# CLCH QUALITY ACCOUNT 2018-19

## PART 1: ABOUT OUR QUALITY ACCOUNT

Welcome to the Central London Community Healthcare NHS Trust (CLCH) Quality Account for 2018-2019

**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 seventh 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 describes our six quality campaigns namely; Positive patient experience; Preventing Harm; Smart Effective care; Modelling the Way; Here, Happy, Heard and Healthy and Value Added Care. Key outcomes, along with their associated measures of success are listed for each campaign. The strategy also explains how our Quality Account priorities are aligned with the six campaigns.

Performance against these are continuously monitored and reported via the Quality Committee and Trust Board. In accordance with the strategy, we have collected information about our performance against the measures of success. We will use this information to look at how well we have performed over the past year and we will also identify where we could improve over the next and future years.

The strategy also 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.

In March 2019 we took the opportunity to refresh the quality strategy. The quality priorities remained the same but we made some minor changes to the measures of success for 2019-2020. The updated strategy can be found here:
https://www.clch.nhs.uk/application/files/5815/5264/8619/FinalQS.pdf

**How can I get involved now and in future?**

At the end of this document you will find details of how to let us know what you think of our Quality Account, what we can improve on and how you can be involved in developing the report for next year. If you would like to receive a printed copy of the CLCH Quality Account, please contact us via e-mail communications@clch.nhs.uk or telephone 020 7798 1420.

## ABOUT CLCH

We provide community based NHS health services across Greater London and Hertfordshire. We care for more than two million people with over 10 million patient contacts per year. Every day, our professionals provide high quality healthcare in people's homes and local clinics, helping them to stay well, manage their own health with the right support and avoid unnecessary trips to, or long stays in hospital. We support our patients at every stage of their lives; providing health visiting for new-born babies through to community nursing, stroke rehabilitation and palliative care for people towards the end of their lives.

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

- Adult community nursing, including 24 hour district nursing, community matrons and case management.
- Specialist nursing including; continence; respiratory, heart failure; tissue viability and diabetes.
- 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.

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

### Vision mission and values:

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/1715/3747/5337/CLCH_Annual_Report_2017_-_18.pdf

## STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

I am pleased to present the Quality Account for the year ending March 2019. During another busy year for CLCH we have welcomed new services to the Trust, including 0-19 services in Ealing and school nursing in Wandsworth, and also moved our South London Sexual Health Service into new premises in Clapham Junction. I would like to thank all the staff involved in the design and re-location of services; moving a service is always challenging and our staff went the extra mile to make this happen.

Last year when I introduced the Quality Account I reported that that we were finalists for the Health Service Journal (HSJ) Patient Safety Award in the category of **Organization of the Year.** This was for our work on our Quality Strategy, *Simply the Best, Every Time* and I am delighted to report that the Trust subsequently won this award.

Learning from when things go wrong is always one of the most difficult, and important, areas of our practice. In the last year we have continued to make sure we learn from incidents, to improve our practice and to reduce, and prevent harm, to the people in our care.

Looking ahead to 2019/20 we look forward to welcoming new colleagues joining us, as the Trust takes on responsibility for providing adult community services in Hertfordshire, and also opening our CLCH Academy. The Academy will provide education and training opportunities enabling community and primary care professionals to learn together. We will also support new roles and ways of working such as Apprentice Nursing Associates as well as rotations across community and primary care.

Finally my thanks to all our staff for their continued commitment to providing excellent care.

**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.**

**Andrew Ridley - Chief Executive Officer**

## STATEMENT OF THE CHAIR OF THE QUALITY COMMITTEE

Our aim is simple: to ensure CLCH provides outstanding care. We want our services to be as safe, effective and patient-focussed as possible. To achieve this, the Trust's Quality Committee has continued to monitor progress against our Quality Strategy *Simply the Best, Every Time*, its six quality campaigns and the associated quality priorities described within the strategy. The committee, as well as receiving monthly updates and a quality dashboard, also reviewed in-depth reports on our progress towards achieving our quality objectives.

The committee continued to invite staff to give quality presentations. This enables us to hear the voice of staff and service users first-hand, focussing our attention on areas where we have got things right and those where we need to do better. Additionally, as part of our Board Commitment to undertaking `15 Step Challenges', committee members visited a range of clinical areas in order to see and hear for themselves how the Trust is delivering services. This has been a powerful source of information and feedback for committee members and has translated into tangible improvements in how the Trust delivers its services.

During the year, as part of our continuing journey to recognise quality and learn from each other, we have embedded 18 quality councils across the Trust. This is an impressive achievement. I would like to extend my thanks to our users, members of the public and staff who play such a significant role in making these a success.

I am delighted to say that this year we awarded Quality Development Unit (QDU) status to:

- Barnet muscular skeletal (MSK) team
- Inner London paediatric dietetics
- Merton holistic and rapid investigation services (HARI)
- Hertfordshire respiratory service
- Harrow podiatry service
- Colville health visiting team
- Hammersmith & Fulham speech and language therapy education team

QDU status is only awarded after a team has achieved excellent results in their self-assessments, quality indicators and quality inspection team visits and has applied to the Quality Panel to become a QDU. Units that achieve this status receive support to invest in their service and become a resource for other teams seeking to improve.

I am pleased that during the year we saw a significant reduction in falls on our bedded rehabilitation units and also an improved friends and family test score which exceeded the national target for both December and January.

Looking ahead, in 2019-20 the Quality Committee will continue to monitor progress against the objectives set out in the final year of our current, updated Quality Strategy and will be working closely with the Chief Nurse and his team as we develop our CLCH new quality strategy to support our aspirations to provide the best service we can.

**Dr Carol Cole - Chair of Quality Committee**

## PRIORITIES FOR IMPROVEMENT 2019-2020

Our quality priorities for 2019 – 2020 are the same as laid out in our updated 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 2019-2020 are as follows:

**CAMPAIGN ONE: A POSITIVE PATIENT EXPERIENCE**

| KEY OUTCOMES | MEASURES OF SUCCESS 2019-2020 |
|---|---|
| Service developments and plans of care co-designed with patients and service users | 95% or above of proportion of patients whose care was explained in an understandable way<br><br>92% or above proportion of patients who were involved in planning their care<br><br>All service improvement projects will be supported through co-design<br><br>Patients will be members of the Quality Councils in each division |
| Patient stories and diaries used across pathways to identify touch points and<br>`Always events' | Always Events to become integral to Quality Councils as a method used to improve patient experience<br><br>Evaluation of Always Events* and their impact on patient experience<br><br>Thematic analysis of previous year's stories with shared learning.<br><br>Continued use of patient stories shared at Divisional and Trust forums.<br><br>Evaluation of the use of patient diaries/innovative approaches to patient stories and their 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<br><br>Evaluate the use of patient stories as part of learning from serious incident reviews. Patient stories and feedback will be integral to the learning from serious incident reviews |
| Divisional Quality Council Objectives | Three objectives with outcome measures |

* **Always Events:** 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 five criteria: important; evidence- based; measurable; affordable and sustainable.

**CAMPAIGN TWO: PREVENTING HARM**

| KEY OUTCOMES | MEASURES OF SUCCESS 2019-2020 |
|---|---|
| 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<br><br>Incidence of pressure ulcers (PU) and falls will continue to fall (5%)<br><br>Maintain high levels of reporting and low levels of harm.<br><br>0 % PU in bedded areas<br><br>100% Root Cause Analysis (RCA)* completed on time<br><br>0% falls with moderate or above harm in bedded areas |
| Safety culture and activities signed up to in ALL services | No outstanding actions from serious incidents.<br><br>All risk register actions are met by identified completion date. |
| Variations in practice identified and acted upon | All staff using repository* in practice |
| Divisional Quality Council Objectives | Three objectives with outcome measures |

**Repository:** the lessons identified from pressure ulcer learning are placed in a `repository'. This allows staff to reflect on their practice and modify future actions as appropriate.

**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.

**CAMPAIGN THREE: SMART, EFFECTIVE CARE**

| KEY OUTCOMES | MEASURES OF SUCCESS 2019-2020 |
|---|---|
| Clinical staff use the most up to date clinical practices | Central alerting system (CAS)* alerts (including Patient Safety Alerts (PSAs))<br><br>Monthly Board KPI target for timely alert closure ≥90%<br><br>NICE 90% of services complete a Baseline Assessment Form for NICE* Guidance within the agreed timeframe. |
| 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 | Three objectives with outcome measures |

*** CAS:** 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.

*** PSAs:** These alerts rapidly warn the healthcare system of risks. They provide guidance on preventing potential incidents that may lead to harm or death

***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.

**CAMPAIGN FOUR: MODELLING THE WAY – PROVIDING WORLD CLASS MODELS OF CARE, EDUCATION AND PROFESSIONAL PRACTICE**

| KEY OUTCOMES | MEASURES OF SUCCESS 2019-2020 |
|---|---|
| New roles and career pathways are in place which support the needs of patients/service users. | Review of career pathway frameworks to include integrated roles and primary care.<br><br>The continued implementation of clinical apprenticeship roles<br><br>The implementation and evaluation of the Nursing Associate role across the Trust<br><br>Rotation programmes implemented across the Trust<br><br>Continued improvement in Staff survey results in relation to education and learning<br><br>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. | Evaluate the model of professional practice<br>Staff survey results |
| The Implementation of the CLCH Community and Primary Care Nursing Academy | Evaluation of the year one successes of the Academy |
| Processes in place to enable statutory mandatory training compliance to meet Trust target | Undertake service audits to identify gaps in training<br>Training linked to incidents and risk assessments<br>95% training compliance |
| Divisional Quality Council Objectives | Three objectives with outcome measures |

