CLCH DRAFT QUALITY ACCOUNT 2017-18

PART 1: ABOUT OUR QUALITY ACCOUNT

Welcome to the Central London Community Healthcare NHS Trust (CLCH) Quality Account for 2017-18.

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 sixth year that we have done so.

What does the CLCH Quality Account include?

In January 2017 we launched our Quality Strategy *Simply the Best, Every Time*: *A strategy for the delivery of outstanding care 2017-2020.* The strategy can be found in full at https://www.clch.nhs.uk/application/files/6015/1066/8582/quality_strategy_2017-20.pdf

The strategy describes our six quality campaigns. These are Positive patient experience; Preventing harm; Smart effective care; Modelling the way; Here, happy, healthy and heard and Value added care. Key outcomes, along with their associated measures of success are listed for each campaign. Over the course of the three years, the measures of success become increasingly demanding. Performance against the measures of success will be continuously monitored and reported via the Quality Committee and Trust Board as well as via the shared governance model.

The strategy also explains how our Quality Account priorities will be aligned with these campaigns and outlines how the Trust will need to invest in resources to implement them.

In accordance with the strategy, we have collected information about our performance against the six quality campaigns and we have used this information to look at how well we have performed over the past year and to identify where we could improve over the next year.

The strategy introduced the concept of shared governance. This is a partnership which ensures that front line staff, as well as patients and members of the public, are involved in the delivery of care. Following its introduction, shared governance is being successfully rolled out across CLCH.

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

CLCH provides healthcare in people's own homes and in a wide range of community settings including GP practices, walk in centres (WiCs) schools and early year centres. We provide community health services for two million people across ten London boroughs and in Hertfordshire.

We provide a wide range of services in the community including:

- Adult community nursing, including 24 hour district nursing, community matrons and case management.
- Children and family services including health visiting, school nursing, community nursing, speech and language therapy, blood disorders and occupational therapy.
- Rehabilitation and therapies including physiotherapy, occupational therapy, foot care, speech and language therapy.
- End of life care, supporting people to make decisions and to receive care at the end of their life.
- Long-term condition management supporting people with complex and substantial ongoing health needs caused by disability or chronic illness.
- Specialist services including delivering parts of long term condition management for people living with diabetes, heart failure, Parkinson's and lung disease, homeless health services, community dental services, sexual health and contraceptive services and psychological therapies.
- Walk-in and urgent care centres providing care for people with minor illnesses, minor injuries and providing a range of health advice and information. Our Central London walk-in and urgent care centres help support healthcare for the influx of workers and tourists which more than trebles the resident population during the working week.

In October 2017 CLCH acquired adult community services in Wandsworth as well as community nursing; these included complex case management of a GP Team, a primary care therapy team; intermediate care services; phlebotomy services and specialist nursing including; continence; respiratory, heart failure, tissue viability and diabetes.

Further Information about CLCH, including about the services we provide and the areas that we provide them in, is provided on our website at the following link https://www.clch.nhs.uk/about-us

Our vision is *Great care closer to home* and our mission is *Working together to give children a better start and adults greater independence.* Further and more detailed information about our vision, mission and values can be found in our annual report.
https://www.clch.nhs.uk/application/files/7515/1680/4204/clch_Annual-Report_2016-17_final.pdf

STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

I am pleased to present the Quality Account for the year ending March 2018; it has been a busy time for CLCH where we welcomed new services to the Trust this year, including Wandsworth Adult Community Services, Wandsworth and Richmond Sexual Health Services and Children's services in Wandsworth and Richmond. I was delighted to hear in April this year that we are one of 4 finalists for the Patient Safety Award category of Organisation of the year for our work on the Quality Strategy, Simply the Best, Every Time.

We also prepared for our CQC inspection which took place in September 2017. We welcomed the opportunity to highlight the work our clinical services deliver. During the visit CLCH hosted a team of 28 CQC inspectors and specialist advisors, who assessed four of our services: Children's; Adults; Inpatient and End of life care. The team visited 17 sites, in six boroughs, where they talked to over 150 staff, carers, patients and service users about their experience of CLCH and observed the care that CLCH provides. They also reviewed our documentation and patient notes, evaluated our systems and processes and assessed the environment in which we provide care. A focus group was also held with some of our Black, Asian and Minority Ethnic staff. We were pleased to receive an overall *Good* rating for the trust.

This year we have rolled out a number of projects and initiatives to improve quality and these are outlined in the account. Of particular note has been the work we have progressed with our Shared Governance quality councils of which we now have 13 across the Trust. You can read more about these in the Quality Account. I would like to extend my thanks to our users, members of the public and staff who played a significant role in making these such a success.

I am pleased to say that this year we awarded Quality Development Unit status to our first two teams: Podiatry in Harrow and the Respiratory Team in Hertfordshire. Once a team has achieved excellent results in their self-assessments, quality indicators and quality inspection team visits, they can apply to the Quality Panel to become a Quality Development Unit. The panel comprises members of the Trust Board, Chief Nurse, Director of Nursing, external stakeholders (including a patient representative) and peers. Units that achieve this status receive support to invest in the service and become a resource for other teams looking to improve.

I would like to thank all our staff for their continued commitment to providing excellent care. I would particularly like to recognise our staff in both adult and children's services who worked to support the community following the terrible events at Grenfell Tower last year and also our nurse practitioners who provided care to those affected on the morning of the Parsons Green tube bombing.

I can confirm that the information contained in this document is, to the best of my knowledge and belief, an accurate reflection of our performance for the period covered by the report*.

Signed

Andrew Ridley
Chief Executive Officer
*mandatory statement for CEO

STATEMENT OF THE CHAIR OF THE QUALITY COMMITTEE

The Trust Quality Committee has continued to review progress against our Quality Strategy *Simply the Best, Every Time* and associated priorities. Our aim is simple: to ensure CLCH provides outstanding care. As well as receiving monthly updates and a quality dashboard, the committee has reviewed a more in-depth quarterly report on progress. The committee has continued to invite staff, service users and carers to give quality presentations each month and committee members have regularly visited a range of clinical areas in order to see and hear for themselves how the Trust is delivering services.

I am pleased to note that during the year that there has been:

- a reduction in the incidence of pressure ulcers,
- a reduction in falls that caused harm,
- an increase in the number of patients who reported that they were treated with dignity and respect.

We continued to concentrate on the reduction of pressure ulcers in bedded units and whilst we have had a number of pressure ulcers this year, I was pleased to read in our CQC report that inspectors felt we had put in place a range of measures to help prevent pressure ulcers and that they recognised the good work of our pressure ulcer working group.

Like Andrew, our Chief Executive, I have been pleased to see the success of our Shared Governance Quality Councils. Shared governance is a dynamic partnership involving staff, managers and patients that promotes collaboration, shared decision- making and accountability for improving quality of care, safety, and enhancing work life. We will continue as a committee to do everything we can to champion this approach.

In 2018-19 the Quality Committee will continue to monitor progress against the objectives set out this year in the Quality Strategy and to support our staff in achieving these objectives. I would like to take this opportunity to thank all members of the Committee for their hard work in putting quality at the heart of everything we do.

Carol Cole

Chair of Quality Committee

PART 2 – PRIORITIES FOR IMPROVEMENT 2018-19

Our quality priorities for 2018 – 2019 are the same as laid out in our Quality Strategy: *Simply the Best Every Time: A strategy for the delivery of outstanding care 2017 – 2020.* The six quality campaigns and their associated measures of success, were selected to reflect both national priorities, such as the Five Year Forward View and Leading Change, Adding Value, and also local priorities, such as achieving the Trust's objective of moving from an overall CQC rating of `Good' to `Outstanding'. Further and more detailed information about the development of, and the rationale behind, our quality priorities can be found in our Quality Strategy.

The Trust's Quality Committee agreed a dashboard to monitor progress against each of these priorities. Progress against our priorities is reported to the committee on a quarterly basis as part of our comprehensive quality report and is also reported to the Board via a performance report. The quality campaigns, their key outcomes and associated measures of success for 2018-19 are as follows:

CAMPAIGN ONE: A POSITIVE PATIENT EXPERIENCE

Key Outcomes	Measures of success 2018-19
Service developments and plans of care co-designed with patients and service users	92% or above of proportion of patients whose care was explained in an understandable way 90% of proportion of patients who were involved in planning their care The use of co-design will be evaluated across the organisation Evaluation from patient feedback of their involvement in the Quality Councils
Patient stories and diaries used across pathways to identify touch points	Evaluation of Always Events and their impact on patient experience Quality Councils to start leading on the development of Always Events with local implementation Thematic analysis of previous year's stories with shared learning Continued use of patient stories by all services and shared at Divisional and Trust forums Evaluation of patient diaries and the impact on patient experience
Patient feedback used to inform staff training	Patient feedback will be integral to the review and development of education and training Evaluate how patient feedback has influenced training and education Evaluate the use of patient stories as part of learning from serious incident reviews
Divisional quality council objectives	Two objectives with outcome measures

CAMPAIGN TWO: PREVENTING HARM

Key Outcomes	Measures of success 2018-19
Systems in place to provide early warning to illness, service failure or a reduction in the quality of care	Maintenance of 98% or > harm free care Incidence of PU and falls will continue to fall (5%) Red flag evaluation will take place Reporting of incidents increases whilst levels of harm reduce 0% PU in bedded areas 100% RCA completed on time
Safety culture and activities signed up to in ALL services	Safety culture and activities signed up to in all services
Variations in practice identified and acted upon	Quality Action Teams to develop areas to exemplars Develop a learning repository to enable teams and services to share issues identified from incidents 2017-18 and evaluate the use of the repository and its effectiveness 2018-19.
Divisional quality council objectives	Two objectives with outcome measures.

CAMPAIGN THREE: SMART EFFECTIVE CARE

Key Outcomes	Measures of success 2018-19
Clinical staff use the most up to date clinical practices	Central alerting system (CAS) alerts. KPI target for timely alert closure ≥90% NICE 80% of services complete a Baseline Assessment Form for NICE Guidance within the agreed timeframe
There will be demonstrable culture of clinical enquiry and continuous improvement across the Trust	78% staff able to contribute to improvements at work (staff survey) Central resource dedicated to improvement analytics
CLCH will be a leader in innovative community practice	Each Division to identify within business planning process an innovation for 2018/19 Research activity increased by 5%
Divisional quality council objectives	Two objectives with outcome measures.

