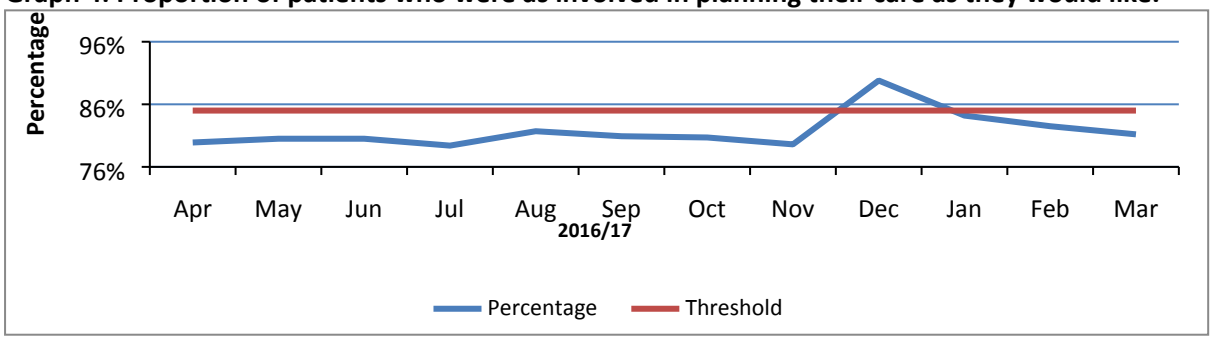
Graph 3: Proportion of patients whose care was explained to them in an understandable way.



1.4 Involvement in care

The Trust asks patients how involved they have been in planning their own care. Graph 4 represents those patients who said that they were as involved as they wanted to be. The target has not been achieved at the end of Q4 however it is hoped that this will improve with the *Always Event* project.

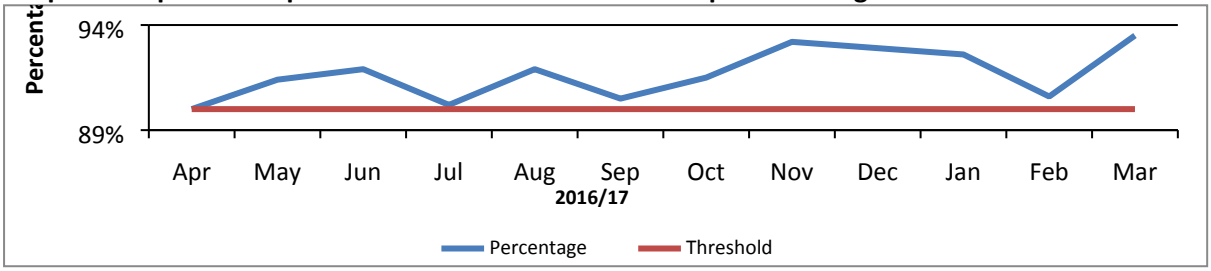
Graph 4: Proportion of patients who were as involved in planning their care as they would like.



1.5 Overall Experience

The Trust asks patients to rate their overall experience of care. Graph 5 shows patients who said that their care was good or excellent. This target has been consistently exceeded this year.

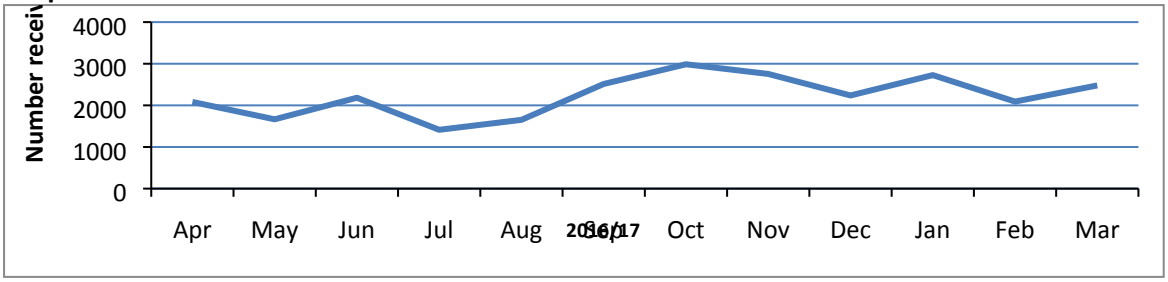
Graph 5: Proportion of patients who rated their overall experience as good or excellent



1.6 Number of PREMS received

The Trust is committed to receiving feedback from as many patients as possible and from a group that represent our patients' diversity. The Trust collects PREMS using electronic tablets, paper surveys, kiosks, comment cards and telephone interviews. The Trust target of collecting 1700 surveys per month has been achieved in Q4 and for the full year.

