CLCH QUALITY ACCOUNT 2021 – 22

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 2022. This has been another challenging year due to the ongoing Covid -19 pandemic. I'm however proud to note that our staff and services have successfully responded to ongoing pressures and have continued to deliver safe & effective care to the communities we serve.

During the year we have successfully maintained a strong performance against the quality key performance indicators (KPIs) despite the impact of the pandemic. We have continued to report excellent feedback from our positive patient experience campaign, with nearly 100% of patients reporting through our experience surveys that they were treated with respect and dignity. We have embedded our Equality Strategy and have reported improvements in the recording of ethnicity in our clinical records and hosted a national meeting in November 2021 attended by staff from NHS organisations from across the country, where we shared examples of our good practice.

We are extremely proud that our teams have continued to excel with some being recognised in national award schemes. The Academy was shortlisted for three awards at the Student Nursing Times Awards and the Merton Tissue Viability Team won the Community Nursing Placement of the Year. Five of our staff received The Queen's Nurse award from the Queen's Nursing Institute (QNI). The award is given to community nurses who provide exceptional care to their patients and demonstrate a continuing passion and enthusiasm for nursing. It is a very special acknowledgement of the commitment made and work undertaken to ensure the very best provision of care is achieved for our communities and patients.

In 2021 we also successfully welcomed our new Brent services into the newly formed Outer Northwest Division and worked through the pandemic to ensure systems were in place to enable the delivery of good quality and safe community services to the population of Brent.

Finally, my sincere thanks to all our staff for their continued commitment and compassion in successfully delivering high quality care over this 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.

James Benson – Interim Chief Executive Officer

STATEMENT OF THE CHAIR OF THE QUALITY COMMITTEE

We are in the second year of delivering our refreshed quality strategy '*Improving Quality in Everything We Do'.* The Quality Committee has continued to meet quarterly throughout 2021/2022 and has monitored the delivery of our quality priorities and outcomes. As in previous years the committee has received monthly updates, including a quality dashboard and in-depth reports on progress against our targets. I am pleased to report that once again we have been successful in delivering on our strategy campaigns despite the pandemic.

In particular, the Trust has maintained strong performance against its quality key performance indicators (KPIs). We have achieved excellent levels of engagement and feedback from our patients, with over 96% of patients who completed our experience survey reporting their overall experience as either good or very good. We have also secured marked improvements in our preventing harm indicators, as our safety improvement initiatives continue to have a positive impact on quality whilst we bed in the new NHS Strategy.

There has been unprecedented demand on our staffing resource this year and we are grateful to our volunteers who have stepped forward to help ease the pressure on our clinical teams. We have successfully enhanced our work with volunteers, and they are now supporting us in improving the recruitment processes and implementation of the new Volunteer Communications & Engagement Plan.

To ensure we maintain safe staffing levels, our recruitment work is ongoing. I am pleased to report success in our international recruitment processes, with 100% of our candidates passing their test of competence (OSCEs) to date. We can also report that we have maintained high levels of statutory & mandatory training compliance through our Academy, whilst our Clinical Simulation Team have designed training sessions to support our school engagement programme.

The pandemic has undoubtedly posed a challenge to the delivery of business-as-usual activities across our organisation and the NHS, which has made the existence of robust governance processes essential to maintaining high levels of patient safety. In the last year we have enhanced our quality monitoring and assurance processes through the roll out of our e-core standards self-assessment process. This complements our quality development units (QDU) Accreditation by allowing us to identify and celebrate outstanding care by great teams and enabling the early identification of quality improvement opportunities. Our service improvements initiative, through Quality Councils & Shared Governance, remains in place, with 200 staff involved in over 35 councils across the Trust.

We have also been working to deliver on the goals set out in our Promoting Equality and Tackling Inequality Strategy. In the last year the Quality Committee has received assurance on equality of access to our services, with particular focus on Diabetes Services, together with the lessons we can learn from different communities' groups.

Even with such unprecedented demands on our services as a result of the pandemic, it has been a successful year and this is a testament to the resilience and hard work of all our staff who have supported new ways of working as well as numerous NHS initiatives such as the large scale covid 19 vaccination processes and the roll out of virtual wards.

