CLCH QUALITY ACCOUNT 2019 – 2020

PART 1: ABOUT OUR QUALITY ACCOUNT

Welcome to the Central London Community Healthcare NHS Trust (CLCH) Quality Account for 2019-2020

What is a Quality Account?

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

Why has CLCH produced a Quality Account?

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

What does the CLCH Quality Account include?

In April 2020 we launched our new quality strategy:
Improving Quality in Everything We Do Our Quality Strategy 2020 – 2025

The new quality strategy describes our four quality campaigns namely: a positive patient experience; preventing harm; smart effective care and modelling the way. Within the strategy key outcomes, along with their associated measures of success are listed for each of the campaigns.

The strategy also makes clear how our Quality Account priorities are aligned with the four campaigns.
Performance against these campaigns will be continuously monitored and reported via the quality committee and trust board.

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 clch.communications@nhs.net or telephone 020 7798 1420.

ABOUT CLCH

We provide community health services to more than two million people across eleven London boroughs and Hertfordshire. 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.
- A lymphedema service in Hertfordshire providing support and management for cancer related lymphedema and for those with complex oedema at end of life.

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 Information about these and about our services and where we provide them is provided on our website at the following link: https://clch.nhs.uk/about-us

Safeguarding:
Further information about safeguarding and the annual safeguarding declaration can be found in the CLCH annual safeguarding report https://www.clch.nhs.uk/services/safeguarding

STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

I am pleased to present the CLCH Quality Account for the year ending March 2020. During another busy year for CLCH we took on responsibility for providing adult community services in Hertfordshire. I would like to thank all the staff involved in the design and re-location of services. Moving services is always challenging and as always our staff worked well and tirelessly to make sure that this happened smoothly.

During the year we successfully launched our CLCH Academy which will provide education and training opportunities to enable community and primary care professionals, to continue to deliver effective and compassionate care. It is a place where staff can learn together gaining skills, knowledge, academic accreditation and professional support enabling them to grow and develop their career.

We have also continued to identify and celebrate excellence in our teams and I am pleased to say that the Wandsworth care home in-reach team was short-listed in the 'Care of Older People' category at the Nursing Times awards. The CLCH Academy was recently shortlisted for the Nursing Times Long term Conditions for the work it had undertaken with Macmillan and the South West London Health and Care Partnership in the development of a Community Nursing Module - Cancer as a long term condition.

In February and March we welcomed the CQC who inspected the trust's services for children, young people and families.

Following the outbreak of Covid-19 we are working with our healthcare partners to ensure a collaborative response to this. As part of our response, Parson's Green health centre became one of the first drive-through swabbing hubs in the country. This was widely reported on in the national media.

Finally, my thanks as ever to all our staff for their continued commitment to providing excellent care. This has been more true than ever this year in the light of the Covid 19 outbreak.

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

During 2019-2020 we have reviewed, updated and relaunched our quality strategy. The updated strategy *Improving Quality in Everything We Do – Our Quality Strategy 2020-2025* provides us with a framework through which improvements in the services we offer to patients can be focused and measured for the planning, implementation, evaluation and reporting of quality services. We believe that our updated quality strategy will ensure that CLCH remains as the best provider of high quality community healthcare it can be.

Our revised strategy lists our four quality campaigns which are as follows:

- A positive patient experience
- Preventing harm
- Smart, effective care
- Modelling the way

Each of these campaigns has associated key priorities and outcomes as well as associated measures of success and these will all be monitored at meetings of the quality committee. As in previous years the committee will receive monthly updates, including a quality dashboard and in-depth reports about our progress to our quality targets. By monitoring these, we will ensure that we achieve our quality objectives as set out in the quality strategy.

During the year the number of our shared governance quality councils has doubled and they have implemented a range of excellent initiatives which include one in Barnet, which has looked at improving pressure ulcer care in care homes through the development of a resource pack. Following distribution to care homes in Barnet, the council found that there has been an increase in the confidence of care homes staff in recognizing a pressure ulcer

Since the introduction of quality development unit accreditation (QDU) two years ago, 8 teams have been awarded QDU status. We currently have 9 teams in the process of applying for QDU by completing the QDU Excellence Standards which were introduced in 19/20 to strengthen the QDU Accreditation process. In 20/21 new core standards for delivering high quality care will be introduced for all teams to complete prior to starting their journey to QDU accreditation.

As in previous years our quality account priorities will be the same as those described in our quality strategy. Further detail about these priorities and their associated measures of success can be found in part 2 of this account.

As referred to by the Chief Executive, along with the rest of the NHS, the Trust has had to respond to the outbreak of Covid 19. I am proud of the way that our staff have responded to this huge challenge and I would like to thank them for working so tirelessly and professionally following the outbreak of the pandemic.

Our Trust is unashamedly aspirational about providing the best services it can. I would therefore like to take this opportunity to thank all members of the Quality Committee for their professionalism and hard work in putting quality at the heart of all that we do.

Dr. Carol Cole
Chair of Quality Committee

PART 2 - PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

PRIORITIES FOR IMPROVEMENT 2020 - 2021

Our four quality campaigns for 2020-2021 are the same as laid out in our new quality strategy namely:

- a positive patient experience;
- preventing harm;
- smart effective care
- modelling the way.

For each of these campaigns there are key outcomes and associated measures of success.
To measure our performance against these outcomes, the Trust's quality committee has agreed a dashboard which will measure our progress against them. Progress against the outcomes will be reported to the committee on a quarterly basis as part of our comprehensive quality report. It will also be reported to the board via the quality section of the performance report. The information we collect will be used to look at how well we have performed over the year. Good practice will be shared and of weaknesses are identified we will address these

Further and more detailed information about the development of, and the rationale behind, our quality priorities can also be found in our quality strategy. The strategy can be found here: https://clch.nhs.uk/about-us/quality

The quality campaigns, their key outcomes and associated measures of success for 2020 – 2021 are as described as follows:

CAMPAIGN ONE: A POSITIVE PATIENT EXPERIENCE

Enhancing the experience of our patients, carers and their families.

KEY OUTCOMES	MEASURES OF SUCCESS
Services are designed and care delivered in a way that involves patients, carers and families as partners in care	We will maintain the proportion of patients who felt that they were treated with respect and dignity at 95% We will maintain the proportion of patients reporting their overall experience as very good or good at 95% The proportion of patients who felt staff took time to find out about them will be 95% We will develop a policy and process to ensure patient/ user/ carer are involved in every service change.
Staff* work in services that they believe are delivering the best positive outcomes for patients, carers and families *including volunteers	Staff, friends and family test - percentage of staff recommending CLCH as a place for Treatment will be 75%
	We will enhance the number of volunteers for the Trust and embed volunteers as part of the service
	We will complete an annual volunteer survey to understand their impact on services and their experience
Feedback from patients, carers and families is taken seriously and influences improvements in care	We will continue to respond to 95% of patients' concerns (PALS) within 5 working days
	We will continue to respond to 100% of complaints within 25 days
	We will continue to respond to 100% of complex complaints within the agreed deadline
	We will continue to acknowledge 100% of complaints within 3 working days
The patients and the publics voice is integral in the decision making process when making changes to services or care delivery	We will develop and implement one Always Events in each division
	We will continue to deliver borough based quarterly co-design initiatives using patient and staff feedback/ stories
Transforming healthcare for babies, their mothers and families in the UK (UNICEF Baby Friendly Initiative)	All health visiting services will have a plan for breastfeeding assessment at level 1 -3 (Where services have already achieved this, they will achieve gold in the 1 year assessment)

CAMPAIGN TWO: PREVENTING HARM

Keeping our patients, their families and our staff safe.

KEY OUTCOMES	MEASURES OF SUCCESS
Robust, effective systems and processes in place to deliver harm free care all the time	97% of clinical incidents will not cause harm
	100% of patients in bedded units will not have a fall with harm (moderate or above)
	100% of patients in bedded units will not have a NEW (CLCH acquired) category 2-4 pressure ulcer
	100% of all Serious Incident investigations will be completed on time in accordance with national guidance
	100% of all Serious Incident actions will be completed on time in accordance with locally agreed timescales
Enhance the embedding of a safety culture in the Trust ensuring learning from adverse events and compliance with national best practice	We will undertake a safety culture survey
	Each division will share a single serious incident learning example using the 7 minute learning tool through divisional board and patient safety risk group
	80% of teams will have undertaken a core standards annual health check assessment
	100% compliance with the timely closure of actions from risks on the register

CAMPAIGN THREE: SMART, EFFECTIVE CARE

Ensuring patients and service users receive the best evidence based care, every time

KEY OUTCOMES	MEASURES OF SUCCESS
Making Every Contact Count (MECC) : promoting health in the population we serve	95% staff trained at MECC* level one 95% clinical staff trained at level two
	We will launch MECC link across the Trust
All staff are supported to drive a clinically curious culture and increase shared learning while improving clinical effectiveness	We will increase the number of research projects involving/led by clinical staff within the Trust by ≥ 10%
	100% of services/ individuals undertaking a clinical audit/service evaluation/QI project will submit a clinical improvement poster to the Clinical Effectiveness Team

CAMPAIGN FOUR: MODELLING THE WAY

Providing innovative models of care, education and professional practice

KEY OUTCOMES	MEASUIRES OF SUCCESS
Implementing Reverse Mentoring for all staff ensuring career opportunities are accessible to all	Training will be in place for senior clinical staff at band 8b or above to undertake reverse mentor training A support network for reverse mentors will be implemented
All staff have the core identified statutory and mandatory skills for their roles	We will continue to maintain Statutory and mandatory training compliance at 95%
Staff receive appropriate education and training to ensure they have the right skills to support new models of care	All learning needs will be discussed as part of the annual appraisal process
Safe, sustainable and productive staffing: Right place and time	100% of clinical staffing establishment changes will be discussed through the Clinical staffing panel prior to Quality Impact Assessment
Ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times	We will continue to implement and support the Apprentice Nursing Associate role across the Trust
	We will develop safe staffing models for the allied health professional (AHP) workforce and review opportunities for new AHP roles supporting new models of care
	We will continue to develop professional networks and deliver events for all staffing groups across the Trust

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

In January 2020 we refreshed and updated our quality strategy and sent it to all our external stakeholders for their comments. During the consultation we confirmed that the quality priorities described in the strategy would be the same as the quality priorities in our *Quality Account.*

As part of the consultation, the Trust facilitated engagement events across each of our divisions, these allowed us to engage with both staff and patients asking them for their views on the updated quality strategy. Additionally we held meetings with staff, patients and other stakeholders, for example with our Healthwatch colleagues, requesting their input into our updated quality strategy and reminding them that the quality priorities in the strategy would be mapped to our *Quality Account.*

STATEMENTS OF ASSURANCE FROM THE BOARD

Review of services

During 2019-2020 CLCH provided 92 NHS services. The Trust 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 2019-2020 represents 100% of the total income generated from the provision of NHS services by CLCH for 2019-2020.

Secondary use services

CLCH submitted records during 2019 – 2020 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 93.99% and which included the patient's valid General Medical Practice Code was 91.2%

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 2019 – 2020

Data security and protection (DSP) toolkit

The Trust submitted a *standards met* for the 2019/20 DSP toolkit which stated that CLCH had met all the standards required of the toolkit. We submitted this assessment following a report from the Trust's auditors which had given CLCH an overall assessment of *substantial assurance* in relation to our assessment of our performance against the toolkit.

PARTICIPATION IN CLINICAL AUDITS

Clinical outcome reviews.

During 2019-20, there were no clinical outcome reviews (formerly known as national confidential enquires) which covered services provided by CLCH. Therefore, CLCH did not participate in any clinical outcome reviews.

National clinical audits

For the same period CLCH registered in all five (i.e. a 100%) of the national clinical audits that the Trust was eligible to participate in.

These audits, for which data collection was completed in 2018-19, 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 the five national clinical audits were reviewed by CLCH. The actions that CLCH intends taking in response to the audit are incorporated into the table below.