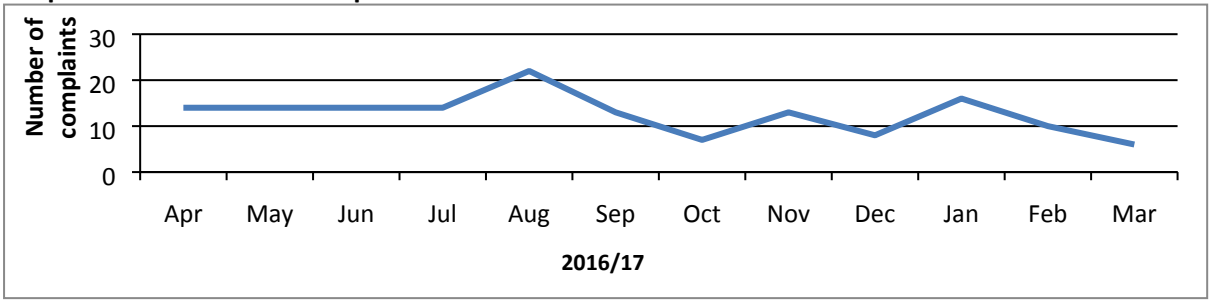
Graph 6: Number of PREMS received



1.7 Complaints

The Trust categorises 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 95% of complaints in 25 working day and 100% of complex complaints within the agreed timescale. All complaint targets have been achieved this quarter and overall for the year.

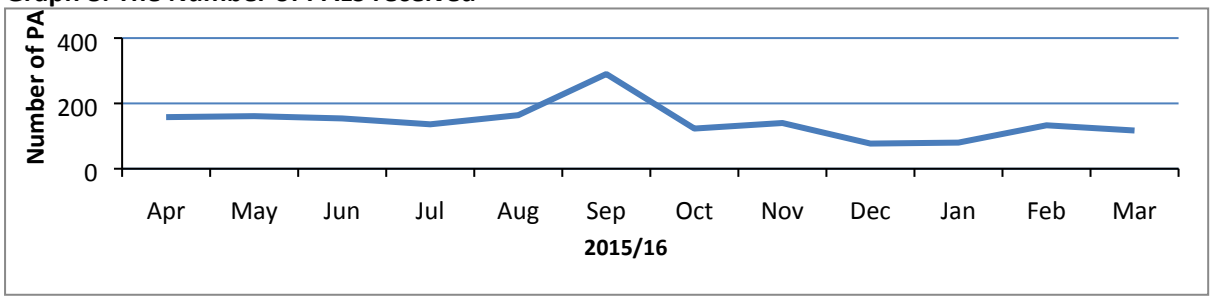
Graph 7: The number of complaints received



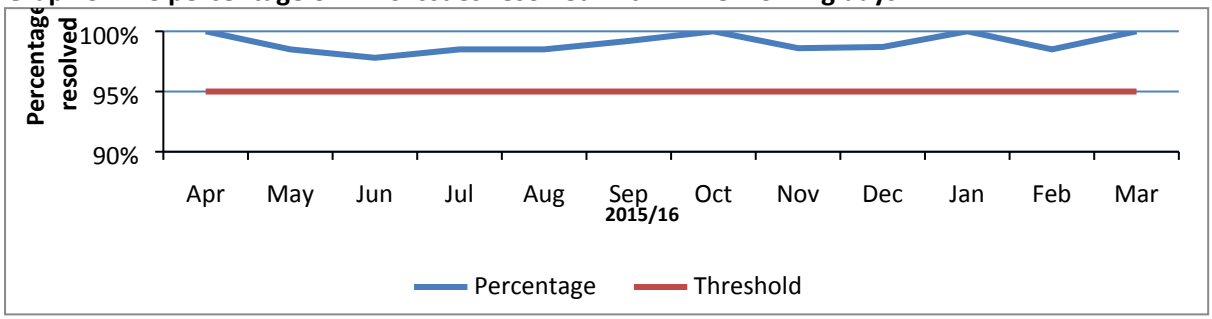
1.8 Patient Advice & Liaison Service (PALS)

The Trust aims to resolve 90% of all PALS issues within 5 working days. This performance has been sustained fully for over a year.

Graph 8: The Number of PALS received



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



2.0 Preventing Harm

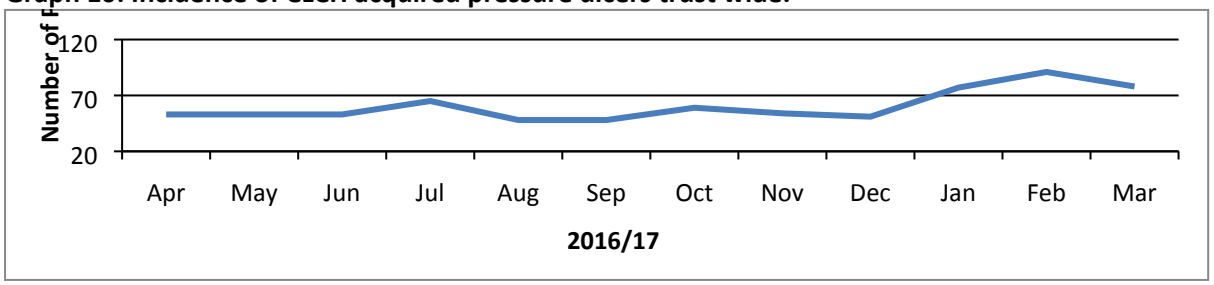
2.1 Pressure Ulcers

98% of our patients have remained free from CLCH acquired pressure ulcers for more than a year. These are prevalence figures from the NHS Safety Thermometer. The national benchmark shows that we are within the expected limits for a community trust.