I would like to take this opportunity to thank our staff as well as 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 2022 - 2023

Our four quality campaigns for 2022-2023 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 **2022 – 2023** 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 February 2022 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 2020- NOV 2021	MEASURES OF SUCCESS DEC 2021- JULY 2023
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 2020 – NOV 2021	MEASURES OF SUCCES DEC 2021 – JULY 2023
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 2020- NOV 2021	MEASURES OF SUCCESS DEC 2021- JULY 2023
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 2020- NOV 2021	MEASURES OF SUCCESS DEC 2021- JULY 2023
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 2020- NOV 2021	MEASURES OF SUCCESS DEC 2021- JULY 2023
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- JULY 2023
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

STATEMENTS OF ASSURANCE FROM THE BOARD

Review of services

During 2021-2022 CLCH provided 111 different 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 2021-2022 represents 100% of the total income generated from the provision of NHS services by CLCH for 2021-2022

Secondary use services

CLCH submitted records during 2021-2022 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics. The percentage of records in the published data which included patients' valid NHS number was 99.4% and which included patient's valid General Medical Practice Code was 97.3%.

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 2021-22.

Data Security and Protection (DSP) Toolkit

The Trust last 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. The next submission is not due until June 2022.

PARTICIPATION IN CLINICAL AUDITS

Clinical outcome reviews.

During 2021-22, 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

During this period, CLCH registered in all five eligible national clinical audits, namely, the National Diabetes Audit (NDA), the Sentinel Stroke National Audit Programme (SSNAP), the National Audit of Cardiac Rehabilitation (NACR), the National Asthma and COPD Audit Programme (NACAP) Pulmonary Rehabilitation Audit, and the National Audit of Inpatient Falls (NAIF). However, we only undertook work on the three national clinical audits listed below due to the pandemic.

National clinical audits		
National Clinical Audit	Participation	Outcomes and actions
National Audit of Cardiac Rehabilitation (NACR)	Services taking part: • Harrow COPD Respiratory Service • West Herts Respiratory Service • Merton Cardio-Respiratory Service • Barnet Community Respiratory COPD Service • Cardiac Rehabilitation Service, Hertfordshire Data collection is in progress.	At the peak of the pandemic, redeployment of cardiac rehabilitation (CR) staff to other services (close to 80% at its peak), together with reduced referral from cardiology, reduced uptake to CR. The NACR Steering Group stated the audit should not place an additional burden on clinical teams to check and validate uptake figures; therefore, the report focused on CR service delivery quality and inequalities related to patient participation during the pandemic. Actions: • Develop and implement strategies to halt the widening inequalities gap in CR participation • Ensure that the content and quality of CR delivery align with national standards • Ensure that all CR delivery modes (home-based, group-based and hybrid versions) are offered to all eligible patients and that patient choice is supported
National Asthma and COPD Audit Programme (NACAP) Pulmonary Rehabilitation Audit	Services taking part: • Harrow COPD Respiratory Service • West Herts Respiratory Service • Merton Cardio-Respiratory Service • Barnet Community Respiratory COPD Service • Respiratory Service Hertfordshire. Data collection is in progress.	The NACAP has not yet published the Pulmonary Rehabilitation Audit Report for the 2021 period.

National Audit of Inpatient Falls (NAIF)	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. These patients would be included in the audit and subsequent orthopaedic care would be monitored. We however participated in the NAIF Facilities Audit in 2021. Services taking part: • Inpatient Units: Inner (Alexandra Unit) • Inpatient Units: Inner (Athlone House) • Inpatient Units: Barnet (Jade Ward) • Inpatient Units: Barnet (Adams Ward)	Key outcome from the Facilities Audit: - Leadership/resources Senior leaders should include time for participation in NAIF and related QI activities in job specifications and plans for falls leads/practitioners/coordinators. For 2022, we will look to register new inpatient areas across Brent and units in Hertfordshire.

LOCAL AUDITS

The reports of nine local clinical audits that were reviewed by CLCH in 2021-2022 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. Due to COVID-19, pandemic there have been fewer audits than in previous years.