National clinical audits

National Clinical Audit	Participation	Submitted cases or reason for non-participation	Outcomes & Actions
National Diabetes Audit (NDA)	Yes	Participation was 100%. Service taking part: Merton Diabetes	**Outcomes:** Hospital admissions for adverse outcomes of diabetes are associated with personal characteristics, such as type and duration of diabetes, social deprivation and, in some cases, sex and ethnicity. Treatment and lifestyle characteristics, such as glucose levels (HbA1c) and blood pressure during the past five years (plus smoking and obesity), are also significant and modifiable factors. **Actions:** Support all people with diabetes to achieve lifestyle and treatment targets that will reduce adverse outcomes. Address the additional risks associated with Type 1 diabetes, longer duration of diabetes and social deprivation. Recognise and manage the most prevalent adverse outcome – heart failure.
Sentinel Stroke National Audit programme (SSNAP)	Yes	75 cases were submitted, which is 100% cases required. Services/teams taking part: Neuro-Therapies: Merton, Early Supported Stroke Discharge (ESSD): Hertfordshire, Inpatient Units: Hertfordshire (Holywell Ward), Inpatient Units: Hertfordshire (Oakmere Ward), Community Neuro Rehabilitation: Hertfordshire.	**Outcomes** There is improvement in the delivery of therapies across many of the domains. However, many patients are still left without specialist psychological support. A focus is required on assessments and outcomes six month after stroke to highlight the needs of patients and their families and carers over the longer term.

National Audit of Cardiac Rehabilitation (NACR)	Yes	80 cases were submitted, 100% of the cases required Services taking part: Harrow COPD Respiratory Service, West Herts Respiratory Service, Merton Cardio-Respiratory Service, and Barnet Community Respiratory COPD Service, Cardiac Rehabilitation Service, Hertfordshire.	**Outcomes:** 50% of eligible patients in the UK attend cardiac rehabilitation, the overall mean uptake to CR in the UK remains at 50% with uptake highest in patients treated with CABG, followed by MI+PCI, PCI and post-MI medical management. **Actions**: Review recruitment protocols and management of post-MI patients to increase uptake. Report more extensively on this next year; and ensure that CR is tailored to the needs of female patients, particularly interventions aimed at managing CVD risk factors and encouraging more physical activity.
National Asthma and COPD Audit Programme (NACAP) Pulmonary Rehabilitation Audit.	Yes	129 cases were submitted which is 100% of the 129 cases required. Services taking part: Harrow COPD Respiratory Service, West Herts Respiratory Service, Merton Cardio-Respiratory Service, and Barnet Community Respiratory COPD Service, Respiratory Service, Hertfordshire. 126 cases were submitted which is 97.6 % of the 129 cases required. Further data is being collected.	**Outcomes and actions:** Two key national recommendations for 2020/21 have been defined: To resource and organise respiratory services to the national quality standards and guidelines highlighted in this report, and work with commissioners and with patients to achieve these standards.

National Audit of Inpatient Falls (NAIF)	Yes	A requirement of the audit was that the National Hip Fractures Database (NHFD) would identify any patients who sustain a hip fracture in our patient services. Such patients would then be included in the audit where subsequent orthopaedic care would be monitored. Our services did not have any such patients during the audit. The only key performance indicator for this audit was the proportion of trust/health board type that participated in the organisational audit at the beginning of the audit. We achieved 68% for this KPI. Services taking part: Inpatient Units: Inner (Alexandra Unit), Inpatient Units: Inner (Athlone House), Inpatient Units: Barnet (Jade Ward) Inpatient Units: Barnet (Adams Ward)	Senior leaders: Ensure the Trust participates in NAIF by registering and providing facilities data (August 2020). Senior leaders and clinical teams: Report all inpatient falls resulting in hip fracture as 'severe harm', regardless of circumstances and outcome, as recommended by the National Reporting and Learning System (NRLS).

LOCAL AUDITS

The reports of 27 clinical audits that were reviewed by CLCH in 2019 – 2020 are described in the table below. The actions that the Trust intends to take, as a response to the audits, to improve the quality of healthcare provided are incorporated into the table below.

Title	Division	Service	Outcomes and Actions
1. To review the complete patient journey from stratification to discharge and to ensure implementation of all treatment recommendations and compliance with spinal pathway.	North Central	Nutrition Musculoskeletal Therapies/CLCH Specialist Therapies/Musculoskeletal Physiotherapy	The audit aimed to review 'low back pain' patient journey from stratification to discharge according to the departmental spinal pathway. In addition, ensuring that the spinal pathway is compliant with NICE guidance and National Back Pain Pathway. **Findings:** Screening for red flags, outcome measure (MSK-HQ) pre and post treatment and treatment In line with current guidelines met full compliance. However, GOAL setting was in place 50% of the time and Exercise prescription documented (sets, repetitions and times per week) 25%. **Actions included:** Continue provision of good practice. Improve documentation of exercises prescription sets, repetitions and times by the physiotherapist and further checked by supervisor. Re-audit to ensure full compliance and adherence to the guidance.
2. Management and care of children receiving nasogastric tube feeding in a community setting	Children	Integrated Complex Children Paediatric Dietetics	The aim of this audit was to assess the compliance of completed risk assessments for all children discharged in the community on nasogastric tube feeding. **Findings:** 83% of children discharged home (Barnet) on nasogastric tube feeding had a completed risk assessment provided as part of their referral process. **Actions included:** Ensure 100% of children are referred with a completed risk assessment for their nasogastric feeding. Improve liaison with hospital paediatric dietetic teams to confirm that nasogastric tube risk assessment will be completed with all new referrals. Re audit in 12 months to monitor compliance with nasogastric tube risk assessment.

3. Patient Recorded Outcome Measure (PROM) for patients attending with sore throats.	Children	Edgware WIC	The aim of the audit was to review antibiotic prescribing for sore throat symptoms against NICE and Public Health England's prescribing Guidelines to ensure best practice throughout the services. **Findings:** Appropriate antibiotic prescribing, documentation of allergies, including aftercare met 100% compliance. **Actions included:** Raise awareness of the dosage and frequency of Phenoxymethylpenicillin in treating bacterial sore throats and revise tool for the next audit.
4. Community weight loss intervention in women of child bearing age.	North West Clinical Business Unit	Specialist Therapies	The aim of this audit was to ensure compliance with the NICE and Royal College of Obstetricians and Gynaecologists (RCOG) guidance on weight management. **Findings:** Patients who attend the Specialist Weight Management Service (SWMS) for longer achieved better weight loss results, as more appointments with healthcare professionals increase advice provision, motivation and support greater weight loss. This audit also demonstrated that the majority of patients within the SWMS service were not meeting the NICE guidelines due to lack of education. **Actions included:** Encourage patients to complete the two-year SWMS service. Collaboration with Obstetricians at Chelsea and Westminster Hospital to develop a referral pathway for high BMI antenatal clinic. Liaison with local GPs to encourage more patient referrals to the service for pre-conception weight management. Ensure plans for future pregnancy are discussed with relevant patients in the initial dietitian consultation to include advice on folic acid.

5. Stratification of GP- referred patients to the musculoskeletal physiotherapy service with a "frozen shoulder"	North West Clinical Business Unit	Specialist Therapies Physiotherapy /service	The aim of this audit was to introduce a one stop shop within the "frozen shoulder clinic" to streamline care for those patients referred by their GP with a "frozen shoulder". **Findings**: All patients assessed with a clinical diagnosis of a frozen shoulder at first contact were referred for an x-ray where indicated. One third of patients were placed on a three month SOS period and were happy to be discharged with self-management at the end of this period. **Actions identified**: Review patient satisfaction e-survey questionnaire and review PROMS outcome measure scores and ensure that this is collected and accurately recorded on system1 for all patients at first contact.
6. UNICEF Baby Friendly Initiative Staff Audit	Children's	Health and Development	The aim of this audit was to meet the standards for staff knowledge, skills and training for the UNICEF Baby Friendly Initiative (BFI) to achieve Level 2 Baby Friendly Accreditation. **Findings**: 100% percentage of staff were able to demonstrate how best to support pregnant women to recognise the importance of early relationships and breastfeeding on the health and well-being of their baby. Nearly 100% demonstrated how best to support all parents and babies to initiate close and loving relationships soon after birth alongside feeding practices. Greater awareness was required on breastfeeding positioning and attachment, hand expressing and the importance of not advertising formula milk. **Actions included**: All staff to be trained on mandatory 2 day Breastfeeding Management, by February 2020 to ensure full compliance. Staff to attend mandatory update sessions in preparation for Stage 2 assessment in February. Infant Feeding Lead to attend all team meetings to keep staff informed of overall progress and lead 1 to 1 Practical Skills Reviews with individual staff.

7. Food quality Audit	North West	24hr services (North West)	The aim of this audit was to ensure the quality the food service meet patients' needs and expectations **Findings**: Most patients rated quality of the food and presentation as poor. The availability of drinks was food to be good and the availability of snacks between meals was fair. Most patients reported the care of staff as helpful, but the help from catering staff was found to be poor. **Actions included**: Disseminating findings to Sanctuary Care, CBU, Matron and Team Lead Nurse. Dietitian Review of Nutrition and Hydration Policy. Implement nutrition training for CLCH nursing staff, housekeeper and clinical support workers. Re-audit in September 2020.
8. Hydration Audit 2020	North West	Barnet Bedded Services	The aim of this audit was to improve identification of patients who are at risk of dehydration. **Findings**: Fluid charts were completed for 88% of patients on admission for first 48 hours. Water jugs were refreshed regularly on all wards and all tea/coffee rounds were made on time. 8% of all patients required thickened fluids which were appropriately provided across all wards. 20% of all patients were identified to be at risk of dehydration. Over 90% adherence to the strategies in place for patients identified to be at risk of dehydration. **Actions included**: Disseminate findings to the wards. Ensure fluid charts are added in admission pack and the nursing staff complete fluid charts accurately. Repeat audit annually to collect comparable data and evaluate if recommendations are improving compliance

9. 11. An audit to evaluate the completion of (MUST) Malnutrition Universal Screening tool 2020	North West	Inner WiCs and Inpatients	The aim of this audit was to improve identification of patients who are malnourished or at risk across the bedded rehabilitation units in the North West Division. **Findings**: MUST charts were completed for 100% of patients, of which 96% were completed on admission across both units. BMI was correctly calculated for 96% of all patients. A care plan was in place for 88% of all patients. A food record chart was commenced for 86% of patients who were indicated. Patients who required a Dietetic referral, 86% were referred. Screening was repeated on a weekly basis for 90% of patients when indicated. **Actions included**: Disseminate findings to the units. Dietitian to provide MUST training to current relevant members of staff and ensure MUST training is provided regularly to ensure new members of staff are adequate to complete malnutrition screening. Focus the MUST training on findings from the audit i.e. how to calculate percentage of weight loss, reinforce the importance of documenting a care plan as well as recording signature/name. Repeat audit annually.
10. MUST (Malnutrition Universal Screening Tool) Chart Completion	North West	Barnet Bedded Services	The aim of this audit was to improve the identification of patients who are at risk of malnutrition and determine if MUST charts are being completed adequately and appropriate care plans are being implemented across all wards **Findings**: 95% of patients on admission across all wards had MUST charts and BMI score completed. The overall MUST score was calculated correctly for 90% of patients and MUST had been repeated weekly for 95% of all patients. All patients were given the correct acute disease effect score. 87% of all patients had the correct care plan in place. A food record chart had been started for 79% of all patients. All patients with MUST score 2 or more had been referred to the dietitian. **Actions included:** Disseminate findings to the wards. Dietitian(s) to complete MUST training on areas for improvement i.e. alternative measurements to use if it is not possible to obtain height/weight, calculating BMI/weight loss percentage, subjective assessment if information not possible to obtain and completion of food record charts with relevant ward staff. Dietitian(s) to regularly check MUST charts/scores to ensure appropriate care plan is followed. Repeat audit annually.