CAMPAIGN FOUR: MODELLING THE WAY

Key Outcomes	Measures of success 2018-19
New roles and career pathways are in place which supports the needs of patients/service users	Vacancy rates across the Trust to be reduced to 10% or less. Staff turnover (voluntary) to be reduced to 10% (or less). The continued implementation of Apprenticeship roles The evaluation of the Nurse Associate pilots in Adults and Children services The evaluation of the Capital Nurse Foundation rotation programme pilots The evaluation of the staffing models in all clinical services Staff survey results Evaluation of fast track programmes
Each clinical profession has a clear and successful model of professional practice which includes their role in improving population health as health champions	Implement and evaluate a model of professional practice for clinical staff across the Trust
Clinical staff are well led, educated, trained and involved in research to evidence the impact of what they do	Increase the number of research projects involving / led by clinical staff within the Trust
Divisional quality council objectives	Two objectives with outcome measures.

CAMPAIGN FIVE: HERE, HAPPY AND HEALTHY

Key Outcomes	Measures of success 2018-19
Staff are fully engaged and involved in the model of shared governance	Four to five Quality Councils are established per division and well attended. Shared governance forums are effective at resolving issues and concerns
Staff turnover (voluntary) below 10% by 2020 Staff vacancies below 10% by 2020	Staff turnover (voluntary) to be 10% or less. Staff vacancy rate below 10%
Staff surveys are undertaken which demonstrate improving levels of staff engagement	0.5+ on staff engagement index compared to the average for other community Trusts nationally
Wellbeing strategy to support staff health and well-being and reduce staff absence	A 3% reduction in the number of staff who report feeling unwell as a result of work related stress in the 2018 Staff Survey Sickness absence remains below target of 3.5%
The Trust is committed to and makes demonstrable reductions to agency spend	Agency spend is proportionally reduced as sickness, turnover and vacancy rates reduce The number of staff recruited to staff bank increases by 15%
Divisional quality council objectives	Two objectives with outcome measures.

CAMPAIGN SIX: VALUE ADDED CARE

Key Outcomes	Measures of success 2018-19
The user experience across CLCH, primary care, specialist services and social care is as seamless as possible	Implementation of actions that resulted from the divisions' assessments of the patient/user experience.
Clinical staff use the latest technology to improve care delivery	Each Division to identify within business planning process an innovation for 2018/19 Each division has used improvement tools to improve 1% of services
Front line staff lead new lean ways of working	Each Division to identify within business planning process an innovation for 2018/19 Each division has used improvement tools to improve 1% of services
Divisional quality council objectives	Two objectives with outcome measures.

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

Prior to the January 2017 launch of our *Quality Strategy 2017-2020* we consulted widely on the strategy and all our stakeholders for comments on our quality campaigns; the proposed key outcomes and the associated measures of success. We also described how the quality priorities in the *Quality Strategy* would be the same as for the *Quality Account.*

The consultation on our quality priorities this year took place between 11th January and the 4th May 2018. We again wrote to all our external stakeholders requesting their comments on the quality campaigns and proposed measures of success for 2018-19. Information was also provided for staff via internal communications and our *Spotlight on Quality.* Our external website also allowed people to comment on our quality priorities.

Responses to the proposed quality campaigns have generally been positive although some responses thought that the proposed number of outcomes was too high. Some responders suggested that the outcomes were not realistic in the light of workforce and funding issues that the Trust faced.

Some of the specific issues raised in response to the consultation were as follows:

Patient experience: The use of patient stories was considered a good way of involving patients and carers in the work of the Trust.

The need for a glossary to explain the acronyms. This has been addressed and glossaries have been incorporated into the account.

The way that CLCH communicates with volunteers: This issue is being looked at in more detail at the Quality Stakeholder Reference Group (QSRG)

Membership of the Trust: In response to a question how members of the public could become members, details of how to become a member were sent to the requestee. The issue of encouraging non staff to become members of the Trust will also be discussed at the QSRG.

The podiatry service: This response did not provide comments in respect of the quality priorities but raised queries about booking a podiatry appointment. A response was provided to the responder by a senior manager from the service.

STATEMENTS OF ASSURANCE FROM THE BOARD

REVIEW OF SERVICES

During 2017-18 CLCH provided and/ or sub contracted 82 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 2017-18 represents 100% of the total income generated from the provision of NHS services by CLCH for 2017-18.

PARTICIPATION IN CLINICAL AUDITS

The Trust has a comprehensive clinical audit and service evaluation programme based on national and mandatory requirements as well as locally driven priorities in the year under review.

Clinical outcome reviews.

During 2017-18 There were no clinical outcome reviews (formerly known as national confidential enquires) which covered services provided by CLCH therefore CLCH did not participate in any clinical outcome reviews.

National clinical audits

For the same period CLCH registered in all five (i.e. a 100%) of the national clinical audits that the Trust was eligible to participate in. These audits, for which data collection was completed in 2017-18, are listed in the table below alongside the number of cases submitted to each audit as a percentage of the number of registered cases required by the terms of that audit.

The reports of five national clinical audits were reviewed by CLCH. The actions that CLCH intends taking in response to the audit are incorporated into the table below.

Please note that the table below will be further updated when the results from the audits have been received.

National Clinical Audit	Participation	Submitted cases or reason for non-participation	Outcomes and actions
National chronic Obstructive pulmonary disease (COPD) audit programme	Yes	126 cases were submitted which was 97.6 % of the 129 cases required The services taking part were: West Herts respiratory service; Barnet respiratory service, Merton respiratory service, Harrow respiratory service.	*Awaiting results due late March/early April*
SSNAP (Sentinel stroke national audit programme) (Previously known as the National Stroke Audit)	Yes	69 cases were submitted which was 88.4 % of the 78 cases required. The services/team taking part were the Stroke early support discharge (ESD) team, Merton ESD team, Merton community neuro rehabilitation team.	*Awaiting results due late March/early April*
National audit of intermediate care 2017.	Yes	12911 cases were submitted which was 47% of the 27470 cases required. The services/team taking part were Alexander rehabilitation unit at Princess Louise nursing Home; Athlone rehabilitation unit; Edgware Community Hospital (Barnet CCG patients); Finchley Memorial Hospital (Margery Warren Ward, Barnet CCG patients); Ruby Ward, Edgware Community Hospital (Harrow CCG patients) Barnet intermediate care services.	Evidence from the audit indicated that intermediate care works with more than 91% of service users. The audit demonstrated that the service either maintained or improved their level of independence. **Action**: The audit will run again in 2018, and will focus on maximising independence, and reducing use of hospitals, and care homes.
National Audit of Hip Fracture Services	Yes	Barnet intermediate care services Data collection still in progress	*Waiting for results due late March/April*
National Diabetes Foot Care Audit (NDFA)	Yes	Services participating: Community diabetes podiatry service (Westminster), Community diabetes podiatry service (Kensington and Chelsea)Data collection is still in progress	*Waiting for results due late March/April*

Local audits

The reports of 24 clinical audits were reviewed by CLCH in 2017-18. The actions that the Trust intends to take, as a response to the audits, to improve the quality of healthcare provided are incorporated into the table below.

Title	Division	Service	Outcomes and actions
1. Clinical audit of cognitive assessment of patients admitted to Rehabilitation wards	North	Jade and Ruby inpatient wards	This audit aimed at ensuring compliance of cognitive assessment as per NICE guidelines for dementia care and falls assessment. **Findings included:** Assessment for cognitive screening was completed for 70% of patients within 24 hours 100% of patient had screen completed with a standardised screening tool. Of the patients screened 60% were shown to have some form of cognitive impairment. 50% of patients were screened further using another objective measurement or functional assessment. 60% of patients had the results of cognitive assessment discussed with their family. 100% of patient had results of cognitive assessment shared with the relevant multi-disciplinary team and GP. **Actions identified included:** OT team to prioritise assessing patients within 24 hours of admission to ward to achieve 100% compliance. 100% of patient's assessment found to have cognitive impairment to have further screen or functional assessment completed within 5 days of initial assessment. All results of cognitive impairment to be discuss with carers/family within 5 days of assessment.
2. Dysphagia diet audit checklist	North	Jade, Ruby and Marjory Warren wards	To reduce the risk of aspiration and choking incidents, this audit aimed at ensuring all modified diet textures were appropriate for patients with swallowing difficulties measured against the National Patient Safety Agency - Dysphagia diet food texture descriptors. **Findings included:** Texture C thick puree, texture D pre-mashed and texture E fork mashable diet passed except for the following: Texture C thick puree diet, Texture D pre-mashed diet, Texture E fork-mashable diet. **Actions identified included:** Kitchen staff to be trained to remove all pre-packaged texture C, D and E meals from packaging and served on a plate to ensure no loose fluid. Any meals with garnish are not to be ordered for texture C thick puree i.e. salmon in dill. Weetabix (milk fully absorbed and smooth consistency) is to be used for texture C thick puree breakfasts (not porridge).

Title	Division	Service	Outcomes and actions
3. The effectiveness of acupuncture versus low level omega laser in the treatment of plantar fasciitis service	North	Harrow Nursing Intermediate care and podiatry	This evaluation aimed to understand which form of treatment (namely acupuncture or low level omega laser) was more effective in relieving the pain experienced by patients that suffer from plantar fasciitis. **Findings included:** Patients who received acupuncture showed that their pain was reduced by 22% after first treatment and 34% after second treatment. Patients who received laser treatment had their pain reduced by 7% after first treatment and 24% after first treatment. Patients who received acupuncture treatment were satisfied with their treatment; increased their confidence in the treatment received as a result they felt encouraged to continue with their treatment. Acupuncture treatment provides fast and consistent pain relief to plantar fasciitis pain when compared to laser treatment. **Actions identified included**: More sessions to be provided in the acupuncture clinic. Another study to compare the two forms of treatment, included the pain score after the third treatment, bigger size sample to be collected.
4. Accident and emergency school nursing response - Service evaluation / Clinical audit for Hounslow school nursing service 2017	CHD	Safeguarding Children [Hounslow] jointly with the London Borough of Hounslow,	The audit aimed at ensuring clinicians and their skill mix teams were accurately recording a child's allergies and sensitivities status onto the Trust's clinical system and that record keeping compliance has increased **Findings included:** The audit achieved 95% compliance for the teams that took part which is significant **Actions identified included**: By mid- December the professional Lead for children's nursing will have met/or discussed with all team leads the required entry on the clinical system and the associated crib sheet. An action plan will be agreed with team leads where concerns were raised.