**CAMPAIGN FIVE: HERE, HAPPY, HEARD AND HEALTHY – RECRUITING AND RETAINING AN OUTSTANDING WORKFORCE**

| KEY OUTCOMES | MEASURES OF SUCCESS 2019-2020 |
|---|---|
| Staff are fully engaged and involved in the model of shared governance | Six Quality Councils are established per division and well attended.<br>Shared governance becomes part of "the way we do things" at CLCH |
| Voluntary staff turnover below 10% by 2020<br><br>Staff vacancies below 10% by 2020 | Voluntary staff turnover below 8%<br><br>Staff vacancy rate below 8% by March 2020 |
| Staff surveys are undertaken which demonstrate improving levels of staff engagement | Above 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 4% reduction in the number of staff who report feeling unwell as a result of work related stress in the 201 Staff Survey.<br><br>Sickness absence remains below target of 3% |
| The Trust is committed to and makes demonstrable reductions to agency spend | Agency spend is proportionally reduced as sickness, turnover and vacancy rates reduce<br><br>The number of staff recruited to staff bank increases by 20% |
| Divisional Quality Council Objectives | Three objectives with outcome measures |

**CAMPAIGN SIX: VALUE ADDED CARE – USING ENHANCED TOOLS, TECHNOLOGY AND LEAN METHODOLOGIES TO MANAGE RESOURCES WELL INCLUDING TIME, EQUIPMENT AND REFERRALS.**

| KEY OUTCOMES | MEASURES OF SUCCESS 2019-2020 |
|---|---|
| The user experience across CLCH, primary care, specialist services and social care is as seamless as possible | Continued assessment of patient pathway is embedded in divisional planning<br><br>Patient involvement is the norm |
| Clinical staff use the latest technology to improve care delivery | Each division has used improvement tools to improve15 % of services |
| Front line staff lead new lean ways of working | 25 % staff to have been trained to basic level in improvement skills , including lean |
| There will be demonstrable culture of clinical enquiry and continuous improvement across the Trust | 80% staff able to contribute to improvements at work<br><br>80% staff reporting they have access to improvement analytics when required |
| Divisional Quality Council Objectives | Three 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.*

In January 2019 we refreshed our *Quality Strategy* and sent it to all our external stakeholders. We confirmed that the quality priorities described in the strategy would be the quality priorities for our *Quality Account* and asked for comments on this.

Furthermore we consulted on our quality priorities and their associated measures of success between 1st February and 5th April 2019. Information was provided for staff via internal communications and our *Spotlight on Quality.* Our external website also allowed people to comment on our quality priorities and we also wrote to our shadow members asking for their comments.

The issues raised in response to the consultation are listed below and were all individually responded to. There were no objections to any of the proposed priorities. Where appropriate the feedback will be used to inform the next update of our quality strategy.

- More consideration to be given to community engagement
- Support for openness and transparency
- Support for engagement with patients as described in campaign one
- Request for further information about no blame culture
- Podiatry appointments waiting times

## STATEMENTS OF ASSURANCE FROM THE BOARD

**Review of services**

During 2018-2019 CLCH provided 79 NHS services.

CLCH has reviewed all the data available to them on the quality of care in 100% of services. The income generated by the NHS services reviewed in 2018-2019 represents 100% of the total income generated from the provision of NHS services by CLCH for 2018-2019

**Secondary use services**

CLCH submitted records during 2018-19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics. The percentage of records in the published data which included the patient's valid NHS number was 93.5% and which included the patient's valid General Medical Practice Code was 92.9%.

All (100%) of this information related to records for patients admitted to our Walk in Centres.

**Clinical coding error rate**

CLCH was not subject to the Payment by Results clinical coding audit during 2018-2019

**Data Security and protection (DSP) toolkit**

The DSP has replaced the information governance toolkit. The Trust's auditors have confirmed that CLCH has met all standards required of the DSP toolkit.

## 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 2018-2019 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 six (100%) of the national clinical audits that the Trust was eligible to participate in. These audits, for which data collection was completed in 2018-2019, 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 six national clinical audits were reviewed by CLCH. The actions that CLCH intends taking in response to the audit are incorporated into the table below.

## NATIONAL CLINICAL AUDITS

**Please note that for all cases data collection and analysis is still in progress and won't be finalised until the final account is produced.**

| National Clinical Audits | Participation | Submitted Cases or Reasons for non-Participation | Outcomes and Actions |
|---|---|---|---|
| Sentinel stroke national audit programme (SSNAP)<br><br>(Previously known as the national stroke audit) | **Yes** | Xxx cases submitted which is yyy% of total required.<br><br>This continuous audit aims to drive improvements in the quality of care and services provided for COPD patients. The period under review has been addressing service improvement<br><br>The services/teams taking part were the Stroke ESD team, Merton ESD team, Merton community neuro rehab team. | **Actions: TBC** but will address service improvement. |
| National Audit of Intermediate Care (NAIC) 2018 | Yes | Xxx cases submitted which is yyy% of total required.<br><br>Please note that unlike in previous years this information can no longer be obtained NAIC. Therefore we are calculating the figures but the final information is not currently available<br><br>Services that took part: Athlone Rehabilitation Unit, Alexander Rehabilitation Unit at Princess Louise Nursing Home, Harrow (Peer 1 & 2), Harrow (Locality 2 & Night Service), Barnet Intermediate Care Services, Harrow Rapid Response, Harrow (Peer 5 & 6), Intermediate Bedded Unit, Merton, MERIT-Home based Intermediate Care, Jade Ward, Edgware Community Hospital (Barnet CCG patients), Marjory Warren Ward, Finchley Memorial Hospital (Barnet CCG patients), Adams Ward, Finchley Memorial Hospital (Barnet CCG patients), Intermediate Care Services Wandsworth | **Outcomes:** Evidence indicated that intermediate care works with more than 93% of service users weather maintaining or improving their level of independence in undertaking activities or daily living during their episode of care (up from 91% in 2017).<br><br>**Action:** The NAIC has been removed from the 2019/20 Quality Accounts List. The audit is not being funded by NHSE for 2019/20 and will therefore not be collecting data during this financial year. |

| | | | |
|---|---|---|---|
| National audit of hip fracture services | Yes | Xxx cases submitted which is yyy% of total required.<br><br>(Due to a key member of staff leaving we are not currently able to finalise the number of cases submitted)<br><br>Barnet intermediate Care Services | **Outcomes:** Evidence indicated there was variation in understanding how many patients were transferred from acute to rehabilitation units which resulted in some hip fracture teams not knowing whether rehabilitation was successful.<br><br>**Action:** This audit has been redesigned so that in future it will transition from a 'snapshot' to the National Audit of Inpatient Falls (NAIF). This will provide continuous data collection. |
| National diabetes foot care audit (NDFCA) | Yes | Xxx cases submitted which is yyy% of total required.<br><br>The NDFCA is continuous, and measures care structures, patient management and care outcomes for people with diabetic foot ulcers.<br><br>Services participating: Community Diabetes Podiatry Service (Westminster), Community Diabetes Podiatry Service (Kensington & Chelsea). | **Outcomes:** The report indicated that services needed to establish local pathways that minimise the time taken to be seen by a specialist foot care service<br><br>**Action: TBC** |
| National Audit of Cardiac Rehabilitation (NACR) | Yes | Xxx cases submitted which is yyy% of total required.<br><br>The NACR aims to increase the availability &uptake of cardiovascular prevention and rehabilitation, promote best practice and improve service quality in cardiovascular prevention and rehabilitation service<br><br>Harrow COPD Respiratory Service, West Herts Respiratory Service, Merton Cardio-Respiratory Service, and Barnet Community Respiratory COPD Service | **Outcomes TBC.**<br><br>**Action: TBC** |

| | | | |
|---|---|---|---|
| National Asthma and COPD Audit Programme (NACAP) Pulmonary Rehabilitation Audit | Yes | Xxx cases submitted which is yyy% of total required.<br><br>This audit aims to improve the quality of care, services and clinical outcomes for patients with asthma (adult; children and young people) and chronic obstructive pulmonary disease (COPD).<br><br>Data collection in progress because this was registered in December 2018. Therefore this will not be finalised until November 2019. | **Outcomes: TBC**<br><br>**Action: TBC** |

**Local clinical audits**

The reports of xxx local clinical audits were reviewed by CLCH in 2018-19. 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.

Information concerning local audits is currently being worked upon. We will be reporting on 40 local audits. This information will be included in the final quality account.

**Acronyms and explanations of terms**

| | |
|---|---|
| **AAC** | Assistive Communication Service within the Children Health's Division |
| **AAF** | Amino Acid Formula (infant feeding formula) |
| **AECOPD** | Acute exacerbation of COPD |
| **BERG Balance Score** | The BERG Balance Scale is a clinical test of a person's static and dynamic balance abilities |
| **BMI** | Body Mass Index |
| **Braden Scale** | The Braden Scale uses a special scoring system to evaluate a patient's risk of developing a pressure ulcer |
| **CAMHS** | Child and Adolescent Mental Health Services |
| **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) |
| **ESP** | Extended Scope Physiotherapist |
| **EQ-5D-5L** | A standardised measure of health status that provides measures of health for clinical and economic appraisal |
| **FRHA** | First Review Health Assessment |
| **FOM** | Faculty of Occupational Medicine |
| **HARI** | Holistic assessment and Rapid Intervention. |
| **HETF** | Home Enteral Tube Feed |
| **ICS** | Intermediate Care Service |
| **IG** | Information Governance |
| **IHA** | Initial Health Assessment |
| **IP** | Infection Prevention |
| **IPN** | Infection Prevention Nurse |
| **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 |
| **PMLDTC** | Profound and Multiple Learning Disability Therapies Clinic |
| **PR** | Pulmonary Rehabilitation |
| **PRN** | 'pro re nata' - medicines that are taken "as needed" |
| **RCW** | Rehabilitation Care Worker |
| **SMART** | Specific, Measurable, Accurate, Realistic and Timely |
| **SIFP** | Specialist Infant Formulae Prescribing guidance |
| **SRHA** | Second Review Health Assessment |
| **SOP** | Standard Operating Procedure |
| **TI** | Technical Instructor |
| **TOMs** | Therapy Outcome Measures |
| **WHO** | World Health Organisation |

## PARTICIPATION IN RESEARCH

Research is essential to find out which treatments work better for patients; it also enables the development of new treatments. CLCH is committed to high quality research and to this end, the CLCH Research Strategy 2018-2021 identified the following aims:

- To allow all CLCH staff and service users the opportunity to participate in health care research.
- To expand research opportunities across services and geography tapping into all 4 divisions.
- To increase the research culture within CLCH.
- To become a leader for healthcare research in community settings.