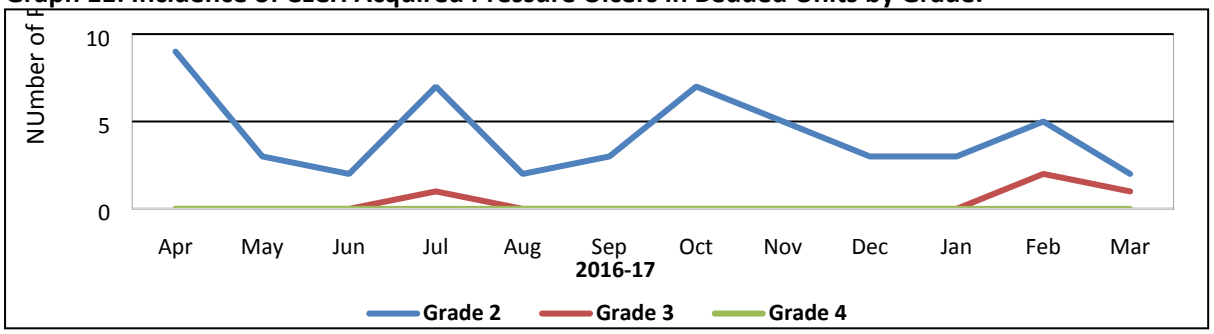
2.2 Incidence CLCH-Acquired pressure ulcers

No individual teams have shown any significant increase in incidence in March. There were increases in incidence in District Nursing in CWHHE which is being investigated by RCA, but that has decreased in March. Merton and Harrow data were added to the Trust total from April leading to the overall increase in incidence. Please note that the Datix data is retrospectively refreshed every month. As a result, incidence numbers may vary from previous reports, but will stabilize approximately two months after the reporting date. Detail by team is included as appendix two.

Graph 10: Incidence of CLCH acquired pressure ulcers trust wide.



Graph 11: Incidence of CLCH Acquired Pressure Ulcers in Bedded Units by Grade.



2.3 Zero Tolerance of CLCH-acquired pressure ulcer in bedded units

There were three grade three pressure ulcers in bedded units in Q4, two on Alexandra Rehabilitation Unit (PLK) and one on Marjory Warren Ward.

2.4 Marjory Warren Ward

The grade three pressure ulcers on MWW have been reviewed by the Director of Nursing and Quality and has been confirmed as CLCH acquired (due to deterioration), has been declared as a serious incident and is being investigated. The ulcer was initially a moisture lesion however due to the fact that skin integrity has broken down this has now been classified as a grade three pressure ulcer and will be investigated. Whilst moisture lesions are not pressure ulcers they can lead to skin breakdown as in this case and we want to undertake the investigation in order to see if there is additional learning we can implement on the ward.

2.5 Alexandra Rehabilitation Unit

Two patients on Alexandra Unit developed a grade three pressure ulcer. A number of actions have been taken as part of the QAT action plan and as an internal immediate quality assurance check. These actions include the following:

- Both the Deputy Chief Nurse and Associate Director of Quality completed an announced visit to the unit. The visit involved seeking patient's views on the standard of care within the unit. Patient's records were also reviewed to check the standards of record keeping. From the visit no immediate concerns were identified.
- Both the Unit manager and the Matron are currently reviewing the process for delegated responsibilities and leadership, in terms of overseeing the day the day monitoring of the quality of care provided, in the absence of the Unit Manager. This is to ensure that there are no gaps in leadership within the Unit.
- Both pressure ulcer root cause analysis investigations have been presented at a serious incident panel. The lessons learnt have been taken forward by the unit manager and matron.
- The Associate Director of Quality (ADQ) for the inner division has also attended a unit team meeting and discussed the QAT action plan with staff in order to ensure compliance with the organisation's policies and procedures. Both the ADQ and the matron will be completing an audit within one month, to ensure that staff remain compliant with the use of organisational policies.

2.6 Statutory & Mandatory Training

Statutory mandatory training compliance has been maintained at 92%. The rate for the end of April is 92%. The new target from May 2017 is 95%. An amnesty action plan for improving resuscitation, infection control and safeguarding children compliance is in place with the objective of achieving 90% by May 31st. Senior and CBU managers receive weekly emails detailing the compliance for their teams, staff outstanding and non-attendance at training.