Title	Division	Service	Outcomes and actions
5. Allergies and sensitivities mini audit	CHD	Children's nursing	The audit reviewed whether current advice on specialist formula prescription is in line with local CLCH primary care specialist infant formulae prescribing guidance (SIFP guidance). **Findings included:** GP/Specialist Doctors (particularly in the private sector) appear to be the majority of professionals who initiate prescriptions for specialist infant formula in primary care Amino acid formula (AAF) appears to be over prescribed; It would appear that specialist infant formula, initially prescribed in primary care, continued to be prescribed even when it was not appropriate - inappropriate prescribing results in unnecessary spend of NHS money and could affect patients' clinical outcomes **Actions identified included:** CLCH paediatric dietitian team to continue to promote the local SIFP guidance to GPs, Specialist NHS and private doctors and dietitians; CLCH paediatric dietitians team to continue to review patients prescribed a specialist infant formula.
6. Baby friendly initiative (BFI) standards	CHD		*Information awaited*
7. X ray requesting and interpreting audit.	North	St Charles UCC	*Information awaited*
8. Clinical record keeping	South	Community dental services	The aim of this audit was to investigate all information recorded by community dental services (CDS) at new patient examinations as against national guidelines. **Findings included:** The average percentage of records with information recorded in each category indicated: Basic 49 (range 4-100%); other 39 (range 0-100%); conditional 27 (range 2-79%), and aspirational 16 (range 0-38%). **Actions identified included:** An accepted standard template, with slight variation for adults and children, to be drafted for use with immediate effect by all CDS staff, to improve information recording and standardise records. Spot checks to be made throughout the year that the agreed template is being used. Audit to be repeated in the next audit cycle 2018/19.
9. Antimicrobial prescribing	South	Community dental services	This audit assessed the current antibiotic prescription recording in the 10 sites in CLCH dental services measured against Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use, NICE guidance (NG15), Aug 2015

Title	Division	Service	Outcomes and actions
			Findings included: 61 antimicrobial prescriptions were issued from 10 sites over a 3-month period, which is an average of 2.03 prescriptions per site per month, indicating a low level of antimicrobial prescribing is taking place. Justification for prescription was recorded in the Prescription Log in 90% of cases and a treatment plan post antimicrobial was recorded in the prescription log in 97% cases, indicating antimicrobial prescribing is being done appropriately. **Actions identified included:** Written prescription logs to be completed fully, legibly or with entries Y/N/NA only. Electronic R4 prescription template to be developed and used for all prescriptions so that all details are in the Patient R4 electronic notes. Staff awareness of antimicrobial resistance to be reinforced, to prevent improper use of such drugs. Patient awareness of antimicrobial resistance to be increased,
10. Use of fluoride in adults with learning disabilities (Inner CLCH community dental service)	South	Community Dental Services	*Information awaited*
11. Safe and secure handling of medicines audit for 2015 – 2016.	Medical Directorate / Trust-wide	Medicines Management	*Information awaited*
12. Patient group directions	Medical Directorate / Trust-wide	Medicines Management	*Information awaited*
13. Use of antimicrobial prescribing at bedded services	Medical directorate / Trust-wide	Medicines Management	The audit aimed to ascertain whether antimicrobial prescribing and associated documentation in CLCH bedded areas was in line with CLCH antimicrobial prescribing guidelines **Findings included** 9 standards were addressed: 3 standards achieved 100% compliance. 6 standards achieved a compliance range of 13 % to 99% representing and improvement from previous audits. **Actions identified included:** Provide information relating to antimicrobial prescribing for doctors. Prescribers on bedded sites to notify ward

Title	Division	Service	Outcomes and actions
			pharmacist each time an antimicrobial is prescribed. CLCH bedded services doctors to have regular meetings, pharmacists to attend. Monitor patients' blood results to ensure appropriate action is taken.
14. Safe management and use of controlled drugs - Bedded areas	Medical directorate / Trust-wide	Medicines Management	This audit aimed to assess compliance with the audit standards for the safe and secure management of CDs as laid out in CD legislation and the CLCH CD policy. **Findings included:** 2 of the bedded services were fully compliant, 2 of the services improved their compliance since the last audit. In 2 of the services there was a slight worsening of compliance. **Actions identified included:** An action plan to address the specific issues completed for each bedded service with all actions to be completed by 31st March 2017.
15. Safe management and use of controlled drugs in community services	Medical directorate / Trust-wide	Medicines Management	The audit was aimed at identifying and ensuring the Trust's 41 sites were compliant with the CLCH medicines management policy relating to the safe and secure handling of controlled drugs (CD) as well as national guidance. **Findings included:** Overall services comply with most aspects of the CD Policy. **Actions identified included:** CLCH CD standard operating procedure (SOP) template to be updated incorporate more details on management of CDs on site e.g. CD keys, delivery of CDs.
16. Aseptic non-touch technique (ANTT) audit	Medical Directorate / Trust-wide	Infection Prevention	This audit measured the practice of staff that undertake invasive procedures against ANTT Department of Health and NICE guidance. **Findings included:** Of 49 staff observed in practice, 43 demonstrated 100% compliance. Of staff who did not demonstrate full compliance (6 of 49) the compliance scores ranged between 82 – 96%. **Actions identified included:** Increase number of ANTT audits undertaken to increase available data.
17. Dental audits	Medical Directorate / Trust-wide	Infection Prevention	This audit evaluated whether all patients are cared for in a safe and clean environment protected from infection and that all re-usable dental equipment is safely decontaminated. **Findings included**: Two out of fifteen areas did not meet essential quality requirements and one out of fifteen did not meet best practice. Five out of fifteen services scored gold (98 – 100%).

Title	Division	Service	Outcomes and actions
			The remaining ten services scored green (90 – 97.9%). **Actions identified included:** Annual and six monthly infection prevention audit reports must be carried out locally by the dental practice and results available at all sites, Spillage kits must be complete and products within expiry date.
18. Hand hygiene audits (Bedded services)	Medical Directorate / Trust-wide	Infection Prevention	This audit measured compliance with the hand hygiene policy. **Findings included:** Compliance = 94.6% against the Trust Board KPI of 97%. The validation compliance result ranged between 86.7% - 100%. **Actions identified included:** To address compliance concerns (including scores below 97%) with a collaborative local action plan; A review of the hand hygiene audit tool to include recording barriers to hand hygiene.
19. Hand hygiene audits (Community services)	Medical Directorate / Trust-wide	Infection Prevention	The aim of this audit was too assess hand hygiene compliance with the hand hygiene policy. **Findings included :** 97% if staff were compliant with 'bare below the elbow', 22% of clinical staff reported that they had covered cuts and abrasions on their hands with a plaster. **Actions identified included:** Continued support to clinical teams through visibility, continued clinical support visits, attending meetings; organizing a hand hygiene road show to drive home the importance of effective hand hygiene.
20. Urinary catheter care documentation audit	Medical Directorate / North / Trust-wide	Infection Prevention / Continence	This audit evaluated whether all adult patients with a urinary catheter in situ at the time of audit were assessed and monitored regarding the need for a catheter; and whether all catheter care was documented accurately in accordance with the urinary catheter policy. It also aimed at ensuring compliance with NICE quality statement and NICE Guidelines 2012 regarding the urinary catheter pathway; the use of CLCH's urinary catheter assessment and monitoring form. **Findings included:** 63% of the assessment forms were completed; 42%) gave urinary retention as the reason for catheterization. 11% accounted for incontinence. Urethral catheterization accounted for 74% and suprapubic for 26%. 67% of patients had been catheterized for longer than one year. 4% of with a catheter in situ had a urinary infection at the time of the audit compared to 2.4% in 2015. **Actions identified included:** Training in completion of catheter care documentations to be included as part of the catheterization training/study day.
21. Clinical records keeping re-audit 2017	Medical Directorate / Trust-	Clinical Effectivene	The aim of this re- audit was to obtain assurance that the services that had not previously met the 90% compliance in the annual audit had achieved compliance in line with the Trust's clinical record keeping

Title	Division	Service	Outcomes and actions
	wide	ss Team	standards. **Findings included:** The re-audit show indicated overall ≥90% compliance. **Actions identified (*information awaited)*** The clinical records steering group will be meeting to discuss the report and put forward recommendations.
22. Clinical records keeping audit 2017	Medical Directorate / Trust-wide	Clinical Effectiveness Team	The aim of the audit was to monitor Trust record keeping standards **Findings included:** The compliance level achieved by the Trust was 83% demonstrating a 'significant assurance rating. **Actions identified included:** A wider publication and dissemination of crib sheets for recording patients' allergies and sensitivities In advance of the next re-audit, the clinical effectiveness team to deliver training (initially to non-compliant teams) in advance of the next re-audit.
23. Community nursing NICE guidance CG179 pressure ulcer	Quality/trust-wide		This audit aimed to measure the extent to which the record of patient care reflects the NICE guideline CG179 for prevention and management of pressure ulcers. **Findings included:** 192 (91%) of records demonstrated that patient held records or electronic progress notes were updated appropriately. 172 (81%) reported that information and advice on pressure ulcer prevention was given to patients (and carers if applicable), whilst 16 (8%) stated this was not applicable. This shows good compliance with regard to these standards, although not the required 251 (100%). **Actions identified included:** *Information awaited.*
24. Rating effectiveness of physiotherapy interventions within employee Health	Quality and Learning	Employee Health Service	The audit aimed to ensure that 80% of all employees accessing the service reporting improvement in their symptoms by the end of therapy, and with a minimum improvement of 40% in their EQ-5D-5L scoring. **Finding included:** Employees reporting improvement 82.04% (target 80%), improvement reported: 28.29% (target 40%). **Actions identified included:** Increase training on chronic pain management and provide advice on managing ergonomic risk factors in work settings.

Acronyms and explanations of terms

AAC	Assistive Communication Service within the Children Health's Division
AAF	Amino Acid Formula (infant feeding formula)
BERG Balance Score	The BERG Balance Scale is a clinical test of a person's static and dynamic balance abilities
Braden Scale	The Braden Scale uses a special scoring system to evaluate a patient's risk of developing a pressure ulcer
CG	Clinical Guideline
CHD	Children Health's Division
CMaps	Conversation Maps (diabetes structured education programme)
COPD	Chronic obstructive pulmonary disease
CRK Audit	Clinical Records Keeping Audit
Doppler	A safety check carried out before compression bandages or hosiery are prescribed for patients with venous leg ulcers
eHF	extensively hydrolysed formula (infant feeding formula)
EQ-5D-5L	A standardised measure of health status that provides measures of health for clinical and economic appraisal
MDT	Multi-disciplinary Team
MFRA	Multifactorial Falls Risk Assessment
MUST	Malnutrition Universal Screening Tool
NCNR	CLCH Network Community and Rehabilitation
NICE	The National Institute for Health and Care Excellence
OT	Occupational Therapy
PRN	'pro re nata' - medicines that are taken "as needed"
SIFP	Specialist Infant Formulae Prescribing guidance
SOP	Standard Operating Procedure
TOMs	Therapy Outcome Measures
WHO	World Health Organisation

PARTICIPATION IN RESEARCH

CLCH has introduced a new three year Research Strategy (2018-2020). The strategy outlines how CLCH will enhance patient experience through building research capability and capacity.
The strategy also makes a pledge that `all staff and patients in CLCH will have the opportunity to participate in research.' To support this aim CLCH will, in May 2018, take part in the National Institute for Health Research's (NIHR) *I Am Research* campaign. This campaign aims to build
awareness of health and care research and celebrates how research has shaped, and continues to shape, the NHS and patient outcomes. Much of the activity will take place at our community sites and the campaign will give us s an opportunity to engage closely with our patients and also give staff a boost and a thank you.