During the last year CLCH demonstrated an increase in research activity. This related to both the recruitment of patients into studies and also the number of studies open. Additionally there were more staff trained in Good Clinical Practice training, which is a requirement for research. Examples of current studies that CLCH are involved in include:

**Sexual health services**:

- PreP Impact study: the study is the clinical trial of a drug, which 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. This study is continuing and has recruited well across all sites.

**Children's services**:

- Active Child study: CLCH is working with researchers at Newcastle University to invite parents with children where there are motor developmental delays to participate in this study.

**Parkinson's service:**

- Parkinson's Pain study**:** this study looks at the type and frequency of pain experienced by patients with Parkinson Disease.
- Parkinson's communication study**:** this is a randomised control trial, for patients requiring speech and language therapy.

During 2018-19, there were over 25 clinical staff participating in 14 clinical research studies in 5 specialities: respiratory; sexual health; Parkinson's; children's; and speech and language therapies that had been approved by a research ethics committee. CLCH is a host site for 11 studies, and CLCH acts as a participation identification site (PIC) for the remaining studies.

The number of patients receiving relevant health services provided or subcontracted by CLCH during 2018-19 that were recruited during that period to participate in research approved by a research ethics committee was 304.

**FREEDOM TO SPEAK UP (FTSU)**

Staffs are encouraged to raise concerns over the quality of care, patient safety or bullying and harassment within CLCH so that we have an opportunity to address them. Staff can raise concerns through their line manager or clinical lead, freedom to speak up (FTSU) guardians, the patient safety team, staff representatives, directors, nominated non-executive director, trust local counter fraud specialist. Staff are also provided with details as to how they can speak up to an outside body. Occasionally, concerns may come to light through, for example, an HR process.

Staff can raise concerns in person, by phone or in writing, including email. There are separate email addresses for FTSU *(accessed by FTSU Guardians)* and Whistleblowing *(accessed by the Nominated Non-Executive Director)*.

Staff can choose to raise their concern by name, confidentially or anonymously. If confidential, we strive to maintain confidentiality unless we are required to disclose it by law, e.g. by the police. Staff are encouraged to provide their name to make it easier to investigate thoroughly and to provide feedback on the outcome.

Feedback will be given to staff who raise concerns through progress updates and, wherever possible, by sharing the full investigation report with them whilst respecting the confidentiality of others.

CLCH wants staff to feel safe to raise their concerns. Within the FTSU: Raising Concerns Policy, it makes clear that staff will not be at risk of losing their job or suffering any form of reprisal as a result. The policy also confirms that the Trust will not tolerate the harassment or victimisation of anyone raising a concern or any attempts to bully staff into not raising any such concern.
Furthermore the FTSU Guardian will escalate to the board any indications that staff are being subjected to detriment for raising their concern, regardless of whether it was before or after the staff member contacted a FTSU Guardian.

In addition to the FTSU policy, staff are made aware and reminded of other routes to raise concerns. This includes the 'How to Raise a Concern' handout; the CLCH Welcome Booklet for new starters; a handout given to new volunteers and bank workers; induction talks for new staff and those TUPEed into CLCH; the Statutory and Mandatory Handbook that requires completion by staff annually; ad hoc team talks and presentations; events such as the AGM; intranet page, posters and articles in CLCH communications.

Regular reports on FTSU are provided to the Trust Board; the workforce committee and the FTSU working group. Additionally data and themes are fed through the patient safety and risk group and to the quality committee.

## COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN) PAYMENT FRAMEWORK

A proportion of CLCH's income during 2018-19 was linked to achieving national CQUIN 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), and NHS Harrow.

Achieving the agreed CQUIN goals represents an additional 2.5% of the contract values of these contracts. For 2018/19, as with 2017/18, only 1.5% of the total CQUIN value was associated with actual CQUIN schemes. The remaining 1% was divided between STP engagement (0.5%) and a risk reserve relating to the control total (0.5%).

Please note that it was agreed within the STPs that full payment would be made regardless of achievement.

Some of the more recently commissioned services procured through contracts with NHS Merton CCG and the Battersea Community Healthcare Community Interest Company (for the Wandsworth Adult Community Health Services contract) are not driven by CQUIN schemes; they are delivered by local incentive schemes.

Our achievements against the CQUIN goals and incentive schemes for 2018-19 are detailed in the following tables.

| CQUIN Title | Goal | Plan for 18/19 | Forecast Achievement for 18/19 |
|---|---|---|---|
| Supporting Local Areas | To achieve financial control targets set by the STP planning process | £261,975 | £261,975 |
| Supporting Local Areas | To demonstrate engagement with the STP process and engaging with locality and system wide pathway developments | £261,975 | £261,975 |
| Health & Wellbeing | Improving the uptake of flu vaccinations for frontline clinical staff | £157,185 | £157,185 |
| Health & Wellbeing | Improvement of staff health and wellbeing | £157,185 | £157,185 |
| 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. | £157,185 | £157,185 |
| Improving Wound Care Assessments | To increase the number of full wound assessments for wounds which have failed to heal after 4 weeks. | £157,185 | £157,185 |
| 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. | £157,184 | £157,184 |
| | | **£1,309,874** | **£1,309,874** |

**BARNET CCG**

| CQUIN Title | Goal | Plan for 18/19 | Forecast Achievement for 18/19 |
|---|---|---|---|
| Supporting Local Areas | To achieve financial control targets set by the STP planning process | £184745.50 | £184745.50 |
| Supporting Local Areas | To demonstrate engagement with the STP process and engaging with locality and system wide pathway developments | £184745.50 | £184745.50 |
| Health & Wellbeing | Improving the uptake of flu vaccinations for frontline clinical staff | £110,847.24 | £110,847.24 |
| Health & Wellbeing | Improvement of staff health and wellbeing | £110,847.25 | £110,847.25 |
| 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. | £110,847.25 | £110,847.25 |
| Improving Wound Care Assessments | To increase the number of full wound assessments for wounds which have failed to heal after 4 weeks. | £110,847.25 | £110,847.25 |
| 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. | £110,847.24 | £110,847.24 |
| | | **£923,727.23** | **£923,727.23** |

**HARROW CCG**

| CQUIN Title | Goal | Plan for 18/19 | Forecast Achievement for 18/19 |
|---|---|---|---|
| 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 | £24,281.88 | £24,281.88 |
| Health & Wellbeing | Improvement of staff health and wellbeing | £24,281.88 | £24,281.88 |
| 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 |
| | | **£202,349.05** | **£202,349.05** |

**INCENTIVE SCHEMES**

**MERTON CCG**

Merton CCG's incentive scheme relates to the reduction of emergency hospital admissions and the achievement of patient outcome measures:

This scheme is worth 10% of the contract value, which would represent **£698,669** over and above the contract value.

| LIS Title | Goal | Scheme values<br><br>£ | Forecast Achievement for 18/19 |
|---|---|---|---|
| Prevention of hospital admissions | To reduce and prevent hospital admissions that also reduces mortality rates. | £139,741 | £39,302 |
| Overall experience rating | Annual improvement in proportion of people who rate their overall experience as good or excellent. | £41,921 | £41,921 |
| Involvement in care and support | Annual improvement in proportion of people who said they were involved as much as they wanted to be in decisions about their care and support. | £41,921 | £41,921 |
| Before and after outcomes measures | 1) Annual improvement of number of patients who have recorded before and after outcomes measures.<br>2) Annual improvement in proportion of patients who have recorded before and after outcome measure/ indicator reported in patient record and achieve improvement in PROMS. | £41,922 | £41,922 |
| Rate of non-elective admissions | Annual reduction of the rate of non-elective admissions for people know to community services. | £349,350 | £122,273 |
| Managing your own health | Annual improvement in proportion of people who answer positively to the question "How confident are you that you can manage your own health?" | £41,922 | £0.00 |

| | | | |
|---|---|---|---|
| People working well together | Annual reduction in proportion of people (patients and referrers) who respond “no, they do not work well together “ to the question: “do all the different people treating and caring for you work well together and give you the best case and support?” | £41,922 | £41,922 |
| | | **£698,699** | **£329,261** |

**WANDSWORTH (Battersea Healthcare CIC)**

The Wandsworth incentive scheme is worth 10% of the contract value, which would represent **£1,568,552.40** over and above the contract value.