2.7 NHS Safety Thermometer

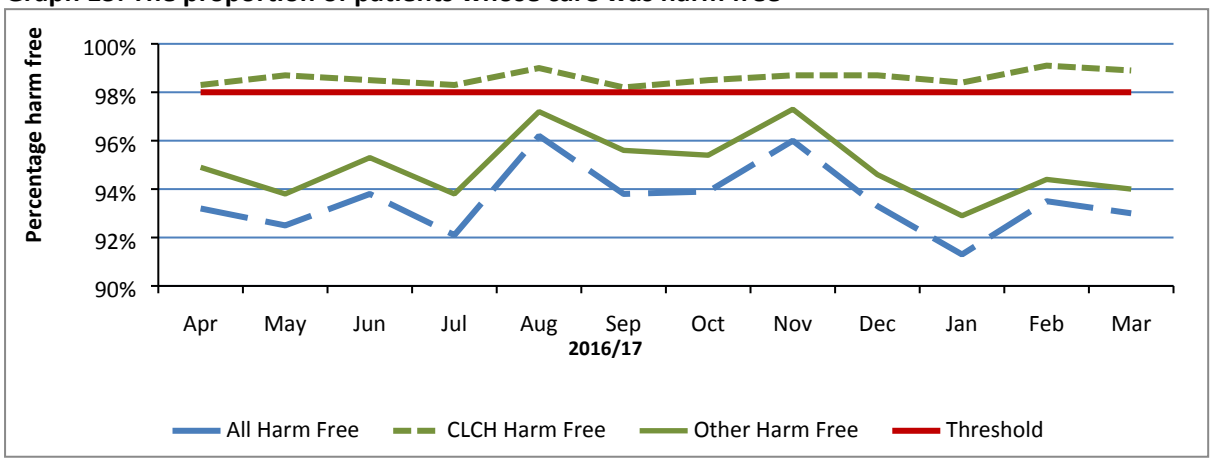
The NHS safety thermometer is a national prevalence survey. It is conducted on one day each month when our nurses review all relevant patients to determine if they have suffered any harm as a result of their healthcare. The categories they review include pressure ulcers, falls, catheter associated urinary tract infections (CAUTIs) and venous thromboembolism (VTE). 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 Board has set a stretch target that 98% of patients are harm free.

2.8 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 majority of patients suffer no harm at all. For the whole of the last year (2016/17) more than 98% of patients were free from any CLCH acquired harm. More than 92% of patients were free from any harm.

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. Both the national and board targets were exceeded overall last year and in most individual months.

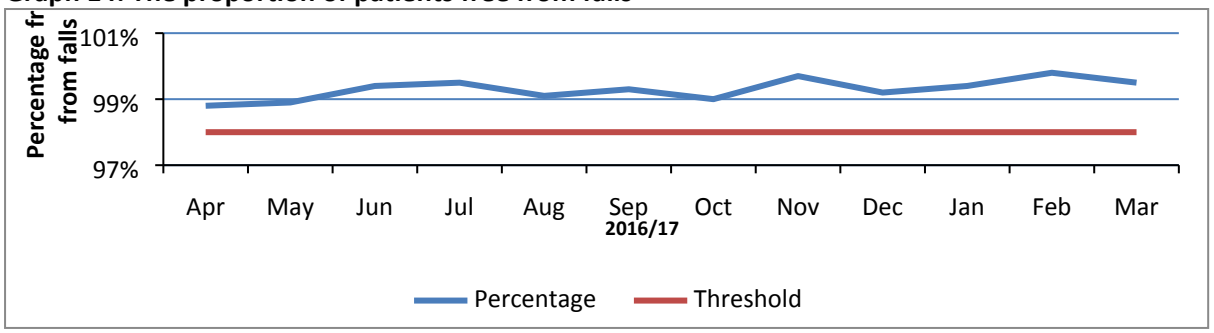
Graph 13: The proportion of patients whose care was harm free



2.9 Patients who did not fall

On the survey day, we count the number of patients who fell in the previous 3 days in CLCH. The national target has been achieved for the last 12 months.