Examples of current studies that CLCH is involved in include:

Sexual health services:

- PreP Impact study: this is the clinical trial of a drug. It aims to assess the impact on the occurrence of sexually transmitted infections and HIV diagnosis. This may lead to clinical and cost effective access to the drug in the future.

- A randomised control trial called SAFETXT is a randomised controlled trial of an intervention delivered by mobile phone messaging. It aims to reduce sexually transmitted infections by increasing sexual health precaution behaviours in young people (16-24) and is due to be completed by June 2018.

Parkinson's service:

- Pain study**:** this study looked at the type and frequency of pain experienced by people with Parkinson disease

- Familial Parkinson's study**:** a study using genetics to understand Parkinson's disease. This may lead CLCH future involvement into research for new treatments

During 2017-18, there were over 25 clinical staff participating in 17 clinical research studies in 5 specialities that had been approved by a research ethics committee. CLCH is a host site for approximately one half 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 for MSc or PhD qualifications.

The number of patients receiving relevant health services provided by CLCH during 2017-18 that were recruited during that period to participate in research approved by a research ethics committee was 165

COMMISSIONING FOR QUALITY AND INNOVATION (CQIN) PAYMENT FRAMEWORK

A proportion of CLCH's income during 2017-18 was conditional on achieving quality improvement and innovation goals directed by NHS England and built in to the contracts held with our NHS Commissioners. These included NHS Central London CCG (as co-ordinating commissioner on behalf of NHS West London, NHS Hammersmith and Fulham, NHS Hounslow, NHS Brent, NHS Ealing, NHS Hounslow and NHS Camden CCGs as Associates), NHS Barnet (as co-ordinating commissioner on behalf of NHS Enfield, NHS Haringey and NHS Camden CCGs as Associates), NHS Harrow and NHS Herts Valleys. Achieving the agreed CQIN goals represents an additional 2.5% of the contract values of these contracts. Our achievements against the CQIN goals for 2017-18 are detailed in the following tables.

(Please note that the figures in the tables below are based on the evidence submitted by CLCH to commissioners and the amount that we believe has been demonstrably achieved. However, we have not yet received formal confirmation of achievement for all of these CQINs and hence final achievement could vary).

CWHHE

CQIN Title	Goal	Plan for 17/18	Forecast Achievement for 17/18
Supporting Local Areas	To achieve financial control targets set by the STP planning process	£241,844.28	£241,844.28
Supporting Local Areas	To demonstrate engagement with the STP process and engaging with locality and system wide pathway developments	£241,844.28	£241,844.28
Health & Wellbeing	Improving the uptake of flu vaccinations for frontline clinical staff	£72,553.28	£32,648.45
Health & Wellbeing	Improvement of staff health and wellbeing	£72,553.28	£36,276.64
Supporting proactive and safe discharge	Enabling patients to get back to their usual place of residence in a timely and safe way.	£145,106.57	£145,106.57
Preventing ill health by risky behaviours – alcohol and tobacco	To support people to change their behaviour to reduce the risk to their health from alcohol and tobacco.	£145,106.57	£145,106.57
Improving Wound Care Assessments	To increase the number of full wound assessments for wounds which have failed to heal after 4 weeks.	£145,106.57	£145,106.57
Personalised care and support planning	To identify the groups of patients who would benefit most from the delivery of personalised care and support planning and provide this support to them.	£145,106.57	£145,106.57

BARNET CCG

CQIN Title	Goal	Plan for 17/18	Forecast Achievement for 17/18
Supporting Local Areas	To achieve financial control targets set by the STP planning process	£157,005.96	£157,005.96
Supporting Local Areas	To demonstrate engagement with the STP process and engaging with locality and system wide pathway developments	£157,005.96	£157,005.96
Health & Wellbeing	Improving the uptake of flu vaccinations for frontline clinical staff	£47,101.79	£0
Health & Wellbeing	Improvement of staff health and wellbeing	£47,101.79	£23550.89
Supporting proactive and safe discharge	Enabling patients to get back to their usual place of residence in a timely and safe way.	£94,203.58	£94,203.58
Preventing ill health by risky behaviours – alcohol and tobacco	To support people to change their behaviour to reduce the risk to their health from alcohol and tobacco.	£94,203.58	£94,203.58
Improving Wound Care Assessments	To increase the number of full wound assessments for wounds which have failed to heal after 4 weeks.	£94,203.58	£94,203.58
Personalised care and support planning	To identify the groups of patients who would benefit most from the delivery of personalised care and support planning and provide this support to them.	£94,203.58	£94,203.58

HARROW CCG

CQIN Title	Goal	Plan for 17/18	Forecast Achievement for 17/18
Supporting Local Areas	To achieve financial control targets set by the STP planning process	£40,469.81	£40,469.81
Supporting Local Areas	To demonstrate engagement with the STP process and engaging with locality and system wide pathway developments	£40,469.81	£40,469.81
Health & Wellbeing	Improving the uptake of flu vaccinations for frontline clinical staff	£12,140.94	£12,140.94
Health & Wellbeing	Improvement of staff health and wellbeing	£12,140.94	£12,140.94
Supporting proactive and safe discharge	Enabling patients to get back to their usual place of residence in a timely and safe way.	£24,281.89	£24,281.89
Preventing ill health by risky behaviours – alcohol and tobacco	To support people to change their behaviour to reduce the risk to their health from alcohol and tobacco.	£24,281.89	£24,281.89
Improving Wound Care Assessments	To increase the number of full wound assessments for wounds which have failed to heal after 4 weeks.	£24,281.89	£24,281.89
Personalised care and support planning	To identify the groups of patients who would benefit most from the delivery of personalised care and support planning and provide this support to them.	£24,281.89	£24,281.89

HERTS VALLEY CCG

CQIN Title	Goal	Plan for 17/18	Forecast Achievement for 17/18
Supporting Local Areas	To achieve financial control targets set by the STP planning process	£1,678.93	£1,678.93
Supporting Local Areas	To demonstrate engagement with the STP process and engaging with locality and system wide pathway developments	£1,678.93	£1,678.93
Health & Wellbeing	Improving the uptake of flu vaccinations for frontline clinical staff	£503.68	£0
Health & Wellbeing	Improvement of staff health and wellbeing	£503.68	£251.84
Supporting proactive and safe discharge	Enabling patients to get back to their usual place of residence in a timely and safe way.	£1,007.36	£1,007.36
Preventing ill health by risky behaviours – alcohol and tobacco	To support people to change their behaviour to reduce the risk to their health from alcohol and tobacco.	£1,007.36	£1,007.36
Improving Wound Care Assessments	To increase the number of full wound assessments for wounds which have failed to heal after 4 weeks.	£1,007.36	£1,007.36
Personalised care and support planning	To identify the groups of patients who would benefit most from the delivery of personalised care and support planning and provide this support to them.	£1,007.36	£1,007.36

LOCAL INCENTIVE SCHEMES (LIS)

Merton CCG: Merton CCG contract does not have a CQIN with CLCH but instead had an incentive scheme, related to the reduction of emergency hospital admissions and the achievement of patient outcome measures. This scheme was worth 2% of the contract value, which would represent £539,772.00 over and above the contract value.

LIS Title	Goal	Plan for 17/18	Forecast Achievement for 17/18
Reduction in the annual rate of potential years of life lost for those patients known to Merton Community Services	None set	£0	£0
Patient Experience 1	To achieve 92% of responders rating Merton Community Services either good or excellent	£53,977.00	£16,193.00
Patient involvement with care decisions	To achieve 87% of responders stating that they were involved as much as they required in their care and support management.	£53,977.00	£16,193.00
Patient Reported Outcome Measures (PROMs)	To achieve an improvement in the number of patients with PROMs recorded prior to and post service intervention	£53,977.00	£16,193.00
Non-Elective Admissions Avoidance	To achieve an annual reduction in non-elective admissions for those patients known to Merton Community Services	£269,886.00	£80,965.00
Patient self-management	Improvement in the percentage of patients reporting that they are confident in their ability to manage their own health following a service intervention	£53,977.00	£16,193.00
Patient Experience 2	Improvement in the percentage of patients reporting that their team delivering their care operated in a co-ordinated manner to deliver the best possible care and support	£53,977.00	£16,193.00

WANDSWORTH

Wandsworth contract does not have a CQIN with CLCH but instead had an incentive scheme.

Year One of the scheme focuses on service processes to deliver a more a fuller understanding of the patient cohorts and workforce levels required to support the delivery of services to this cohort.

The LIS equates to 10% of the contract value.

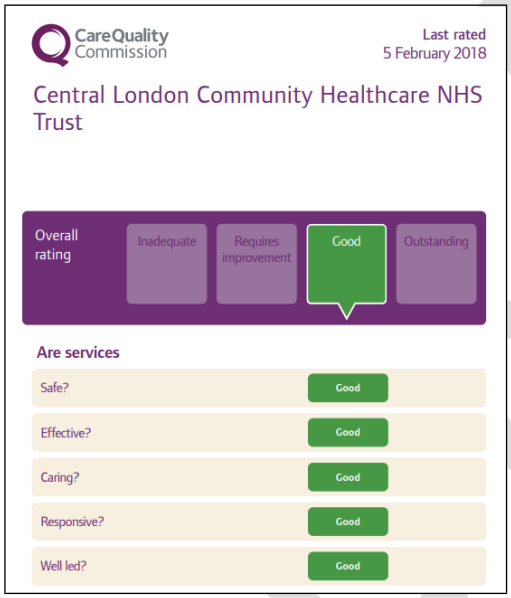
LIS Title	Goal	Plan for 17/18	Forecast Achievement for 17/18
IV Antibiotics	The development of IV antibiotics protocol that will support case management of CAHS patients in the community	£155,300.00	£116,475.00
CAHS Caseloads	Review of existing CAHS caseload including baselining and banding of patients according to low, medium and high acuity	£155,300.00	£116,475.00
CAHS Staffing	Review of CAHS staffing establishment including training needs analysis, opportunities for workforce planning and development; planning for future demand and supply in light of demographic changes and delivery of the SWL Sustainability and Transformation Plan	£155,300.00	£116,475.00
Clinical Data Migration	Migration of Community Clinical data sets from RIO to EMIS	£310,600.00	£310,600.00