| LIS Title | Goal | Scheme values | Forecast Achievement for 18/19 |
|---|---|---|---|
| LAS – Care Pathways | To set up referral pathways and processes to enable LAS to quickly and safely refer agreed patient cohorts to CAHS services (e.g. MI / QS / Care Home Support team and community nursing) and for relevant CAHS services to provide a rapid response. | £104,570.16 | £104,570.16 |
| SPA for Enablement | To provide a simple, single and safe referral route for St George's Hospital (SGH) and other local trusts to send referrals for all Wandsworth patients requiring enablement services from health or social care into CLCH SPA. | £104,570.16 | £104,570.16 |
| Facilitated and Supportive Discharge | To improve seamless care for patients on ECP caseload and reduce the DTOCs relating to this group of patients. | £104,570.16 | £104,570.16 |
| GSF | To support MDT discussions at GSF meetings by increasing attendance by community nurses at these meetings | £104,570.16 | £104,570.16 |
| IV Pathway Implementation | To have a safe, sustainable and cost effective IV therapy provision provided by CLCH for health conditions listed under goals. | £104,570.16 | £104,570.16 |
| Caseload and Acuity Management | To continue to refine and develop outputs of LIS schemes 2a and 2b of 2017/18 to enable better understanding of demand and capacity across all functions of care. | £313,710.48 | £313,710.48 |
| Workforce – Staffing/ budgets | To establish the current staffing levels across functions of care. To agree the means to agree/sign off future changes. | £313,710.48 | £313,710.48 |

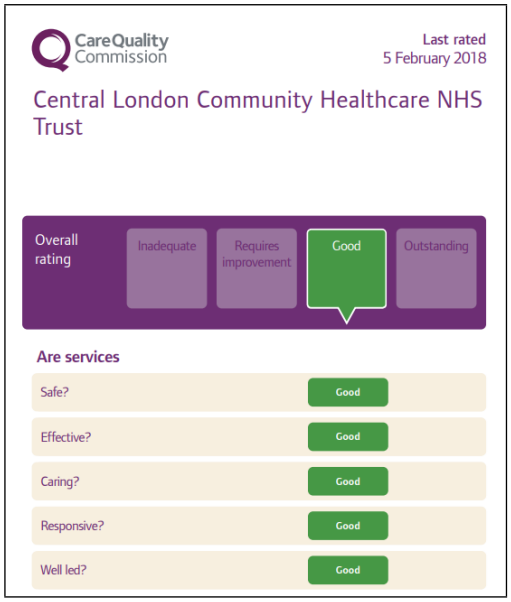
| | | | |
|---|---|---|---|
| MDT developments | To implement the SOP (which will include access to information, expected attendees with reasons for exception, meeting structure, TOR) Audit compliance against the SOP and meeting structure to support the SOP. | £104,570.16 | £104,570.16 |
| SPA | To review referral pathways as specified under goals and document and implement any recommendations for change to the pathways. | £104,570.16 | £104,570.16 |
| Diabetes Pathway | To implement a new model of care for Diabetes Specialist Nurses across Wandsworth that is more efficient, ensures the DSNs review more appropriate patients while upskilling and supporting primary care. | £104,570.16 | £104,570.16 |
| Care Homes | To develop the model for, and recruit to a Care home in-reach team. | £104,570.16 | £104,570.16 |
| | | **£1,568,552.40** | **£1,568,552.40** |

## 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 2018-2019.

CLCH has not participated in any special reviews or investigations by the CQC during the reporting period that ended 31st March 2019.

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 caseloads within the health visiting service, and using the Laming recommendations found that caseloads were higher those recommendations.

Whilst the CQC accepted that, a new clinical model had been introduced utilising the skills of nursery nurses, the assessors concluded that the model was not clearly understood by the staff in the service. In response this, the division created and have delivered an action plan to work with the health visiting teams to increase their understanding of the clinical model.

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.

## DATA QUALITY

CLCH appreciates that high quality data is a key component of Information Governance. It also recognizes that it is essential for both the effective delivery of patient care and enabling continuous improvements in care provision. 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 Trust recognizes the importance of keeping personal data 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.

The following is a summary of the actions that CLCH has taken to improve its data quality during the 2018 - 2019 year:

- Completed a single version of the truth Trust Data Warehouse.
- Provided a data quality plan. The plan has been overseen by the Trust Data Forum that has both clinical and operational input.
- Delivered a data quality portal and assurance tool which is in use by relevant divisional staff.
- Appointed a Trust lead for data quality and an Assistant Director for Business Intelligence and Information Management.

The Data Forum (DF), led by the Chief Information Officer, has oversight of this area of work. It has a strong operational input from divisional Business Managers. In the context of data quality, this group has the following specific aims to improve data quality in 2019-20:

- 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 also be taking the following actions in 2019-20 to improve data quality.

- Working with teams to improve the quality of their data collection and reporting, utilising tools developed in the previous year.
- Working with the BI function to make data more accessible and visible, thereby increasing understanding of Trust activity and identifying data quality issues more quickly.

## LEARNING FROM DEATHS: 2018 - 2019

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. This is the report linked to the Learning from Death Policy and case record reviews.

In October 2018 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 ongoing refinement but has now become embedded across the Divisional teams. All deaths within the Trust are reported via Datix. Named Team Leaders with each team triage each case to ascertain whether a case record review should be carried out using a modified PRISM 2 (Preventable Incidents, Survival and Mortality Study 2) form. The case record reviews are completed by the Divisional Directors of Quality or the Clinical Directors from the relevant divisions.

Improvement is required in documentation and collation of the reporting.

**Table 1**

| | Prescribed information | Form of statement |
|---|---|---|
| 1 | The number of in- patients who have died during the reporting period, including a quarterly breakdown of the annual figure. | During 2018 - 2019, 1291 CLCH patients died as follows (Includes expected hospice deaths)<br><br>292 in the first quarter<br>354 in the second quarter<br>325 in the third quarter<br>320 in the fourth quarter |
| 2 | The number of deaths included in item 1 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. | In 2018 - 2019, 11 case record reviews and 2 investigations were carried out in relation to the 1291 of the deaths included in item 1<br><br>In 2 cases, a death was subjected to both a case record review and an investigation.<br><br>The number of cases in each quarter for which a case record review or an investigation was carried out was:<br><br>2 in the first quarter;<br>6 in the second quarter;<br>2 in the third quarter;<br>1 in the fourth quarter; |
| 3 | An estimate of the number of deaths during the reporting period included in item 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 0% 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.<br><br>In relation to each quarter, this consisted of: 0% |

| | Prescribed information | Form of statement |
|---|---|---|
| 4 | A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 3. | **Case 1:** No action points noted.<br>The Coroner commended the unit on its record keeping around cognitive assessment and relevant documentation<br><br>**Case 2:** No action points noted<br><br>**Case 3:** No Next of Kin documented in medical records which caused a delay in the Next of Kin being contacted *<br><br>**Case 4:** No action points noted<br><br>**Case 5:** No action points noted *<br><br>**Case 6:** No action points noted<br><br>**Case 7:** No action points noted *<br><br>**Case 8:** No action points noted<br><br>**Case 9:** No action points noted<br><br>**Case 10:** No action points noted<br><br>**Case 11:** No action points noted |
| * Please note that in cases 5 and 7 we did not judge that there were any shortcomings in our practice as the care provider and there was no learning from these cases with regard to the provision of patient care. However in both these cases there was learning for the Trust and this is described in the paragraph below. | | |

| | | |
|---|---|---|
| 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 4). | **Case 3:** NOK now audited quarterly as part of the service's medical record audit. From 2020, NOK documentation to be audited as part of the Annual Trustwide Clinical Record Keeping audit.<br><br>**Case 5:** This case record review was conducted as the communication between staff and family members had been poor during the patient's admission. Staff in the unit reflected that in future, cases such as these will be investigated via the complaints process rather than by case record reviews.<br><br>**Case 7:** Information was missing regarding a Mental Capacity Act assessment which had been conducted shortly prior to the patient's death as the assessment was carried out by a third party and we did not have access to these records. The Trust's Medical Director liaised with NHS England Deputy Medical Director to enquire whether there was any way that we could gain access to records held by third parties for the purposes of completing case record reviews and investigations following patients' deaths but was informed that his was not possible due to data protection laws. The Medical Director is liaising with the Trust's Clinical Chief Information Officer to see what process, if any, we can follow for obtaining relevant information when third party organisations are involved. |
| 6 | An assessment of the impact of the actions described in item 5 which were taken by the provider during the reporting period. | **Case 3:** No impact as yet<br><br>**Case 5:** No impact as yet<br><br>**Case 7:** No impact as yet |

| | Prescribed information | Form of statement |
|---|---|---|
| 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 2 in the relevant document for that previous reporting period. | 0 case record reviews and 0 investigations completed after 2017 -2018 which related to deaths which took place before the start of the reporting period. |
| 8 | An estimate of the number of deaths included in item 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 representing 0% of patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.<br><br>This number has been estimated using the PRISM 2 (Preventable Incidents, Survival and Mortality Study 2) CLCH Review Form, which is a tool recognised by NHS Health Research Authority used for assessing case records, and which has been adapted for use by CLCH. |
| 9 | A revised estimate of the number of deaths during the previous reporting period stated in item 3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 8. | 0 representing 0% of the patient deaths during 2018 - 2019 are judged to be more likely than not to have been due to problems in the care provided to patients. |

## INCIDENT REPORTING

The following two questions have been 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 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.**

For the period 2018-19 there were 8946 patient safety incidents reported within CLCH. Of these incidents 33 (or 0.368%) resulted in severe harm. There were no patient safety incidents that resulted in a death. (Community Trusts are no longer provided with information from the National Reporting and Learning System (NRLS) regarding the rate of patient safety incidents so this information is not available). The patient safety incidents reported that resulted in severe harm consisted of thirty pressure ulcers, one fall, one delay/failure to diagnose and one information breach.

Within the arena of patient safety it is considered that organisations that report incidents have a better and more effective safety culture. This is because to learn and improve you need to know what any problems and issues are.