Title	Division	Service	Outcomes and Actions
1. FP10 Handling Audit	Trust-wide	All Services	The FP10 handling audit aimed at ensuring that Non-Medical Prescribers (NMPs) were compliant with Trust and national standards for FP10 storage and record keeping, in line CQC Regulation 17. Key findings included: 95% overall Trust compliance, 83% of NMPs completed the audit, the lowest standard compliance (92%) is 'access to room/area where NMP prescription pad kept is controlled', 97% of NMPs were aware of the reporting process when prescriptions are lost/stolen. Recommended actions included the Medicines Management Team to update its internal NMP database to ensure updated records of active and develop guidance on storage; they will also roll out electronic prescriptions to all community services where clinical systems allow; services/prescribers will work with CBUs and Estates to

			ensure locks are installed in rooms where prescriptions are kept.
2. NEWS2 Audit in Bedded and Rapid Response service	Trust- wide	All Services	This audit aimed at seeking assurance that the NEWS2 scoring tool was in use across the bedded and rapid response services in the Trust and measured practice against the Royal College of General Practitioners guidance (NEWS2, 2017) and the trust Deteriorating Patient policy, and the NICE Sepsis Quality Standard: Assessment and escalation (Sepsis Quality standard QS161, 2017). Key findings included: overall accuracy of calculations and frequency of vital sign monitoring – high compliance in line with Trust policy, there was good compliance with monitoring patients in line with Trust policy because of an escalated NEWS2 score - 99.1%. Recommended actions included: NEWS2 should be included in clinical supervision sessions with clinicians, where appropriate, to reinforce good practice and address any areas for improvement with staff, a campaign to improve awareness of sepsis in bedded and rapid response services, and to reinforce the importance of considering sepsis as a differential when NEWS2 scores are elevated; case-based discussions during group supervision to allow for discussion between team members.
3. Written Consent for Dental Sedation in CLCH Community Dental Service (CDS)	Inner North West	Community Dental Services	The audit aimed to see if CLCH Dental practitioners were complying with GDC guidelines to obtain appropriate written consent prior to carrying out IS or IVS in the CDS. All patients who have conscious sedation should have a pre-operative written consent form which is kept securely as part of the patient's dental record on Carestream R4 (dental electronic patient record system – R4). Findings included: 92 patients received sedation in the period February - April 2021 and out this number - ▪ 100% of adult patients had a consent form in their R4 notes.

			▪ 100% of adult patients who could consent had Consent Form 1 in their R4 notes ▪ 92% of paediatric patients had a consent form in their R4 notes ▪ 2% of paediatric patients had Consent Form 1 in their R4 notes instead of Consent Form 2. Recommended actions included reminding staff that all conscious sedation patients should have written consent prior to dental treatment, all consent forms should be uploaded and stored in R4 contemporaneously, and that all patients should have their consent recorded on an appropriate form depending on age and capacity.
4. Compliance with Reporting of Radiographs in Clinical Records and Quality Assurance Image Audit	Inner North West	Community Dental Services	The re-audit aimed at providing assurance in the service's high-quality record keeping including the justification, grading, and reporting of dental radiographs Findings included: justification was recorded in 92% of records audited (10% increase from 2019 and 27% increase from 2018), grading was recorded in 87% of radiographs taken (13% increase from 2019 and 16% increase from 2018), Reporting was recorded in 98% of radiographs taken (11% increase since 2019 and 2018). Recommended actions included reminding dental clinicians of the need to record appropriately; and increase awareness and encourage use of R4 for data entry and reporting management capabilities.
5. Recording of Recommended Recall Interval for CDS patients	Inner North West	Community Dental Services	The audit aimed at establishing that CLCH Community Dentists were compliant with NICE guidance CG19, with the objective that patients were being offered the appropriate level of care according to their individual needs Key findings included: 98% of patients receiving continuing care with the CDS had a recommended recall interval recorded in the clinical records, 20% of patients were discharged from CDS care at the end of their course of treatment, 45% of the discharged

			patients had a letter sent to their general dental practitioner (GDP) which included a Recommended Recall interval. Recommendation actions included CDS dentists to continue recording recommended recall Interval in clinical notes for all patients receiving continuing care with the CDS. This can be in the Clinical Notes and/or the NICE Oral Health Review tab at the discretion of the dentist; discharged patients should have a recommended recall interval included in the discharge letter to their GDP – to be spot checked; domiciliary patient records should include a risk assessment and specific detail if a recommended recall interval is not made – to be spot checked.
6. Female genital mutilation audit (FGM)	Safeguarding/ Quality Division	Relevant services	The FGM audit aimed at ascertaining that staff were following mandatory reporting procedures and routine screening in line with the 2015 guidance and that the CLCH FGM Recording, and Reporting Policy was being implemented in the Trust. Key findings included information regarding FGM was included on 37% of summaries; 54% of the mother's records were flagged; 6% of the records showed that female children's records had been flagged and alerts added. Recommended actions included the incorporation of the audit findings into the new CLCH FGM policy and update all staff across CLCH with the recording requirements; share the findings through Safeguarding committee, safeguarding bulletin and professional/quality forums; share findings with the designated professionals across all boroughs; review the new FGM processes in January 2023.
7. Documentation audit	Safeguarding/ Quality Division	Brent 0-19 Universal Service	The aim of this audit was to measure Brent 0-19 Universal Service's record keeping practices against NMC and CLCH record keeping standards. Findings included the London Continuum of Need (LCON) was recorded accurately in 63.1% of

