CLCH QUALITY ACCOUNT 2020 – 21

PART 1: ABOUT OUR QUALITY ACCOUNT

Welcome to the Central London Community Healthcare NHS Trust (CLCH) Quality Account for 2021 – 2022.

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 quality strategy: *Improving Quality in Everything We Do Our Quality Strategy* 2020 – 2025.

The quality strategy described our four quality campaigns. These are: a positive patient experience; preventing harm; smart effective care and modelling the way. Within the strategy key outcomes and their associated measures of success were listed for each of these four campaigns.

The quality strategy also made clear how our Quality Account priorities would be aligned with the four quality campaigns. Performance against these campaigns is incorporated into the Quality Account.

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.

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 provide care and support for people 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 over 220,000 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 to *Deliver great care closer to home.*

Our mission is *Working together to give children a better start and adults greater independence.*
Our core values provide a reference point for staff on how we should conduct ourselves when working with patients, colleagues and partners and they are as follows:

- Quality: we put quality at the heart of everything we do
- Relationships: we value our relationships with others
- Delivery: we deliver services we are proud of
- Community: we make a positive difference in our communities

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 2021. This year has proved to be one of the most challenging for us and the wider NHS, but I'm proud to note that our staff have gone beyond the call of duty, bravely undertaking their roles while faced with the real risk of increased exposure to Covid -19.

During the year we continued to maintain a strong performance against the quality key performance indicators (KPIs) despite the ongoing impact of the pandemic. The positive patient experience campaign restarted patient feedback phone calls in June ahead of the national deadline of November. We supported even more education programs to move online and the CLCH Academy has continued to support a range of education and training initiatives across the trust and the system.

We are extremely proud that our teams have continued to excel with some being recognised in national award schemes. Our Westminster Homeless Health Team were the winners of the Student Nursing Times Award for Student Placement of the Year: Community 2020. Our respiratory team in Hertfordshire received a high commendation award for the Respiratory Care Initiative of the Year category at the Health Service Journal (HSJ) Value Awards 2020. In collaboration with London South Bank University and the Mary Seacole Centre in Surrey, CLCH was successful in obtaining a Burdett Trust Grant to undertake a research project entitled 'Rehabilitation and Recovery following Critical Illness related to Covid-19'.

As an anchor organization we have worked with partners across the health system supporting the deployment of staff to the Nightingale hospitals and to the large scale vaccination hubs across North West London, where we have taken an active role in leading the governance agenda and through our CLCH academy we have provided training to the vaccination workforce.

Finally, my sincere thanks to all our staff for their continued commitment and compassion in successfully delivering safe and effective services in this challenging period.

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

Throughout 2020-2021 we have been embedding our refreshed quality strategy *Improving Quality in Everything We Do.* I am pleased to be able to report that each of our strategy campaigns has delivered against its associated key priorities and outcomes as well as its measures of success, all of which have been monitored at quarterly meetings of the quality committee. As in previous years the committee has also continued to receive monthly updates, including a quality dashboard and in-depth reports on progress against our targets.

It is a testament to the hard work of all our staff that as a result of this focus, the trust has maintained a strong performance against its quality key performance indicators (KPIs) despite the ongoing impact of the Covid-19 pandemic. While this has undoubtedly posed a challenge to the delivery of business as usual, we have continued to enhance quality and reduce levels of harm through our robust governance structures that have remained active throughout this period. Indeed a majority of our quality KPIs have continued not just to meet but to exceed their targets each month and we have seen a steady improvement against the new training KPI `Making every contact count'.

We have maintained good compliance against our patient experience KPIs and have also ensured timely responses to complaints, acknowledging all of them within the statutory timeframe of 3 working days. Through our positive patient experience campaign we restarted patient feedback phone calls in June, well in advance of the national deadline of November. Furthermore, patient feedback has increased at both policy and committee level, as per our strategic objective. We have continued to enhance our monitoring and assurance through our quality development units (QDU) and the introduction of the new bedded scorecard, which is now being used in our monthly matrons' meetings to inform learning and identify improvement.

The shared governance approach through the quality councils has continued enthusiastically throughout the pandemic, with over 200 staff engaged in this process. Some of the work has had to be put on hold to enable staff to respond to the rising demands on their clinical time, but we have still maintained the momentum around continuous improvement, including in the children's division, where we have been supporting the re-imagining initiative around the design and delivery of health visiting services

In February and March 2020 we welcomed the Care Quality Commission (CQC) who inspected the trust's services for children, young people and families. Following this they confirmed our existing rating of Good. We continue to progress our action plans to ensure ongoing compliance and hold bi-monthly relationship meetings with our CQC inspector. More recently we have been supporting the CQC vaccination monitoring approach as the registered provider organisation for the hospital-led large-scale vaccination hubs in North West London.

As we strive to deliver high quality care in a strained health system, there have inevitably been some challenges that have affected our ability to maintain business as usual. Nonetheless, even with such unexpected demands on our time and resources, due to the pandemic, we have had a strong year and ensured that the great work being undertaken by our teams and the care that we deliver remain best in class.

As referred to by the Chief Executive, the trust, along with the rest of the NHS, has had to respond to the outbreak of Covid 19 in bold, inventive and courageous ways. I am proud of how we have risen to the challenge and I would like to thank every single member of our staff across the whole organisation, for working so tirelessly and professionally throughout.

I would also like to take this opportunity to thank all members of the Quality Committee for their commitment, dedication and support 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 2021 - 2022

Our four quality campaigns for 2021-2022 are the same as laid out in our 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. Progress is reported to the board via the quality section of the performance report. The information we collect will be used to review how well we have performed over the year. Good practice will be shared and where areas of weaknesses have been 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 **2021 – 2022** are as described in the tables below. It should be noted that as the strategy is a five year one, the measures of success have been divided up and split across different financial years.

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 this original 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, 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.* Following this in January 2021 we wrote to our stakeholders and asked if they had any further comments on our quality priorities. We also took the opportunity to confirm that, as in previous years, the priorities as outlined in our quality strategy would be taken forward as our quality priorities in our *Quality Account.*

CAMPAIGN ONE: A POSITIVE PATIENT EXPERIENCE

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

KEY PRIORITY / OUTCOME	MEASURES OF SUCCESS APRIL 2021- NOV 2021	MEASURES OF SUCCESS DEC 2021-MARCH 2022
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 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%	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%	The proportion of patients who felt staff took time to find out about them will be maintained at 95%
	We will develop a policy and process to ensure patient/ user/ carer are involved in every service change.	We will ensure that 80% of patient/ user/ carer feel involved in each 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%	Staff, friends and family test - percentage of staff recommending CLCH as a place for Treatment will be 80%
	We will enhance the number of volunteers for the Trust and embed volunteers as part of the service	We will increase volunteer numbers by 50% from 2020/21 baseline in services where volunteer participation improves patient experience
	We will complete an annual volunteer survey to understand their impact on services and their experience	We will develop you said we did stories to share volunteers experiences To continue to complete an annual volunteer survey to understand their impact on services and their experience

KEY PRIORITY /OUTCOME	MEASURES OF SUCCESS APRIL 2021 – NOV 2021	MEASURES OF SUCCES DEC 2021 – MARCH 2022
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 97% 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 complaints within 25 days
	We will continue to respond to 100% of complex complaints within the agreed deadline	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	We will continue to acknowledge 100% of complaints within 3 working days
The patients and the public's 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 transfer the learning from each *always event* across the Trust
	We will continue to deliver borough based quarterly co-design initiatives using patient and staff feedback/ stories	We will review the impact and learning from quarterly projects on the overall patient experience
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)	50% of health visiting services will have achieved level 2 breast feeding accreditation or greater

CAMPAIGN TWO: PREVENTING HARM

Keeping our patients, their families and our staff safe.

KEY PRIORITY / OUTCOME	MEASURES OF SUCCESS APRIL 2021- NOV 2021	MEASURES OF SUCCESS DEC 2021-MARCH 2022
Robust, effective systems and processes in place to deliver harm free care all the time	97% of clinical incidents will not cause harm	Maintain/ or improve on the Proportion of clinical incidents that did not cause harm reported in 2020/21
	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 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 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 investigations will continue to 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	100% of all Serious Incident actions will continue to be completed on time in accordance with locally agreed timescales

KEY PRIORITY / OUTCOME	MEASURES OF SUCCESS APRIL 2021- NOV 2021	MEASURES OF SUCCESS DEC 2021-MARCH 2022
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	There will be evidence of an improvement in the safety culture compared to baseline
	Each division will share a single serious incident learning example using the 7-minute learning tool through divisional board and patient safety risk group	Each division will share at least 4 incident learning examples in divisional boards 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	90% of teams will have undertaken a core standards annual health check assessment and identified action plans that are completed on time
	100% compliance with the timely closure of actions from risks on the register	No outstanding 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 PRIORITY / OUTCOME	MEASURES OF SUCCESS APRIL 2021- NOV 2021	MEASURES OF SUCCESS DEC 2021-MARCH 2022
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	95% staff trained at MECC level one 95% clinical staff trained at level two
	We will launch MECC link across the Trust"	We will evaluate the use of MECC link with our clinical staff
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%	We will increase the number of research projects involving/led by clinical staff within the trust by ≥ 15%
	100% of services/ individuals undertaking a clinical audit/service evaluation/QI project will submit a clinical improvement poster to the clinical effectiveness team	Clinical improvement posters will be displayed on all key Trust sites presented at Trust business meetings, divisional and service/team meetings, other appropriate settings and uploaded to the Hub. Target: ≥ 80%

CAMPAIGN FOUR: MODELLING THE WAY

Providing innovative models of care, education and professional practice

KEY PRIORITY / OUTCOME	MEASURES OF SUCCESS APRIL 2020 - NOV 2021	MEASURES OF SUCCESS DEC 2021-MARCH 2022
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	60% of clinical staff at band 8b or above will have undertaken training Mentoring opportunities will be publicised for staff trust wide
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%	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	Each professional group will have development portfolios to support staff having the right skills and knowledge to support new models of care
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	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 (ANA) role across the Trust	All community nursing and bedded services will have 1/2 ANAs in place
	We will develop safe staffing models for the AHP workforce and review opportunities for new AHP roles supporting new models of care	We will evaluate safe staffing models for AHP workforce and any new roles developed
	We will continue to develop professional networks and deliver events for all staffing groups across the trust	We will continue to develop Professional networks and deliver / events to be delivered for all staffing groups across the trust and primary care

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

In January 2020 we refreshed and updated our quality strategy and we 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 this initial 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.*

Building on this consultation in 2021 we took the opportunity to write to our stakeholders to ask them if, in addition to the areas described in the quality strategy, they had any specific areas for inclusion or focus they would like incorporated into the *Quality Account.*

STATEMENTS OF ASSURANCE FROM THE BOARD

Review of services

During 2020-2021 CLCH provided 93 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 2020-2021 represents 100% of the total income generated from the provision of NHS services by CLCH for 2020-2021

Secondary use services

CLCH submitted records during 2020-2021 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 99.1% and which included the patient's valid General Medical Practice Code was 97.4%

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 2020-21

Data Security and Protection (DSP) Toolkit

The Trust submitted a *standards met* for the 2020-2021 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 2020-21, 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. Following this in April 2020, all national clinical audit work was halted. This was due to the impact of the pandemic on the work of our clinicians.