**CLCH considers that this data is as described for the following reasons:**

- The Patient Safety Managers continue to work closely with clinical colleagues to raise awareness about the types of incidents that should be recorded on the incident reporting system
- The patient safety team actively promote the work of the team, providing presentations at induction and being part of the apprenticeship scheme for staff on development programmes.
- Regular feedback is provided through communication channels such as the Hub and Spotlight on Quality as well as direct feedback to incident reporters so that staff can see that we do respond to the incidents reported and action is taken as a result.
- The number of severe harm pressure ulcers has reduced and during the last year we have provided monthly and quarterly feedback on the lessons learnt from pressure ulcer investigations completed.
- Maintenance of a fair-blame culture so that staff feel confident in reporting incidents.

**The Trust has taken the following actions to improve this and so the quality of its services, by:**

- Sharing learning from incidents through the Trust's publication *Spotlight on Quality.*
- Including key themes and learning from the pressure ulcer incident investigations on the pressure ulcer pages on the Trust's intranet.
- Collating the themes into a quarterly report which is shared every month with each division for discussion and dissemination.
- Encouraging incident reporting at all available opportunities including presentations at the new face to face induction and delivering training to apprenticeship and other development programmes.
- Developing and sharing 'how to' guides so that staff are helped to report incidents.
- Sharing learning from incidents through a standing item on the patient safety and risk group.
- Developing a Trust wide action plan for pressure ulcers which is monitored and maintained by the pressure ulcer working group.
- Implementing action plans following the completion of investigations to prevent reoccurrence

## PART 3: OTHER INFORMATION

### QUALITY PERFORMANCE AND PROGRESS AGAINST OUR QUALITY PRIORITIES 2018-19

**Trust wide quality scorecard:** The following scorecard describes Trust performance against the quality campaign KPIs. Where performance targets were not achieved, further information is provided. Additionally performance against our quality strategy measures of success is incorporated into the relevant tables below.

| Quality Campaign | Key Performance Indicator | Target 2018-19 | Performance | |
|---|---|---|---|---|
| | | | Year end 2018-19 | Previous year 2017-2018 |
| **A Positive Patient Experience** | Proportion of patients who were treated with respect and dignity | 95.0 % | 98.3 % | 97.4% |
| | Friends and family test (FFT)- percentage of people that would recommend the service | 95.0 % | 94.5 % | 92.1% |
| | Proportion of patients whose care was explained in an understandable way | 92.0 % | 95.4 % | 92.9% |
| | Proportion of patients who were involved in planning their care | 90.0 % | 92.6 % | 84.5% |
| | Proportion of patients rating their overall experience as good or excellent | 92.0 % | 94.2 % | 92.2% |
| | Proportion of patients' concerns (PALS) responded to within 5 working days | 95.0 % | 99.8 % | 99.3% |
| | Proportion of complaints responded to within 25 days | 100.0 % | 100.0 % | 100.00% |
| | Proportion of complaints responded to within agreed deadline | 100.0 % | 100.0 % | 100.00% |
| | Proportion of complaints acknowledged within 3 working days | 100.0 % | 100.0 % | 100.00% |
| **Preventing Harm** | Proportion of clinical incidents that did not cause harm (moderate to catastrophic categories) | 96.0 % | 97.5 % | 97.2% |
| | Zero tolerance to falls in bedded units with harm (moderate or above) | 0 | 8 | NA – new measure |
| | 5% reduction in pressure ulcers Category 3 / 4 (on 2017/18 baseline) | 96 | 133 | 105 |
| | Zero tolerance of new (CLCH acquired) category 3 & 4 pressure ulcers in bedded units | 0 | 5 | 5 |
| | Proportion of external SIs with reports completed within deadline | 100.0 % | 100.0 % | 98.6% |
| **Preventing Harm** Prevalence (NHS Safety Thermometer) | Proportion of patients who did not have any NEW harms | 98.5 % | 98.4 % | 98.3% |
| | Proportion of patients who did not have a NEW (CLCH acquired) pressure ulcer | 98.5 % | 99.0 % | 99.00% |
| | Proportion of patients who did not have a fall | 98.5 % | 99.3 % | 99.2% |

| Quality Campaign | Key Performance Indicator | Target 2018-19 | Performance | |
|---|---|---|---|---|
| | | | Year end 2018-19 | Previous year |
| Smart, Effective Care | Proportion of patients who did not have a catheter associated urinary tract infection | 99.0 % | 99.6 % | 99.5% |
| | Proportion of patients who did not have a venous thromboembolism | 100.0 % | 99.8 % | 99.8% |
| | Percentage of deaths in community hospitals (expected and unexpected) compared to all discharges (excluding palliative and end of life care) | 3.8 % | 0.0 % | 0.3% |
| | Percentage of Central Alerting System (CAS) alerts including Patient Safety Alerts (PSAs) due, and responded to, within deadline | 90.0 % | 100.0 % | 100% |
| | Percentage of hand hygiene episodes observed across CLCH services (excluding bedded areas) that are compliant with policy | 97.0 % | 98% | 100% |
| | Percentage of local clinical audits, service evaluations and quality improvement projects undertaken by services. | 40.0 % | 65.9 % | 71.7% |
| | Percentage of services completing NICE Baseline Assessment Form within agreed timeframe | 80.0 % | 99.3 % | 65.00% |
| Modelling the Way | Statutory and mandatory training compliance | 95.00 % | 92.9 % | 89.82% |
| Here, Happy, Healthy & Heard | Staff Vacancy rate (Clinical) | 10.00 % | 12.50 % | 12.14% |
| | Staff Turnover rate (Clinical) | 10.00 % | 14.91 % | 16.67% |
| | Staff engagement index score | 7.6% | 7.1% | 3.89% |
| | Sickness absence rate - 12 month rolling (Clinical) | 3.50 % | 3.91 % | 3.65% |
| | Percentage of staff who have an appraisal | 90.00 % | 87.80 % | 86.48% |
| Value Added Care | Staff to have been trained to basic level in improvement skills including Lean | 10.0 % | 11.4 % | 6.0% |
| | Services have used improvement tools | 1.0 % | 7.6 % | 4.9% |

**PROGRESS AGAINST OUR QUALITY PRIORITIES – CAMPAIGN ONE: A POSITIVE PATIENT EXPERIENCE**

| Key Outcomes | Measures of success 2018/19 | Update |
|---|---|---|
| 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 | Achieved |
| | 90% of proportion of patients who were involved in planning their care | Achieved: |
| | The use of co-design will be evaluated across the organisation | Partially achieved: A formal evaluation of the use of co-design has not yet been completed but will be completed in the first quarter of 2019-2020. |
| | Evaluation from patient feedback of their involvement in the Quality Councils | Partially achieved: The Assistant Director of Patient Experience chairs the Shared Governance Council addressing the challenges with staff and patient representative's recruitment and retention. The feedback from patients on their involvement in quality councils is being shared. This included the need for a role specification for patient representatives to ensure they are aware of what is involved and ensuring that chairmanship training is available for patients and staff alike.<br><br>As a result of the feedback, two patient representatives have completed training and further sessions will be taking place. Members of the council will be the first to pilot patient focussed QI training. |
| Patient stories and diaries used across pathways to identify touch points and *`Always events'* Patient stories *contd.* | Evaluation of *Always Events* and their impact on patient experience | Partially achieved: The evaluation of the first Always Event has been completed and its impact can be evidenced through the successful achievement of our PREMs indicators and the positive feedback that we get through patients stories and compliments.<br><br>The Patient Experience Team have audited the use of the improvement tools implemented through the initial Always Event. This focused on staff awareness and use of the three initiatives rolled out as part of the Always Event.<br><br>The training aspect of the Always Event has is now embedded in the Band 5 Core Competency training and therefore is no longer specific only to the District Nursing teams. |

| | | |
|---|---|---|
| | Quality Councils to start leading on the development of *Always Events* with local implementation | Not achieved: The patient and staff recruitment and retention council are currently looking at how Always Events can be supported through Quality Councils. Alongside this, the Patient Experience team continue to engage patients and staff in the Always Events Journey and involve established Quality Councils where possible. |
| | Thematic analysis of previous year's stories with shared learning | Achieved: The thematic analysis of patient stories was completed and used to help shape the 2018-2020 PPE strategy. The Patient Experience team have started collating the patient stories collected in 2018/19 and these will be shared across the Trust. |
| | Continued use of patient stories by all services and shared at Divisional and Trust forums | Achieved: The Patient Experience Team continue to deliver patient stories training across each of the divisions supporting staff to collect and learn from patient stories. The Patient Stories information pack has also been updated. There were a total of 227 patient stories submitted to the team in 2018/19 which were shared across the Trust at Divisional and Trust Forums |
| Patient feedback used to inform staff training | Patient feedback will be integral to the review and development of education and training | Partially achieved: To ensure that the patient voice is heard, any incidents or complaints where staff training needs have been identified are shared at the Modelling the Way forum. Incidents and patient feedback continue to be discussed at the Trust End of Life Care Operational Group and Learning Disability forum to identify any specific training requirements. |
| | Evaluate how patient feedback has influenced training and education | Achieved: Following the inception of the patient and staff representative recruitment and retention shared governance council; patient representatives have continued to reiterate the importance of training, education and accreditation to ensure that they feel confident to be an equal decision maker alongside NHS professionals. |
| | Evaluate the use of patient stories as part of learning from serious incident reviews | Achieved: A member of the Patient Experience team attends each of the serious incident panels and works closely with lead investigators to engage with the patients involved. |

**Amber quality KPI not described in table above - Family and friends test:** In line with the national target for the number of patients who would recommend the service to their families and friends, the Trust has a target of 95%. We did not achieve overall year-end target of 95% falling just short with a score of 94. %%. significant improvements have been made and in the final quarter of the year (Q4) the Trust exceeded its target with a score of 95.2%.