			records; allergies and sensitivities were not recorded in 46% of records; safeguarding alerts/flags were not updated in 31% of cases; 73% of cases recorded a care plan. Recommended actions included record keeping aide memoires to be circulated to staff; School nurse staff to design more appropriate school nurse audit tool for auditing purposes; team leads to complete an audit with staff who did not undertake the 2021 audit.
8. The Manual Handling Risk Assessment form and patient white board service evaluation	North Central	Jade Ward	Information on the Moving and Handling Risk Assessment form completed by Physiotherapists was not always the same as the information on whiteboards above patients' beds or was incorrectly updated. This service evaluation aimed to ensure the correct updating of both items to help prevent falls and aid communication with the MDT. The findings indicated a broad variation of input. Recommended actions identified included sharing findings with staff, including those working at weekends, and implementing a trial to set protected time for updating.

Acronyms and explanations of terms

AMaT	The Trust's clinical audit management system (Audit Management and Tracking)
BPE	Basic Periodontal Examination
CBU	Clinical Business Unit
CDS	Community Dental Services
CLCH	Central London Community Healthcare NHS Trust
CR	Cardiac rehabilitation
CQC	Care Quality Commission
FGM	Female Genital Mutilation
FP10	Prescription form
GDC	General Dental Council
GDP	General Dental Practitioner
IS	Inhalation Sedation
IVS	Intravenous Sedation
LCON	London Continuum of Need (a guide used to assess and meet the needs of children and their families)
NEWS2	National Early Warning Score
NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
NMC	Nursing And Midwifery Council
NMPs	Non-Medical Prescribers
PRN	*'pro re nata'* - medicines that are taken "as needed"
QA	Quality Assurance
QS	Quality Standards
R4	Carestream R4 (dental electronic patient record system)

PARTICIPATION IN RESEARCH

Research at CLCH has embarked on a new journey to adapt to the everchanging impacts of the COVID-19 pandemic. The pandemic has demonstrated the importance of research in the NHS with world class innovative vaccines, and treatments to prevent and reduce the health implications of the corona virus. We launched the new CLCH Research Strategy (2021-2024) as part of our commitment to embedding an inclusive research culture and creating equity of opportunity. The strategic vision is underpinned by key priorities:

1. To increase the research culture within CLCH
2. To give all CLCH staff and service users the chance to participate in health care research
3. To expand research opportunities across the Trust
4. To become a leader for healthcare research in community settings

132 CLCH patients and staff were recruited during 2020/21 to participate in research approved by a research ethics committee.

Participant recruitment across studies 2021-2022.		
IRAS Ref	Full Title	Recruitment
277676	AHP perceptions of NHS research capability and culture: A national research capacity in context survey.	57
282858	Psychological impact of COVID- 19- pandemic and experience: An international survey.	24
282232	A randomised, double blind, placebo-controlled study to evaluate clinical performance and safety of the Gedea pessary in adult women with bacterial vaginosis – Nefertiti.	18
235092	A prospective, multicentre, randomised, assessor blinded study comparing the efficacy and patient reported outcomes of two different daily gekotm treatment duration in conjunction with standard care, with each other and to standard care alone, in patients with venous leg ulcers.	5
293143	Electronic Palliative Care Co-ordination Systems (EPaCCS) in end-of-life care: evaluating their implementation and optimising future service provision.	4
291746	BabyBreathe Trial: A randomised controlled trial of a complex intervention to prevent return to smoking postpartum.	3
300361	Neuropsychological Consequences of COVID-19: Long COVID and the role of Virtual Hospitals.	20
290383	Mental health and wellbeing of NW London health and social care staff during COVID-19.	1
Total:		132

For the Geko VLU Efficacy study (235092), the clinical team successfully recruited five patients in year and twelve patients overall against a target of five. This success led to CLCH being in the top three highest recruiting sites out of 21 participating NHS Trusts and was the 2nd highest recruiting site in 2021/22.