11. CES clinical audit	North Central	Integrated Community Musculoskeletal (ICMSK) - Barnet	The audit aimed at reviewing the effective implementation of CLCH MSK CES pathway, assessing documentation of patients' symptoms and signs in suspected CES. In addition, projects leads recorded the outcomes of patients with scan-negative CES to assess whether these patients require further referral to specialists. **Findings**: Out of 27 patients only one patient was positive with acute cauda equine syndrome and had emergency surgery. Only 9 patients out of 27 who had emergency MRI in A&E and only one was positive with acute onset of CES. **Actions included**: Continue with the screening process and clear documentation (including each symptoms, onset and duration); discuss Documentation audit for CES in 2020 and 6/12 training regarding CES and updates
12. Completed Risk Assessments for Children receiving Intravenous Cytarabine at home	CHD	Children`s Community Nursing	The aim of this audit was to assess compliance with the policy to ensure there is a completed home risk assessment for all children receiving cytarabine at home to support patient safety and minimise the risks associated with the administration of chemotherapy in the community. **Findings**: All children who received cytarabine at home had a care plan on SystmOne. 6 out of 9 children had a risk assessment in their CCN Health Records; whilst, 5 out of 9 children had a risk assessment on SystmOne. There was no difference between the 3 boroughs. Of the children receiving cytarabine in 2018, 50% had a risk assessment in their health records whilst only 1 child (25%) had a risk assessment on SystmOne. Of the children receiving cytarabine in 2019, 80% had a risk assessment both in their health records and on SystmOne. **Actions included**: All CCNs who administer cytarabine would be aware of the audit results; provide training to all CCNs who administer cytarabine regarding the importance of home risk assessments; all children who receive cytarabine at home will have a home risk assessment on their SystmOne records

13. Use of pain charts for patients attending Day Hospice	North West	Pembridge Day Care - West London	The audit aimed at analysing the use of a pain chart, mainly whether the pain assessment tool charts are correctly and fully completed. **Findings**: In total, 58 attended Pembridge Day Hospice between 1st January 2019 and 30th June 2019 inclusive. Of these: 43 patients had a record of IPOS and reported to have pain; 7 patients did not report to have pain on IPOS; 7 patients had no IPOS recorded by the Day Hospice member during the audit period in the electronic patient's notes (including 3 patients who only came for the 1st assessment only). 1 patient attended Day Hospice only for bisphosphonate infusion and no IPOS by the Day Hospice staff was done in 2019. **Actions included**: Update current Standard Operating Procedure (SOP) for use of the Pain Assessment and Evaluation Tool; patients who report to have pain should have an accurate pain assessment on the pain chart/record; patients who have been given PRN analgesia, should have an accurate assessment of pain prior and after the medication; improve accuracy and completeness of documentation
14. Falls Assessment and Management in Inpatient Units	North Central	North Bedded Rehabilitation	The purpose of this piece of work was to complete a re-audit of performance on the units, in line with falls prevention and NICE guidelines. **Findings**: Marjory Warren Ward achieved 80% or above compliance in 11 of the 13 domains. 'Postural blood pressure recorded as part of falls assessment', completion of the MFFRA, the patient having a urine dip have improved since previous audit. However, further improvement is still required within urine dip documentation, walking aid documentation and when falls management actions have been put in place. **Actions included**: Lying and standing blood pressure to be completed during the patients stay; ensure falls risk, and actions required, are being clearly documented after every interaction with the patient; ongoing re-audit to ensure compliance with standards already achieved, and progress with those requiring ongoing improvement work.

15. Audit of Podiatry summary completion following initial podiatry assessment	North West	Podiatry Hammersmith and Fulham	This audit aimed at benchmarking Hammersmith and Fulham Podiatry Department compliance with letter writing following new patient assessment and will serve as a base line for future audits using the PDSA cycle. NB. The PDSA cycle is shorthand for testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act). **Findings**: From the result, there is a significant variation in the compliance with letter writing among podiatrists. There is opportunity of significant improvement in compliance for 3 of the 8 Podiatrists (37% of the team). Non completion of letter writing is not subject to banding of the podiatrists. **Actions included**: Review of Clinical and Domiciliary SOP (standard operating procedure); PDSA cycle re-audit in three months for all current staffs; undertake PDSA cycle in six months.
16. Merton School Nurse Involvement in Child Protection Processes	Quality	Safeguarding Children	This project aimed to objectively analyse the decision making undertaken by the school nurse in relation to the appropriateness of school nurses involvement in child protection processes to gain assurance that children subject to child protection plans are having their health needs met. **Findings**: The majority of cases do require school nurse input. However, those that do not are not being identified by the school health team. Therefore the policy does not appear to being implemented. Assessments did not appear to have a SMART action plan as to what School Nursing was to offer and therefore whether continued involvement should occur. **Actions included**: To arrange meetings between school nurses and social workers to increase understanding of each other's roles; re-launch the school nurse Child Protection process with engagement from local authority and School Health; to arrange workshops with School Nurses to see where the blocks and challenges are to stepping out of cases; to look at the use of SMART action plans; to have an action plan from these workshops.

17. Musculoskeletal (MSK) Podiatry PASCOM-10 Outcomes	North West	Podiatry – Hammersmith and Fulham	The audit aimed at measuring the impact of the MSK Podiatry in the patient's general quality of life. **Findings**: MSK Podiatry service has a positive impact in the patient wellbeing resulting in low secondary care referrals. Patients also demonstrated a high level of satisfaction with the Podiatry service, Friends and Family test revealed that 96.3% of patients responded they were extremely likely to recommend our service and 3.2% likely. Although, PASCOM-10 has proven to be an effective tool to capture patients' reported outcome measures in MSK Podiatry but may not be sustainable due to increased time consumption. Alternative data tools will be explored and may be introduced to replace PASCOM-10. **Actions included**: Introduce PASCOM 10 or new data collection tool to other MSK Podiatrists; re-audit MSK Podiatry outcomes at the end of every financial year and demonstrate further alignment with PHE MSK framework; include a larger sample and increase variety by adding MSK Podiatry high risk foot care data and demonstrate compliance with NICE GL 19
18. A service review of the current clinical supervision practice across SLT CBU, against the Royal College of Speech and Language Therapists (RCSLT) and CLCH guidelines	CHD	Speech and Language Therapy services	This service review aimed at ascertaining whether the clinical supervision provided to SLTs at CLCH across Children's Health and Development Division (CHD) meets the guidance of the RCSLT professional body, as well as the Trust's policy. **Findings**: The audit found that the service was meeting both Trust and RCSLT supervision responsibilities and staff were largely happy with the quality of their supervision. No major concerns were shared by SLTs and no therapist reported that they were not currently receiving supervision. The feedback gathered from staff did however highlight some areas to further improve the quality of supervision. **Actions included**: Explore ways in which staff can access further peer support to discuss cases; provide refresher training for clinical supervisors; review paperwork linked to clinical supervision; ensure staff are aware of line management responsibilities and trust processes; review time allocated to supervision and the number of supervisees per supervisor.

19. Re-Audit of Antimicrobial Prescribing within the CLCH Emergency Dental Service	North West	Community and Emergency Dental Service	The audit aimed at assessing clinician's compliance with best practice recommendations when prescribing antimicrobials and to compare current prescribing patterns within the Emergency Dental Service (EDS) in 2019 to those of 2018. **Findings**: An overall improved accuracy of record keeping was seen, with a significant increase in appropriate prescribing since the initial audit 2018/19. **Actions included**: To share audit findings with all dental team; to communicate individually with all dentists involved in the audit to share their results and advise recommendations; to reinforce awareness and update all Emergency Dental Service dentists with current guidelines regarding prescribing of antimicrobials.
20. Compliance with Reporting of Radiographs in Clinical Records and Quality Assurance Image Quality Audit for CLCH NHS Trust Dental Services in 2019	North West	Specialist and Community Dental Services	The aim of this re-audit was to establish compliance with reporting of radiographs in clinical records and quality assurance image quality audit by CLCH NHS Trust dental services in the first six months of 2019. **Findings:** 61% of audited clinical records had justification, grading and reporting clearly written - an improvement of 10% compared to data in 2018. Increase in recording of 'justification' (16%) and grading (3%) of dental radiographs were also noted. 5% did not have any of the three items written. This is also an improvement compared to baseline data of 9% recorded in 2018. **Actions included**: Remind dental clinicians of the need to record justification, grading and reporting of all dental radiographs; increase awareness and encourage use of Carestream R4; continuous re-audit of clinical records until target of 90% written justification, grading and reporting is achieved.

21. Periodontal Screening of New Paediatric Patients (age 7-15 years) within the Community Dental Service	North West	Community Dental Service - Paediatrics	The audits aimed at ensuring all new patients, aged between 7-15 years of age, were screened for periodontal disease using the simplified BPE as per the BSP/ BSPD guidelines. **Findings:** 74% of new patients aged between 7-15 years were screened for periodontal disease or a reason was documented why they could not be screened; Standards for Periodontal Screening in children and adolescents were not met by 26%. **Actions included**: To present on audit results at staff meeting; to feedback to individual dentists on their performance Cycle 2; to undertake spot checks that BPE is recorded or reason why not for all new paediatric patients.
22. Recording of Recommended Recall Interval for CDS patients	North West	Community Dental Service	The audit aimed at reviewing adherence by dentists in the CLCH Community Dental Service (CDS) to NICE guidelines CG19 Guidelines. **Findings:** 11/55 (20%) patients were discharged from CDS care at the end of their course of treatment; 5/11 (45%) of the discharged patients had a letter sent to their general dental practitioner (GDP) which included a recommended recall interval; 3/55 (5%) patients had received domiciliary care and "patient to contact the dentist prn" had been advised; 41/55 (75%) patients were therefore eligible for Recommended Recall interval recording; Of the 41 patients 40/41 (98%) had a Recommended Recall interval recorded. Actions included: CDS dentists to continue recording Agreed Recall Interval in clinical notes for all patients receiving continuing care with the CDS; Patients who are discharged should have a recommended recall interval included in the discharge letter to their GDP; Domiciliary patients` records should include a risk assessment and specific detail if an Agreed Recall interval is not made.

23. Audit on Inhalation Sedation Record Keeping	North West	Community Dental Service	The audit aimed to see if the RCS guidelines are being followed, with paper logbooks and electronic records tallying exactly. **Findings:** 100% patients had records kept in both the shared paper logbook and their electronic records. The logbook entries tallied exactly with electronic records 40 times out of 96 i.e. a 42% accuracy rate. **Actions included**: High standards of IHS and electronic record keeping to be met; logbook recordings and electronic notes to tally exactly; level of sedation and operating condition to be recorded for all sedations in both paper logbooks and electronic patient records; template to be used for electronic records to improve accuracy.
24. Parents experiences of the Woodfield Child Development Service ASD assessment pathway	CHD	Children Psychology	The aim of the project was to explore parents' or carers' perceptions of the Woodfield Child Development Service ASD assessment pathway, including communication with the service, experience of their child receiving a diagnosis, support available post-diagnosis, and to identify changes to the service if required. **Findings:** There were two key themes that emerged as areas of improvement: communication and ongoing post diagnostic support. **Actions included**: Re-design letters templates and information given to parents; Review CDS referral form and consent; Redesign final CDS report templates and ensure consistency in diagnostic terms used; Reduce time between assessment completed and report being sent out; Improve signposting post-diagnosis; Provide post-diagnostic follow up with a member of the clinical team.
25. Special School Medicine Policy Audit	CHD	Special School Nursing	The aim of the audit was to ensure the policy was being used appropriately by all the schools where nurses are based. **Findings:** The findings demonstrate that the Special Schools Medicine Policy is being implemented with 100% adherence in 5 of the 7 categories audited. **Actions included:** Staff requiring re-assessment to be undertaken; All staff to be assessed annually in future; Appendices to be reviewed by teams and any proposed changes to forms to be discussed with MMG and formally approved; Audit to be repeated in 1 year.

26. Audit of process to evidence assurance: Family Nurse Partnership (FNP) adopting CLCH 0-19 Movement In/Out Policy	Children	Family Nurse Partnership	The audit aimed at ensuring that FNP clients that have disengaged from the programme and moved out of service area are transferred to receiving health visiting or FNP team in line with CLCH movement in and out policy standard. F**indings:** The vast majority of FNP clients 68% were handed over to a receiving team within 5 days of intent to transfer; 52% of clients were offered and received a joint handover home visit; 93% of clients had an FNP discharge summary attached to their notes and forwarded to receiving team. **Actions included:** Follow up audit to assure that FNP transfer outs are completed in line with CLCH guidelines and the new FNP Movement in/out guidance that is now in place for all CLCH FNP Teams; Movement in/out policy, Failure to bring or attend children's health appointments and no access visits policy and FNP transfer of care policy to be discussed and updated at CLCH FNP teams joint training sessions.
27. Falls assessment and management of PD fallers in the Parkinson's Unit at Edgware Community Hospital	North Central	Parkinson`s Service - Barnet	The audit aimed at establishing compliance with the NICE Falls Guidance, the CLCH Trust falls policy and the PD UK clinical summary for PD fallers within the Parkinson's Unit, to ascertain whether the service is providing the appropriate multifactorial falls assessment and management for our patients. **Findings:** There were no areas for improvement identified by the audit. All objectives were met: PD fallers within the Parkinson's Unit were offered an appropriate multifactorial therapy assessment; Assessment is being followed up with multifactorial intervention for these patients; Appropriate therapy outcome measures for PD fallers are being used as part of the assessment. **Actions included:** To maintain the current standard of care provided to PD patients with respect to falls assessment and treatment.