Later on in the year, the Trust was able to undertake work on the 3 national clinical audits as listed below. These audits, for which data collection was undertaken, 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.

NATIONAL CLINICAL AUDITS

National Clinical Audit	Participation	Submitted cases or reason for non-participation	Outcomes and actions
National Audit of Cardiac Rehabilitation (NACR)	Yes	20 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. Data collection is in progress.	Services were either reduced or suspended prior to or during lockdown. This resulted in a lack of uptake figures as normally required. The NACR will monitor changes in CR mode of delivery reflecting changes in NHS practice and will carry out an analysis of patient outcomes for the 12 months before and after the start of the Covid-19 pandemic.
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. Data collection is in progress.	Awaiting final report.
National Audit of Inpatient Falls (NAIF)	Yes	A requirement of the audit was that the National Hip Fractures Database (BHFD) 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. We did not have any patients in this year. We however participated in the NAIF Facilities Audit in August 2020. Services taking part: Inpatient Units: Inner (Alexandra Unit), Inpatient Units: Inner (Athlone House), Inpatient Units: Barnet (Jade Ward) Inpatient Units: Barnet (Adams Ward)	Awaiting final report.

LOCAL AUDITS

The reports of 18 local clinical audits that were reviewed by CLCH in 2020-2021 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 also incorporated into the table below. Inevitably due to the pandemic there have been fewer audits than in previous years.

Title	Division	Service	Outcomes and Actions
1. Antibiotic prescribing for paediatric dental patients in CLCH	North West	Community Dental Services	The audit aimed at assessing antibiotic prescribing for dental paediatric patients within CLCH and adherence to national guidelines. **Findings:** There was an overall improvement in the percentage of antibiotics prescribed for an appropriate reason (from 89% in the initial audit to 94% now) and at the correct dose (from 47% in the initial audit to 77% now). **Actions identified:** Audit findings to be resented at staff meeting; Clinicians responsible for the prescription errors to be informed by respective line managers; correct paediatric antibiotic dose to be printed and placed in a suitable location within respective clinics; To spot check antibiotic prescribing for CLCH paediatric dental patients.
2. Basic Periodontal Examination (BPE) Screening for Adult Homeless Patients at Great Chapel Street Clinic	North West	Homeless Dental Services	The aim of the audit was to ensure that all adult homeless patients have a BPE done as part of a full examination. **Findings:** BPE was recorded in the majority of cases (68%). When there was an explanation for BPE not being recorded, there were good reasons for BPE not being recorded. These included patients being edentulous or having only a single root left. However, Great Chapel Street Clinic fell short of the 100% target for BPE being recorded. In addition, in the majority of cases where BPE was not documented (87.5%), no reason was given. **Actions identified:** Dentists working at Great Chapel street to be reminded that they must record BPE as part of all examinations or document why this is not done; The examination template at Great Chapel Street

			to be amended to remind dentists to document why BPE was not recorded; To spot check records – 10 cases per dentist – to ensure actions 1 and 2 are implemented.

3. Care Pathway Progression for Dental Phobic Patients	North West	Community Dental Services	The project aimed at looking at the care progression for dental phobic patients, from referral to discharge. **Findings:** 69% of phobic patients were seen promptly for Clinical Triage in less than a month from referral and 60% of Clinical Triage appointments were kept. 78% of patients that attended clinical triage were accepted for care by the CDS. 70% of the accepted patients kept their first CDS appointment and 33% of accepted patients continued with appointments to complete their course of treatment. In addition, sedation with local anaesthesia was used for 77% patients, of which 46% was for inhalation sedation and 31% for intravenous sedation. **Actions identified:** To continue with short clinical triage appointments for all phobic referrals; To complete discharge correspondence back to the referring dentist if appointments are not kept; To encourage patients to attend for all appointments – clinicians to keep patients under review to consider if care could be better provided with an alternative approach e.g. IV rather than IS; To discharge patients back to the GDS with record of communication logged in notes at the end of a course of treatment.
4. Audit of Dental Facilities for Inhalation Sedation across CLCH sites	North West	Community Dental Services	The aim of the audit was to investigate the current facilities in place and identify any areas where improvements needed to be made. **Findings:** The Covid-19 pandemic led to suspension of clinical services in March 2020. Some facilities could not be assessed in this audit with clinics not running. Overall, the facilities in place that could be assessed were good, ranging from 71-87% standards met. The audit identified 22 different action points, which included 8 common action points to be addressed at every site. Individual site action plans have been issued, with designated people responsible.

4. Dental services contd.			**Actions identified:** All individual site action plans to be implemented; Annual checks to be made to ensure that high standard facilities for IS are in place, including those not checked during Covid-19 restrictions.
5. Pre-operative assessment checks for dental phobic patients scheduled for intra venous sedation	North West	Community Dental Services	The aim of the project was to look at accuracy in pre-operative checks made at the consultation appointment before the treatment appointment. **Findings:** Audit showed that pre-operative documentation at the assessment appointment was incomplete in the cases June 2019 – Jan 2020. All detail was eventually recorded i.e. before treatment commenced, at the subsequent visit. Pre-operative checklists were introduced in early February 2020 which resulted in significant improvements in recorded detail at the assessment appointment - 100% for all parameters checked in Feb 2020. **Actions identified**: To introduce a checklist at the pre-operative assessment appointment; To involve dental nurse colleagues to support adherence of clinicians to the checklist.
6. Re-audit on Inhalation sedation record keeping	North West	Community Dental Services	The aim of the re-audit was to see if the RCS guidelines were being followed, with paper logbooks and electronic clinical notes tallying exactly. **Findings:** The logbook entries tallied with the clinical notes 87 times out of 132 i.e. 66% of the details were accurately recorded. In the previous audit cycle, 42% of the details were accurately recorded; therefore, there has been significant improvement, but still a need for more accurate recording. Generally, the clinicians who performed best had a standard template that they used ensuring that all relevant data was recorded.

6. Sedation record keeping contd.			**Actions identified:** To meet high standards of IHS log and electronic clinical record keeping, including level of sedation and operating condition to be recorded for all sedations in both places; Template to be used for electronic records to improve accuracy; Logbook to be moved to electronic format on shared drive; To repeat audit to see that logbook recordings and electronic clinical notes tally exactly.
7. Service review of paediatric dental patients seen at emergency dental hub sites during COVID-19 period	Dental	Community Dental Services	The aim of the project was to review the emergency paediatric dental patients seen during the COVID-19 period at two different emergency dental hubs: Eastman dental hospital (EDH) hot hub site and CLCH community clinics cold hub sites to assess for appropriate management. **Findings:** 393 patients seen across both sites (306 EDH, 87 CLCH). CLCH saw more face-to-face patients (46%) than EDH (19%). Most common reason for appointment was pain (43% EDH, 47% CLCH). Trauma was managed appropriately (95% EDH, 100% CLCH). Antibiotics were generally prescribed appropriately (81% EDH, 89% CLCH); There was incorrect prescribing due to reduced doses of amoxicillin (8% EDH, 47% CLCH). **Actions identified:** Further education of CLCH dental team immediately; presentation of findings at local clinical governance meeting; Prospective audit on antibiotic prescribing for CLCH paediatric dental patients.

8. Child Protection and Children in Need Care Plan Audit Continuity of Practice during Covid -19	Children's	Health Visiting Services	The aim of the audit was to assess health visiting practice following the introduction of new ways of working on 23 March 2020 to identify areas of good practice and an action plan where improvement was necessary. **Findings:** Many practitioners were following best practice guidance for record keeping and care planning. Out of 14 questions, compliance was 70% and above on 11 of these questions. However, whilst the Divisional steer at the time was that first contact should, where possible, be through the BlueJeans video conference app followed by a face-to-face contact when a clinical need indicated, this wasn't followed in many cases. In addition, over 70 families hadn't been seen in the last 2 months. Comments revealed that a significant number of these families also hadn't been seen since 2019. **Actions identified:** For all CBU's to review their borough data and develop immediate/longer term action plans to address the key areas for improvement; For care plans to be reviewed for all families on Level 3 and 4 continuum of need; Team 'peers to work alongside staff on a 1:1 basis to support them to complete templates; To unpick the challenges regarding the 'allergies' question and review crib sheet guidance; To review the supervision question response regarding staff contacting their safeguarding advisors for advice, support and supervision during Covid – 19, making recommendations as required.

9. Completed Home Risk Assessment for Children receiving Cytarabine at Home	Children's	Children's Community Nursing	The aim of the re – audit was to assess compliance with the policy to ensure there was 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**: In 2019 to 2020, 100% of children receiving Cytarabine at home had a completed home risk assessment, all of which were on SystmOne; All children had an administration of Cytarabine care plan on their SystmOne records. **Actions identified:** To ensure all new staff who administer Cytarabine are taught of the importance of completing and uploading the home risk assessment; To ensure that current level of compliance is maintained – all children who receive Cytarabine at home will have a completed home risk assessment in their SystmOne records.
10. Audit of DNACR forms at the day hospice	North West	Pembridge Day Care – West London	The aim of this audit was to measure compliance of Pembridge Day Hospice medical staff in discussing and documenting Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions. **Findings:** Resuscitation was discussed with 22 out 44 Day Hospice patients. Out of these, 17 patients had DNACPR form filed in paper notes. All 17 forms had a documented reason for DNACPR and communication with the patient, but only 8 forms had documentation of a discussion with family; while, 1 patient did not want to discuss it. Out of the forms completed, only 1 might have had a signature of the MDT member. 16 out of 17 forms were signed by the consultant.