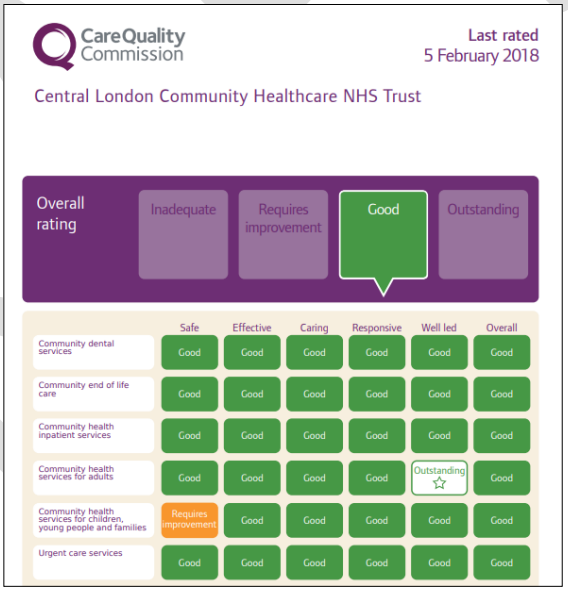
Care Quality Commission (CQC)

CLCH is required to register with the Care Quality Commission (CQC) and the Trust is registered with the CQC (under the provider code RYX) without any conditions. The CQC has not taken any enforcement action against Central London Community Healthcare NHS Trust during 2017-18

CLCH has not participated in any special reviews or investigations by the CQC during the reporting period that ended 31st March 2018.

In September 2017, the CQC inspected four of the Trust's core services. These were Community health services for adults; Community health services for children and young people; Community health inpatient services; and End of life care. Additionally they undertook a well-led assessment in October 2017. In January 2018 their report rated the Trust as 'Good' overall, with several improved ratings in individual core services. The grids below reflect the inspection report ratings.





The Trust received improved ratings in the 'Safe', 'Effective' and 'Well-Led' domains for Community End of Life Care domain from 'Requires Improvement' to 'Good', and an improved rating of 'Good' overall for the core service (previously 'Requires Improvement'). The Trust also received a rating of 'Outstanding' for the 'Well-Led' domain in the Community health services for adults' core service (previously 'Good').

The Trust was not issued with any actions which it must take to improve, nor was it issued with any requirement notices. The CQC did highlight actions that the Trust should do to improve and in response, CLCH created plans to achieve them.

As can be seen from the above grid, CLCH was given a rating of 'Requires Improvement' for the *Safe* domain in community health services for children and young people. This rating was awarded mainly due to staff caseloads. The Trust has recruitment and retention plans in place to address this. Recruitment and retention is described in more detail in the section regarding progress against the Trust's quality priorities.

The CQC did not set the Trust any 'must do' action in order to improve children's services; they did however suggest some actions that the Trust implement to improve. We continue to work with our commissioners of children's services to provide care within the commissioned model

The Trust's compliance team continues to actively work towards improving the Trust's rating from 'Good' to 'Outstanding'. This includes all teams assessing themselves against CQC standards and benchmarking against providers that have been rated as outstanding.

Secondary use services

CLCH submitted records during 2017-18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. We reported that 93.1% of records included the patients' NHS number and 90.2% their general medical practice.

CLCH submitted information about the percentage of records for patients admitted to our Walk in Centres which included the patients' NHS number to the Secondary Uses System (SUS) for inclusion in the Hospital Episode Statistics. We reported that 93.1% of records included the patient's NHS number and 90.2% included their General Medical Practice number.

Information governance toolkit

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

Clinical coding error rate

CLCH was not subject to the Payment by Results clinical coding audit during 2017-18

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 accurate and up to date, is treated in the strictest confidence, managed securely and is shared for the purposes of direct care in line with the Caldicott principles.

Given the importance of good quality data to the effective delivery of patient care, 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 during the 2017 - 2018 year:

- The data quality policy has been reviewed and approved to set the expectations of the organisation as a whole and of staff.

- A data quality plan overseen by the Trust Data Quality Forum has been developed with clinical and operational input and includes the identification of prioritised data quality matters to address.

- Data quality reports are provided on a key number of data quality matters to address and reported through to all divisional and trust level so action may be taken.

The Data Quality Forum (DQF) has oversight of this area of work led by the Chief Information officer. It has a very strong operational input with divisional Business Managers and is supported by the relevant functions responsible for clinical systems and reporting. In the context of data quality, this group has the following specific aims to improve data quality in 2018-19

- To actively support the implementation of the Data Quality Strategy by assisting in the operational implementation of the data quality plan.
- To identify, and regularly review, a representative set of data quality metrics which appropriately reflect the level of data quality within the Trust with a view to establishing improvement activity and corrective actions.
- To support the development of an internal audit programme for data quality issues and to regularly review the results of those audits with a view to establishing improvement activity and corrective actions.
- To agree and promote a series of data standards within the Trust.
- To act as an advocate/champion for the importance of data quality issues.

CLCH will be taking the following actions in 2018-19 to improve data quality.

- Appointing a trust lead for data quality and information
- Working with teams to improve the quality of their data collection and reporting

The Capita Business intelligence performance analytics (BIPA) function is an active contributor to both understanding and exposing areas where data quality may be improved to aid an understanding of performance and effective delivery of care. CLCH will complete the development of our data warehouse in 2018/19 that will automate reporting including for data quality so that any issues identified can be fixed.

LEARNING FROM DEATHS 2017 – 2018

Learning from deaths of people in our care can help us NHS organization's improve the quality of the care we provide to patients and their families, and identify where we could have done more.
In October we published a 'Learning from Death Policy' based on The National Quality Board at NHS Improvement's 'National Guidance on Learning from Deaths'. Implementing this policy, which was written with the acute sector in mind, within the context of a community Trust has required some thought and is subject to on-going refinement.

CLCH openly publishes the numbers of deaths within the inpatient units of the trust, (there are 5 in-patient units and an inpatient hospice) and any deaths in these units are all reviewed using an accredited review tool, the CLCH Mortality Review Form, based on an accredited case review methodology.
Since January 2018 the trust has widened the eligibility criteria for patient's deaths that require reviews as shown below;

- All deaths in inpatient beds
- All known deaths from adult community services within 30 days of date of discharge
- All deaths of homeless health caseload within 30 days of discharge.

(Children and patients with learning disability are subject to different review procedures).

From January 2018 divisional leaders have been working with teams to implement the new processes that set out how to record all deaths within the scope described above. This still requires further work to embed and to date the numbers coming through the reporting system Datix are not significantly different from the inpatient bed mortality data. The medical director has re-communicated the importance of this change in approach and is working with operational teams to make the reporting robust but streamlined, including setting up weekly mortality meetings at Clinical Business Unit level. This annual report describes the number of deaths in the inpatient cohort and how those deaths have been reviewed and the learning that was captured set out in Table 1 below.

Table 1 -*Note; the final data for March 2018 is not yet available.*

	Prescribed information	Form of statement
27.1	The number of in- patients who have died during the reporting period, including a quarterly breakdown of the annual figure	30 in the first quarter 32 in the second quarter 38 in the third quarter 27 in the fourth quarter Includes expected hospice deaths
27.1.1	The number of other deaths within the community where this approach was used to generate learning	2 1-The death of a homeless man in Central London 2- Patient found dead at home as a result of suicide.
27.2	The number of deaths included in item 27 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.	Across 2017-18, 127 deaths have been recorded and 6 investigations have been carried out in relation to the 127 deaths included in item 27.1 0 in the first quarter; 2 in the second quarter; 2 in the third quarter; 2 in the fourth quarter.
27.3	An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.	0 representing of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: 0%

	Prescribed information	Form of statement
27.4	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3.	Case 1 - Whilst there was a completed DNAR form in the records there was no evidence of the discussion with the family in the body of the medical record. CPR was commenced, although stopped very quickly this was inappropriate given the DNAR decision. Case 2-No action points noted Case 3 no actions noted Case 4 - Some of the assessment forms were not signed and dated. The 1st DNAR was complete but did not have evidence of discussion with patient family documented in the clinical record. Boxes were checked on the clerking form to indicate the DNAR form had been completed. Case 5- a user of the homeless heath team the patient was receiving care within local hostels and community clinics – there were no issues identified for learning. Case 6 Unclear mental health history in records. Good evidence of utilisation of all the skills within community teams, proactive support within difficult circumstances
27.5	A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4).	Lead Clinician for the ward asked to feed back to local team in case 1. Case 4 led to discussion regarding acuity levels for rehab- incorporated into a wider review of Trust rehab functions and admission criteria. Case 5 has a high profile and there was some pressure to review as an SI. The case review process was more applicable and did not lead to an SI investigation
27.6	An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.	Insufficient scope in actions identified to undertake this. The widening of the scope of the reviews from January 2018 should affect this

	Prescribed information	Form of statement
27.7	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period.	0
27.8	An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.	0
27.9	A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8.	0

Incident reporting – NHS 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 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.

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

Information awaited – data has not yet been published by NRLS.

PART 3: OTHER INFORMATION

QUALITY PERFORMANCE AND PROGRESS AGAINST OUR QUALITY PRIORITIES 2017-18

Progress against our quality campaigns is described in detail in the dashboard and performance report below. These outline the Trust quality performance both for quarter four and the full year.