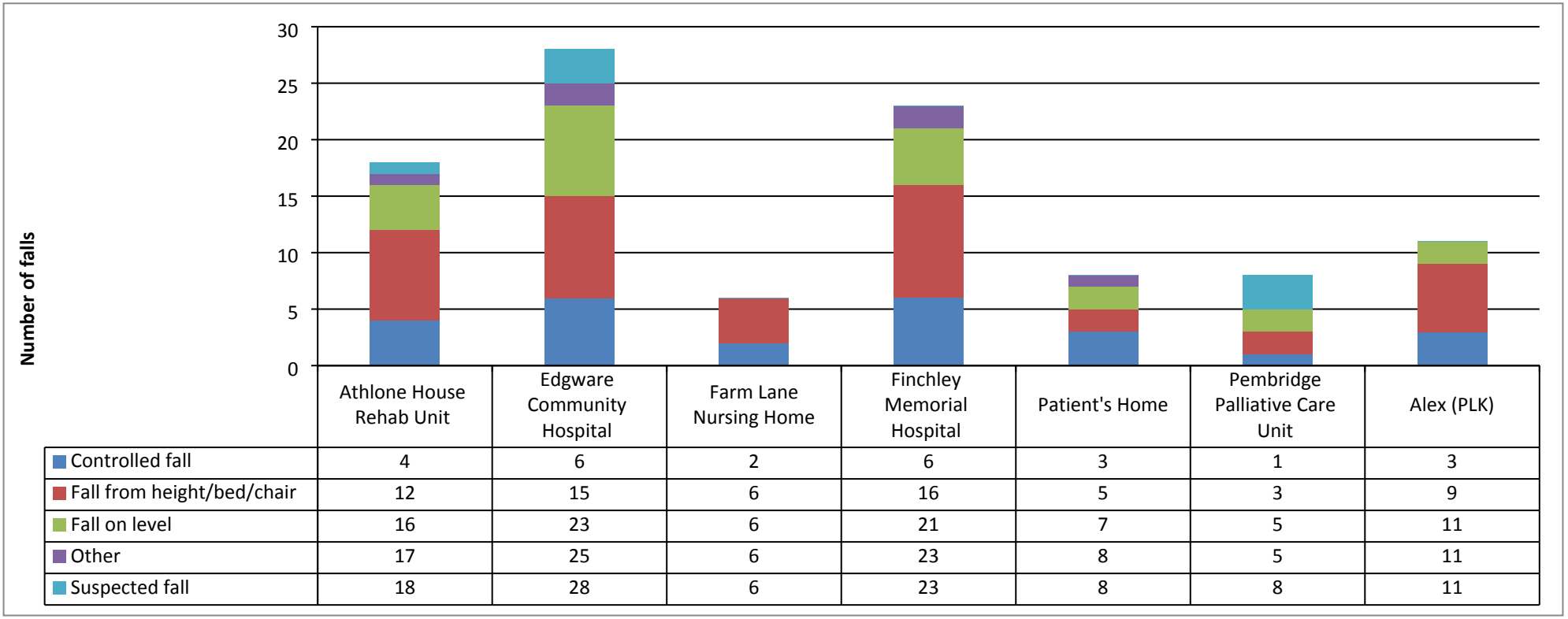
Graph 14: The proportion of patients free from falls



2.10 Zero Tolerance of falls with harm in bedded units

There have been no falls with harm (moderate or above) in bedded units in Q4.

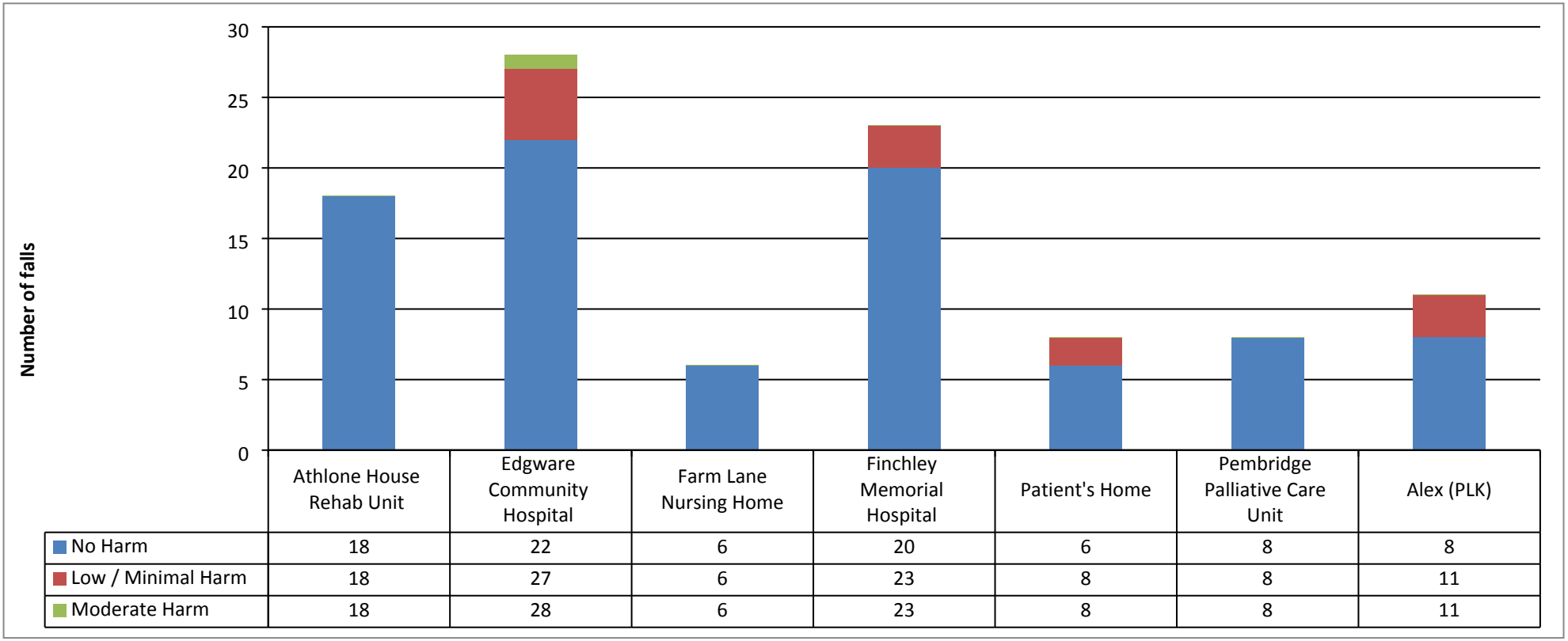
Graph 15: Patient falls Q4 2016/17 by Location & sub category



	Athlone House Rehab Unit	Edgware Community Hospital	Farm Lane Nursing Home	Finchley Memorial Hospital	Patient's Home	Pembridge Palliative Care Unit	Alex (PLK)
Controlled fall	4	6	2	6	3	1	3
Fall from height/bed/chair	12	15	6	16	5	3	9
Fall on level	16	23	6	21	7	5	11
Other	17	25	6	23	8	5	11
Suspected fall	18	28	6	23	8	8	11

Please note that the data for this graph was taken from Datix on 28/04/2017 searching on the incident category 'Slips/Trips/Falls – CLCH Attributable', affecting patients and the graph excludes five sites where single falls were reported in Q4.