10. Audit of DNAR forms contd.			**Actions identified:** All patients attending day hospice should have a discussion with regard to resuscitation, which should be documented; DNACPR decision should be communicated to patient's family if possible; Either members of the MDT team should sign the DNACPR form as per CLCH policy, or the policy should be amended so that stating the names of the MDT members is enough; Re-audit in 12 months and consider checking coordinate my care record.
11. Audit into the efficiency of correct caseload management at Hammersmith and Fulham Community Podiatry	North West	Podiatry – Hammersmith and Fulham	The aim of the audit was to quantify the percentage of new patients correctly allocated into an appropriate caseload on SystmOne from the 6th December 2019 onwards to ensure new patients are allocated to the accepted threshold of CLCH SOP policy. **Findings:** Out of 70 patients, 55 (78.67%) were correctly allocated; Out of 26 diabetic patients, 16 (61.54%) were correctly allocated; Out of 6 vascular patients, 4 (66.66%) were correctly allocated; Out of 12 biomechanics patients, 9 (75%) were correctly allocated. **Actions identified:** Podiatrist to review own caseloads to assess efficiency in correct caseload allocation; Podiatrists to consider/understand importance of correct caseload allocation; Podiatrist to be able to understand criteria requirement for each caseload; Podiatrists to be able to justify selected caseload allocation.

12. Food quality survey on Barnet bedded Services 2020	North Central	Nutrition and Dietetics	The aim of the audit was to measure patient's satisfaction with the food served on Barnet Bedded Services. **Findings:** Most patient's thought the overall quality of the food was 'Good'; All patients rated the variety and the quantity of food as 'Fair', 'Good' or 'Very Good'. Most patient were unable to rate the quality of the snacks as several patients reported not having snacks between meals. The availability of drinks was rated 'Good' by most patients; whilst, the catering and care staff were both rated 'Very Good' for helpfulness by the majority of patients. **Actions identified:** To disseminate findings to the wards and catering managers; To ensure ward staff and patients are aware of the variety of snacks and drinks available; To ensure ward staff and patients are aware smaller or larger meal portions offered; to repeat survey annually.
13. Hydration Audit 2020 (Alexandra Rehabilitation Unit)	North West	Nutrition and Dietetics	The aim of the audit was to provide optimum hydration to patients at Alexandra Rehabilitation Unit, through improvement of the adherence to the local hydration policy guidelines and improving identification of those who are at risk of dehydration. **Findings:** Fluid charts were completed for 100% of patients on admission for first 48 hours; 37% of fluid charts were completed accurately. Water jugs were refreshed regularly on all wards; No patients required thickened fluids during this audit. 37% of patients were identified to be at risk of dehydration; For patients at risk of dehydration, 33% had fluid charts completed/ continued and was given a red jug. **Actions identified:** To disseminate findings to the Unit; To identify possible barriers that may be impacting on the policy compliance; Dietitian to provide training to Clinical Support Workers and Nursing Staff; To repeat audit annually to collect comparable data and evaluate compliance after recommendations provided; To increase awareness of the CLCH hydration policy.

14. Hydration Audit 2020 (Athlone Rehabilitation Unit)	North West	Nutrition and Dietetics	The aim of the audit was to provide optimum hydration to patients at Athlone Rehabilitation Unit, through improvement of the adherence to the local hydration policy guidelines and improving identification of those who are at risk of dehydration. **Findings:** Fluid charts were completed for 100% of patients on admission for first 48 hours; 28% of fluid charts were completed accurately. Water jugs were refreshed regularly on all wards and all tea/coffee rounds were made on time. No patients required thickened fluids at time of audit. 56% of all patients were identified to be at risk of dehydration. **Actions identified:** To disseminate findings to the Unit; To identify possible barriers that may be impacting on the policy compliance; Dietitian to provide training to Clinical Support Workers and Nursing Staff; Repeat audit annually to collect comparable data and evaluate compliance after recommendations provided; To increase awareness of the CLCH hydration policy.
15. Observational audit of protected meal times 2020	North Central	Nutrition and Dietetics	The aim of the audit was to ensure compliance with protected mealtimes. **Findings:** 100% of patients across all wards received assistance and had food charts completed where needed; There were no obstructions of items preventing meals being eaten from tables; All patients were offered toileting before meal service and the majority of patients were positioned comfortably for eating. 100% of patients at Finchley Memorial Hospital were given hand wipes, 1/3 audit days at Jade ward demonstrated no wipes on trays or given to patients during mealtime. Only one mealtime interruption occurred on Adams, there were several interruptions that occurred during mealtimes on both Marjory Warren and Jade.

15. Meal times audit contd.			**Actions identified**: To disseminate findings to the wards; To repeat audit annually to collect comparable data and evaluate if recommendations are improving compliance.
16. Observational Audit of Protected Mealtimes 2020 (Alexandra Rehabilitation Unit)	North West	Nutrition and Dietetics	The audit aimed to assess whether protected mealtimes was implemented for all patients and if appropriate care plans were in place for those who require additional assistance. **Findings:** Due to COVID-19 pandemic patients were not able to use the dining area, and were eating their meals in their own rooms. Hand wipes were placed on 100% of the trays; All patients received their meals within 30 minutes. However, one patient who required full assistance with their meals did not get assistance offered at the time the meal service was observed. Food chart was not completed for all patients. Red trays and jugs were in place. Members of staff serving the meals lacked of space to serve meals safely and adequately - it was informed that the food trolley was a replacement from a more suitable broken trolley. Patients' tables were not clutter free when meals were served. All patients were offered toileting before meal service and the majority of patients were positioned comfortably for eating. There were no interruptions during mealtime service. **Actions identified:** To disseminate findings to the Unit; To liaise with Sanctuary Care to ascertain catering equipment replacement; To increase awareness of Protected Mealtimes within members of staff; To repeat audit annually to collect comparable data and evaluate compliance after recommendations provided.

17. Observational Audit of Protected Mealtimes 2020 (Athlone Rehabilitation Unit)	North West	Nutrition and Dietetics	The aim of the audit was to assess whether protected mealtimes was implemented for all patients and if appropriate care plans were in place for those who require additional assistance. **Findings:** Due to the COVID-19 pandemic, patients' meals were served in their rooms. Hand wipes were placed on 100% of patients trays. Staff reported that all patients were asked whether they needed to use a toilet prior to their meal. All patients received their meals within 30 minutes; they looked comfortable and were asked whether they needed assistance. 100% of patients requiring assistance received help and had food charts completed. Red trays were not in place; therefore, it was not clear when a patient required extra assistance. Patients' tables were not clutter free when food was served. Only one mealtime was interrupted at Athlone where the drug round ran into mealtime; however, it was noted that food from the kitchen came to the unit later than its expected time. **Actions identified:** To disseminate findings to the Unit; To re-implement red tray guidance and to provide training as needed; To ensure there are enough red trays/jugs available at the unit; To repeat the audit annually to collect comparable data and evaluate compliance after recommendations provided.

18. Integration of remote consultations at the onset of the coronavirus pandemic 2020: A snapshot audit	North West	Podiatry – Inner	The aim of the audit was to benchmark the podiatrists' compliance with the Tele triaging expectation of the Podiatry service pandemic handbook and identify whether additional training was required to support the embedding of remote consultations. **Findings:** All patients scheduled for remote consultations received a phone call and all patients requiring a face to face were provided with an appointment. In addition, all patients requiring active monitoring were scheduled for follow up triage. However, there was inconsistency in the use of the published tele triage template which introduced risk to the service. There were also individual Podiatrists who have not adopted the template but created their own approach which does not provide assurance as per the pandemic handbook. **Actions identified:** To re-write the template to ensure the content is suitable for phase of pandemic and current Podiatry practice; Team leads to identify Podiatrists who require support to embed the template and provide guidance; To re-audit in October.

Acronyms and explanations of terms

BPE	Basic periodontal examination
CBU	Clinical business unit
CDS	Community dental services
CLCH	Central London community healthcare NHS trust
COPD	Chronic obstructive pulmonary disease
DNACPR	Do not attempt cardiopulmonary resuscitation
EDH	Eastman dental hospital
GDP	General dental practitioner
GDS	General dental service
IS/IHS	Inhalation sedation
IV	Intravenous sedation
MDT	Multi – disciplinary team
RCS	Royal College of Surgeons
SOP	Standard operating procedure
SystmOne	Electronic patient record system

PARTICIPATION IN RESEARCH

During the pandemic, the trust research and development department focussed on supporting urgent public health studies and Covid related research studies. Most non-Covid studies were suspended during this period due to staff redeployment and Covid restrictions.

The pandemic raised the profile of research, creating interest from both patients and clinical teams, and facilitating the building of new relationships with local universities in collaborating on studies that will benefit the trust's patients. All clinical teams involved in research receive good clinical practice training, provided by North West London clinical research network.

Over the past year clinical staff developed new ways of working, reaching patients through digital or remote means, and as a result more on line research studies were offered.

The following are examples of current studies that CLCH is involved with:

- **UK-Reach:** an urgent public health research study into Ethnicity and covid – 19 outcomes in healthcare workers.

- ***MeCareWell:*** a study of mental wellbeing of North West London health and social care staff during Covid – 19.

- R**ehabilitation and recovery following Covid 19:** a study investigating factors following rehabilitation and recovery.

The number of patients receiving health services provided by CLCH during 2020-2021 that were recruited during that period to participate in research approved by a research ethics committee was 504. In line with ethical practice in research, there is a process in place to protect the identity of all research participants, and this uses a unique identifier, which is usually a number.

Moving forward to 2021-2022, the trust research team will be recruiting two additional staff, to support the growth in research studies looking into long covid and working towards achieving the goal of hosting more research studies and developing research activity in new clinical areas. Finally, the overarching goal of the research department is unchanged, that is to ensure that all staff and patients in CLCH have the opportunity to participate in research.

FREEDOM TO SPEAK UP (FTSU)

CLCH is committed to promoting an open and transparent culture across the organisation to ensure that all members of staff experience a compassionate climate where they are confident to speak up and everyone can learn. This includes anyone who undertakes work for the trust.

FTSU is included within the trust's welcome booklet, induction for staff, a handout given to bank workers and volunteers. Core FTSU training, developed in line with the '*National guidelines on Freedom to Speak Up training in the health sector in England*' (August 2019), is included within the statutory and mandatory booklet completed annually by all staff. Items are published regularly in trust communications, in line with the FTSU communication plan, including a new quarterly FTSU newsletter. There is a FTSU page on the intranet that includes a video of our chief executive, staff experiences of speaking up and other information. A FTSU module has been developed for inclusion in the new *leadership and people development programme*, in line with the national guidelines, which covers creating the right environment, supporting speaking up and listening well.