**PROGRESS AGAINST OUR QUALITY PRIORITIES – CAMPAIGN TWO PREVENTING HARM**

| Key Outcomes | Measures of success 2018-19 | 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 (Safety Thermometer) | Achieved |
| | Incidence of PU and falls will continue to fall | **Pressure ulcers:** Not achieved as the final YTD figure for category 3 /4 pressure ulcers was 133. This exceeded the target of 96. As measured by the NHS Safety Thermometer 99% of our patients did not acquire a pressure ulcer whilst under CLCH care.<br>Actions are being taken to address the issue. These include monthly feedback to divisions on the numbers of reported pressure ulcers and the sharing of the top learning points from completed investigations.<br><br>**Falls:** The target was not achieved as the final YTD figure was 8 falls with moderate harm reported on the bedded units however the level of harm attributed to each fall has reduced this year.<br><br>As measured by the NHS Safety Thermometer 99.3 % of patients did not fall. The Trust Falls Steering group continues to review actions that can be taken to support reduced falls and divisions are working with acute trust providers and commissioners to ensure that appropriate patients are transferred to our rehabilitation units. |
| | Reporting of incidents increases whilst levels of harm reduce | Achieved: There was an overall increase in incident reporting (incidents affecting patients) in 2018/19. |

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| Systems in place – *contd.* | Zero tolerance of category 3 and 4 PU acquired in bedded areas | Not achieved: The final year to date figure was 5 category 3 or 4 pressure ulcers reported as acquired in bedded areas.<br><br>All the cases are investigated via a root cause analysis and we continue to look at improving the way we share specific learning from pressure ulcers occurring on our bedded units. |
| | 100% RCA completed on time | Achieved; all external Serious Incident Root Cause Analysis reports were submitted on or ahead of schedule during the year. |
| | Proportion of clinical incidents that did not cause harm (moderate to catastrophic categories) | Achieved: |
| Safety culture and activities signed up to in ALL services | Safety culture and activities signed up to in all services | Achieved: During the year the quarterly reports on learning from pressure ulcer investigations were shared with the South, Inner and North Divisions. The North Division continues the Wound Wednesday initiative and other areas are now replicating this. The South Division has implemented a new Quality Forum and the Inner London division continues to discuss safety initiatives and activities in their quality forum. The Spotlight on Quality newsletter is used to share news and learning. |
| Variations in practice identified and acted upon<br>. | Quality Action Teams to develop areas to exemplars | Partially achieved: During 2018/19, six services were assessed and awarded Quality Development Unit status, although none were developed from QATs. |
| | Develop a learning repository to enable teams and services to share issues identified from incidents and evaluate the use of the repository | Achieved: the key learning from pressure ulcer investigations has been shared on a dedicated pressure ulcer learning page of the Hub during 2018/19, and a survey was developed to evaluate the use of it. The survey was targeted to those who may find the web page useful in their work. |

**PROGRESS AGAINST OUR QUALITY PRIORITIES – CAMPAIGN THREE: SMART EFFECTIVE CARE**

| Key Outcomes | Measures of success 2018/19 | Update |
|---|---|---|
| Clinical staff use the most up to date clinical practices | CAS alerts (Inc. PSAs) –Monthly Board KPI target for timely alert closure ≥90% | Achieved |
| | NICE – 80% of services complete a Baseline Assessment Form for NICE Guidance within the agreed timeframe | Achieved |
| There will be a demonstrable culture of clinical enquiry and continuous improvement across the trust | 78% staff able to contribute to improvements at work (staff survey) | Partially achieved: Results from the National Staff Survey 2018 indicated we had achieved 74.6% compared to 77.8% in 2017 on the question of whether staff can suggest improvements to their work. |
| | Central resource dedicated to improvement analytics | Achieved: Staff had access to the Continuous Improvement page on the Hub which contains analytical tools, support materials and training information. Support and training can also be accessed from peers or the Improvement Team via the analytics and improvement networks using a web-based forum on the Hub. |
| CLCH will be a leader in innovative community practice | Each Division to identify within business planning process an innovation for 2018/19 | Partially achieved: The West Herts service continues working on setting up innovative work to improve patient care and outcomes. Work continues to work with divisions to ensure innovations are identified. |
| | Research activity increased by 5% | Achieved: |

**Amber quality KPI not described in table above - Proportion of patients who did not have a VTE:** We count the number of patients on the day of the patient safety thermometer survey who have a VTE, such as a deep vein thrombosis (DVT). Throughout the course of the year 2 patients were identified with new VTEs in two of our rehabilitation units. Appropriate measures were taken by the relevant divisional directors of nursing to deal with these incidents.

**PROGRESS AGAINST OUR QUALITY PRIORITIES – CAMPAIGN FOUR: MODELLING THE WAY**

| Key Outcomes | Measures of success 2018/19 | Update |
|---|---|---|
| New roles and career pathways are in place which supports the needs of patients/service users. | Reduction of vacancy rates across the Trust (10%) | Not achieved: In February 2019, the Trust vacancy rate was 12.48%.<br><br>The Trust continues to engage with our partner HEIs attending job fairs and placement forums to actively promote the recruitment of newly qualified staff into band 5 posts. The 18 host students due to qualify September 2019 have all received offers of Band 5 community nursing posts. |
| | Improved staff turnover across the Trust (10%) | Not achieved: In February 2019, the Trust's clinical turnover rate was 14.91%.<br><br>The Trust continues to support and implement a number of training and development programmes to support staffs career development. The Trust will focus on the AHP development portfolios undertaking an initial review to identify gaps and develop a plan accordingly. A survey has been undertaken with AHP staff across the Trust to identify what is their experience about access to learning and development opportunities and a paper will be presented to modelling the way in April 2019 outlining the key themes. |
| | The continued implementation of Apprenticeship roles | Achieved: The Trust has seen the number of apprentices increase over 2018/19 with over 70 staff undertaking an apprenticeship across the Trust.<br><br>58 Apprentice Nursing Associates (ANAs) commenced since November 2019, as noted in the campaign update, 4 ANAs are based within learning disability services across the Trust. |

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| New roles – *contd* | The evaluation of the Nurse Associate pilots in Adults and Children services | Achieved: The Trust remains involved in 4 pilot sites across London and are involved in the evaluation of these with Health Education England. 2 training nurse associates (TNAs) have successfully completed their programme and registered with the NMC moving into band 4 Nursing Associates positions within the Inner Division. The remaining 5 are due to qualify in April 2019 |
| | The evaluation of the Capital Nurse Foundation rotation programme pilots | Achieved: The Trust continues to offer the Capital Nurse Foundation Programme with positive feedback from staff and the divisions. Currently 34 staff are on the programme and there has 100% retention on the programme. The Trust was also successful in obtaining the CapitalNurse Preceptorship Charter mark. |
| | The evaluation of the staffing models in all clinical services | Partially achieved: Work is taking place across all divisions to review staffing models to support new ways of integrated working. A new Clinical Staffing Establishment panel has been implemented chaired by the Director of Nursing and Therapies. The panel will review establishments with no change annually and where changes are being made, to ensure they are in line with national and trust safe staffing models. |
| | Staff survey results | Not achieved: The 2018 staff survey results showed that we were below average in equality, diversion and inclusion. The Academy team continue to work across a range of groups inputting into the WRES action plan. The plan was published at the end of September 2018 before the survey was run and it was too early for the impact of the WRES action plan to be reflected in the 2018 survey results.<br><br>The results identified 'leaving for education and training' as one of the top 5 reasons for leaving the Trust. To ensure staff have a positive experience of education and training, we have been implementing initiatives such as the Academy, apprenticeships for both clinical and non-clinical staff and the launch of the new Clinical Workforce strategy. |

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| New roles – *contd.* | Evaluation of fast track programmes | Achieved: An evaluation of the fast track programme was undertaken and the recommendations implemented. |
| 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 | Partially achieved: Following workforce events, staff have proposed a number of models of professional practice. These will be shared Trustwide. The feedback from this will be collated and developed in to a draft model of professional practice by May 2019. |
| 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 | Partially achieved: The Trust has attended an initial meeting hosted by HEE to look at how across NW London we support clinical academic careers. |

**Amber quality KPI not described in table above –statutory and mandatory training compliance:** The Trust has not yet reached its target of 95% compliance. However improvements have been made and a number of actions have been taken to achieve the target. These include additional training sessions being implemented in local areas and staff being written to when they are not compliant and if necessary, invited to attend meetings with the divisional management team. Divisions have also been asked to support staff with protected time in order to complete their training.

**PROGRESS AGAINST OUR QUALITY PRIORITIES – CAMPAIGN FIVE: HERE, HAPPY, HEARD AND HEALTHY**

| Key Outcomes | Measures of success 2018/19 | Update |
|---|---|---|
| Staff are fully engaged and involved in the model of shared governance | Four to five Quality Councils are established per division and well attended. | Partially achieved: There are currently 18 Quality Councils across CLCH. The recruitment drive continues with an emphasis on recruiting and retaining patient representatives and increasing the number of frontline staff. The Quality Councils |
| | Shared governance forums are effective at resolving issues and concerns | Partially achieved: The profile of using shared governance to make quality improvements has been raised and there has been an increase in staff completing the Quality Improvement training and using quality improvement methodology. The information gained through shared governance has started to be shared across all divisions and we anticipate that this will increase in the future. |
| Voluntary staff turnover below 8% by 2020 | Voluntary staff turnover at 10% | Not achieved: The year-end position was 14.91%. To address this a new working group has been formed and is focused on delivering elements of the NHSI retention agenda including looking at: retire and return; an internal transfer scheme and "itchy feet" conversations and focussing on clinical staff who leave within 12 months of joining |
| Staff vacancies to 10% by 2020 | Staff vacancy rate to 10% by March 2018 | Not achieved: The clinical vacancy was 12.50<br>Each Division has its own plan to reduce their vacancy rates |
| 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 | Partially achieved: The national metric has been re-indexed from a 0.01-5.00 scale to a 0.1-10.0 point scale. The Trust score is now 7.1. |

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| 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 | Not achieved: The 2018 survey published position on stress worsened with an increase to 41.3%. The Trust has a Mental Health nurse and counselling facilities available via Employee Health which are being advertised widely to ensure staff are aware of them. |
| | Sickness absence remains below target of 3.5% | Not achieved: (As of February) the absence was 3.87%. The overall picture is of an increasing issue that the HR team are seeking to address with operational managers. |
| The Trust is committed to and makes demonstrable reductions to agency spend | Agency spend is proportionally reduced as sickness, turnover and vacancy rates reduce | Achieved: At the close of Month 11 (February 2019), the Trust posted a year to date agency spend of £3,865,664.93 against the stretch target of £4,818,043.23 |
| | The number of staff recruited to staff bank increases by 15% | Achieved: At the end of 2016/17, CLCH had 942 pure bank staff; at the end of 2017/18 it was 1261 and at the close of February 2019 CLCH have 1391 on the system. |

**Amber quality KPI not described in table above – Staff appraisals:** Significant work has been undertaken to improve the appraisal rate. Details of staff who have not been appraised and those due to be appraised are shared with managers to ensure that the appraisals can be planned and undertaken in a timely manner. This is being monitored within divisions and reported monthly at the Trust Performance meetings.