Acronyms and explanations of terms

A&E	Accident and Emergency
AAC	Assistive Communication Service within the Children Health's Division
AAF	Amino Acid Formula (infant feeding formula)
AECOPD	Acute exacerbation of COPD
ASD	Autism Spectrum Disorder
BERG Balance Score	The BERG Balance Scale is a clinical test of a person's static and dynamic balance abilities
BMI	Body Mass Index
BPE	Basic Periodontal Examination
Braden Scale	The Braden Scale uses a special scoring system to evaluate a patient's risk of developing a pressure ulcer
BSP	British Society of Periodontology
BSPD	British Society of Paediatric Dentistry
CABG	Coronary artery bypass graft (CABG), a surgical procedure used to treat coronary heart disease.
CAMHS	Child and Adolescent Mental Health Services
Carestream R4	Dental electronic patient record system
CBU	Clinical Business Unit
CCNs	Children`s Community Nurses
CDS	Child Development Service
CES	Cauda Equina Syndrome
CG	Clinical Guideline
CHD	Children Health's Division
CMaps	Conversation Maps (diabetes structured education programme)
COPD	Chronic obstructive pulmonary disease
CR	Cardiac Rehabilitation
CRK Audit	Clinical Records Keeping Audit
Doppler	A safety check carried out before compression bandages or hosiery are prescribed for patients with venous leg ulcers
eHF	Extensively hydrolysed formula (infant feeding formula)
EQ-5D-5L	A standardised measure of health status that provides measures of health for clinical and economic appraisal
ESP	Extended Scope Physiotherapist
FNP	Family Nurse Partnership
FOM	Faculty of Occupational Medicine
FRHA	First Review Health Assessment
GDP	General Dental Practitioner
HARI	Holistic assessment and Rapid Intervention.
HbA1c	Average blood glucose (sugar) levels for the last two to three months
HETF	Home Enteral Tube Feed
ICS	Intermediate Care Service
IG	Information Governance
IHA	Initial Health Assessment
IP	Infection Prevention

IPN	Infection Prevention Nurse
IPOS	Integrated Palliative Care Outcome Scale
MDT	Multi-disciplinary Team
MFRA	Multifactorial Falls Risk Assessment
MI+PCI	myocardial infarction + Percutaneous Coronary Intervention
MMG	Medicines Management Group
MRI	Magnetic Resonance Imaging
MSK	Musculoskeletal
MUST	Malnutrition Universal Screening Tool
NCNR	CLCH Network Community and Rehabilitation
NHFD	National Hip Fractures Database
NICE	The National Institute for Health and Care Excellence
OT	Occupational Therapy
PASCOM 10	Podiatry audit tool
PD	Parkinson`s Disease
PDSA	Plan Do Study Act
PHE	Public Health England
PI	Percutaneous Coronary Intervention
PMLDTC	Profound and Multiple Learning Disability Therapies Clinic
PR	Pulmonary Rehabilitation
PRN	*'pro re nata'* - medicines that are taken "as needed"
RCSLT	Royal College of Speech and Language Therapists
RCW	Rehabilitation Care Worker
SIFP	Specialist Infant Formulae Prescribing guidance
SLTs	Speech and Language Therapists
SMART	Specific, Measurable, Accurate, Realistic and Timely
SOP	Standard Operating Procedure
SRHA	Second Review Health Assessment
SystmOne	Electronic patient record system
TI	Technical Instructor
TOMs	Therapy Outcome Measures
WHO	World Health Organisation

PARTICIPATION IN RESEARCH

The Trust research and development department is working towards the implementation of the CLCH research strategy 2018-2021. The overall goal of the strategy is to ensure that all *staff and patients in CLCH have the opportunity to participate in research.*

The research strategy has the following aims:

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

CLCH is currently a host site for eight studies, there are a further 3 being set up with an additional five under discussion. The services involved with research include sexual health services, West Herts respiratory services, Parkinson's service, homeless dental services, tissue viability and children's services. The teams receive good clinical practice training, a requirement for research, which is provided by the North West London clinical research network (NWLCRN)

Examples of current studies that CLCH is involved include:

Sexual health services - **PreP Impact study:**
This is a study relating to a clinical trial of a drug. The research 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.

Parkinson's service:
This study is a comparison of cost effectiveness of two different speech and language approaches to treatment

Homeless dental Service:
This study is looking at the acceptability of offering an HIV test in a dental setting.

During 2019-2020, there were 21 clinical staff participating in 7 clinical research studies in 4 specialties namely: respiratory, sexual health, Parkinson's, and speech and language therapies that had been approved by a research ethics committee

The number of patients receiving relevant health services provided by CLCH during 2019-20 that were recruited during that period to participate in research approved by a research ethics committee was 251. In line with ethical practice in research, a process is in place to protect the identity of research participants. This is via a unique identifier which is usually a number.

FREEDOM TO SPEAK UP (FTSU)

Staff 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, more senior managers, clinical leads, Freedom to Speak Up (FTSU) Guardian, 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.

The FTSU structure was reviewed and a full-time FTSU Guardian has been in place since 1 April 2019. A new network of eight FTSU Champions were trained in January 2020 and will support the work of the FTSU Guardian by, locally to where they are based, raising awareness of the importance of staff raising concerns; listening to those who approach them with concerns and signposting them to how and/or where they can raise their concerns.

Staff can raise concerns in person, by phone or in writing, including email. There are separate email addresses for FTSU *(accessed by FTSU Guardian)* 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.

FREEDOM TO SPEAK UP DATA FOR 2019-2020

The table below details the Freedom to Speak Up contacts data from 1 April 2019 to 31 March 2020 *(data as at 29/04/20; may change slightly when data cleansed)*. The data indicates the main themes raised at the point of recording by the reporter, rather than those which might have later been identified during or following investigation.

The main points to note are:

Over the 1 year period, there were a total of 179 new contacts made with the FTSU Guardian and those contacts raised 408 concerns between them, 4 of which fell outside the concern categories, e.g. possible fraud. Categories for 11 contacts with the FTSU Guardian are unknown, e.g. have not spoken with FTSUG following initial contact. Through data cleansing, this number may reduce.

Within the 408 concerns:

- 129 related to safety / quality issues (78 for patients, 51 for staff).
- 205 related to behaviours these were further categorised as: behaviours/relationships – 89, bullying / harassment – 53, culture - 19, leadership - 29, middle management – 14, senior management - 1.
- It should be noted that some concern raisers' concerns will fit more than one of those categories so caution should be used when considering data.
- The FTSU Guardian meets with Divisional Directors of Operations to talk about concerns raised within their divisions including themes and actions. Confidentiality is maintained by the FTSU Guardian.

Freedom to Speak Up data: FTSU categories by Division: 2019 – 2020 *(subject to data cleansing)*							
Division	**Children**	**Corporate**	**Hertfordshire** *(6 months' data)*	**North Central**	**North West**	**South West**	**Total**
New FTSU Guardian contacts	**55**	**12**	**19**	**49**	**29**	**15**	**179**
Patient safety/quality – other	17	0	9	25	6	6	63
Patient safety/quality – capacity	2	0	7	6	0	0	15
Staff safety	12	0	8	22	7	2	51
Behavioural/relationship	32	5	9	19	16	8	89
Bullying/harassment	22	4	2	5	15	5	53
System/process	17	5	8	29	8	3	70
Infrastructure/environmental	0	0	0	0	0	0	0
Culture	10	2	2	3	1	1	19
Leadership	20	1	1	3	2	2	29
Middle management issue	5	2	0	1	6	0	14
Senior management issue	0	0	0	0	0	1	1
Other (outside of these categories, e.g. possible fraud)	0	0	0	3	1	0	4
Total no. of concerns categorised	**137**	**19**	**46**	**116**	**62**	**28**	**408**
Unknown category (conversation has not taken place)	2	1	2	2	3	1	11
Data as at 29/04/20 – subject to change							

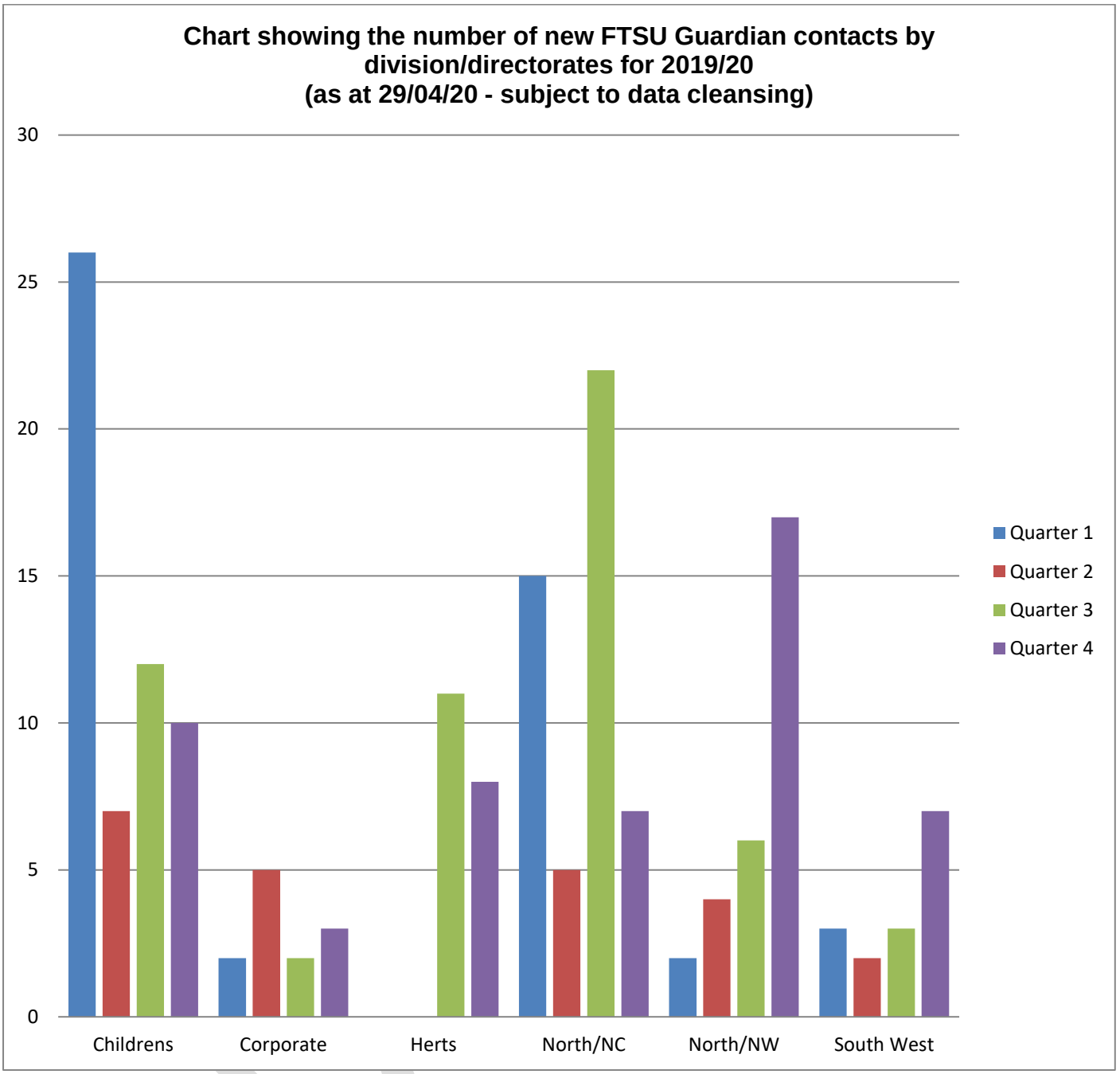


Chart showing the number of new FTSU Guardian contacts by division/directorates for 2019/20
(as at 29/04/20 - subject to data cleansing)
30
25
20
15
10
5
0
Childrens
Corporate
Herts
North/NC
North/NW
South West
Quarter 1
Quarter 2
Quarter 3
Quarter 4

COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN) AND LOCAL INCENTIVE SCHEME (LIS) PAYMENT FRAMEWORKS

A proportion of CLCH's income during 2019 – 2020 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 coordinating 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 coordinating commissioner on behalf of NHS Enfield, NHS Haringey and NHS Camden) NHS Harrow, and more recently NHS Herts Valley CCG since 1 October 2019.