The Freedom to Speak Up policy was reviewed in 2020, taking into account the NHSE/I national 'standard integrated policy' and learning from use of the trust's previous version. The policy includes the need for workers to speak up, in line with the recommendations and in response to the independent '*Freedom to Speak Up'* review (2015) led by Sir Robert Francis QC, and highlights the Trust's commitment to fostering a culture of safety and learning in which everyone feels safe and supported to raise concerns. It describes routes through which concerns can be raised and includes a process chart for easy understanding.

Staff are encouraged to speak up about anything related to the quality of care, patient safety, bullying or harassment or anything else that affects their working lives, so that we have an opportunity to address their issues. Staff can raise concerns through their line manager, more senior managers, clinical leads, Freedom to Speak Up (FTSU) Guardian, the patient safety team, safeguarding team, staff representatives, Human Resources, directors, nominated non-executive director, trust local counter fraud specialist, or by using formal processes. Staff are also provided with details as to how they can speak up to an outside body.

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

The Trust has a full-time FTSU guardian, who is a national guardian's office trained trainer. The guardian is actively involved in the London regional network and is a member of the national guardian's office's network of chairs and trainers.

The FTSU Guardian is supported by eleven FTSU champions, volunteer staff who were appointed following an open invitation for expressions of interest. Five are from BAME backgrounds. They were trained in line with the national guardian's office training for FTUS guardians, made bespoke for the champions. A continuous programme of training is provided to enhance skills. They provide a safe space for staff who approach them with concerns, listen to them, and provide support, guidance and signposting where appropriate. They also help to raise awareness of the importance of speaking up and how staff can do so.

Governance is provided through FTSU guardian reports to the trust board (six-monthly), the trust's people committee (four-monthly) and quality committee (quarterly). The Trust also has a FTSU Group that comprises the FTSU Guardian, chief executive officer, chief operating officer, chief nurse, director of people (executive lead for FTSU), non-executive director lead for FTSU, and staff side chair, who meet six-monthly to discuss particular themes. data is submitted to the national guardian's office on a quarterly basis.

The FTSU guardian is involved in trust-wide staff networks, the trust's equalities group and preventing bullying and harassment taskforce, as well as other initiatives and groups as they arise. This provides an opportunity to influence culture and actions.

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

Due to the pandemic, in March 2020 NHS England decided to roll forward all NHS block contracts. These contracts would normally be renegotiated annually. This also applied to CQUINs and LISs – i.e. that 100% delivery should be assumed for 2020-2021. The aim of this was to allow NHS trusts to free up as much capacity as possible and prioritise their workloads to be focused on managing their response to the pandemic.

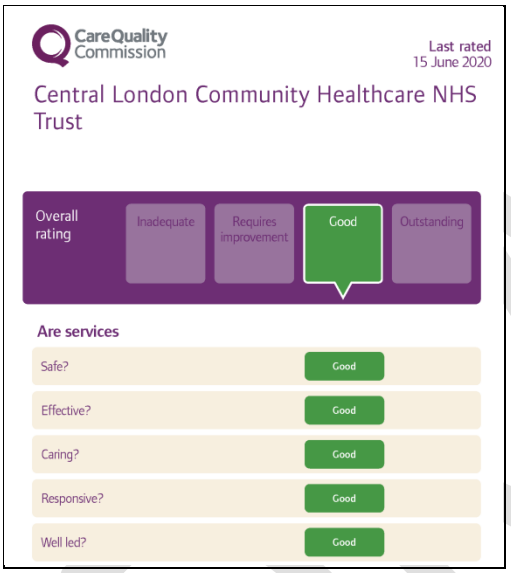
Given this the usual information in respect of planned CQUINS and our achievement in respect of them is not available for inclusion in the 2020-2021 quality account.

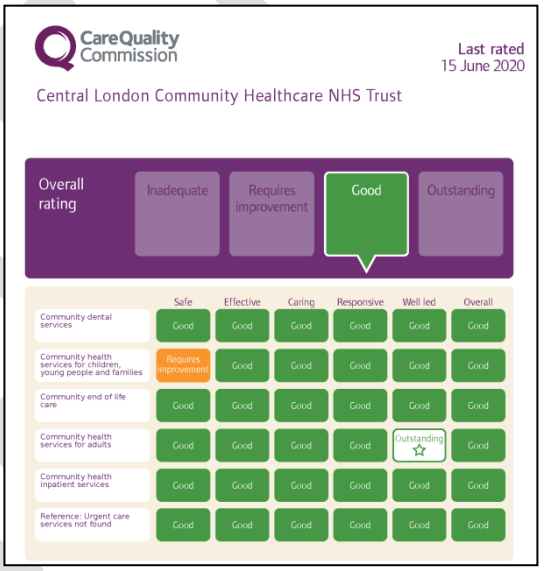
CARE QUALITY COMMISSION (CQC)

CLCH is required to register with the CQC. The trust is registered with the CQC under the provider code RYX without any conditions. The CQC has not taken any enforcement action against CLCH during 2020/21. Furthermore, the trust has not participated in any special reviews or investigations by the CQC during the reporting period that ended 31st March 2021.

At our last inspection, in February 2020, the CQC inspected one of the Trust's core services- community health services for children and young people. The well-led assessment element of the inspection, scheduled for March 2020, was postponed due to the Covid-19 outbreak.

In June 2020, CQC published their report which rated the trust as 'Good' overall, with no changes to the ratings in the core service inspected. The grids below reflect the Trust's current rating.





As can be seen from the grid the trust was (at the 2020 inspection) given a rating of *requires improvement for* the *safe domain* in community health services for children and young people.

This rating was awarded based on the following judgements made by CQC:

- High vacancy rates and large caseload sizes in Brent, which impacted on the delivery of the mandated Healthy Child Programme and the safe management of waiting lists;
- Staff did not always complete or review treatment records in a timely manner with important information;
- Lone working practices were not robust and staff understanding varied;
- No robust system in place to monitor the use of prescription pads in the children's community nursing team.

CLCH was issued with three actions which it must take to improve in the core service's *safe domain.* Individual plans to address the actions were written and assigned to responsible owners and progress is monitored through the trust's monthly patient safety and risk group.

Our 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 data across all of its services.

CLCH also recognises the importance its duties with regards to personal data; keeping it accurate and up to date; treating it with the strictest confidence; managing it securely; and when sharing doing so in full conformance with the Caldicott principles.

The following is a summary of the actions that CLCH has taken to improve its data quality during the 2020-2021:

- Developed a data quality plan and undertaken a wide range of data improvement tasks set out therein. The plan has built upon previous work seeking to add value and improve the accuracy of the Trust's reporting data. It has also sought to make more data available for scrutiny by relevant stakeholders and a greater emphasis on reconciliation. The plan has been overseen and delivered by members of the Trust's data forum that has both clinical and operational input.

- Delivered a trust information portal on *QlikView*, which provides activity and performance reporting refreshed on a daily basis, including contacts, referrals, ethnicity completeness and outcome timeliness. The accessibility of the portal has brought trust activity data to a much wider corporate and clinical audience for the first time.

- In collaboration with wider corporate teams, staff in IM and T have been engaged with data quality initiatives such as clinical template and counting rules standardisation, and anticipating the migration towards broader use of the Community Services Dataset with continuous improvement and closer monitoring of Trust submissions.

- Launched initiatives to increase the completeness of patient ethnicity recording, which resulted in an improvement from 70% to 84% between April and December. This has involved creating new reporting, amending systems templates and mapping, and engaging with staff in divisions and services to improve their recording practices.

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 2021-2022:

- 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 work collaboratively amongst all divisions, corporate services and stakeholders to consider data and reporting improvement initiatives, and uphold a high standard of data integrity throughout.

- 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 2021-2022 to improve data quality.

- Continue working on the tasks set out in the data quality plan and setting a new plan for the year ahead. These comprise a broad range of projects of varying sizes and complexities to improve the quality of data recorded and reported. In particular, a future focus will be on having a systematic approach to standardisation and adhering to emergent national data standards for community services.

- Working directly with services to expose data quality problems at source, highlighting their responsibilities and encouraging the improvement of their data collection and reporting.

- Continuing to oversee the rollout of the Self-Service Business Intelligence portal, and the migration of data quality monitoring into this accessible platform.

- Aligning with contemporary Trust strategies to enhance the value of data and extend its use for service improvement and much wider analysis.

LEARNING FROM DEATHS: 2020 – 2021

From April 2017, all Trusts have been required to collect and publish information on deaths and serious incidents, including evidence of learning and improvements being made as a result of that information. In October 2018, CLCH published a *Learning from Death* (LfD) policy based on NHS Improvement's *National Guidance on Learning from Deaths* and this policy was updated in January 2020. The policy is fully embedded for adults across CLCH services. All deaths within the Trust are reported via the incident reporting system - Datix. As part of the LfD process, named team leaders, within each team, triage each case to ascertain whether a case record review should be carried out using a modified PRISM 2 (preventable incidents, survival and mortality study 2) form. The case record reviews are completed by clinical directors from the relevant organizational divisions and discussed at the trust's resuscitation and mortality group which meets bi-monthly.

Due to the COVID-19 pandemic, the triage and case record review process described above were suspended from March 2020 to November 2020 to free up staff to coordinate and help the clinical effort. However, deaths continued to be monitored using the Datix, the divisional director of nursing and therapies and the clinical director from each division reviewed deaths, and any deaths which required further investigation and discussion were investigated through the trust's serious incident process.

CLCH is engaged in the multiagency statutory review of deaths of children and young people and, in 2020, in light of the changes introduced by *Working Together to Safeguard Children 2018* revised our internal processes to support learning and governance with the child death review process. As part of this process, the associate director of safeguarding and the trust's children's division present an overview of deaths of children and young people known to our services biannually at the resuscitation and mortality group meeting. This includes findings from the child death overview panels (CDOPs), themes and lessons learnt.

Internal processes relating to the overview of deaths of people with learning disabilities within the Trust were also revised in 2020 – 2021. All deaths of people with learning disabilities have been reported to the learning disabilities mortality review programme (LeDeR) since 2017. In addition to this, from March 2021, the learning disability teams started presenting an overview of deaths of people with biannual reports to the trust's resuscitation and mortality group meeting. This includes findings from the LeDeR reviews, themes and lessons learnt. the learning disability strategy was reviewed in December 2020 and emphasis is given to learning from deaths of people with Learning Disabilities e.g. a CLCH *Learning from LeDeR* event and a commitment to train all staff who are band 6 and above to carry out multi-agency reviews.

* Please note final figures are in some cases still awaited. These have been highlighted in yellow.