**PROGRESS AGAINST OUR QUALITY PRIORITIES – CAMPAIGN SIX: VALUE ADDED CARE**

| Key Outcomes | Measures of success 2018 -19 | Update |
|---|---|---|
| The user experience across CLCH, primary care, specialist services and social care is as seamless as possible | Implement actions from assessments undertaken in 2017/18 | Partially achieved: A Shared Governance Council is now in place for staff and patient representatives are involved in recruitment and retention. Issues being addressed by the group include<br><br>Members of the council will be the first to pilot patient focussed quality improvement training – this is being developed with the Continuous Improvement team. |
| Clinical staff use the latest technology to improve care delivery | Each Division to identify within business planning process an innovation for 2018/19 | Partially achieved: The CLCH Way programme work streams 'Improving our digital competence' and 'Telemedicine' are supporting divisions to explore and implement the opportunity for technology enabled innovation.<br><br>The Innovation Portal has now been launched online on the CLCH hub and new technology applications for funding have commenced. Community nurses and Health Visitors are being supported to use laptops when visiting their patients and families and scheduling technology is being procured to help with route planning and visit allocation |
| | Each division has used improvement tools to improve 1% of services.* | Achieved: Eight services and four quality councils have demonstrated all the requirements for this KPI. This represents a Trust position of 7.6% which is ahead of trajectory (1%). All divisions have met this requirement. |
| Front line staff lead new lean ways of working | 10% staff to have been trained to basic level in improvement skills, including lean | Achieved: 377 staff have achieved basic level improvement knowledge. This represents 11.4% of staff in post |

## DIVISIONAL QUALITY COUNCIL OBJECTIVES

There are currently a total of 18 Quality Councils as follows:
North: 5 quality councils
Inner: 3 quality councils
South: 2 quality councils
Children's: 4 quality councils
Trustwide: 4 quality councils

The following is a summary of their work.

| Division | Quality Campaign | Project |
|---|---|---|
| **North** | **Modelling the Way** | **Increasing compliance against mandatory training:** This council is focussed on improving statutory and mandatory training across the North Division. They have recently started a pilot study concentrating on Infection Control compliance Level 2 in District Nursing. Questionnaires have been completed and distributed to staff to obtain data on the ease of booking, management support, and suitable reminders. The results will be analysed and shared with the Modelling the Way forum. |
| | **Here, happy, heard and healthy** | **Local induction for new starters:** This project commenced in February 2019 and its objective is to create a standardised local induction pack to make the workplace for new starters more welcoming and supportive. It will be piloted in the North Division with the aim to be shared across all divisions. The council have started to collect data specifically looking at different types of induction packs already being used across clinical and non-clinical teams. |
| | **Preventing Harm** | **Monitoring and maintaining healthy pressure areas in care homes:** This council has focussed on supporting residential home staff in maintaining healthy pressure areas for residents to prevent pressure damage. A Pressure Ulcer Core Care Resource Pack is now completed, and has been disseminated out to care homes in the North Division. This will be used as a resource to the care home staff and has also been shared across CLCH to be used as a resource for all staff. Impact and outcome of these resources to be reviewed in 3 months. |

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| | **Value added Care** | **Improve the quality of referrals in Barnet received in planned care in order to improve patient care within the next 6 – 12 months.** The council started in March 2019. At present, the team is on a fact finding mission to collect relevant data. |
| | **Smart, effective care** | **Identify the causes of breaching the length of stay in Adams Ward and to reduce the length of stay to 21 days**. The council commenced in January 2019 to review the journey of 11 patients on admission through to discharge. Social Services have been included and initial recommendations have been discussed. |
| **Inner** | **Modelling the Way** | **Adherence with the Accessible Information Standards Policy across the Trust.** The project has conducted an initial baseline survey and an audit of SystmOne template completion in patient records across 3 DN teams in Westminster. This will enable the council to understand if there are any gaps and understand what actions need to be taken to improve adherence with the Accessible Information Standard. |
| | **Here, Happy Heard and Healthy** | **To address staff happiness and increase staff morale.** The project aim is to gain a better understanding of what effects staff morale in the workplace and to make recommendations to the trust on potential areas for improvement. An initial survey demonstrated that some staff do not feel valued and listened too. "Talking Mondays" was piloted across 4 teams where staff could discuss any chosen topics work or non-work related. Outcomes of this project will be reviewed through a further survey and feedback from staff. |
| | **Here, Happy, Heard and Healthy** | **Improving staff morale across Harrow Community Services:** The project aims to reduce the proportion of staff feeling that they are wasting time due to a lack of awareness of other services. A list of services and access detail lists are being compiled. They will be reviewed to ensure they are accurate, then disseminated in both hard and soft copies. The council will then gather reviewing data to analyse if the information has reduced wasted time from 54.6% to 30% by December 2019. |
| **South** | **Positive Patient Experience** | **Reduction in numbers of patients on podiatry waiting lists:** The project aim was to agree a systematic approach to reducing the numbers of new and follow up patients waiting on the podiatry waiting lists to improve patient experience. The project has made improvements to patient experience by reducing the waiting lists. The Council Chair is working with the Continuous Improvement Team to present the outcomes in data form which can be used across the Trust. |

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| | **Smart Effective Care** | **Communication information folder for patients in the Community in Merton:** The aim of the project is to improve communication and share information through the introduction of a patient information folder into the home. The folder contains contact numbers and names of therapists that the patient is seeing and will contain non-confidential information. |
| **Children's** | **Smart Effective Care** | **To reduce DNA rates for Health Reviews (HR) 1 and 2 in Barnet and Brent:** This is a new project for the council There is a high rate of DNAs of HR1s and HR2s across Barnet and Brent. Data on DNAs of HR1 and HR2 is being collected . The process of the Health Review from booking to appointment date with the health professional is being mapped. |
| | **Positive Patient Experience** | **Development of bespoke PREMS for children/families:** The objective of this project is to make PREMs more relevant and user friendly to school age children, encouraging an increased return and to utilise the feedback to maintain the quality of the service. Richmond School Nursing team have piloted PREMs with changes and following the feedback from the pilot they have involved a focus group of students to make further changes which they will review. |
| | **Here, Happy, Heard and Healthy** | **Improving Communication within Merton's Children's Service.** The aim is to improve communication between staff and senior management in Merton's Children's Services and to increase from baseline % by 20% by September 2019. Feedback from ICN and 0-19 Forums have been collected, data analysed and issues such as the timing of information and not being involved in change has been highlighted. The results have been represented in a Bar Chart and comments listed into positive and negative sent to Line managers to do "you said" "we Did". |

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| | **Preventing Harm** | **Improving the communication of safeguarding information between Social Care services, Health Visitors and School Nurses:** The project aim is to improve the flow of communication and increase the knowledge and education of roles. Questionnaires for both 0 to 19 and Social Care have been disseminated. Presentations at relevant forums have been carried out by the council. Data will be analysed to take feedback to senior management and move forward improvements. |
| **Trust wide Quality Council** | **Preventing Harm** | **Safe implementation of the International Dysphagia Diet Standardisation Initiative (IDDSI):** The objective of the Council was to ensure communication of the changes and education of relevant staff was carried out safely to describe the thickness of modified foods and fluids and to prevent harm to patients due to choking. Outcomes of knowledge and safety of the IDDSI will be collected in June 2019. |
| | **Here, Happy, Heard and Healthy** | **Reduce the staff turnover rate from 14.7% to 8% by March 2020: the** Council is gathering data about staff retention and recruitment. Each division has started collecting information from staff who are thinking of leaving. This information will be analysed for themes and issues and this will be forwarded to the relevant management and HR team. |
| | **Positive Patient Experience** | **Recruitment and retention of Patient Representatives and Staff in Quality Councils:** This council's objective is to improve the recruitment and retention of Quality Council Members through updated marketing resources such as posters and ensuring there is a clear role specification for patient representatives and staff to ensure they are fully aware of the role and the commitment involved. Training for Chairs and Quality Improvement training is now being taken forward for patient representatives. |
| | **Here, Happy, Heard and Healthy** | **Recommending the Trust as a place to work to Friends and Family**: The council's objective is to collect data across CLCH regarding the reasons for and against recommending the Trust as a place to work and to confirm the understanding of the question. |

**TRUST QUALITY PROJECTS AND INITIATIVES**

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

**CLCH Academy:** This is an exciting new initiative which supports a hub of learning and development for both trust and primary care nursing staff (both registered and unregistered). The Academy will provides an excellent opportunity to support the development of a workforce that is both fit for the future and that is competent and capable to provide care within new models of working.