Achieving the agreed CQUIN goals represents an additional 1.25% of the contract values of these contracts. For the inner-NW London CCGs, which include Harrow CCG, it has been agreed within the STPs that full payment will be made regardless of achievement.

Barnet CCG has, however, decided to pay 50% up front and the remaining 50% will be based on actual achievement in accordance with the NHS Standard Contract. Herts Valley CCG will pay based only on outcome.

Some of the other large contracts - 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 local incentive schemes for 2019-20 are detailed in the following tables.

CENTRAL LONDON, WEST LONDON, HAMMERSMITH AND FULHAM, HOUNSLOW AND EALING (CWHHE) CCGS

CQUIN Title	Goal	Plan for 19/20	Forecast Achievement for 19/20
CCG2: Staff Flu Vaccinations	To achieve an 80% uptake of flu vaccinations by frontline clinical staff	£213,487.68	£213,487.68
CCG3a: Alcohol and Tobacco – Screening	Achieving 80% of inpatients admitted to an inpatient ward for at least one night who are screened for both smoking and alcohol use	£71,162.55	£71,162.55
CCG3b: Alcohol and Tobacco – Tobacco Brief Advice	Achieving 90% of identified smokers given brief advice	£71,162.55	£71,162.55
CCG3c: Alcohol and Tobacco – Alcohol Brief Advice	Achieving 90% of patients identified as drinking above low risk levels, given brief advice or offered a specialist referral.	£71,162.55	£71,162.55
CCG7: Three high impact actions to prevent Hospital Falls	Achieving 80% of older inpatients receiving key falls prevention actions.	£213,487.67	£213,487.67
Total		**£640,463.00**	**£640,463.00**

BARNET CCG

CQUIN Title	Goal	Plan for 19/20	Forecast Achievement for 19/20
CCG2: Staff Flu Vaccinations	To achieve an 80% uptake of flu vaccinations by frontline clinical staff	£153,654.78	£0.00
CCG3a: Alcohol and Tobacco – Screening	Achieving 80% of inpatients admitted to an inpatient ward for at least one night who are screened for both smoking and alcohol use	£51,218,26	£51,218,26
CCG3b: Alcohol and Tobacco – Tobacco Brief Advice	Achieving 90% of identified smokers given brief advice	£51,218,26	£51,218,26
CCG3c: Alcohol and Tobacco – Alcohol Brief Advice	Achieving 90% of patients identified as drinking above low risk levels, given brief advice or offered a specialist referral.	£51,218,26	£51,218,26
CCG7: Three high impact actions to prevent Hospital Falls	Achieving 80% of older inpatients receiving key falls prevention actions.	£153,654.78	£153,654.78
Local Wound Care CQUIN	To increase improvement in the number of wounds which have failed to heal after 4 weeks that receive a full wound assessment.	£51,218.26	£0.00
Total		**£512,812.60**	**£307,309.60**

HARROW CCG

CQUIN Title	Goal	Plan for 19/20	Forecast Achievement for 19/20
CCG2: Staff Flu Vaccinations	To achieve an 80% uptake of flu vaccinations by frontline clinical staff	£59,555.73	£59,555.73
CCG3a: Alcohol and Tobacco – Screening	Achieving 80% of inpatients admitted to an inpatient ward for at least one night who are screened for both smoking and alcohol use	£19,851.91	£19,851.91
CCG3b: Alcohol and Tobacco – Tobacco Brief Advice	Achieving 90% of identified smokers given brief advice	£19851.91	£19851.91
CCG3c: Alcohol and Tobacco – Alcohol Brief Advice	Achieving 90% of patients identified as drinking above low risk levels, given brief advice or offered a specialist referral.	£19852.91	£19852.91
Total		**£119,111.46**	**£119,111.46**

HERTS VALLEY CCG

CQUIN Title	Goal	Plan for 19/20	Forecast Achievement for 19/20
CCG2: Staff Flu Vaccinations	To achieve an 80% uptake of flu vaccinations by frontline clinical staff	£62,720.53	£62,720.53
CCG3a: Alcohol and Tobacco – Screening	Achieving 80% of inpatients admitted to an inpatient ward for at least one night who are screened for both smoking and alcohol use	£20,906.84	£20,906.84
CCG3b: Alcohol and Tobacco – Tobacco Brief Advice	Achieving 90% of identified smokers given brief advice	£20,906.84	£20,906.84
CCG3c: Alcohol and Tobacco – Alcohol Brief Advice	Achieving 90% of patients identified as drinking above low risk levels, given brief advice or offered a specialist referral.	£20,906.84	£20,906.84
CCG7: Three high impact actions to prevent Hospital Falls	Achieving 80% of older inpatients receiving key falls prevention actions.	£62,720.53	£62,720.53
CCG9: Six month reviews for stroke survivors	Achieving 55% of eligible stroke survivors receiving a six-month follow up within 4-8 months of their stroke.	£62,720.53	£62,720.53
Total		***£250,882.11**	**£250,882.11**

***Represents CQUIN value for the half year period - 01/10/2019 – 31/03/2020.**

LOCAL 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 4% of the contract value, which would represent **£709,137.38** over and above the contract value.

There are a number of different goals that are to be achieved each quarter for each of the Merton CCG LIS indicators. Examples are included in the table below.

LIS Title	Goals include:	Scheme values £	Forecast Achievement for 19/20
Improving Service Integration with STP and Local Health Partners	(I) Identify possible pathways for joint working between CLCH and Connect MSK. (ii) Produce report on improving access to psychological therapies (IAPT) long term condition pathway showing progress to date, expected outcomes and timelines for implementation and completion.	£88,642.17	£88,642.17
To case find patients that would benefit from CLCH services.	Review of older patients with multiple long-term conditions and encourage use of HARI instead of existing Outpatient acute hospital appointments (where appropriate).	£88,103.55	£35,456.86
Alternative Care Pathways (ACPs) in the community	ACPs developed which provide community clinical pathways as alternatives to conveyancing / attendance / admission. Pathway 1 - LAS to refer directly into CLCH MERIT & Night Nursing Pathway 2 - Community exacerbation support for patients with identified respiratory conditions to prevent avoidable admissions.	£44,321.09	£44,321.09
Pathways for admission avoidance and earlier discharge	Development of POA pathways in partnership with Merton GP Federation to support patients in the community, including the use of Heathlands Court Intermediate Care Beds as step up beds	£44,321.09	£33,240.81

Annual reduction of the rate of non-elective admissions for people known to community services	Process in place to reduce hospital admissions a. Number of patients (identified as at risk of frequent hospital admissions) with Admission Prevention Plan b. Number of patients with CMC record completed	£354,568.69	£320,884.67
Scheme to support increased awareness of CLCH specialist services amongst Merton GPs	Scheme to support increase awareness and therefore increased use of CLCH specialist services by Merton GPs. The aim is for CLCH to receive referrals for specialist services appropriately and in a timely manner.	£22,160.54	£22,160.54
Improving Access to structured education in Merton Q4 19/20	Engage with practices to understand reasons for low referrals/low attendance. Identify at least 3 practices with low referral rates and establish key contacts and agree ways of working. Use information on diabetes book and learn platform as service directory to identify type of courses available, location and times which patients may find	£66,481.63	£66,481.63
Total		**£709,137.38**	**£611,187.77**

WANDSWORTH (Battersea Healthcare CIC)

The Wandsworth incentive scheme is set at **£200,000** which is equivalent to **1.24%** of the 2019/20 contract value.

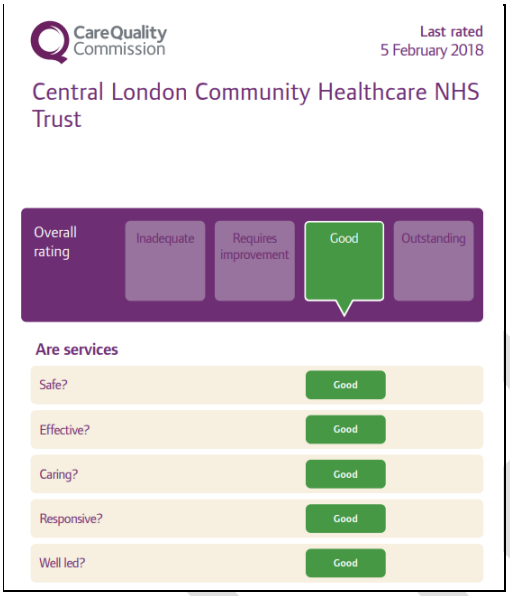
LIS Title	Goal	Scheme values	Forecast Achievement for 19/20
Transforming data into information: Making a difference in the way that we work	Provide a knowledge base which has robust information, at a granular level.	£50,000	£50,000
Translating information into quality: Making us better in 3D	At the end of Q4 the objective is for CLCH to be able to triangulate and describe and present performance to include patient feedback (PREMS/PROMS) and clinical outcome measured as well as KPIs.	£50,000	£50,000
Knowledge powers learning: Sharing knowledge and working together	At the end of Q4 the objective is for there to be the building of trust and confidence between CLCH and Primary Care to develop a shared understanding of current service delivery and create opportunities to work collaboratively to design services in line with strategic priorities within the NHS Long Term Plan.	£50,000	£50,000
Driving service development: Using diabetes to test our learning	The scheme objectives are to use the current and then the new diabetes pathway to demonstrate: • Transforming data into information • Making us better in 3D • Sharing knowledge and working together	£50,000	£50,000
Total		**£200,000**	**£200,000**

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 2019-2020. CLCH has not participated in any special reviews or investigations by the CQC during the reporting period that ended 31st March 2020

At our last full in inspection, 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').

Following the 2017 inspection, the Trust was not issued with any actions which it must take to improve, nor was it issued with any requirement notices. As can be seen from the above grid CLCH was (at the 2017 inspection) 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 response this, the division created and delivered an action plan to work with the health visiting teams to increase their understanding of the clinical model.

The CQC undertook an inspection of our children and family services in March 2020. The well led inspection was paused due to the emergent pandemic. Therefore no revised rating has been received for the inspection of children's services.

The Trust's current rating and latest inspection reports can be found on the CQC website at: https://www.cqc.org.uk/provider/RYX.

DATA QUALITY

CLCH appreciates that high quality data is a key component of information governance. It recognises 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 recognises 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 2019-2020:

- Embedded the single version of the truth Trust data warehouse, which had been introduced in 2018-2019, including refinement of the activity mapping rules applied.

- Developed a data quality plan and undertaken a wide range of data improvement tasks set out therein. The plan included foundational work on mapping and business rules, to add value and improve the accuracy of the Trust's reporting data. The plan has been overseen and delivered by members of the Trust's data forum that has both clinical and operational input.

- Delivered a waiting times portal, which has for the first time revealed our patients' waiting times across all our community services and made accessible in a single accessible location. This is in widespread use by relevant divisional staff, and used to keep track of access waits and observe data quality.

- Appointed Information business partners, who will provide support and direction for divisional information requirements, and will be responsible for the Trust's finance and performance report (IFPR) and quality scorecard reporting during 2020.

The data forum (DF), led by the associate director of information management and business intelligence, has oversight of this area of work. The group has strong operational input from divisional business managers. This group has the following specific aims to improve data quality in 2020-21:

- To actively support the implementation of the data quality framework 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 and champion for the importance of data quality issues.

CLCH will also be taking the following actions in 2020-21 to improve data quality.

- Continue working on the tasks set out in the data quality plan. These comprise a broad range of projects of varying sizes and complexities to improve the quality of data recorded and reported.

- Working with teams to improve the quality of their data collection and reporting, utilising tools developed in the previous year, and with a particular focus on the accurate capture of data within the front end of clinical systems.