	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 2020 – Jan 2021, 2710 CLCH patients died as follows (includes expected hospice deaths) 970 in the first quarter 655 in the second quarter 713 in the third quarter 641 in the fourth quarter (Jan)
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 2020 to Jan 21 0 case record (PRISM) reviews and 5 investigations were carried out in relation to the 2710 of the deaths included in item 1 In 0 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: 1 in the first quarter; 2 in the second quarter; 6 in the third quarter; 6 in the fourth quarter
3	An estimate of the number of deaths during the reporting period included in item 2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.	0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: 0 in the first quarter 0 in the second quarter 0 in the third quarter 0 in the fourth quarter

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 relating to Learning from Death or the clinical management of the patient were noted. No evidence was found that the care provided contributed to any harm of the client. **Case 2:** 1. More clarity needed with regards to record keeping to document anatomical pressure areas checked, and if they were unable to check. 2. End of life care discussions needed to be considered earlier. 3. reassessment of ADLs (Activities of Daily Living) and pain assessments should be considered and carried out more frequently. 4. Routine observations performed at every new episode of care should include MUST and Walsall scores. **Case 3:** **1.** Better communication is needed with acute providers regarding when patients are admitted and discharged (acute provider did not communicate with CLCH community service that patient had been discharged from their unit so there was a delay in visiting the patient). **2.** Staff should adhere to the Trust's No Access policy if they are unable to contact patients for planned visits (patient was found deceased at home. An HCP who visited the patient's home the day before did not follow the Trust's No Access policy). **Case 4:** 1. Medication should be checked as part of the holistic assessment. 2. There needs to be a clearer understanding of all services available to assist with End of Life care for care home staff, including escalation processes 3. and relevant contact numbers.

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. Contd.	**Case 5:** 1. Handover between planned care and unplanned care teams needs to be more effective. 2. The Acute Trust did not discharge the patients into the community with the correct medication administration charts so there was a delay in the patient receiving medication. 3. Discussion between triage nurses of services needs to be more robust. 4. V300 prescribers should consider prescribing if it is within their scope of practice. 5. Follow up of patients after administering PRN (as needed) medications should be standard practice. **Case 6:** No action points relating to Learning from Death or the clinical management of the patient were noted. **Case 7:** No action points relating to Learning from Death were noted. Good practice included close collaboration by several CLCH and other NHS services to ensure that holistic care was provided. **Case 8:** No action points relating to Learning from Death or the clinical management of the patient were noted. **Case 9:** No action points relating to Learning from Death or the clinical management of the patient were noted. **Case 10:** No action points relating to Learning from Death or the clinical management of the patient were noted. **Case 11:** Patients who are expected to die within the next few days should be reviewed by a doctor as soon as practicable. If doctors are reviewing virtually, this needs to be via a video call to enable easier process of certification. **Case 12:**Outbreak on ward where patient contracted Covid-19 may have in part been due to a staff member who cross-covered a unit where there was a Covid-19 outbreak.

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. Contd.	**Case 13:** No action points relating to Learning from Death or the clinical management of the patient were noted. **Case 14:** No action points relating to Learning from Death or the clinical management of the patient were noted. **Case 15:** No action points relating to Learning from Death or the clinical management of the patient were noted.
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 1:** No actions taken. **Case 2:** • Learning described in section 4 discussed with the District Nursing Team during handovers. Learning regarding documentation discussed at team meeting and sent via email to staff who were asked to sign to confirm they understood. • Discussion with the patient's GP practice took place re: how the team and the GP could learn from the inadequate and late communication relating to End of Life Care. • Email sent to all staff detailing up-to-date GP phone numbers and email addresses. • Audit of routine observations performed at every new episode completed. **Case 3:** • The acute provider was alerted about the incident and their internal investigation was followed up. An agreement was put in place that CLCH will have access to ward level information. • An agreement was put in place with GP (via the GP Federation. regarding supporting CLCH community staff and mutual sharing of information. • All Community staff were updated about the No Access Policy. • GP by-pass numbers were shared with community teams. • A SOP was written for triaging of welfare checks and response times.

5.	A description of the actions etc. Contd.	**Case 4:** • Learning from section 4 was disseminated to staff in team meetings. • Training was provided via iLearn on the new medication chart which was recently implemented. • An email was sent to local care homes from the CCG with details of support available for management of patients at the end of life, including contact numbers for relevant support. • Training regarding recognition of dying patients was implemented. **Case 5:** • A meeting was held with locality team managers to reinforce roles, responsibilities and the importance of handover and communication. • A "deep dive" into End of Life Care incidents will be completed by the divisional director of nursing and therapies. • Training has been arranged for V300 prescribers on prescribing End of Life Care medication. • Triage processes and flowcharts for criteria in unplanned care was recirculated to triage clinicians in both planned care and unplanned care teams. **Cases 6 to 10:** No actions taken. **Case 11:** • Chair of Resuscitation & Mortality Group will cascade this information to Clinical Leads, Team Leaders and doctors working in bedded units via email. • This information will be shared with teams working in the bedded units in Team Meetings. **Case 12:**

		Case 12: • Root Cause Analysis completed by the Infection Prevention Team and shared with commissioners. • Staff to ensure a minimum of 48 hours break when working with Covid positive patient and avoid cross-covering during outbreaks. • Development of system wide service for staff to access regular PCR testing. • 7 minute learning plan disseminated to services for shared learning. **Case 13:** No actions taken. **Case 14:** No actions taken. **Case 15:** No actions taken.
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 as yet. Case 3: No impact as yet. Case 4: No impact as yet. Case 5: No impact as yet. Case 11: No impact as yet. Case 12: No impact assessed as yet. Cases 13-15 - NA

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 2019 -2020 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.
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 2019 – 2020 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 2020-21 there were 10,723 patient safety incidents reported within CLCH. Of these incidents 13 or 0.12% resulted in severe harm. For the previous year we reported that 11 incidents from 9397 resulted in severe harm which was also at 0.12%.

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 five pressure ulcers, four falls, two treatment problem and two delay/failure to diagnose

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.
- The assistant director 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:

- Refreshing the quality strategy which is monitored by the patient safety and risk group (PSRG) (monthly) and quality committee (quarterly).
- Adding a new measure of success to the quality strategy using the 7-minute learning tool for sharing the learning from incidents. These are presented by each clinical division at PSRG monthly and shared through the trust's publication *spotlight on quality.*
- Encouraging incident reporting at all available opportunities including presentations at induction for which the assistant director of patient safety has recorded videos.
- Developing and sharing *how to* guides so that staff are helped to report incidents.
- 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.
- Continuing with patient safety processes throughout the year.
- Establishing a ward matron's network.
- Reviewing podiatry incidents monthly across the organisation for thematic review and shared learning.
- Implementing a programme of harm free care networks to share learning from incidents.
- Improving the weekly pressure ulcer review meeting, using technology and updating the preliminary investigation checklist to receive the necessary assurance.

PART 3: OTHER INFORMATION
QUALITY PERFORMANCE AND PROGRESS AGAINST OUR QUALITY PRIORITIES 2020-2021

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.

TRUST WIDE PERFORMANCE SCORECARD

QUALITY CAMPAIGN	KEY PERFORMANCE INDICATOR	TARGET	PERFORMANCE	
			Previous year 2019-2020	2020-2021
A Positive Patient Experience Changing behaviours and care to enhance the experience of our patients and service users	Proportion of patients who felt staff took time to find out about them	95.0 %	95%	97.7 %
	Proportion of patients who were treated with respect and dignity	95.0 %	95.00%	98.8 %
	Friends and family test - Percentage of Staff recommending CLCH as a place for Treatment	75.0 %	95.00	NA*
	Patient Friends and family test - Proportion of Patients rating their overall experience as very good or good	92.0 %	94.10%	96.9 %
	Proportion of patients' concerns (PALS) responded to within 5 working days	95.0 %	98.20%	100.0 %
	Proportion of complaints responded to within 25 days	100.0 %	100%	100.0 %
	Proportion of complaints responded to within agreed deadline	100.0 %	100%	100.0 %
	Proportion of complaints acknowledged within 3 working days	100.0 %	100%	100.0 %

*Due to the pandemic trusts were asked to suspend the FFT.

QUALITY CAMPAIGN	KEY PERFORMANCE INDICATOR	TARGET	PREVIOUS YEAR	2020-2021
Preventing Harm Incidents and Risk	Proportion of clinical incidents that did not cause harm (moderate to catastrophic categories)	97.0 %	98.50	99.2 %
	Zero tolerance to falls in bedded units with harm (moderate or above)	0	7	9
	Zero tolerance of new (CLCH acquired) category 3 and 4 pressure ulcers in bedded units	0	1	4
	Zero tolerance of new (CLCH acquired) category 2 pressure ulcers in bedded units	0	44	43
Smart, Effective Care	Percentage of deaths in community hospitals (expected and unexpected) compared to all discharges (excluding palliative and end of life care)	3.8 %	0.1	0.25 %
	Percentage of Central Alerting System (CAS) alerts including Patient Safety Alerts (PSAs) due, and responded to, within deadline	90.0 %	100.00%	94.6 %
	Percentage of hand hygiene episodes observed across CLCH bedded areas that are compliant with policy	97.0 %	98.00%	100.0 %
	Percentage of staff trained at Making Every Contact Count level one. Non – Clinical	95%	NA New	95.7 %
	Percentage of staff trained at Making Every Contact Count level two. Clinical	95%	NA New	92.9 %
Modelling the Way	Statutory and Mandatory training - Non-Clinical*	95 %	NA*	96.2 %
	Statutory and Mandatory training – Clinical*	95 %	NA *	94.1 %

QUALITY CAMPAIGN	KEY PERFORMANCE INDICATOR	TARGET	PREVIOUS YEAR	2020-2021
Workforce **	Staff Turnover rate – 12 month rolling (Clinical)		14.7%	12.9 %
	Sickness absence rate - 12 month rolling (Clinical)		4.4%	5.5 %
	Percentage of staff who have an appraisal		84.6%	78.9 %
	Staff Vacancy rate (Clinical)		13.3%	13.9 %

* The performance figure for statutory mandatory training was not previously split between clinical and non-clinical. The total figure for all staff for the previous year was 94.4%

** Workforce is not one of the quality priorities as described in the Trust quality strategy but information has been included here for completeness

PROGRESS AGAINST OUR QUALITY PRIORITIES

CAMPAIGN ONE: A POSITIVE PATIENT EXPERIENCE

KEY PRIORITY / OUTCOME	MEASURES OF SUCCESS APRIL 2020-NOV 2021	UPDATE
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%	This KPI has been achieved throughout 2020/21. The year-end position is 98.8%. The Trust Privacy, Dignity and Respect Policy has been updated and approved by the Patient Experience Group. This now includes an audit tool for staff to use to support areas of good practice.
	We will maintain the proportion of patients reporting their overall experience as very good or good at 95%	This KPI has been achieved throughout 2020/21. The year-end position is 96.9%.
	The proportion of patients who felt staff took time to find out about them will be 95%	This KPI has been achieved throughout 2020/21. The year-end position is 97.7%.
	We will develop a policy and process to ensure patient/user/ carer are involved in every service change.	The assistant director of patient experience and the Director of Transformation have developed a policy to ensure that every service change in the Trust captures the patient or carer's voice. The policy was agreed at the Patient Experience Group and an implementation plan is underway. Key programmes of work which involve user engagement and patient feedback include: • Reimagining Health Visiting • Patient Access and Digital First Workstream • Tackling Inequalities Workstream. The Patient Access Campaign will be showcased with a patient story at the Equality Conference on 10th May 2021.