Our Quality KPIs

Quality Campaign	Key Performance Indicator	Target	Performance		Previous Year 2016-17	Performance improved or maintained
			Mar-18	Year end		
A Positive Patient Experience Changing behaviours and care to enhance the experience of our patients and service users	Proportion of patients who were treated with respect and dignity	95.0 %	98.6 %	97.4 %	94.5%	Yes
	Friends and family test - percentage of people that would recommend the service	95.0 %	94.1 %	92.1 %	91.3%	Yes
	Proportion of patients whose care was explained in an understandable way	90.0 %	94.3 %	92.9 %	90.1%	Yes
	Proportion of patients who were involved in planning their care	85.0 %	92.3 %	84.5 %	81.8%	Yes
	Proportion of patients rating their overall experience as good or excellent	92.0 %	91.4 %	92.2 %	91.8%	Yes
	Proportion of patients' concerns (PALS) responded to within 5 working days	95.0 %	100.0 %	99.3 %	99%	Yes
	Proportion of complaints responded to within 25 days	95.0 %	100.0 %	100.0 %	100%	Yes
	Proportion of complaints responded to within agreed deadline	100.0 %	100.0 %	100.0 %	100%	Yes
	Proportion of complaints acknowledged within 3 working days	100.0 %	100.0 %	100.0 %	100%	Yes
Preventing Harm Incidents & Risk	Proportion of clinical incidents that did not cause harm (moderate to catastrophic categories)	96.0 %	97.6 %	97.2 %	95%	Yes
	5% reduction in falls causing harm (on 2016/17 baseline)	4	8	81	-	New measure
	5% reduction in pressure ulcers grade 3 / 4 (on 2016/17 baseline)	12	11	105	144	Yes
	Zero tolerance of new (CLCH acquired) category 3 & 4 pressure ulcers in bedded units	0	0	5	4	No
	Proportion of external SIs with reports completed within deadline	100.0 %	100.0 %	98.6 %	99.4%	No
Preventing Harm Prevalence (NHS Safety Thermometer)	Proportion of patients with harm free care	98.0 %	93.2 %	93.7 %	93.6 %	Yes
	Proportion of patients who did not have any NEW harms	98.5 %	98.2 %	98.3 %	98.6%	No
	Proportion of patients who did not have a NEW (CLCH acquired) pressure ulcer	98.5 %	99.1 %	99.0 %	95%	Yes
	Proportion of patients who did not have a fall	98.5 %	99.4 %	99.2 %	99.3%	Same

Smart, Effective Care Ensuring patients and service users receive the best evidence based care, every time **Effective Services**	Proportion of patients who did not have a catheter associated urinary tract infection	99.0 %	99.4 %	99.5 %	99.4 %	Yes
	Proportion of patients who did not have a venous thromboembolism	100.0 %	99.8 %	99.8 %	99.8 %	Yes
	Percentage of deaths in community hospitals (expected and unexpected) compared to all discharges (excluding palliative and end of life care)	3.8 %	0.8 %	0.3 %	0.4 %	Yes
	Percentage of Central Alerting System (CAS) alerts including Patient Safety Alerts (PSAs) due, and responded to, within deadline	90.0 %	100.0 %	100.0 %	99.1%	Yes
	Percentage of hand hygiene episodes observed across CLCH services (excluding bedded areas) that are compliant with policy	97.0 %	100.0 %	100.0 %	99.3 %	Yes
	Percentage of local clinical audits, service evaluations and quality improvement projects undertaken by services.	40.0 %	65.9 %	71.7 %	65.9 %	Yes
	Percentage of services completing NICE Baseline Assessment Form within agreed timeframe	75.0 %	100.0 %	65.0 %	100.0 %	No
Modelling the Way Providing world class models of care, education and professional practice	Statutory and mandatory training compliance	95.00 %	89.82 %	89.82 %	91.95%	No
Here, Happy, Healthy & Heard Recruiting and retaining outstanding clinical workforce	Staff Vacancy rate (Clinical)	12.00 %	12.14 %	12.14 %	15.53%	Yes
	Staff Turnover rate (Clinical)	12.00 %	16.67 %	16.67 %	12.91%	No
	Staff engagement index score	3.88 %	3.89 %	3.89 %	3.86%	Yes
	Sickness absence rate - 12 month rolling (Clinical)	3.50 %	3.65 %	3.65 %	3.69%	Yes
	New Bank staff recruited		170	309.00	256	Yes
	Percentage of staff who have an appraisal	90.00 %	86.48 %	86.48 %	87.79%	No
Value Added Care	Staff to have been trained to basic level in improvement skills including Lean	6%	6.0 %	6.0 %		New
	Services have used improvement tools	5%	4.8 %	4.9 %		New

OUR PRIORITIES
POSITIVE PATIENT EXPERIENCE

Key Outcomes	Measures of success 2017 - 18	Update
Service developments and plans of care co-designed with patients and service users	Maintenance of 90% and above of proportion of patients whose care was explained in an understandable way	The Trust continues to achieve above 90% compliance relating to the PREM question 'was your care explained to you in an understandable way?' The *Always Event Project* has been aimed at addressing this issue and ensuring that patients are fully aware of their care plans and feel involved in the decision-making process.
	Achievement of 85% of proportion of patients who were involved in planning their care	This has been achieved in quarter 4. The Patient Experience Team have successfully rolled out the first *Always Event* across all community nursing teams and all of the teams are now using the new script, training material and leaflets designed to involve patients in their care. The next Always Event projects have now been launched across both End of Life Care and the Learning Disability services with meetings taking place in February and March 2018 respectively. The Always Event for End of Life care will be related to bereavement and the specific objective is currently being discussed. The Learning Disability project will be delivered in partnership with the Carers Network and will be the first of its kind as there is yet to be a joint Always Event project successfully delivered by any other NHS provider.
	The use of co-design will be embedded throughout the organisation	The Patient Experience Team has successfully delivered patient led engagement and co-design events to discuss and help shape the proposed Continence Service transformational change. This has included the successful recruitment of patients to test current and new continence products options. The Patient Experience Team has also led a co-design project to improve patient experience with front of house staff. This is a continuation of the previous walk-in centre project and has been highlighted as an area for improvement through additional analysis of patient feedback and complaints. As a result of the co-design work, bespoke training sessions for front of house staff have been developed and delivered. The sessions took place in January and March 2018 and

		attended by over 25 staff in total. The feedback was overwhelmingly positive with attendees noting 'the training was delivered at a good pace' and was 'full of useful examples of how to improve the patient experience for each of our patients'. The patient experience team are looking at opportunities to deliver further training throughout 18/19. The Patient Experience Team has led on the delivery of engagement roadshows taking colleagues and clinicians out to patient groups/events to talk about the change in the Patient Transport Criteria. The change to the eligibility criteria has also been shared with partners such as Healthwatch, Commissioners and GPs to ensure that all of our key stakeholders have been made aware of them before they are implemented in May 2018. The Patient Experience team have successfully delivered the '*Gold Standard of Care' Project* alongside the bedded rehabilitation transformation project. This has involved gathering patient feedback on Alex rehabilitation unit in order to better understand our patient's expectations during their time on the ward. The patient feedback and outcomes were shared alongside a patient story at the 'Rehabilitation Transformation Programme Workshop, Our Future Model' event on the 22nd March. The Patient Experience team helped facilitate two Podiatry engagement events in Merton, on 5th and 8th March. These events were to help inform patients of the change in eligibility criteria for low risk patients. They also provided an opportunity to signpost patients to other organisations who can provide support for low risk patients who are to be discharged from the service. These events were run in collaboration with NHS South West London Alliance. As part of the Patient and Public Engagement Strategy update, the Patient Experience team are aiming to host two engagement events. The first will be held at Southfields Library in Wandsworth on 9th May and the second will be held at Edgware Community Hospital on 21st May. This will be an opportunity for our patients to be involved and engaged in our strategy.

	Patients will be members of the Quality Councils in each division	As of January 2018, there are currently 13 Quality Councils in place. Patient representatives are on 9 of the 13 Quality Councils with more representatives identified to add to the 4 new councils. Patient engagement continues to be high and well received and in a patient representative feedback session held on 19th March 2018, patients provided positive feedback about their ability to engage and help improve quality.
Patient stories and diaries used across pathways to identify touch points and `Always events'	Always Events will be implemented across the Trust	The initial *Always Event Project* has now been rolled out across all community nursing teams. The aim is to undertake an audit of patient feedback in May 18 in order to identify any changes or further actions that need to be taken having implemented the three initiatives developed as part of the project (guidance for the initial call and visit from the District Nursing Service, a service leaflet and face to face training which was co-designed with patients and carers). The Patient Experience Team will then audit the success of the this project every 6 months running a similar patient survey to that used during the pilot phase of the project to ensure that the scripts, training and leaflets continue to have a positive impact on the patient experience. As one of only three Trusts in the country who have successfully implemented Always Events, Jane Cummings visited the Trust on the 16th February along with members of her team to listen to the work that the Trust has undertaken to implement Always Events and to present the Trust with an award. Staff and a patient representative talked about the Always Event journey taken by the Trust, providing an overview of the work that has been undertaken and the impact that this has had on our patient and staff experience. Two further Always Events are being planned across End of Life Care and the Learning Disability service as noted earlier in the report.

	Continued use of patient stories by all services and shared at Divisional and Trust forums.	Patient stories continue to be collected by staff and the Patient Experience team and shared at divisional and Trust wide forums. The stories vary from written stories to video stories and provide a rich understanding of our patient's experience. The Patient Stories Annual report will be developed and presented to the Trust Quality Committee in July 2018.
	Develop a plan to implement patient diaries in services and how these can be used to inform service improvement.	The Pembridge volunteers have been trained in collecting Patient Stories and Patient Diaries to assist with this project. The Patient Experience Team has set up a Patient Experience Steering Group specifically for Pembridge patients. The members have now met on a number of occasions to discuss the best way to implement diaries with patients, volunteers and carers. The aim will be to pilot this in May 2018. This work continues to be complemented by the *Swan Song Project* which is an innovative way of collecting patient's stories/diaries, putting their experiences to music. Engaging patients to manage a personal experience diary upon admission to Alex rehabilitation ward has proven very difficult with a number of patients identified across Alex and Athlone, whom have failed to complete the diaries provided. However, as part of the rehabilitation transformation programme it has been agreed that the implementation of patient diaries will be included in the improvement metrics moving into 2018/19.
Patient feedback used to inform staff training	Implement patient feedback into the Trust Education Forum using complaints/ PALs and patient stories	The Modelling the Way Forum continues to have a standing agenda item for a staff or student story which outlines areas that have gone well and areas where improvements could be made. Incidents and patient feedback are also discussed at the Trust End of Life Care Operational Group and Learning Disability Forum to identify any specific training requirements.

	Identify opportunities for patients and carers to participate in training	Patients have been engaged with the development of patient videos to support the training for staff on collecting patient stories. Patients with a diagnosis of dementia and their carers continue to be involved in the Dementia Care Champion training listening to student's projects and providing advice on where improvements could be made. The first Patient led user group met at Pembridge Hospice on Monday 26th March, the group was attended by 6 patients and a carer and the discussion centred around improving the activities available to patients attending the day centre Patients have requested better visibility of 'you said, we did' on a specific notice board and more information about the Hospice itself and the newly formed user group on the charity website. The next meeting has been scheduled for 23rd May and will take a more formal approach with the TOR set to be agreed. The meetings will continue every other month. The Head of Patient Experience and Corporate Governance Manager have successfully recruited 12 patients to act as expert patient representatives on future recruitment panels. The training of these patients took place on 6th March and the aim is to now involve these patients on future recruitment panels in the North Division.
	Develop and implement patient stories as part of the learning from serious incident reviews, for example impact of a pressure ulcer/ fall.	The Patient Experience team are being invited to each of the 48-hour meetings for patients who have developed a pressure ulcer. The aim is to identify patients who can be interviewed. Unfortunately, there have not yet been any patients willing to share their stories, but this work will continue. When received it is planned to feed these stories into the Serious Incident Panel and the learning will be shared with the relevant teams and services.
	Patients to be members of the Quality Councils for education and training	Three of the shared governance councils continue to focus on the Positive Patient Experience Quality Campaign. Each of the council chairs are invited to the Trust Patient Experience Coordinating Committee to provide feedback and to ensure they are engaged and aware of Trust wide patient experience feedback and ongoing initiatives.