- Working with our business information performance and analytics team (BIPA) to make data more accessible and visible, thereby increasing understanding of Trust activity and identifying data quality issues more quickly. In particular, overseeing the rollout of the self-service business intelligence project; this will bring Trust activity data to a much wider corporate and clinical audience for the first time.

LEARNING FROM DEATHS: 2019 – 2020

Learning from deaths of people in our care can help NHS organisations improve the quality of the care we provide to patients and their families, and identify where we could have done more.

In October 2018, CLCH published a 'Learning from Death Policy' based on NHS Improvement's 'National Guidance on Learning from Deaths'. This policy was updated in January 2020.

In October 2019, CLCH acquired services in Hertfordshire. These services had a transition period of 4 months (until the beginning of February 2020) to embed CLCH Learning from Death processes. Following this, the CLCH Learning from Death policy is now embedded across all divisions including the Hertfordshire.

All deaths within the Trust are reported via Datix and named team leaders. Team leaders 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 clinical directors from the relevant divisions and discussed at the Trust's resuscitation and mortality group which meets bi-monthly.

Learning disabilities: Deaths of people with learning disabilities within the Trust are reported to LeDeR (learning disabilities mortality review programme). In light of the changes introduced by DFE in 'Working Together to Safeguard Children 2018', the learning from the child death overview panels are also reviewed by the CLCH resuscitation and mortality group bi-annually.

Covid pandemic: Due to the COVID-19 pandemic, Learning from Death reporting processes in the Trust were suspended from the beginning of March to free up staff to coordinate and help the clinical effort. This included collation of the Trust's KPI around the number of deaths in the Trust and writing and reviewing PRISM reports for patients who died in February.

Until the pandemic is over, the divisional director of nursing and therapies and the clinical director from each division will review deaths. Any deaths which require further investigation and discussion will be investigated through the Trust's serious incident process.

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.	From Apr 2019 – Feb 2020, 1284 CLCH patients died as follows (Includes expected hospice deaths) 285 in the first quarter 272 in the second quarter 378 in the third quarter 349 in the fourth quarter (Jan – Feb)
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.	From Apr 2019 – Feb 2020, 9 case record (PRISM) reviews and 2 investigations were carried out in relation to the 1284 of the deaths included in item 1 In 2 cases, deaths were subjected to both a case record (PRISM) review and an investigation. The number of cases in each quarter for which a case record review or an investigation was carried out was: 1in the first quarter; 2 in the second quarter; 3 in the third quarter; 3 in the fourth quarter; (Jan – Feb)
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.	2 representing 0.16% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: 0.8% in the first quarter 0% in the second quarter 0% in the third quarter 0.8% in the fourth quarter

	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. **Case 2:** More attention needs to be paid to patients with fluctuating NEW scores, prompting holistic assessment. Need for adherence to our admission criteria for patients in the rehabilitation units. If patient deteriorates and no longer fits admission criteria, consideration must be given regarding transferring them back to the acute unit. At weekly multi-disciplinary team (MDT), if a patient is not progressing with rehabilitation, this should prompt a consultant led holistic assessment. Should an individual group of staff have concerns regarding the patients care and disagree with the MDT decision, this should be escalated to the Director of Nursing and Therapies or the Clinical Director of that Division. **Case 3:** Should a community CLCH HCP make a clinical decision that the patients' needs to be reviewed by their GP, they should escalate to the GP rather than leaving instructions with the patient's carer to escalate to the GP. **Case 4:** No action points noted. **Case 5:** No action points noted. **Case 6:** Within 48 hours of the patient being admitted to the unit it was clear that she did not meet referral criteria for a rehabilitation unit. There is a need for adherence to our admission criteria for patients in the rehabilitation units. Patient had regular observations recorded while she was receiving End of Life care (EoLC). This was a reflection of the fact that she was being cared for by staff with little experience of EoLC. Regular observations should be discontinued on EoLC patients. .

	PRESCRIBED INFORMATION	FORM OF STATEMENT
		Case 7: No action points noted. C**ase 8:** More attention needs to be paid to patients with fluctuating National Early Warning (NEW) scores, prompting holistic assessment. Actions from clinical management plans should be reviewed at each MDT/ ward round as investigations which were recommended had not been ordered. Lack of leadership by senior staff led to patient with unstable symptoms not being escalated to the acute unit. **Case 9:** No action points noted.

	PRESCRIBED INFORMATION	**FORM OF STATEMENT**
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 2:** This learning has been disseminated to the Trust by the Divisional Director of Nursing and Therapies and Clinical Director. The "Care of the Deteriorating Patient" policy has been reviewed and discussions taking place with CLCH Academy to relaunch this policy with dedicated teaching sessions and resources to highlight the processes within the policy. An annual audit to look at documentation & actions in response to NEW scores has been designed and is at consultation stage at present awaiting comments from the Resuscitation & Mortality Group. This audit will be conducted annually in all CLCH walk-in centres, bedded units and rapid response teams. The role out of this audit has been delayed due to the current COVID-19 pandemic but will be rolled out as a priority when our audit programme resumes. **Case 3:** The Divisional Directors of Nursing and Therapies and Clinical Directors have been instructed to disseminate this action to the community team leaders within their divisions for discussion at community team meetings. **Case 6:** The Divisional Directors of Nursing & Therapies and Clinical Directors have fed back to the rehabilitation services regarding the importance of adherence to the admission criteria as these services are not equipped to care for patients who are not fit for rehabilitation and approaching the end of their life.

	PRESCRIBED INFORMATION	FORM OF STATEMENT
5.	Contd.	**Case 8:** This learning has been disseminated to the Trust by the Divisional Director of Nursing & Therapies and Clinical Director who have met with the consultant who was responsible for the patient's care, Root cause analysis chaired by Trust's Medical Director leading to following actions: 1.NEWS2 training update for all clinical staff 2. Confirmation to staff of criteria of patients to be accepted and medical acuity necessitating transfer from ward to acute unit. 3. Daily nursing huddles implemented to share concerns and "need to knows" 4. Senior nurse on ward to accompany consultant ward rounds and provide challenge to medical decisions if nursing concerns identified (previously it was a senior nurse attending).
6.	An assessment of the impact of the actions described in item 5 which were taken by the provider during the reporting period.	**Case 2:** No impact assessed yet as audit not rolled out due to COVID-19. **Case 3:** No impact as yet **Case 6:** No impact as yet **Case 8:** 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 2018 -2019 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. 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 2019-20 there were 9397 patient safety incidents reported within CLCH. Of these incidents 11 or 0.12% resulted in severe harm. (For the previous year we reported that 33 incidents resulted in severe harm which was 0.43%). Following the KPMG audit of last year's quality account we have excluded notification of death as a category of patient incident as these are not considered by the Trust to be incidents. In accordance with the audit, this has prevented duplication of this information.

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.

There were no patient safety incidents that resulted in a death. The patient safety incidents reported that resulted in severe harm consisted of nine pressure ulcers, one treatment problem, one safeguarding.

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
- 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.
- Maintenance of a fair-blame culture so that staff feel confident in reporting incidents.
- Following the KPMG of our incidents, we took the opportunity to review our data collection process. Following this we removed notifications of death category to prevent duplication. This has further improved our data quality.
- The Head of Patient Safety worked with our business intelligence performance analysis (BIPA) to review data quality check processes.

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.
- Encouraging incident reporting at all available opportunities including presentations at the new face to face induction and delivering training to apprenticeship and other development programs.
- 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
- The Trust has provided four *learning from inquests* training sessions and road shows.

PART 3: OTHER INFORMATION
QUALITY PERFORMANCE AND PROGRESS AGAINST OUR QUALITY PRIORITIES 2019-2020

Trust wide quality scorecard: The following scorecard describes trust performance against the quality campaign key performance indicators (KPIs).

Performance against our quality strategy measures of success is incorporated into the relevant tables below.

Quality campaign	Key Performance Indicator	Target	2019-20	Previous year 2018-19
A Positive Patient Experience Changing behaviours and care to enhance the experience of our patients and service users	Proportion of patients who were treated with respect and dignity	95.0 %	97.4 %	98.3%
	Friends and family test - percentage of people that would recommend the service *	95.0 %	95.0 %	94.5%
	Proportion of patients whose care was explained in an understandable way	95.0 %	95.5 %	95.4%
	Proportion of patients who were involved in planning their care	92.0 %	89.3 %	92.6%
	Proportion of patients rating their overall experience as good or excellent	92.0 %	94.1 %	94.2%
	Proportion of patients' concerns (PALS) responded to within 5 working days	95.0 %	98.2 %	99.8%
	Proportion of complaints responded to within 25 days	100.0 %	100.0 %	100%
	Proportion of complaints responded to within agreed deadline	100.0 %	100.0 %	100%
	Proportion of complaints acknowledged within 3 working days	100.0 %	100.0 %	100%
Preventing Harm Incidents & Risk	Proportion of clinical incidents that did not cause harm (moderate to catastrophic categories)	97.0 %	98.5 %	97.5%
	Zero tolerance to falls in bedded units with harm (moderate or above)	0	7	8
	Zero tolerance of new (CLCH acquired) category 3 & 4 pressure ulcers in bedded units	0	1	5
	Zero tolerance of new (CLCH acquired) category 2 pressure ulcers in bedded units	0	44	57
	Proportion of external SIs with reports completed within deadline	100.0 %	100.0 %	100%

* As of February, CLCH has achieved the national FFT target however due to the pandemic; data was not published by NHSE in March.

Quality campaign	Key Performance Indicator	Target	Year to date	Previous year
Preventing Harm Prevalence (NHS Safety Thermometer)	Proportion of patients who did not have any NEW harms	98.5 %	98.5 %	98.4%
	Proportion of patients who did not have a NEW (CLCH acquired) pressure ulcer	98.5 %	99.0 %	99%
	Proportion of patients who did not have a fall	98.5 %	99.4 %	99.3%
Smart, Effective Care Ensuring patients and service users receive the best evidence based care, every time	Proportion of patients who did not have a catheter associated urinary tract infection	99.0 %	99.6 %	99.6%
	Proportion of patients who did not have a venous thromboembolism	100 %	99.9 %	99.8%
	Percentage of deaths in community hospitals (expected and unexpected) compared to all discharges (excluding palliative and end of life care)	3.8 %	0.1 %	0.0%
	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 %	98.0 %	98%
	Percentage of local clinical audits, service evaluations and quality improvement projects undertaken by services.	40.0 %	68.5 %	65.9%
	Percentage of services completing NICE Baseline Assessment Form within agreed timeframe	90.0 %	100.0 %	99.3%
Modelling the Way	Statutory and mandatory training compliance	95.0 %	94.4 %	95.00%
Here, Happy, Healthy & Heard. (Data is a month in lieu) Recruiting and retaining outstanding clinical workforce	Staff Vacancy rate (Clinical)	8.00 %	13.3 %	11.61%
	Staff Turnover rate (Clinical)	8.00 %	14.7 %	16.63%
	Sickness absence rate - 12 month rolling (Clinical)	3.00 %	4.4 %	3.92%
	New Bank staff recruited. (20% Increase)	329	617	NA
	Percentage of staff who have an appraisal	90.00 %	84.6 %	85.64%
Value Added Care	Staff to have been trained to basic level in improvement skills including Lean	15.0 %	17.1 %	11.4%
	Services have used improvement tools	5.0 %	14.1 %	7.6%

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

Key Outcomes	Measures of success 2019/20	Update
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	Target achieved.
	92% or above proportion of patients who were involved in planning their care	Partially achieved: We achieved an average performance of 88.5% in the year and an above target end of year performance of 93%. With the focus of the Q3/4 projects being on this specific question, there has been a significant month on month improvement shown throughout Q4.
	All service improvement projects will be supported through co-design	Achieved: The patient experience team continues to promote the use of co-design as part of quality improvement initiatives, especially through the quarterly divisional co-design projects. Q4 projects are as follows: • South West Division – Wandsworth services (borough wide) • North West – Therapy Services – Harrow • CHD – Child Development Service • North Central – Walk in Centres • Herts – Respiratory Services The focus of the Q4 projects remained 'involvement in care' for each division.
	Patients will be members of the Quality councils in each division	Achieved: Following the successful development of criteria for CLCH staff to use to help encourage engagement from the patients they come into contact with, there has been an additional four patient representatives who have agreed to join the trust. The patient led quality council continues to meet on a monthly basis and having focussed initially on marketing and promoting the patient representative role, they have now moved onto improving the front of house experience. In quarter 4, the council undertook some observational work in walk-in centres which will form the basis of their improvement work in the new financial year.