Graph 16: Patient falls Q4 2016/17 by Location & severity



	Athlone House Rehab Unit	Edgware Community Hospital	Farm Lane Nursing Home	Finchley Memorial Hospital	Patient's Home	Pembridge Palliative Care Unit	Alex (PLK)
No Harm	18	22	6	20	6	8	8
Low / Minimal Harm	18	27	6	23	8	8	11
Moderate Harm	18	28	6	23	8	8	11

Please note that the data for this graph was taken from Datix on 28/04/2017 searching on the incident category 'Slips/Trips/Falls – CLCH Attributable', affecting patients and the graph excludes five sites where single falls were reported in Q4.

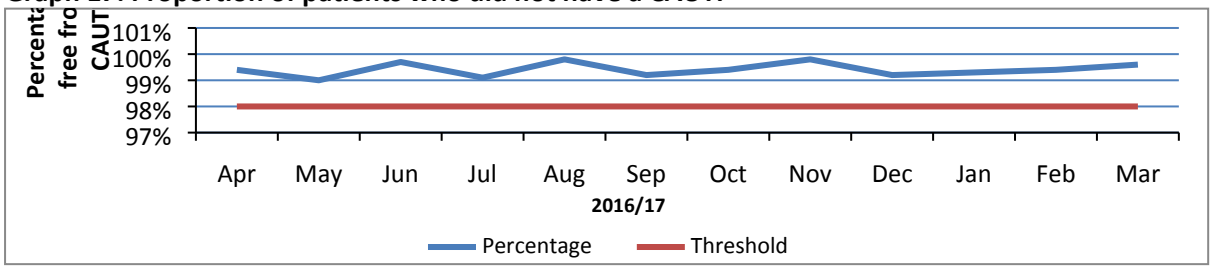
One Moderate Harm fall at Edgware Community Hospital (Jade Ward) has been reported as a Serious Incident and has been subject to Root Cause Analysis (RCA) investigation.

3.0 Smart, effective care.

3.1 Proportion of patients who did not have CAUTI

This KPI counts the number of patients on the survey day who have a CAUTI, performance remains above target.

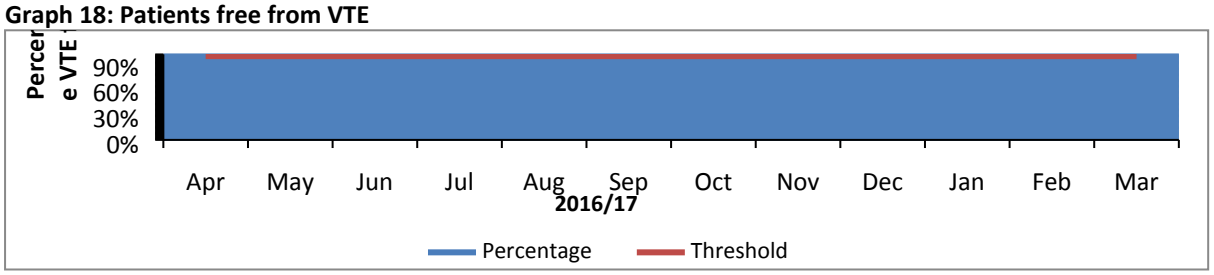
Graph 17: Proportion of patients who did not have a CAUTI



3.2 Proportion of patients who did not VTE

We count the number of patients on the survey day who have a VTE, such as a deep vein thrombosis (DVT), performance remains above target.

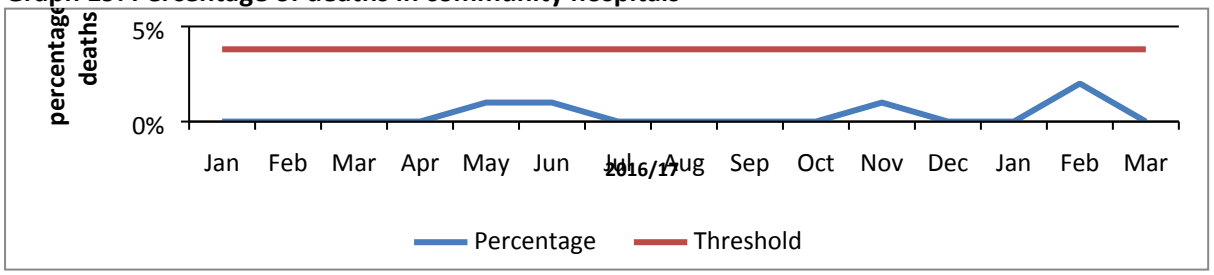
Graph 18: Patients free from VTE



3.3 Percentage of deaths in community hospitals

This KPI measures the percentage of deaths in community hospitals (expected and unexpected) compared to all discharges (excluding palliative and end of life care). In Q4, two deaths were reported. One death was on Marjorie Warren Ward and the other on Ruby Ward. Mortality Reviews are being undertaken as per trust protocol in May.