PREVENTING HARM

Key Outcomes	Measures of success 2017 -18	Update
Systems in place to provide early warning to illness, service failure or a reduction in the quality of care	Maintenance of 98% or > harm free care	Achieved. In terms of Safety Thermometer data, this has been achieved for new (CLCH) harm free care.
	Severity of PU and falls will continue to fall (5%)	We achieved >5% reduction for pressure ulcers Our severity of harm from falls has reduced. During 2016/17 a total of 26 serious incidents related to falls were declared; including internal and external SIs. For 2017/18, 15 were declared; 11 fewer falls serious incidents. As a Trust we report patients who fall three times or more on a bedded unit albeit with no harm as an internal SI. In 2016/17 there were 18 of these internal SIs reported and in 2017/18 there were 8.
	Red flag reporting will be embedded throughout organisation	Achieved
	Revised early warning system developed for patients in community setting including revised early warning assessments for falls and PU	As above
	0% PU in bedded areas	Not achieved, the Trust will continue to report all inpatient PU, undertake root cause analysis and ensure learning events continue with all clinical staff.
	100% RCA completed on time	Achieved – all 18 external SI RCAs due in Q4 were submitted on or ahead of schedule (excluding those de-escalated)

Safety culture and activities signed up to in ALL services	Trust maintains good or outstanding in NHSI learning from mistakes league table	The learning from mistakes league which was last published in March 2016 has not been published for 2017 or 2018.
	No outstanding actions from SIs that are out of date	Achieved
	All risk register actions are met by identified completion date.	Of the 87 approved clinical risks currently open, 26 have actions that were due before the end of Q4, which remain open / overdue. This is an increase from 16 open at the end of Q3, 19 open at the end of Q2 and the same open at the end of Q1 To assist managers in ensuring actions are completed, the Datix system now has automatic reminders turned on, and the Corporate Risk Facilitator has implemented a new reminder process.
Variations in practice identified and acted upon	All staff are aware of learning from incidents	In CLCH we use Spotlight on Quality, the Hub, CLIPS and meetings such as PSRG and team meetings to raise awareness of learning from incidents. We are now into the third quarter for divisions holding learning events about pressure ulcer serious incidents.

SMART EFFECTIVE CARE

Key Outcomes	Measures of success 2017/18	Update
Clinical staff use the most up to date clinical practices	CAS alerts	The Infection Prevention Team met the KPIs target, and achieved 100% compliance during the year.
	NICE – 75% of services complete a Baseline Assessment Form for NICE Guidance within the agreed timeframe.	Measures were put in place after the KPI target was not met in December 2017; as a result, the KPI compliance for January, February, March 2018 was 100%.
There will be a demonstrable culture of clinical enquiry and continuous improvement across the Trusts	76% staff able to contribute to improvements at work	Results from the National Staff Survey 2017 indicated that the Trust had achieved 74% compliance, a slight improvement from the 73% compliance achieved in 2016. It should be noted that the national average for community Trusts for this KPI in 2017 was 71%.
	Staff having access to analytics , training, tools and support via internet	Staff continued to have access to analytical tools and training via the improvement Resource library on the continuous improvement intranet page. Support and training were accessed from peers or the Improvement Team via the analytics and improvement networks using a web-based forum on the hub. In addition, the Clinical Effectiveness Team, alongside the Improvement and Transformation Office (ITO) provided training on how to interpret data, support with the development of analytical tools, auditing tools and provide support for analysing data.
CLCH will be a leader in innovative community practice	Develop a learning repository for lessons learnt regarding change projects	Lessons learnt from all ITO projects were documented and shared through fora such as the Strategic Improvement Group.
	PIDs to include section for on-going learning	A PID/QIA combined form was agreed as part of the QIPP Policy 2017. There was no section for capturing on-going learning, and it was expected this would be captured in the project workbook.

MODELLING THE WAY

Key Outcomes	Measures of success 2017/18	Update
New roles and career pathways are in place which supports the needs of patients/service users.	The development of clear career pathway frameworks for Bands 1-9 for all services and staff groups with associated competencies and skills required	Final versions of the Nursing and AHP (which includes dental, podiatry and pharmacy) have been completed. The skills required for staff have been outlined and associated competencies are in place for the majority of roles. The Nursing career framework was presented at the Nursing workforce event in March 2018 and is currently being updated to incorporate comments and feedback with the aim to launch this formally in May 2018. Work remains ongoing with staff to complete competency frameworks for all staff groups. The AHP career framework will be presented at the AHP workforce event in May 2018 for feedback and comments before being launched in June/July 2018. The career frameworks will be accessible as an interactive tool on the HUB. Work remains ongoing on the non-clinical pathway and the aim is to complete this by July 2018.
	The continued implementation of Apprenticeship roles	The Trust has re-launched an Apprenticeship forum to implement and monitor the Trust Apprenticeship Strategy. As a result, a new Apprenticeship policy has been developed to support Apprenticeships in the Trust. In addition, a communication plan is being developed to raise staff awareness and promote apprenticeships. Work is underway with divisions to establish the numbers and types of apprenticeships that will be supported. The Trust was successfully audited by the Education and Skills Framework Authority (ESFA) on 23rd January 2018. The audit was undertaken to provide assurance to the ESFA that as an employer provider of apprenticeships we have the required structures and processes in place as outlined in our initial Register of Apprentice Training Provider (RoATP) application. The Trust will also be subject to an Ofsted inspection which would normally be within 3 years of being accepted onto the RoATP or drawing down funding from the apprenticeship levy. Work has commenced on the completion of the Trust's self-assessment report (SAR) which will inform the development of the apprentice quality improvement plan (AQIP).

		Both of these documents are required as preparation for an Ofsted inspection. Procurement has been undertaken to appoint training providers for the following apprenticeships: • Healthcare Support Workers level 3 • Children & Young People level 3 • Assistant Practitioner level 5 • Customer Service level 2 • Operational management level 3 • Team Leader level 3 The successful bidders have been informed, and the contracts are in the process of being reviewed and completed. As a training provider, the Trust has commenced delivery of the Team leader level 3 apprenticeships which are incorporated into the Deputy Team Leader Development Programme. 7 staff commenced in October 2017 and a further cohort commenced in February 2018.
	The continued pilot of the Nurse Associate (TNA) role in Adults and Children services	The Trust remains involved in 4 pilot sites across London. 1 TNA has withdrawn from the programme for personal reasons and the remaining 9 adult TNA are progressing well and feedback from them has been very positive. The NMC have published draft Standards of Proficiency for Nursing Associates and Nursing Associate Skills Annex, it is expected that these will be approved by the NMC in Spring 2018. HEE have also published guidance in relation to the Administration of Medicines by Nursing Associates. The Trust will need to review policies and training in relation to this in preparation for the first cohorts of Nursing Associates who are due to qualify in January 2019.The Trust will be implementing 58 Trainee Nurse Associates across adult and children services in September 2018.

	The continued pilot of the Capital Nurse Foundation rotation programme	The Trust continues to recruit staff onto the Capital Nurse Foundation rotation programme and has achieved the target of having 16 staff recruited this year. 9 newly qualified staff commenced a rotation in January which focuses on community nursing and specialist nursing services within the Trust. The rotation programme has been very positively received by staff in divisions who feel that it will help attract staff into the Trust who wish to gain experience in a community setting. Trinity and North London Hospices are still keen to work with the Trust on the End of Life Rotation and we are currently shortlisting applicants for this rotation.
	The implementation of the staffing models into all clinical services following the safer staffing review	Safe staffing levels for the rehabilitation units are in place and staffing levels are reported monthly. The model of care is currently being reviewed as part of a rehabilitation transformation project taking place across each of the units. Safe staffing levels for Community nursing have been implemented in Harrow and all teams within the Inner division. In Merton and Wandsworth, work is currently being undertaken to understand the staffing levels required. The aim is to complete this for sign off in April 2018. In Barnet, the Trust is proposing to develop a long-term model of care. Work is currently being undertaken with the Community Nursing, Rapid response and the Integrated care teams to establish the type of model that will be implemented. In the Walk-in Centres, further analysis has been undertaken in order to establish the specific staffing levels and skill mix required. As a result, specific actions have been taken for each centre including the implementation of a trainee band 6 post supported by a band 6 development programme. This has resulted in reduced vacancy levels and greater retention rates within the service.
	The evaluation of existing fast track programmes and the development and implementation of further fast track programmes.	Following the evaluation of the fast track programme in December 2017, a number of recommendations have been implemented. These include increasing the length of the programme to 15 months and reviewing the management training to better support the development of these skills. A new cohort of 6 staff have been recruited for the inner division and are due to start in April 2018.

		A poster presentation was taken to the RCN Education Conference in March 2018 which described the Fast Track Programme and its benefits. The poster attracted interest from a number of organisations across the UK. Further development programmes have been developed including an 18 month Band 5 programme and a Band 6 development programme. The Education team are currently developing a Band 7 development programme with the aim that this will be implemented in June 2018.
Each clinical profession has a clear and successful model of professional practice which includes their role in improving population health as health champions.	Research and develop a model of professional practice for clinical staff	As a part of the two recent Trust nursing workforce events, discussions have taken place about our model of professional practice. A workshop was undertaken in which staff were asked to consider what a professional practice model would look like for nursing. Staff developed 7 potential professional practice models which the Trust are now reviewing. The aim is to share these further with staff in order to obtain further comments. Once completed, the common themes will be collated and a revised model developed aligning with the Trust Quality Strategy and Clinical Strategy. Further presentations and engagement events will then take place across the Trust before a final decision is made on the Trust model in Summer 2018.
Clinical staff are well led, educated, trained and involved in research to evidence the impact of what they do.	Increase the number of research projects involving/ led by clinical staff within the Trust Raise the profile of research in the Trust in conjunction with the training and education available to staff and the career pathway mapping Review the Trust's research strategy	The Trust has incrementally increased the number of research studies that it is hosting, and therefore increased the number of opportunities for staff and patients to participate in studies. In addition more staff have undertaken research training, for example, Good Clinical Practice training. The Trust commissioned an external review of research in September 2017, which included significant stakeholder feedback and this was used to guide the new Research Strategy 2018 -2021 which was approved in March 2018.