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%	Nationally it was agreed that, due to the pressures of COVID, the Q4 staff FFT would not be collected, therefore the Q3 result (66.2%) is the last result of 2020/21. The collection will restart in Q1 of 2021/22. Actions to reach our target include: • Monthly Schwartz Rounds have continued focussing on 'Caring through COVID'. • The Spotlight on Quality has maintained its monthly editions highlighting best practice and exemplar teams. • The Patient Experience Team continues to collect divisional staff and patient stories focused on caring through COVID.
	We will enhance the number of volunteers for the Trust and embed volunteers as part of the service	This has been achieved. As part of our COVID emergency response, we doubled the number of volunteers on our database, to over 600. During Q4, the Trust maintained all our COVID volunteer support projects including the seasonal cheer volunteer role and boosted the befriending service. New volunteering projects in Q4 included: • Supporting of the staff vaccination hubs. • PPE stock takers • Phlebotomy support volunteers. We have started to reintroduce many of the pre-COVID volunteer roles including on the bedded units.
	We will complete an annual volunteer survey to understand their impact on services and their experience	This has been completed and an evaluation of the service was undertaken by our emergency response volunteers. The findings were presented at the November Patient Experience Group. This led to the launch of a Wellbeing Support Network for volunteers which has received £15k from NHSE. The next annual survey will take place in October 2021.

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	100% compliance was maintained throughout 2020/21.
	We will continue to respond to 100% of complaints within 25 days	100% compliance was maintained throughout 2020/21.
	We will continue to respond to 100% of complex complaints within the agreed deadline	100% compliance was maintained throughout 2020/21.
	We will continue to acknowledge 100% of complaints within 3 working days	100% compliance was maintained throughout 2020/21.
The patient and the public voice are 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	The patient experience team continue to promote the Always Events change methodology at divisional board meetings whilst being mindful of the service pressures relating to COVID-19. The Always Events have continued across both CHD Special Schools and NW EOL care. The Assistant Director of Patient Experience presented our Always Events work at the NHSE conference in January. NHSE is relaunching the initiative nationwide as Trusts restore and recover services in 2021/22.
	We will continue to deliver borough based quarterly co-design initiatives using patient and staff feedback/ stories	To prevent pressure on clinical services during the pandemic, a joint Trust wide project was initiated in Q4. The project aimed to increase public information and awareness around our services and COVID-19 vaccine information. It has expanded into a broader FAQ page on the Trust website to improve patient experience and a PALS 'myth buster' page on the Hub for staff.

CAMPAIGN TWO: PREVENTING HARM

KEY PRIORITY / OUTCOME	MEASURES OF SUCCESS APRIL 2020-NOV 2021	OUTCOME
Robust, effective systems and processes in place to deliver harm free care all the time	97% of clinical incidents will not cause harm	This has been achieved in every month of Q4 and the year-end figure is at 99.2%.
	100% of patients in bedded units will not have a fall with harm (moderate or above)	Nine falls with harm were reported in 2021/22
	100% of patients in bedded units will not have a NEW (CLCH acquired) category 2-4 pressure ulcer	As discussed in sections 3.6 and 3.7, 47 category 2-4 pressure ulcers were reported in 2020/21.
	100% of all Serious Incident investigations will be completed on time in accordance with national guidance	During Q4, 26 Serious Incident Root Cause Analysis (RCA) investigations were due to be completed. All investigations (26) are complete and have been presented at SI panel and are either finally approved (1) or pending final update and approval post SI panel (3). One of these is an IG breach and not patient safety related. During 2020/21, 101 RCA reports were completed, four of which are pending final approval. Two are clinical in nature, have been to two SI panels and are pending final amendment. Two are IG related and have also been to SI panels.

	100% of all Serious Incident actions will be completed on time in accordance with locally agreed timescales	187 individual incident actions were due in Q4 (according to the actions module on Datix) which is an increase from 155 due in Q3. 61 remain open (pertaining to 21 different incidents) and where appropriate, action plan closure meetings are scheduled. There has been a focused effort through PSRG to ensure greater local ownership of closure within agreed deadline dates and a revised template for the clinical divisions reporting action completion status has been in place for six months to ensure appropriate oversight by the group, however it has been challenging during the last few months during the COVID pandemic second wave. During 2020/21, 515 incident actions were logged onto Datix for completion, 451 of which have been completed and just 12% remain open
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	This survey will enable us to review the safety culture of the organisation. The Assistant Director of Patient Safety and Deputy Chief Nurse (Director of Quality and Safety) continue to meet with one of the Trust's Improvement Facilitators who has a background in and experience of using safety culture measurement tools. The proposal is being finalised and is likely to roll out in late summer 2021.
	Each division will share a single serious incident learning example using the 7-minute learning tool through divisional board and patient safety risk group	Thirteen 7-minute learning briefings were shared at PSRG in Q4. Table 11 shows the cases which were presented during Q4. 49 7-minute learning briefing documents were shared via PSRG during 2020/21.
	80% of teams will have undertaken a core standards annual health check assessment	Due to the ongoing pandemic and redeployment of some teams we have not been able to progress rollout of the core standards in Q4. However, as services are now being stood back up the plan is to roll this out in across 2021/22 division by division.

	100% compliance with the timely closure of actions from risks on the register	64 individual risk actions were due in Q4 of which 13 remain open pertaining to 11 risks. Of the individual actions open, 3 pertain to a risk categorised as 'clinical'. There has been a focused piece of work through PSRG to review all risks that are older than 5 years to ensure the risk register remains live and the actions remain relevant. There are now just 3 non-BAF risks which remain open having been opened 2013-2016. Overdue risks and overdue actions are flagged at the PSRG monthly and communicated weekly. During 2020/21 310 risk actions were logged onto Datix for completion, 258 of which have been completed and just 17% remain open.

CAMPAIGN THREE: SMART EFFECTIVE CARE

KEY PRIORITY / OUTCOME	MEASURES OF SUCCESS APRIL 2020 to NOV 2021	UPDATE
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	At year end level two clinical MECC training was just below the target of 95% at 92.9% and non-clinical exceeded target at 95.7%. See section 4.4.
	We will launch MECC link across the Trust.	We completed this task in 2019 when the Medical Director and Chief Nurse, launched and circulated the MECC link. (https://www.mecclink.co.uk) 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%	COVID-19 impacted on the total number of patients recruited into research studies during the 2020/21, which stood at 167 participants on 31 October 2020. The studies below are currently open to recruitment in the Trust: • CLCH COVID-19 Rehabilitation study • CLIMB - people's views on how health data should be shared and used. • Geko – venous leg ulcers • EMBARC - centres in Europe actively managing patients with bronchiectasis • Rehabilitation and recovery following COVID-19 • Helix Centre–Improving neurorehabilitation for stroke survivors • Survey of Practitioners' Education and Attitudes regarding Continence Care • Psychological impact of COVID-19-pandemic and experience: An international survey

	100% of services/ individuals undertaking a clinical audit/service evaluation/QI project will submit a clinical improvement poster to the Clinical Effectiveness Team	Clinical effectiveness work was paused in mid-March 2020 at the start of the pandemic and again in January 2021. We focussed on embedding the new Trust Clinical Audit Management Tool AMaT) into our systems and processes and developing step-by-step user guides during Q1 and Q2. We trained some staff in how to use the system and plan to hold more training sessions in the coming year. In November, the CEG agreed that the Clinical Effectiveness Team could support services in setting up and undertaking clinical audits, including: **Trust-wide audits:** Safeguarding and Pressure Ulcer audit postponed to Q1 2021-22 **CQC-mandated audits:** • Clinical Record Keeping (Quality of the record and assessment) – Children's division • FP10 Prescription Self-Assessment Audit – Medicines Management • Clinical Supervision Audit, CLCH Academy **Local audits:** • Reducing unnecessary hospital admissions for adults with feeding tubes under the care of CLCH dietetics, Nutrition and Dietetics, South West Division **National Clinical Audits:** • National Audit of Inpatient Falls • National Audit of Cardiac Rehabilitation (NACR) • National Asthma and COPD Audit Programme (NACAP) Pulmonary Rehabilitation Audit

CAMPAIGN FOUR: MODELLING THE WAY

KEY PRIORITY / OUTCOME	MEASURES OF SUCCESS APRIL 2020-NOV 2021	UPDATE
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	Mentors and mentees will evaluate the programme in Q1 of 2021/22. Their feedback will shape the future programmes and training. Cohort Two lasts from October 2020 until March 2021. Thirteen staff have started in Cohort Three as of April 2021. The Academy are creating a support network for reverse mentors. We aim to have that in place by the end of Q1.
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%	The Trust continues to work to achieve the 95% compliance target which was narrowly missed at year end. Corrective actions are outlined in section 5.5.
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	The Academy continues to work with divisions to ensure staff are supported with their training and development as identified in the learning needs analysis. A number of study days are now being delivered via MS teams and the feedback from these has been very positive. The recent breast-feeding study day was very well received: "*Thank you so much for this training. I have attended previously face to face training, but MT training was very good, up to high standard".* Practice Development Nurses and the new AHP Practice Development Team are continuing to support staff clinically. The AHP practice development staff have been welcomed by the AHP workforce.