As part of the Academy, the Trust awarded London Southbank University as its University partner. Working with them we are establishing a hub of learning and development activities. We will also exploring the use of innovative approaches to review the way in which training and education is delivered. With the move towards new ways of working and a more integrated approach to borough based care around the patient, the Academy will provide an opportunity to support primary care nurses with their career development. It will also enable community and primary care nurses to train and learn together; looking at how care models can be adapted. The Academy will provide the opportunity to standardise learning across boundaries and to support the workforce with roles, such as the apprenticeship nursing associate, apprenticeships and potentially integrated roles, or a pool of suitable and appropriately skilled staff who can work in a number of environments.

Quality Development Units (QDU): QDUs were introduced as a way of recognising those teams or services which have shown excellence in quality through the assessments process. As described in our Quality Strategy, to achieve QDU status teams/services must have both completed a CQC self-assessment and must not have triggered any red flags. (A red flag is triggered if there has been no team leader for 2 months; vacancies over 10%; high levels of sickness; a reported serious incident or an increase in incidents causing harm and increase in complaints). The team or service must also have evidence that it has implemented quality improvements. Following this, a panel, chaired by the Chief Nurse, will review the evidence and consider a presentation made by the team demonstrating why they should be awarded QDU status. The panel will assess the team within their working environment; this allows all members to take part in the assessment and enables the team to showcase their working environment. It also gives the panel an opportunity to speak to service users.

Teams and services that have been awarded QDU status will be held up as centres of excellence. They will receive a team award of a £1000 and team members will be given lapel badges. Additionally QDUs will be expected to: trial new ways of working; to offer advice to other teams who are struggling and to play a prominent role in our quality councils. Since the introduction of QDU status two years ago, 7 services/teams have been awarded this status. These are Barnet muscular skeletal (MSK) team; Inner London paediatric dietetics; Merton holistic and rapid investigation services (HARI); Hertfordshire respiratory service; Harrow podiatry service; Colville health visiting team and Hammersmith & Fulham speech and language therapy education team

**Shared governance:** This is a is a dynamic staff-leader partnership that promotes collaboration, shared decision making and accountability for improving quality of care, safety and enhancing work life. We are using a model of shared governance to support the delivery of our Quality Strategy. Following the introduction of shared governance two years ago, each of our operational divisions now has Quality Councils

in place. The councils are chaired by a member of staff more junior than a Band 6 with membership consisting of varying numbers of staff from across professions and grades.
Uniquely at CLCH we have decided to include patients and members of the public in our shared governance model and to this end, there are two patients or members of the public on the councils.

Quality Councils have two key functions. Firstly, working within clear guidance, each council has one objective for their division. They will work on that objective throughout the year, pulling in support as required from both their division and across the Trust. Secondly, they act as a resource for other front line staff and managers and will give informed advice on issues. For example if the Chief Nurse was not sure how to take a particular problem or issue forward he might request the advice of one of the quality councils. Alternatively front line staff may want to ask the opinion of a quality council.

We currently have 18 quality councils looking at shared governance projects that include; increasing compliance with mandatory training; creation of a standardized induction pack; supporting residential care home staff in maintaining healthy pressure areas for residents to prevent pressure damage; reviewing the length of stay in Adams Ward with the aim of reducing this; increasing staff happiness and morale, reducing numbers of patients on podiatry waiting lists; and improving the communication of safeguarding information between social care services, health visitors and school nurse and reducing staff turnover rate from 14.7% to 8% by March 2020. We welcome the fact that patients are engaged with our forward facing quality councils.

**Other quality initiatives included:**

**15 Steps Challenge**: this continued to be delivered with great success throughout the year. The 15 Steps Challenge team consists of a patient/carer, a staff member and a board member, including non-executive directors who visit services and speak to patients and staff to discuss the impressions of care they have received. The conversation is structured around a specific set of questions and explores what is working well and where there is room for improvement. After these discussions, the 15 Steps Challenge teams feedback to services focusing on building continuous improvement with the patient's voice at the heart of the process. We are pleased that 15 steps challenges are being made to our hard to reach cohort of patients. This initiative helps staff, patients and the public to work together to help identify improvements that can be made to enhance the overall patient experience

**Allied Health Professional's (AHP) Day:** On the 15th October 2018 we held an AHP's day where we took the opportunity to celebrate our AHPs.

**Capital Nurse Preceptorship:** CLCH was successful in its application for the Health Education England Capital Nurse Preceptorship Quality Mark. Preceptorship workshop and study days are being planned for all professional disciplines; preceptors will be trained to support newly qualified registrants through the preceptorship programme.

**Complaints and PALS surgeries:** these were launched to raise awareness of how to raise a concern; make a formal complaint and provide positive feedback. These were positively received in North Divisional services with some positive feedback at the Edgware Walk in Centre.

**CLCH Dental Service for Homeless People:** is supporting research about the appropriateness of offering HIV testing to clients of our Great Chapel St Dental Clinic. The research is part of a wider study to assess the feasibility of dentists offering HIV tests to their clients. If the uptake is good it will save lives by facilitating early diagnosis of HIV positivity, especially in hard to reach groups such as homeless people.

**End of life/ bereavement**: This was the subject of an *Always Event* that looked at the end of life care provided by our district/ end of life care nurses. Surveys were sent out to relatives following the death of a loved one (who had died in the last 3-6 months) and some relatives were invited to a video interview about the care that was provided to them.

**Infant feeding:** the health visiting teams from Hammersmith and Fulham, Westminster and Kensington and Chelsea achieved re-accreditation of their Level 3 Baby Friendly Initiative (BFI) status with exceptional results. This recognised the high level of support they provide families around infant feeding. The Infant Feeding Leads will be working together with the health visiting teams through 2018 /19 to implement the standards for sustainability in order to achieve the gold award

**Patient stories:** These are an individual's personal account of their healthcare experience described in their own words. Through listening to the patients' voice we capture evidence about the quality of our services and use this to improve our services. CLCH now has a dedicated patient story web page which can be found here: https://www.clch.nhs.uk/get-involved/help-improve-services/patient-stories

**Volunteers**: We have been working to increase the number of volunteers. To this end, we undertook engagement work with patients to find out whether they would benefit from interactions with volunteers and we also consulted with them as to the kind of activities they would like to see volunteers undertake. In response, our patients advised us that they had gaps in their day and suggested that volunteers might be able to address this with various activities. For example patients suggested that volunteers help with talking, poetry reading, gentle exercise encouragement and music.

**Awards:**

We are proud of the work our staff do and we were delighted that this work was twice acknowledged through national award schemes. As well as being awarded the HSJ patient safety award for the organization of the year, our West Herts respiratory team, in collaboration with Herts Valley CCG, was shortlisted in the optimisation of medicines management category at the 2018 HSJ awards. The award was for optimising the use of oxygen for patients with respiratory illnesses in the home.

As well as external validation, CLCH also recognizes outstanding individuals at its own staff awards ceremony. This year 17 different awards, from over 500 nominations, were presented to a range of outstanding teams and individuals.

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

The quality account will be sent out for consultation on or before the 30th April 2019. The response from our commissioners etc. is unlikely to be received until June.

## 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 2018-2019 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 2018 to *date of statement*
  - papers relating to quality reported to the board over the period April 2018 to *date of statement*
  - feedback from commissioners dated xxxx
  - feedback from local Healthwatch organisations received in xxxx
  - feedback from overview and scrutiny committees received in xxxx
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009.

  (NB: The complaints report will be attached as an appendix the Quality Account)
  - the latest national patient survey dated xxx
  - the latest national staff survey dated March 2019
  - 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

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:

Angela Greatley OBE

**Chair**

Andrew Ridley

**Chief Executive**

**dd/mm/2019**

## 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**
C/o Community Barnet
Barnet House, 1255 High Road
London, N20 OEJ
Tel 020 8364 8400 x218 or 219
www.healthwatchbarnet.co.uk

**Central West London Healthwatch**
For Hammersmith and Fulham, Kensington and Chelsea and Westminster
5.22 Grand Union Studios, 332 Ladbroke Grove,
London, W10 5AD
Tel: 020 8968 7049
info@healthwatchcentralwestlondon.org
www.healthwatchcwl.co.uk

**Hertfordshire Healthwatch**
1 Silver Court
Watchmead
Welwyn Garden City
Hertfordshire
AL7 1LT

**Merton Healthwatch**
Vestry Hall, London Road
Mitcham
CR4 3UD
Tel: 0208 685 2282
https://www.healthwatchmerton.co.uk

**Wandsworth Healthwatch**
3rd Floor Trident Business Centre
89 Bickersteth Road
Tooting
SW17 9SH
Tel: 0208 8516 7767
https://www.healthwatchwandsworth.co.uk

**LOCAL CLINICAL COMMISSIONING GROUPS**

**Barnet CCG**
Tel 020 8952 2381 www.barnetccg.nhs.uk

**Central London CCG**
Tel 020 3350 4321 www.centrallondonccg.nhs.uk

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

**East and North Hertfordshire CCG**
Tel 01707 685 000
www.enhertsccg.nhs.uk/contact-us

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

**Hertfordshire Valleys CCG**
Tel 01442 898 888
www.hertsvalleysccg.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

**Hertfordshire County Council**
Tel 0300 123 4040
www.hertfordshire.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 (CQUIN):** The CQUIN payment framework enables commissioners to reward excellence. It links a proportion of a healthcare provider's income to the achievement of local quality improvement goals.

**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 is 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.

**PSAs**: These alerts rapidly warn the healthcare system of risks. They provide guidance on preventing potential incidents that may lead to harm or death

**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

**Repository:** the lessons identified from pressure ulcer learning are placed in a `repository'. This allows staff to reflect on their practice and modify future actions as appropriate.

**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.