HERE, HAPPY, HEARD & HEALTHY

Key Outcomes	Measures of success 2017/18	Update
Staff are fully engaged and involved in the model of shared governance	Three Quality councils per division are established and well attended. Evaluation of the model used and any changes made to support the effective management of the councils.	Membership of the Recruitment & Retention Group includes representation from the Quality Councils to ensure front line staff are contributing to recruitment and retention decisions. The North Quality Council based in Harrow (Honey Pot Lane) have changed their area of focus from the creation of a localised staff newsletter to a localised staff directory. This aims to facilitate the settling of new staff into the area and reduces the amount of staff stress and time wasted searching for local services and health professionals that they may need to contact. The Inner Quality Council that are aiming to address the lack of staff morale in the Inner division have conducted their surveys and are now in the process of holding staff f focus groups to discuss the results of the survey and further explore their answers. In the Children's division the Quality Council based in Merton have conducted another plan, do, study, act cycle in relation to their staff survey; they have refined the questions with the view to building confidence in the staff answering the questions. There was an anxiety from staff surrounding the confidentiality of their answers.
Staff turnover (voluntary) below 10% by 2020 **Staff vacancies below 10% by 2020**	Staff turnover (voluntary) below 15% (12% by 3/18) Staff vacancy rate below 15% by3/17 and 12% by 3/18	Turnover remains a pressure point. The CHD rate is starting to improve following the service change impact experienced in year but more staff are leaving as they view a lack of opportunity to progress internally or have found opportunities elsewhere; are feeling the pressure of balancing their work life or are unable to work with other staff in the organisation. The Recruitment and Retention Group is focusing on career development and ensuring opportunities are known and open to clinical staff which should aid with addressing the perception of a lack of opportunities and ease pressure on those leaving for promotion elsewhere. Clinical Vacancy rates are within acceptable tolerance levels and at the close of Feb

		2018 stand at 12.20%
Staff surveys are undertaken which demonstrate improving levels of staff engagement	Staff engagement index score of 3.88 or above	The Trust successfully achieved a score of 3.89 There are divisional variations marked in the body of the report.
Wellbeing strategy to support staff health and well-being and reduce staff absence	A 2% reduction in the number of staff who report feeling unwell because of work related stress in the 2017 Staff Survey. Sickness absence remains below target of 3.5%	The 2017 results from the **staff survey** show a reduction of 1% on work related stress.* The Sickness rate (12 month rolling) stands at 3.61% which is slightly outside the target range (in the amber rage).
The Trust is committed to and makes demonstrable reductions to agency spend	The trust meets its targets relating to agency spend The number of staff recruited to staff bank increases by 10%	The Trust continues to meet the monthly and year to date agency ceilings with the weekly Executive Agency Reduction Group closely monitoring the position. Recruitment to bank is also well ahead of the targeted position and the ratio of bank to agency is strong at 72:28 in favour of the bank.

* The full results of the staff survey, including the Trust's performance in respect of the Workforce, Race Equality Standard (WRES) can be found here.
http://www.nhsstaffsurveys.com/Caches/Files/NHS_staff_survey_2017_RYX_full.pdf

VALUE ADDED CARE

Key Outcomes	Measures of success 2017 -18	Update
Clinical staff use the latest technology to improve care delivery	Each division has explored how technical innovation can be used to improve quality.	The CLCH Way programme is being developed to explore further use of mobile technologies, scheduling technology and self-booking systems to drive further improvements.
	Each division has used improvement tools to improve one service	As of 26th March 2018, six services and two quality councils have demonstrated all the requirements for this KPI (Merton Specialist Weight Management (SWM) Inner Inpatient rehabilitation, Inner Community Nursing, Harrow Community Nursing, ITO service, Partnerships, South Smart Effective Care (SEC) council and CHD Here, Happy, Heard, Healthy (HHHH) council). This represents a Trust position of 4.85% against a year-end target of 0.5%. The Trust and all operational divisions have met the year-end target for this KPI.
Front line staff lead new lean ways of working	5% staff to have been trained to basic level in improvement skills including lean	202 staff have achieved the Basic level improvement knowledge. This represents 6.03% of staff in post which is ahead of year-end target for the Quality KPI (4.0%). All divisions have achieved the target for staff to have basic level knowledge of quality improvement.

Divisional Quality Council Objectives	One objective with outcome measures	Two quality councils working on value added care have formed in January 2018. The first council will be looking at improving training adoption within the Trust and the second working on teams using visual management tools. The Improvement & Transformation Office will support the work of these councils as they begin to develop. All Quality Councils are required to use the CLCH improvement methodology within their council improvement projects.

TRUST QUALITY PROJECTS AND INITIATIVES

The Trust was also involved in a number of other quality projects and initiatives. These included the following:

Inner bedded areas have been taking part in a pilot regarding the 'Carter Review' which focusses upon how Trusts can save money, whilst improving care. The unit has been piloting the collection of a new metric around care *hours per patient day*. This pilot has enabled the units to roster staff more effectively, whilst ensuring safe staffing levels maintain patient safety.

Pembridge specialist palliative care community nursing team have been running a project to support nursing homes within the Borough Hammersmith and Fulham in providing end of life care to people who reside in the nursing homes. This has included training staff in recognising when individuals require specialist end of life care; managing symptom control and teaching staff to administer medication via syringe drivers. The project will support local commissioners understanding gaps that might exist in providing end of life care for people living in nursing homes.

Community adult nursing staff participated within the *Always Event* project which aimed to improve the way in which patients are involved within their care planning. This project involved co-design between staff and patients and focussed upon the design and implementation of a patient leaflet. The success of the *Always Event* led to the Trust receiving a level 1 *Always Event* recognition award.

Knowledge and skills framework for staff: during 2017-18 this was developed to support the development of a culture of continuous improvement. To support this, we launched a bespoke quality improvement e-learning module and delivered more than 40 face to face training sessions for over 200 CLCH leaders and staff on a range of subjects related to leading improvement, continuous quality improvement and change management.

North division In-patient areas: have taken part in the *Gold Standards* project. This involved asking patients and staff what their top 3 priorities are for providing excellent care. The top three themes for and patients were combined to come up with the top three standards for achieving *Gold Standard* care. This was shared with staff and we are looking at how we can embed the *Gold Standards* in all of our work.

Community teams: introduced *Wound Wednesdays* which involved reviewing all grade 3 and 4 wounds each Wednesday. The whole team reviews the patient to ensure all aspects of patient care are considered. Additionally peer reviews take place to ensure patients are receiving the best care they can. This approach has helped to embed ownership of patient care across whole teams.

Sexual health services: Following patient feedback, new clinics were introduced to support patients with LGBT issues and questions. This initiative has been nominated for a Health Service Jounal (HSJ) Award.

The **Improvement and Transformation office:** provided coaching and facilitation support for numerous project teams as well as the Quality Councils. This led to improvements across a range of services including one Quality Council running a quality improvement project which cleared a waiting list backlog for podiatry patients. This enabled patients to get seen quicker and reduce potential clinical risk.

The Care Home in Reach Team: are a team of advanced trained and experienced community nurses who are working as part of a trial in seven Care and Nursing Homes in Wandsworth. The nurses have been involved in replacing urinary catheters, prescribing antibiotics for urinary infections and chest infections, and prescribing to prevent constipation. These nurses have prevented 25 unnecessary admissions to hospital from the 77 patients seen since February.

STATEMENTS FROM COMMISSIONERS, LOCAL HEALTHWATCH ORGANIZATIONS AND OVERVIEW AND SCRUTINY COMMITTEES

We would like to thank those who reviewed and provided comments on our 2017 – 2018 Quality Account. We have considered the comments received and where appropriate the comments were or will be responded to in the current or future account or used to inform the quality of the services that we provide.

This section will be completed on receipt of comments.

STATEMENT OF DIRECTORS' RESPONSIBILITIES FOR THE QUALITY REPORT

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2017 to xxx [the date of this statement]
  - papers relating to quality reported to the board over the period April 2017 to [the date of this statement]
  - feedback from commissioners dated xxxx
  - feedback from local Healthwatch organisations dated xxx
  - feedback from Overview and Scrutiny Committee dated xxxxx
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009. (The complaints report is attached as an appendix the Quality Account).
  - the national patient survey
  - the national staff survey dated March 2018
  - CQC inspection report dated 8 January 2018.

The Quality Report presents a balanced picture of the NHS trust's performance over the period covered

The performance information reported in the Quality Report is reliable and accurate

There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board:

Date.....Chairman

Date.....Chief Executive

FEEDBACK AND FURTHER INFORMATION

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.

If you would like to comment on the account please e mail
Kate.wilkins6@nhs.uk

Alternatively you can send a letter to:
Kate Wilkins
2nd Floor, Parsons Green Health Centre
5-7 Parsons Green
London SW6 4UL

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 or writing to the PALS team at the above address.

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 HEALTHWATCHES

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

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

Merton Healthwatch
Tel: 0208 685 2282
https://www.healthwatchmerton.co.uk/

Wandsworth Healthwatch
Tel: 0208 8516 7767
https://www.healthwatchwandsworth.co.uk/content/contact

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

Wandsworth CCG
Tel 0208 812 6600
http://www.wandsworthccg.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

Wandsworth
Tel: 020 8871 6000
www.wandsworth.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.

Allied Health Professionals (AHP): Allied health professionals (AHPs) provide treatment and help rehabilitate adults and children who are ill, have disabilities or special needs, to live life as fully as possible. They work across a wide range of different settings including the community, people's homes and schools, as well as hospitals.

Always Event: These are those aspects of the care experience that should *always occur* when patients, their family members or other care partners, and service users interact with health care professionals and the health care delivery system. An Always Event must meet the following four criteria: Important, Evidence – based, Measurable and Affordable and Sustainable.

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.

Central alerting system (CAS) alerts: This is cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others.

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 (CQIN): The CQIN 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.

Cold Chain: This is the process used to maintain optimal cold temperature conditions during the transport, storage, and handling of certain pharmaceuticals, starting at the manufacturer and ending with the administration of the vaccine to the patient.

DATIX: A web based risk management system, via which the Trust manages its complaints, incidents and risks.

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

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.

Nursing and Midwifery Council (NMC): The NMC are the nursing and midwifery regulator.

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.

PALS: Patient advice and liaison service (PALS) provide a point of contact for patients, their families and their carers, and offer confidential advice, support and information about the services at CLCH.

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.

Prevent: Prevent is one of f strands of the government's counter-terrorism strategy

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*.

Schwartz rounds: The Schwartz rounds are an opportunity for staff to acknowledge and reflect upon the emotional impact of our daily working lives openly and honestly

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.

Awaited -