Graph 19: Percentage of deaths in community hospitals



3.4 CI programme graduates

This KPI measures the percentage of CI programme graduates who have participated in an improvement project in the past 12 months. At year end 45 CI programme graduates were active. Of these, 24 had participated in an improvement project within the previous 12 months. This is a performance of 53% against a target of 80%.

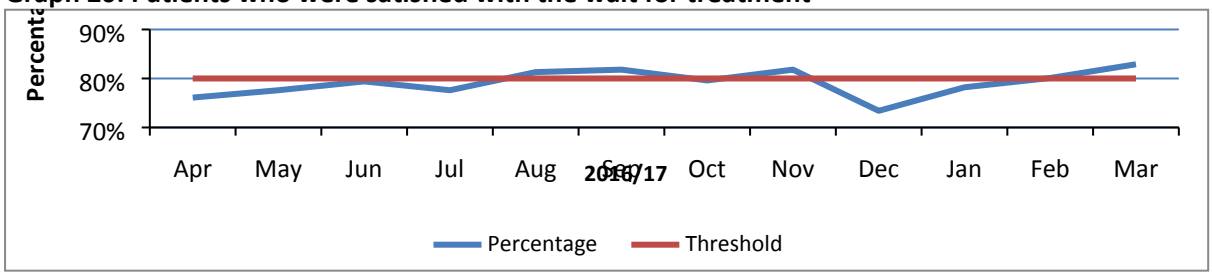
The underlying challenges for enabling widespread application of improvement skills in CLCH were identified in 2016 and led to the development of the Continuous Improvement Strategy, which launched in Q2 2016. In Quarters 3 and 4 of 2016/17 work has been underway to address the system drivers which enable widespread adoption of continuous improvement. The next phase of the Continuous Improvement Strategy for 17/18 will include:

- Launch of a tiered improvement knowledge and skills framework, aligned to job roles, to better target improvement capability development.
- Targeted leading improvement training to help managers make better use of the improvement capability within their teams and in quality councils
- Development of a toolkit to support managers and teams to embed continuous improvement into day to day operations.
- Refreshed training offerings to widen spread and scale of improvement capability development, aligned to improvement knowledge and skills framework
- Development of an improvement network and an improvement analytics network to provide support to staff seeking to make improvements in their area
- Triaging of proposed change projects by the CI and Transformation teams to identify potential skills requirements and enable signposting of competent staff within services that could be deployed to support delivery.

3.5 Proportion of patients who were satisfied with the wait for treatment

Performance has improved and is now above target.

Graph 20: Patients who were satisfied with the wait for treatment



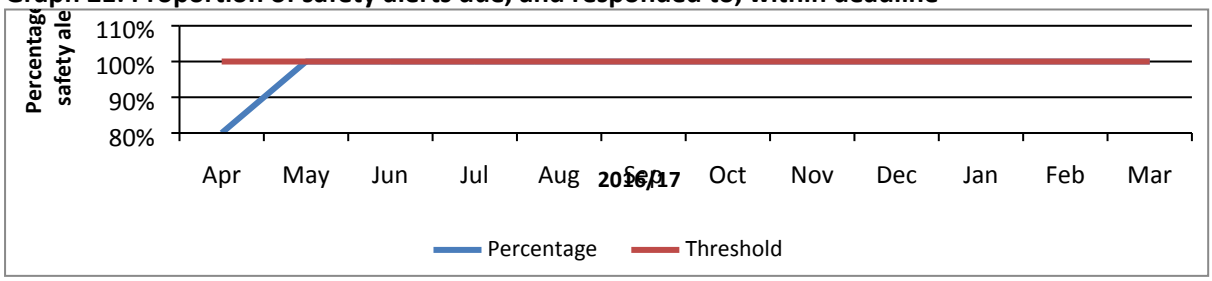
3.6 Proportion of patients reporting a positive Goal Attainment Score

This KPI has been suspended pending review of the data collection process.

3.7 Proportion of safety alerts due, and responded to, within deadline

Performance has been at 100% since May 2016.