Patient stories and diaries used across pathways to identify touch points and `*Always events*'	Always Events to become integral to Quality councils as a method used to improve patient experience	Partially achieved: It continues to be challenging to fully embed quality councils in the development of 'always events.' However, a number of patient representatives continue to play a key role in all 'always events' being delivered by the Trust. Always events will remain a key area of focus in the new quality strategy and we will continue to promote these events as a continuous improvement methodology through our quality councils.
	Evaluation of Always Events and their impact on patient experience	Partially achieved: The most recent 'always events' has focused on end of life care and in quarter 4, the pilot phase has commenced. Children's division *' always event'* – Special Schools A third co-design 'always event' was held in January 2020. At this event, parents and staff of the Brent special school nursing service discussed progress on the two interventions. The new service leaflet, developed by parents and carers for parents and carers, is being translated into the five most widely spoken languages within the borough and the service is liaising with a professional printing company regarding costs and distribution. Following the 'always event' presentation to the patient experience group in January 2020, the service has now created a filmed version of their presentation which is being shared at meetings across the division and will act as a useful introductory tool for teams interested in running future 'always events'.
	Thematic analysis of previous year's stories with shared learning	Achieved: In 2019/20, the patient experience team have focused on video stories, children and young people and patients, relatives and carers who have been part of an SI investigation. These are shared at the Trust board, divisional meetings and the patient experience group (Trust Coordinating Council) in order to hear from our patients and their families and share any learning. Patient stories remain a key mechanism for the collection of patient feedback and examples of patient stories are also shared at Trust induction.
Patient stories contd.		The 2019/20 annual patient stories report will be available for sharing in the next Q1 20/21 quality committee report.

	Continued use of patient stories shared at divisional and Trust forums	Achieved: In Q4, we have collected video patient stories from a number of services, including the neuro rehabilitation service and LD services. This is one of the many ways that we ensure that patients from less frequently heard groups are given the opportunity to share their experience. We have also collected stories from patients who have been contacted through the 15 step challenge phone calls which are undertaken by the patient experience team. Patients who have been part of a serious incident investigation continue to be contacted and asked if they wish to share their story as part of the being open process. However, unfortunately, no patients have agreed to share their story through this process in Q4.
	Patient diaries embedded into services as a method for involving patient feedback into service improvement	Partially achieved: The northwest division has successfully piloted the patient diary project collecting 3 diaries throughout Q3 and Q4. Similar to patient stories this is a way in which we can listen and respond to patients. All three of these diaries were collected from patients who had inpatient stays in our rehabilitation units Patients were asked to keep a diary of their experiences throughout their stay. Unfortunately, the quality of the information held within these diaries did not allow for any concrete actions to be taken.
Patient feedback used to inform staff training	Patient feedback will be integral to the review and development of education and training	Achieved: Any incidents or complaints where staff training needs have been identified are shared with the Trust Modelling the Way group. 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.
	Patient stories and feedback will be integral to the learning from serious incident reviews	Partially achieved: Although, the patient experience team continue to contact patients following the initial 48hr meeting as part of the being open process, we have been unable to collect any further SI stories as these patients have not been willing to share their stories.

PROGRESS AGAINST OUR QUALITY PRIORITIES
CAMPAIGN TWO: PREVENTING HARM

Key Outcomes	Measures of success 2019-20	Update
Systems in place to provide early warning to illness, service failure or a reduction in the quality of care	Maintenance of 98% or > harm free care	Achieved
	Incidence of PU and falls will continue to fall (5%)	Not achieved: The zero tolerance targets were not achieved but the aspiration to reduce harm is fully embedded and we have seen some improvements in performance, for example the end of year figures for falls and category 2 pressure ulcers for these KPIs are lower than those reported in 2018/19. During Q4, 28 category 3 and 4 community acquired pressure ulcers were reported on Datix which is an increase from 21 reported in Q3, 15 reported in Q2 and a slight increase from 27 reported during Q1. More recent incidents will still be under investigation through our usual processes. 29 category 3 and 4 community acquired pressure ulcers were reported in the same quarter (Q4) in 2018/19.
	Maintains high levels of reporting and low levels of harm	Achieved: During Q4 of 2019/20 (calendar months), 2770 incidents affecting patients excluding notifications of death were reported which is an increase from 2594 reported in Q3, 1997 reported in Q2 and 2030 in Q1, in part due to the acquisition of Hertfordshire Community Services at the beginning of Q3 as the division reported 732 of these incidents in Q4 (26%). The level of harm being reported remains fairly static with over 98% of incidents leading to no/low harm
	0 % PU in bedded areas	Partially achieved: One category 3-4 pressure ulcer was reported in the 2019-20. This is a reduction from 5 the previous year. There were 44 category 2 pressure ulcers reported in 19-20. This was a reduction from 57 in the previous year.
	100% RCA completed on time	Achieved
	0% falls with moderate or above harm in bedded areas	Not achieved. However in Q4 there were no falls in a bedded unit resulting in moderate or above harm were reported during this time. The final end of year figure for this KPI is 7 which is a slight improvement on the previous year of 8.

Key Outcomes	Measures of success 2019-20	Update
Safety culture and activities signed up to in ALL services	No outstanding actions from SIs	Partially achieved: Five SI action plans requiring a closure meeting had a last action due date within Q4. One action plan closure meeting was held and the action plan was closed. The closure meetings of two incidents were planned for March but were postponed and the action completion dates for the remaining two incidents were for the end of March 2020 so the meetings are yet to take place. Two action plan closure meetings were held in Q4 for actions plans which had a last action due date of 31/12/2019. One action plan was closed and one remains open although the evidence of completion is with the chair pending approval and closure.
	All risk register actions are met by identified completion date	Partially achieved: There were 17 open 'clinical' risks with open (overdue) actions at the end of Q4, out of 259 open risks which is an increase from the 15 reported in Q3. More than half of these were due for completion at the end of March and are currently being reviewed. Targeted focus on risk ownership and action plan closure is undertaken by the Risk Manager and reviewed through PSRG process where each division provides an update on their management of their risks.
Variations in practice identified and acted upon	Repository being up to date and available to staff.	Achieved: The learning repository for pressure ulcers is still in place and in use on the Hub with learning shared each month freely available to staff. With the introduction of the new Hub we commenced discussion with communications to ensure the space where Quality information is hosted is easily accessible for staff. We will also use this hub space to keep a library of learning shared through the 7 minute learning template.

PROGRESS AGAINST OUR QUALITY PRIORITIES
CAMPAIGN THREE: SMART EFFECTIVE CARE

Key Outcomes	Measures of success 2019/20	Update
Clinical staff use the most up to date clinical practices	CAS alerts (inc. PSAs) – Monthly Board KPI target for timely alert closure greater than or equal to 90%	Achieved: - We met and exceeded the year-end target and achieved 100% compliance throughout the year.
	NICE – 90% of services complete a Baseline Assessment Form for NICE Guidance within the agreed timeframe	Achieved: We met and exceeded the target in during the year under review except for March 2020 where data was not collected due to Covid-19.
There will be a demonstrable culture of clinical enquiry and continuous improvement across the Trust	80% staff able to contribute to improvements at work (staff survey)	Partially achieved: In the NHS Staff Survey 2019, the trust achieved 70% overall on the Staff Engagement theme, which includes questions on whether staff can contribute to improvements at work. In 2018, the result was 71%.
	80% staff reporting they have access to improvement analytics when required	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 Clinical Business Unit (CBU) to identify within business plan an innovation for 2019/20 or describes why would not be applicable	Partially achieved: The CLCH Innovation Committee (IC) chaired by the, Clinical Director for the South West division continued to meet. However all planned actions/activities are currently under review due to Covid-19.
	Increased research activity sustained	Achieved: Research studies undertaken during the year included the PrEP Impact study, venous leg ulcer study Geko, Midfut – podiatric diabetic foot ulcer trial, and Stigma for HIV patients. The main services involved in research studies were Sexual Health, Respiratory, Parkinson's, and the Homeless Dental service

PROGRESS AGAINST OUR QUALITY PRIORITIES
CAMPAIGN FOUR: MODELLING THE WAY

Key Outcomes	Measures of success 2019/20	Update
New roles and career pathways are in place which supports the needs of patients/service users.	Reduction of vacancy rates (8%)	Not achieved: The Trust clinical vacancy rate is 14.7%. Further details are provided in campaign 5 below.
	Improved staff turnover (8%)	Not achieved: Clinical staff turnover is 14.7%. Further details are provided in campaign 5 below.
	The continued implementation of Apprenticeship roles	Achieved: The Trust continues to support apprenticeships across the Trust both clinical and non-clinical. A very successful CLCH Apprenticeship week was managed by the Academy with a number of stories from Apprentices, links to Apprenticeship training opportunities and frequently asked questions and the team available to sign post staff to appropriate training. Continued recruitment for the Apprentice Nursing Associate role continues however, further cohorts are now delayed by our training providers due to the current situation. This will impact on the Trust being able to meet its recruitment target of an additional 76 ANAs by Summer 2020.
	Continued improvement in staff survey results in relation to education and learning.	Not achieved: The 2019 staff survey results have identified two key areas for the Academy to focus on: There was a slight increase in the number of staff reporting support from their manager to receive training, learning and development – increased from 56.3% to 56.8%. The Academy is working with divisions to review how training can be delivered in a number of ways supporting staff to be released. In addition, the Time to Care programme is looking at job planning for staff which includes looking at how staff can be supported with time to undertaken their professional development and training. The second area of focus is supporting opportunities for career progression across all staff groups. The Academy has developed career pathways for clinical groups and is now looking at career pathways frameworks for non-clinical staff. In addition, work continues on the library of competencies for staff enabling them to be supported through any redeployment or transfer to new roles.

Roles contd.	Rotation programmes implemented across the Trust	Partially achieved A number of rotation programmes are in place across the trust for various professional groups. Work remains ongoing to embed these and explore opportunities for further rotational programmes.
	The implementation of the Nurse Associate role across the Trust	Achieved: The Trust continues to support the recruitment of Apprentice Nursing Associates across the trust. The March and May 2020 cohort have now been delayed and while we hope that cohorts will resume in June 2020, this is not confirmed by our HEI partners.
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	Partially achieved: Work remains ongoing across all divisions to review staffing models to support new ways of integrated working. The monthly clinical establishment panel continues to monitor staffing establishments annually where there are no changes and as needed when changes to models or skill mix are being proposed.
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	Achieved: LSBU have agreed the job description for the Professor of Healthcare and we now look to recruit to this. We have been successful in getting agreement to recruit 2 further Darzi Fellows and will be recruiting for these posts in the next few months.

Information not included in the table re campaign target not being met:

Staff appraisals: The reason for remaining slightly below target continues to be as a result of the impact of the services that transferred from Hertfordshire Community Trust (HCT). If the Hertfordshire division rates were not included CLCH performance would be in excess of the Trust's 90% target and rated green.

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

Key Outcomes	Measures of success 2019/20	Update
Voluntary Clinical Staff Turnover below 10% by 2020	8%	Not achieved: Q4 rates were between 14.26% and 14.70%. The WATs have analysed the reasons for leaving and are implementing initiatives to improve retention. Areas for Trust wide action have been identified. Evaluation of progress is underway.
Staff vacancies to 8% by 2020	Staff vacancy rate below 8% by March 2020	Not achieved: Q4 rates were between 13.25% and 14.00% The WATs are taking action to improve the supply of right candidates and the attractiveness of our offer along with improving the effectiveness of recruitment processes and practices. Evaluation of progress is underway.
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	Partially achieved: The results from the Quarter 3 Friends and Family Test indicate that 57.6% of staff would recommend the Trust as a place to work. This is rated as "amber" against the target of 62%
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 2019 Staff Survey	The 2019 survey is being conducted Q3 2019/20 with results released in Q4
	Sickness absence remains below target of 3%	Not achieved: Clinical sickness absence in Q4 has ranged between 4.26% and 4.42%. Action is being taken in relation to the CBUs with sickness absence over 5%. A Trust-wide WAT has been established to identify specific root causes. HR business partners are working with CBU managers to ensure the consistent application of good practice.
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
	The number of staff recruited to staff bank increases by 20%	Achieved.