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	The Clinical staffing panel continues to take place monthly to review all proposed establishment changes prior to QIA.
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	Safe staffing models have been updated and approved through QIA. These include apprentice nursing associate (ANA) and nursing associate (NA) role. Divisions are reviewing their existing workforce using this model to support the continued implementation of the NA role. All the ANAs who qualified this year have been offered posts. Recruitment has been postponed until May/June by universities due to the pandemic.
	We will develop safe staffing models for the AHP workforce and review opportunities for new AHP roles supporting new models of care	A new AHP safe staffing model/set of principles has been developed and discussed at panel. Including how to create AHP establishments for the bedded areas. The proposal has also been discussed with the QIA panel who escalated it to the Executive Leadership Team. This work has been paused during the pandemic and will restart in Q1 2021/22. To support AHP's in practice, we have recruited into AHP Practice Development posts and a new podiatry development post. Hertfordshire Division are exploring the introduction of this role.

SHARED GOVERNANCE PROJECTS

DIVISION	QUALITY CAMPAIGN	PROJECT	NUMBER OF STAFF INVOLVED	PROJECT UPDATE ACROSS THE YEAR
North Central Division	Modelling the Way	Improving training and development opportunities for administrative staff in the North Central Division,	8	Qualitative data was collected by the QC in Q1 regarding barriers to training. These included choice and access to training, and support to attend. Four council members were able to use the support given in this QC to apply for apprenticeships. The learning from the QC is being taken forward with the remain council members into the Trust wide Admin QC.
	Modelling the Way	Recovery Quality Council in the North Central Division following COVID-19 and redeployment.	7	Information was collected regarding the gaps in support during redeployment in the first lockdown in April. This was shared with the Academy, allowing better support in subsequent redeployments.
	Preventing Harm	Reducing the risk of patients falling in the Bedded Unit at FMH.	5	The QC brainstormed the possible reasons, from a frontline perspective, for patients falling on the ward. The council decided to focus firstly on the quality of information they receive before patients' admissions. Data was collected in Q3 and Q4 regarding all information on transfer to the ward. This will be analysed in Q1 and ideas to take forward identified.
	Smart effective care	Improve the quality of referrals in Barnet received in planned care to improve patient care within the next 6 – 12 months.	5	In Q1 and Q2 the changes to the referral form were finalised and shared with senior staff for approval. Council staff were redeployed during the pandemic, but this will restart in Q1.

North West Division	Positive patient experience	Investigating DNA rates of initial assessment appointments within the Specialist Dental Service	6	The council's project has been on hold due to COVID-19 and staff capacity to restart the project will be reviewed in Q1.
	Smart effective care	Introduce and implement internal tasking between administrative staff and clinical teams on System One (S1).	8	Over the past year the aim of the project has become focussed on the use of S1 tasks in the District Nursing team. Process mapping was started in Q3 regarding tasks to District Nurses, to identify gaps in knowledge and the stakeholders involved in S1 tasking. This was paused in Q4 due to the pandemic but will be restarted in Q1.
	Modelling the Way	Standardising the information regarding placements of students in Harrow.	7	The QC started to update and standardise the student booklet used in Harrow in Q2. This was paused due to the pandemic but will be reviewed in Q1.
	Modelling the way	Improving the communications of the new and safer way of working.	4	Questions agreed for survey regarding the best way to communicate to front line staff. Further staff to be recruited in Q1 to take the results of the survey forward.
	Preventing harm	Improve the communication between Podiatrists and DNs and prevent circulation issues.	12	In Q3 we held a virtual meet and greet between TVNs, DNs and Podiatrists. The feedback was positive and that it was an informal but efficient way for staff from different services and locations to meet and exchange contact details. In Q1 ideas to make improvements in communication will be continued.

South West Division	Positive Patient Experience	Improving communication through information folders for patients in the Community in Merton.	4	This council had funding identified this year which was used to order the folders. The folders will be distributed in Q1. Feedback from patients and carers will be collected by the patient experience facilitator.
	Modelling the way	Increasing the uptake of staff having the Flu Vaccine in the SW Division	7	In Q2 the council were identifying the barriers to staff in accessing and receiving the flu vaccine. We promoted ways of supporting staff who were unsure of their choice. They were given the option to vaccinate and link with local pharmacies during Q3. In Q1 the learning from this will be collected and used during the next flu vaccine season.
	Modelling the way	Improving staff morale, engagement and communication in SWD.	6	Presently recruiting staff to take forward this new project in Q1

	Smart Effective Care	To investigate reasons for non-attendance of Health Reviews in the inner divisions of the Children Service.	5	Data has been collected across the year through telephone feedback from parents/carers whose children have not had a Health review. This will be analysed in Q1.
	Positive Patient experience	Improving support given to the parents and carers during waiting times of their children behavioural therapy appointments.	5	Parent survey results have been analysed and summarised. A pre-assessment leaflet has been developed from this and shared with the Parent Forum leaders for feedback. Outcomes and feedback from these changes will be reviewed from Q1 onwards.
	Preventing Harm	Improving the communication of safeguarding information between Social Care Services, Health Visitors and School Nurses	4	Feedback from Social Care and the 0 to 19 Team in Hammersmith and Fulham has been collected about the information given on the HV and SN role and the Duty process used through the project. This will be shared across the CHD and the learning from this project will be taken forward to start a SN Duty QC in Q1.
Children Division	Smart effective care	Improve the uptake of 6-8-week maternal mood contacts with the Health Visiting Service in Barnet.	5	In Q3 the QC tested ideas on the process of booking the 6-to-8-week appointment. The HV has now been booking with the mother at the new birth visit to make sure the time is suitable and ensuring mothers understood the reason for the appointment. In Q4 the change ideas were continued and the impact of this was measured using attendance data.
	Modelling the Way	Improving the local induction process	5	Started in Q3, the QC prepared and distributed a survey to identify the issues staff encounter when they start work in the Trust and also how valued they feel. The QC are identifying local induction checklists in use to update. They are sharing their ideas with HR and will continue with this and gathering more information to support new starters in Q1
	Modelling the Way	Improving staff morale in the Brocklebank, Bridge Lane and Roehampton Team in Wandsworth	6	The QC have started to collect data regarding the reasons for low morale and in Q1 will start testing ideas to improve morale in line with joy at work.

	Positive Patient Experience	Improve the communication and uptake of e-red book between CLCH and the Families in Ealing.	5	In Q3 the QC drafted a guide on how to register an E-Redbook. This included an automated email with a pictorial explanation. The work was paused in Q4 and will restart in Q1.
	Smart effective care	Improving the duty HV support offer in Barnet. (New)	6	We are recruiting staff to start analysing the process already in place for duty, this will continue into Q4.
	Preventing harm	Improve accessibility of safeguarding resources for HV staff and evaluate the content and change as needed (new)	7	Ideas have been collected in Q3 to ensure HV staff have time to review CHD Safeguarding Manual and easier to access quickly when required. The ideas will start to be tested in Q4.
	Smart effective Care	Improving Clinical Digital recording.	6	A small survey was carried out across the 0 to 19 service collecting data on staff confidence and understanding of the NBV template. This is on hold due to redeployment. In Q1 it will be restarted with the results analysed and shared with Clinical Systems who are supporting the project.
Children's Division	Preventing harm	Improve the learning from serious case reviews from single borough to the entire of health visiting service.	7	The QC started in Q4 and are presently carrying out a process map to visualise the gaps and possibilities of sharing the learning of serious case reviews in an alternative way reaching more staff members.
	Positive Patient Experience	Use data to compare areas of deprivation with breastfeeding rates and see if we can give targeted support to improve rates of breastfeeding	4	The project team are forming and gathering information from Public Health England about the breastfeeding rates. Project will be taken forward in Q1.

Hertfordshire	Positive patient experience	To increase the number of walking aids returned in Watford.	6	The QC carried out and costed the process of cleaning equipment in Q3. In Q4 the project was paused due to the pandemic. In Q1 they will review the project aim with regards to continuing or writing up the learning from this project.
	Positive patient experience	Reducing PALs complaints in Planned Care in Herts	7	A carer has been integral to this project which started in Q4. They have supported the QC to map gaps in communication and possible issues. Data collection on the completion of the initial full assessment template and the use of the S1 deferred patient template will be taken forward in Q1.
	Positive patient experience	Increase the number of virtual consultations in Hertfordshire Planned Community Therapy Teams.	6	This is a new project started in Q4 supporting patients with their therapy needs through virtual consultation. Starting with staff confidence using blue jeans, and questions used on the triage template to ascertain the patients' access to and support available at home with a video consultation.
Trust wide	Modelling the Way	Improving development opportunities and raise morale in the finance department.	8	Change ideas have been identified including shadowing other members of staff and improving the appraisal process. A survey has been written and disseminated across the directorate and the outcomes from this will be reviewed in Q1.
	Modelling the Way	Improving the communication of health and wellbeing (HWB) support at work.	6	The results of the HWB survey were analysed in Q3 and themes of the results will be used in focus groups incorporating a shared governance approach in Q1.
	Modelling the way	Supporting research across the Trust.	6	This is a new QC supported by a research sub-group to expand research in the Trust. It was paused in Q4 but will restart in Q1 when they will collect feedback from staff on ideas and barriers that prevents access to research opportunities.

Trust Wide	Modelling the Way	Tackling bullying and harassment in the workplace by staff	10	IN Q3 the Quality Council collected staff stories and carried out a small scale survey. An animation was scripted and produced from this evidence. It demonstrated an eye catching and thought provoking way of how unacceptable behaviour affects staff. In Q1 the QC will continue and will be feeing their ideas into the Bullying and Harassment Steering group to be taken forward.
	Positive patient experience	Patient reception rapport project.	6	This QC led by patient representatives was paused over the year due to the pandemic and now will restart in Q1 and review their aim and objectives in line with the new way of working in clinic reception area.
	Preventing harm	Preventing verbal and physical abuse against staff whilst agile working.	6	The QC will restart in Q1, by analysing the themes in the incidences of verbal and physical abuse reported through Datix in last year.
	Positive patient experience	Improving the uptake and quality of feedback from service users who require assistance with communication.	5	Feedback has been collected using the new digital one question feedback survey. The data will be analysed in Q4 to see if there has been an increase in the amount and quality of feedback over the past 6 months.
	Positive patient experience	Improving Feedback Friday	5	The QC is on hold until Q1. It will then start analysing ways of improving fair coverage of the Trust through monthly visits by the Senior Management team, and how to record these visits.
	Modelling the Way	Improving opportunities for career development of Administrators	15	This new QC met once in Q4 and have split into two groups. One council arranging a regular forum for admin staff and the other looking specifically at the support and possible barriers to training and career opportunities.
	Preventing Harm	Ensuring Infection Control and prevention guidelines are followed across the Trust.	8	A new improvement idea to support staff who are struggling to follow the ICP guidance across the Trust. We are recruiting to gather ideas of how to ensure all staff are safe and follow the guidelines into Q1.