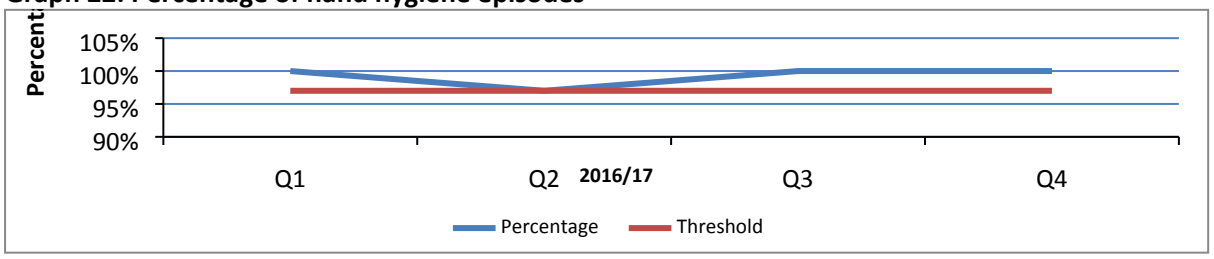
Graph 21: Proportion of safety alerts due, and responded to, within deadline



3.8 Hand Hygiene

This KPI measures the percentage of hand hygiene episodes observed across CLCH services (excluding bedded areas) that are compliant with policy. The target is 97**% (**based on national standards) and is reported quarterly. In Q4, the Trust's compliance was 100%.

Graph 22: Percentage of hand hygiene episodes



4.0 Quality Action Teams

Quality Action Teams (QATs) are established when there is concern about an area of quality for a particular team. The QATs are led by the corporate Quality Directorate who pull together an appropriate group of professionals from across the Trust to undertake a time limited piece of work to analyse the problem, recommend evidence based intervention and support the divisions in implementing and evaluating the plan. Any current QATs are reported to the appropriate Trust wide campaign group as well as the Quality Committee. The QAT are reported in detail as part of the monthly red flag report.

Services with a QAT in place in Q4:

Services with QAT
• Intermediate Care Beds – Merton
• Jade/Ruby Inpatient Rehabilitation • Barnet Community Nursing • Harrow Community Nursing
• Barnet Paediatric Occupational Therapy
• Hammersmith & Fulham Community Nursing • Alexandra Rehabilitation Unit

4.1 Intermediate Care Beds – Merton

The QAT was established following the mobilisation of 17 intermediate care beds in Woodlands House and 7 intermediate care beds in Carter House Merton in October 2016. The nursing provision, estates and facilities are subcontracted from Central and Cecil Housing Association (C&C). Concerns were raised about the level of training of nurses, medicine management, the environment and infection prevention, fire health and safety and incident reporting. An action plan is in place and has been shared with stakeholders. The nursing staff have received resuscitation training, observation and recognition of a deteriorating patient and have access to the CLCH mandatory training booklet. All CLCH patients are now on the Woodlands House site. However, since Central and Cecil Housing Association notified CLCH of their intention to sell the home, there has been a delay in the senior management team delivering on agreed actions. A six-month extension to the

contract is with C&C. There is provision of a CLCH doctor and matron working with the C&C staff and attending a weekly MDT. The Divisional Director has been in discussion with an alternative site.

4.2 Jade/Ruby Inpatient Rehabilitation

A QAT chaired by the Director of Nursing & Quality continues and has been reviewed following the identification of concerns identified through complaints and an unannounced visit to the unit. The unit now has a new Matron in place and an interim CBU manager who are leading on the QAT. QAT meetings are being held on alternate week. The results of an independent investigation into the concerns are scheduled to be presented to the Board in May.

4.3 Barnet Community Nursing

A QAT chaired by the Director of Nursing & Quality continues covering all Barnet Community Nursing Services localities. Key areas of focus include: recruitment, engagement with GP's and Pressure Ulcer management. Active recruitment to vacant positions is in progress and is reducing the overall vacancy position.

4.4 Harrow Community Nursing

A QAT chaired by the Director of Nursing & Quality continues covering all Harrow Community Nursing Service localities. Key areas of focus include: recruitment, documentation including System 1/EMIS usage and Pressure Ulcer management. Active recruitment to vacant positions is in progress.

4.5 Barnet Paediatric Occupational Therapy

This QAT is related to staff vacancies. Active recruitment is ongoing and has been successful. New starters are in the pipeline to start in May and June for the Band 6 posts. The Band 7 post is in active recruitment. Temporary staff are in place. Communication with external stakeholders is being maintained.

4.6 Hammersmith & Fulham Community Nursing

Progress against the action plan related to this QAT continues, especially around the recruitment of staff. Staff have been successfully recruited people into band 5 and band 6 roles. Hammersmith & Fulham Community nursing now has the lowest vacancy rate, in CWHHE. With the additional locality lead now in post for the North of the Borough high quality leadership is being provided to the teams. This has been evident through the reduction in complaints received from patients and families. The QAT action plan is almost complete and will be finished as soon as the final district nursing team leader vacancy is recruited to.

4.7 Alexandra Rehabilitation Unit

The QAT and subsequent action plan for Alexandra rehabilitation unit was introduced as a result of two patients developing grade three pressure ulcers. A patient complaint was also raised about the attitude of some members of staff and the quality of the catering. The QAT action plan is addressing areas such as, existing vacancies within nursing and allied health professional posts, quality of food/catering within the unit, the use of pressure ulcer prevention assessment tools (intermittent use) and ensuring visible nurse leadership. An unannounced visit was made by the Deputy Chief Nurse and Associate Director of Quality. No immediate concerns were identified. The visit included reviewing patient's records and discussions with patients.