Information not included in the table re campaign target not being met

Statutory mandatory training:

At the end of quarter 4, the Trust achieved an overall compliance rate of 94.28% against the target of 95%. The Trust did achieve its target of 95% in January and February 2020. However, due to Covid-19, all classroom training sessions from 16 March 2020 were cancelled which has contributed towards the reduced compliance rate in March.

PROGRESS AGAINST OUR QUALITY PRIORITIES
CAMPAIGN SIX: VALUE ADDED CARE

Key Outcomes	Measures of success 2019-20	Update
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 Patient involvement is the norm	Achieved: Patient and public involvement continues as business as usual as the patient experience team continue to embed their quarterly co-design projects across each division. The new NHSE guidance which was published to ensure there was a shift in focus away from 95% KPI to how the trust will act on the feedback received in order to help influence service level improvement. This has however been postponed until further notice as the FFT itself has been paused. As we move into the new financial year the FFT question is to be complimented by two other PREM questions, as we look to ensure we are getting the most useful feedback possible to ensure we place the patient voice at the forefront of service improvements. The PPE Quarterly projects that continue to engage both staff and patients on their involvement in care have been delivered following pathway review with each service lead and business unit manager and has been assessed and agreed upon through the triangulation of patient feedback (PALS, Complaints, Compliments and FFT). The Q4 projects focussed on Wandsworth services, Herts Respiratory Services, Harrow Therapy Services and Walk in Centres.
Clinical staff use the latest technology to improve care delivery	Each division has used improvement tools to improve 15% of services	Achieved: 16 services and 10 Quality councils (QC) have demonstrated all the requirements for this KPI. This represents a Trust position of 15.1% which in line with the year-end target.

Front line staff lead new lean ways of working	25% staff to have been trained to basic level in improvement skills, including lean	Partially achieved: 20.4% (811) staff have achieved basic level improvement knowledge against a trajectory target of 25. 0f the 713 Herts staff are excluded from the calculation, the final position is 24.2%. There had been a concerted effort by the QI team and operational divisions to meet the overall training target. However, a number of booked training sessions in March had to be cancelled due to the onset of Covid-19. At the end of the financial year, NCL has maintained their strong performance in this area and exceeded the training target (38.9%). NWL showed strong improvement in the final quarter increasing from 17.8% to 23.5% (Amber). SWL and CHD both made modest improvements (from 12.1% to 16.1% and 14.0% to 16.0% respectively). Herts has made a modest improvement from 1.8% to 2.8% staff currently trained via CLCH QI courses. Further work had been started to evaluate the numbers of staff that have transferred from Herts that have previously undertaken QI training but this was interrupted by the onset of Covid-19. This will resume at the earliest possible opportunity.
There will be demonstrable culture of clinical enquiry and continuous improvement across the Trust	80% staff able to contribute to improvements at work 80% staff reporting they have access to improvement analytics when required	Partially achieved: In the 2019 Staff survey, 60.5% CLCH staff indicated that they felt able to contribute to improvements in their work, a small increase from the 2018 score (60.2%). As of 31st March 2020 79.4% (77) of senior leaders have had training in leading/facilitating a culture of improvement and are being encouraged to support local QI projects. The Board completed a QI leadership development programme in January 2020 and the leadership training has been on pause since to ensure alignment with the revised strategic approach to QI at CLCH. A question regarding access to improvement analytics has been added to the most recent quarterly pulse survey but results have not yet been published. Due to the impact of Covid-19, it is not known when these will be available. A new improvement analyst post in currently in recruitment to increase the availability of analytical support for improvement.

DIVISIONAL QUALITY COUNCIL OBJECTIVES

Thirty divisional quality councils are in place across the Trust as follows.

- North Central (3)
- North West (4)
- South West (3)
- Children's (8)
- Hertfordshire (2)
- Trustwide (10)

The following is a summary of their work.

Division	Quality Campaign	Project
North Central Division	**Modelling the Way**	Improving training and development opportunities for Administrative Staff in the North Central Division.
	Preventing Harm	Establish and ensure compliance with Controlled Drugs regulations across the Bedded Services.
	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.
North West Division	**Smart effective care**	Investigating DNA rates of initial assessment appointments within the Specialist Dental Service.
	Here, Happy Heard and Healthy	Improving staff satisfaction through utilising informal time.
	Value added Care	Introduce and implement internal tasking between administrative staff and clinical teams on System One (S1).
	Here, Happy, Heard and Healthy	Improving staff morale across Harrow Community Services through awareness of other services to prevent staff wasting time.
South West	**Positive Patient Experience**	Improving communication through information folders for patients in the Community in Merton.
	Here, Happy, Healthy and Heard	Retaining staff in Merton and Wandsworth.
	Positive Patient Experience	Ensuring all patients are being taken to have meals in Heathlands Court.

Children's	**Smart Effective Care**	Improve the uptake of 6-8 week maternal mood contacts with the Health Visiting Service in Barnet.
	Positive Patient experience	To achieve a productive "listening" visit in Wandsworth HV Service.
	Positive Patient Experience	Improving support given to the parents and carers during waiting times of their children behavioural therapy appointments.
	Modelling the Way	Ensuring all babies are weighed accurately prior to 3 weeks by the CLCH HV Service.
	Preventing Harm	Improving the communication of safeguarding information between social care services, health visitors and school nurses in Hammersmith and Fulham.
	Smart effective care	Investigating the reasons for non-attendance of health reviews in the inner London Divisions of the Children Service.
	Smart effective care	Ensuring an efficient Duty system in Wandsworth/Richmond HV Service.
	Modelling the Way	Quality Council - To achieve a culture of kindness in the Inner Boroughs of the Children Division.
Hertfordshire	**Smart effective care.**	Improving the efficiency of ordering stock in West Herts
	Positive patient experience.	To increase the number of walking aids returned in Watford.

Trustwide	**Preventing Harm.**	Safe implementation of the international dysphagia diet standardisation initiative (IDDSI). Auditing outcomes.
	Preventing Harm	To prevent and manage verbal and physical aggression in the walk-in centres.
	Preventing Harm	To ensure a safe environment and prevent verbal and aggression against agile workers.
	Positive Patient Experience	Improving the uptake and quality of feedback form service users who require assistance with communication.
	Positive Patient experience	Recruitment and retention of patient representatives.
	Positive Patient experience	To achieve a satisfactory rapport between receptionists and patients so that both are more content each time a patient approaches a counter.
	Value added care	Improving Digital Clinical Systems use and recording.
	Modelling the Way	To support speech and language therapists with skill development and skill mix.
	Here, Happy, Heard and Healthy	Reduce the staff turnover rate from 14.7% to 8% by March 2020.
	Here, Happy, heard and healthy.	Preventing bullying and harassment in the workplace.

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: The Academy, which supports a hub of learning and development for both Trust and primary care nursing staff (both registered and unregistered) was up and running from April 2019. The Academy provides 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. The creation of a Trust Academy that works with system partners to ensures our staff have the skills, knowledge and experience to deliver effective care, support and treatment was a great achievement. The Academy provides 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. Through the work of the Academy we maintained a compliance rate of over 95% for the last 3 months for statutory mandatory training.

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. 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, 8 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, Hammersmith and Fulham speech and language therapy education team and Brent Falls team. Furthermore Harrow Podiatry Team has now been successfully reaccredited and in 2020/21 a further 3 teams will also complete this process to retain their QDU status.

We currently have 9 teams in the process of applying for QDU accreditation. In 2020/21 Core Standards will be introduced for all teams to complete to start their journey to QDU accreditation.

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. Following the introduction of shared governance three years ago, there are now 30 quality councils in place across the Trust involving over 190 frontline staff.

The quality councils are chaired by members of staff under band 7. They have memberships consisting of 6 to 10 members of frontline staff from both clinical and non-clinical background. Also, uniquely at CLCH, we have decided to include patients and members of the public in our shared governance model. Patient representatives are integral to the projects and have had training in continuous improvement methodology and chairing meetings.

Quality councils are linked to the quality campaigns and 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.

Examples of the projects running presently in each division are; the North Central division reducing waste and time district nurses spend dealing with inappropriate/incomplete referrals and establishing and ensuring compliance with controlled drugs. In the North West division, investigating DNA rates of initial assessment appointments in the specialist dental service, and improving morale and time wasting in Harrow by improving contact details. In the South West division, improving meal attendance of patients in bedded areas and information folders for patients and/or carers. In the Children division improving the communication of safeguarding information between social care services, health visitors and school nurse and improving support given to the parents and carers during waiting times for behavioral therapy appointments. Trust wide examples are three quality councils tackling unacceptable behavior in the workplace, improving digital clinical recording and retaining staff.

Other quality initiatives included:

15 Steps Challenge: this continued to be delivered with great success throughout the year.

Always events: We have implemented two new Always Events working with patients and staff to co-design areas for improvement. One is focusing on bereavement and the second event is focusing on special schools services with the aim of always communicating with and providing information to parents in their preferred language.

Awards: The Wandsworth care home in-reach team has been short-listed in the 'Care of Older People' category for the Nursing Times awards. CLCH also recognizes outstanding individuals at its own staff awards ceremony. As in previous years different awards, from hundreds of nominations, were presented to a range of outstanding teams and individuals. As each month Trust employees nominate their *employee of the month* with the divisional winners meeting the Trust chairman for teat and the overall winner receiving a £50 voucher.

Brent Health Visiting Service: the service maintained high standards around infant nutrition and are working towards the Baby Friendly Initiative. The service received excellent client feedback from the clinic service evaluation with 83% of responders confirming they were very satisfied with the service.

Capital nurse programme: We have supported nurse development via an established Capital Nurse rotation programme for community nursing across the Trust. There has been a rise in the number of staff undertaking the programme.

CLCH 0-19 Service in Brent: the service achieved Stage 3 UNICEF Baby Friendly accreditation.

Health visiting service in Westminster, Kensington &Chelsea and Hammersmith & Fulham: this became the first service in London to achieve the UNICEF Baby Friendly Gold Sustainability 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**

Wandsworth and Richmond Health visiting services introduced the successful implementation of the eRedbook, with over 250 local families registered with an account in the first 7 weeks.

ANNEX1: STATEMENTS FROM COMMISSIONERS, LOCAL HEALTHWATCH ORGANIZATIONS AND OVERVIEW AND SCRUTINY COMMITTEES

We would like to thank those who reviewed and provided comments on our 2019-2020 Quality Account. We have considered the comments received and where appropriate the comments were responded to.

Westminster City Council was contacted for their comments on our quality account but they did not provide a response to our requests for comments.

NB: The draft quality account will be sent to the commissioners and their comments will be incorporated as appropriate.

RESPONSE FROM NORTH WEST COLLABORATION OF CLINICAL COMMISSIONING GROUPS.

RESPONSE FROM HERTS VALLEY CCG

RESPONSE FROM BARNET OVERVIEW AND SCRUTINY COMMITTEE TO CLCH QUALITY ACCOUNT 2019-20

HEALTHWATCH BARNET RESPONSE TO CLCH QUALITY ACCOUNT 2019-20

healthwatch Barnet

HEALTHWATCH CENTRAL WEST LONDON RESPONSE TO CLCH QUALITY ACCOUNT 2019 - 20

healthwatch Central West London

ANNEX 2: 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 2019 – 2020 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 2019 to March 2020
- papers relating to quality reported to the board over the period April 2020 to March 2020
- feedback from commissioners dated xxxx
- feedback from local Healthwatch organisations dated xxxx
- feedback from Barnet overview and scrutiny committees dated 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 staff survey published xxxx
- CQC inspection report dated xxxx

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

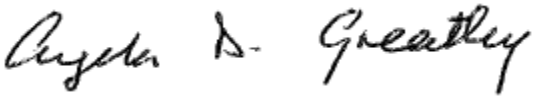
The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review

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

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

Healthwatch Barnet
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

Ealing Healthwatch
46 St. Mary's Road
Ealing
W5 5RG
Tel: 0203 8860830
www.healthwatchealing.org.uk/

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

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

Richmond Healthwatch
www.healthwatchrichmond.co.uk
Tel: 020 8099 5335

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

Ealing CCG
www.ealingccg.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 AUTHORITIES

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

Ealing
Tel: 020 8825 5000
www.ealing.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

Royal Borough of 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

FFT: Family and friends test

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 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: This 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 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.