TRUST QUALITY PROJECTS AND INITIATIVES

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

Covid 19: As with all NHS organizations we were involved in the national effort to ensure that people who became ill with Covid were treated appropriately. We provided guidance and resources for all our services and kept this updated throughout the course of the pandemic. At the height of the pandemic we held up to two daily meetings of our own gold command team as well as being part of daily and weekly calls across the wider STP areas.

At the start of the pandemic we opened a successful drive through swabbing facility at Parsons Green making CLC the first to do so in the community. This was reported on by the BBC and also a number of national newspapers.

Due to the pandemic the Trust was also innovative in creating new ways of working and descriptions of a number of these are included in projects below.

The Academy: The Academy supports learning and development for both Trust and primary care nursing staff (both registered and unregistered). In October 2020 it moved into its new base in Soho Centre for Health which offers a number of dedicated training rooms and a clinical skills laboratory. The Academy provides excellent opportunities 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 the 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. It 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.

Big Diversity Conversation: Both the Inner speech, language and therapy CBU and Merton children's' services CBU held a *big diversity conversation* this year. The purpose was to explore knowledge and understanding of equality, diversity and inclusiveness across the whole team. In particular the SLT *big diversity conversation* was to explore the meaning of culture and how this impacts communication. The team recognised that it was important to discuss this in the context of speech and language therapy because language is seen as the transmission of culture. The conversation highlighted language barriers faced by some service users when trying to access the service. This included the lack of understanding and knowledge of developmental norms in other languages, and lack of insight into the severity of communication difficulties. The particular focus of the Merton *big diversity conversation* was to explore inclusivity and compassionate leadership, throughout all teams.

Breastfeeding: Despite the impact of delivering services in new ways due to the Covid 19 pandemic the divisional plans for achieving this objective continued through the year and all health visiting services will have a plan for breastfeeding assessment at level 1-3. Universal videos have been developed that address introduction to solids and safe sleep. These tools aim to provide additional support and advice to all families. The Unicef Gold standard was awarded to the health visiting service inner public health CBU in 2019 and reassessment is every two years, to ensure high quality services are maintained and are sustainable. The first reassessment took place in February 2021 and was successful.

CLChampions: to recognise the incredible work that happened across CLCH during the pandemic the trust set up *CLChampions.* This campaign was designed to recognise the work that happened across the Trust in response to Covid – 19. The following provides some examples of the work of the CLChampions although there were many other instances: the PPE delivery drivers who moved tens of thousands of PPE items across the Trust: the rehabilitation nurses from Alexandra and Athlone who lead a new team of redeployed staff at the Pembridge Unit: the dental services team which, as all high street practices were closed, was asked by NHS England to provide access to patients seeking emergency treatment and Herts division working closely with West Herts hospital trust (WHHT) as well as Herts county adult care services integrated discharge team to set up a single point of access team to support the discharge of medically optimised patients. The team was based at Watford general hospital and was operational 7 days a week between 8am and 8pm.

Ealing early start CBU – response to Covid: Due to the pandemic, Ealing school nurses started working differently. As schools were either limiting visitors or were closed the service adapted from face to face sessions to providing virtual training sessions to school staff. Training included how to give emergency medication when a child / young person has an anaphylactic reaction, an asthma attack or a seizure in school. The virtual sessions increased uptake by school staff as there was no need to travel to the host school for this. This had a positive impact on providing support for children and it maintained good working relationships with education staff.

Enhanced discharge to access: The South West division in collaboration with St George's acute hospital Trust, led on 'Enhanced discharge to access' (ED2A) pathways. These pathways enable those patients deemed clinically stable by a hospital consultant to be transferred to the community earlier than they would otherwise be. There are 3 pathways with standard operating procedures which have been agreed.

The pathways relate to patients requiring diabetes management following treatment for Covid-19 infection, those patients requiring 'weaning' from oxygen therapy following Covid-19 infection and those patients with heart failure who may require diuretic medication.

Homeless health: Our homeless health service deals with the highest population of rough sleepers of any local authority in the UK. In response to the need for support that homeless people have, Rosa Ungpakorn, a CLCH advanced nurse practitioner, created Westminster Street Nurse. This was an outreach initiative that sees nurse practitioners seeking out people that live on the streets of Westminster and proactively offer them health care. This work earned Rosa the RCNi Advanced Practitioner Award 2020. Following the onset of Covid and the funding of emergency accommodation a lot of the Trust's patients were moved to hotels. The team were able to move in quickly to support the hotels and developed procedures that allowed a lot of care guidance to be provided by telephone. Face to face work, such as applying dressings, also continued.

Housebound vaccinations: Working in collaboration with all Primary Care Networks across Barnet, the Trust CLCH delivered over 16200 first covid vaccinations to housebound residents. Starting in January 2021 the division had 27 vaccinators who worked for 7 days a week visiting all the housebound referrals. The patients expressed their gratitude at receiving their vaccine and the uptake was over 60%.

One Care Home team: During the pandemic the one care home team worked hard to support the care homes in Barnet. From December 2020 through to March 2021 the team, working in partnership with Public Health England supported 59 care homes through Covid outbreaks. Furthermore the community matrons supported the care homes with: infection prevention and control training; swabbing; covid-19 vaccinations; acute covid-19 reviews and advanced care planning.

Quality Development Units (QDU): Despite the pandemic, the QDU accreditation process continued throughout 2020 with another 3 teams successfully gaining accreditation and Harrow Podiatry reapplying and being re-accredited. As described in our quality strategy, teams and services that have been awarded QDU accreditation status are held up as centres of excellence and receive a team award of £1000 as well as lapel badges for team members. Additionally QDU accredited teams are expected to trial new ways of working, offer advice to other teams who are struggling and to play a prominent role in our quality councils. We now have 11 teams who have been accredited with QDU status and another 9 teams on their journey to accreditation

Shared Governance: Our shared governance approach uses quality councils which are a dynamic staff-leader partnership that promotes collaboration, shared decision-making and accountability for improving quality of care, safety and enhancing work life. Each council focuses on one project that aligned with one of the quality campaigns in the quality strategy, with the aim of making an improvement. The councils also act as a two-way resource for frontline staff and managers and give informed advice on issues. Over the three years of the Trust's shared governance programme, we have seen our quality councils grow from strength to strength. We achieved the outcome set out in our earlier (2017-2020) Quality Strategy of having six quality councils per division based on the six quality campaigns and by December 2020, we had 32 quality councils in place that involved over 200 members of staff. The shared governance approach continued during a time of change due to the pandemic and the majority of the quality councils continued throughout the year. The shared governance model has been embedded within larger projects including, new and safer ways of working across; re-imaging health visiting and improving clinical systems.

Virtual consultations: Due to the pandemic staff across the Trust embraced developments in virtual consultations. Examples of this include the multi-disciplinary management of tissue viability; using the *ISLA* visual and virtual platform and the use of virtual technology to bring specialist hospital respiratory consultants into a patient's home, whilst an actual visit from the community specialist nursing teams takes place.

Virtual swallowing assessments for patients: As the pandemic limited services' ability to care for and assess patients, the Barnet Adult speech and language team (SLT) introduced virtual swallowing assessments for patients. These assessments had previously been face-to-face in various settings, including in care homes, so there was a need to work remotely. To do this the team adopted a virtual first approach which included an initial telephone support and advice session followed by a video consultation via BlueJeans to carry out a swallow assessment and intervention.

This change was implemented quickly and completely transformed the service from one which offered

no virtual assessment or care to now providing approximately 75-80% of assessments via BlueJeans. This ensured that our service users who were unable to been seen by us have continued to be offered patient-centred care. This innovative practice has enabled us to support keeping patients out of the hospitals.

Volunteering through Covid- 19: There was an extraordinary response to the pandemic by our incredible volunteers. Over the last 12 months the Trust doubled its number of volunteers who worked in various roles including in PPE; the Academy, befriending and other pivotal support roles.
As our volunteer numbers increased, and in recognition of their continued and invaluable support, the Trust looked at the support it provides and how this could be increased.

Following the successful application for a grant from NHS England to facilitate a volunteer wellbeing project, we now have a named individual, employed by CLCH, to focus on volunteer wellbeing through the following actions:

- Regular wellbeing checks with individual volunteers
- Monthly wellbeing sessions/ workshops.
- Monthly wellbeing newsletter's providing tips and guidance around self-care.

Due to the success of the wellbeing project to date, the Trust will look to continue the work, throughout the pandemic recovery response and into the future.

Walkercise: The pandemic provided a unique opportunity for the Merton, Wandsworth and Hammersmith and Fulham family nurse partnership team to pilot and implement the use of walking and exercise visits; remote video meeting technology and telephone appointments to be able to meet the needs of more vulnerable clients. The team also developed *Walkercise* so instead of home visiting, family nurses would meet the client and child outside their home. The *walkercise* visit provided clients with a safe, private space to explore feelings and discuss their concerns with their named family nurse. At the same time, the walkercise gave the family nurse time to observe the child(ren) and review their growth and development

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 2020-2021 Quality Account. We have considered the comments received and where appropriate the comments were responded to.

NB: The draft quality account will be sent to the commissioners on or before the 30th April 2021 and their comments will be incorporated below.

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 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 2020 to March 2021
- papers relating to quality reported to the board over the period April 2020 to March 2021
- feedback from commissioners
- feedback from local Healthwatch organisations
- 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

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
billy.hatifani@nhs.net

Alternatively you can send a letter to:
Billy Hatifani
Deputy Chief Nurse (Director of Quality and Safety)
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

HEALTHCARE ORGANISATIONS

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

NHS Choices
www.nhs.uk

LOCAL HEALTHWATCHES

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

Brent Healthwatch
SEIDs Hub, Empire Way
Wembley HA9 0RJ
Tel: 0208 102 9174
www.healthwatchbrent.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
www.healthwatchhertfordshire.co.uk/

Hounslow Healthwatch
45 St Mary's Road
Ealing
W5 5RG
Tel: 0203 603 2438
https://www.healthwatchhounslow.co.uk/

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
https://www.healthwatchrichmond.co.uk/

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

LOCAL CLINICAL COMMISSIONING GROUPS

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

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

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

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

Brent
Tel: 020 8937 1234
www.brent.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

Hounslow
Tel: 0208 583 2000
www.hounslow.gov.uk

Richmond
020 8891 1411
www.richmond.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

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.

CBU: Clinical business unit.

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.

PPE: Personal protective equipment.

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.

ANNUAL COMPLAINTS REPORT

The annual complaints report will be attached here.