The Trust was proud to become a member of the North West London Clinical Research Trials Alliance. The alliance is a collaboration of NHS Trust based clinical research facilities, primary care, and the London Ambulance Service. The alliance will bring together expertise across the region to support staff to develop their skills and advanced clinical practice. It will enable CLCH to enhance its footprint in the clinical research landscape with new opportunities for patients to access cutting-edge therapies.

CLCH and London South Bank University (LSBU) have been collaborating to support clinical academic pathways for staff at CLCH. This will develop their skills and knowledge to become future research leaders and build evidence-based practice. One of our Specialist Speech and Language Therapists was

successful in securing a place on the Integrated Clinical Academic (ICA) Internship pathway. This is organised by Health Education England (HEE) and the National Institute for Health Research (NIHR).

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 has been developed in line with National guidelines on Freedom to Speak Up training in the health sector in England and is included within the statutory and mandatory booklet completed annually by all staff.

There is a FTSU page on the intranet and to track and monitor engagement with FTSU, a service timeline has been added to this. A FTSU module has been developed and included in the Trust's Leadership and People Development Programme, in line with the national guidelines, which covers creating the right environment, supporting speaking up and listening well.

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, 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. A new FTSU Guardian has been recruited and we look forward to welcoming them into post in April. Staff are also provided with details as to how they can speak up to an outside body. Our Non-Executive Director Champion for FTSU is Dr Carol Cole, chair of the Quality Committee.

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. 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 FTSU guardian 2021/22 reports have been completed and returns submitted for those periods to the NGO.

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 2021/22. This was to allow NHS Trusts to free up as much capacity as possible and prioritise their workloads to focus 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 2021-2022 quality account. CQUIN work will restart in 2022/23.

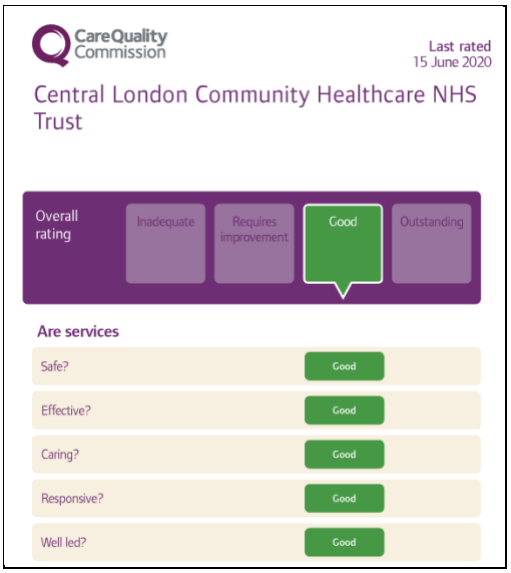
CARE QUALITY COMMISSION (CQC)

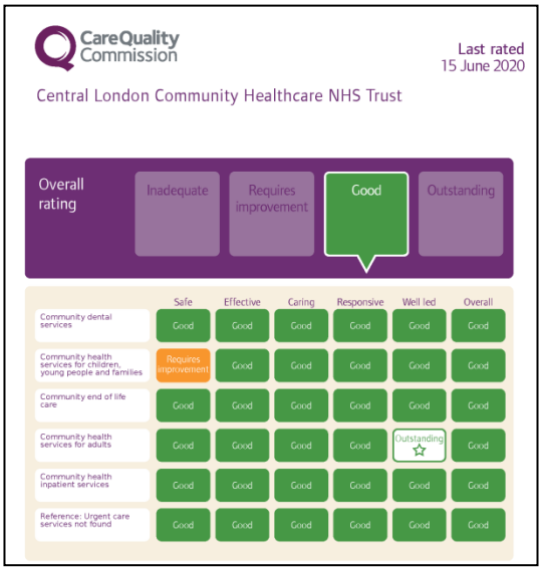
CLCH is registered with the CQC under the provider code RYX without any conditions. The CQC has not taken any enforcement action against CLCH during 2021/22. Furthermore, the Trust has not

participated in any special reviews or investigations by the CQC during the reporting period that ended 31st March 2022.

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 and has not been rescheduled.

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 given a rating of *requires improvement for* the *safe domain* in community health services for children and young people, at the 2020 inspection. 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 was in place to monitor the use of prescription pads in the children's community nursing team.

We were issued with three actions which we were required to take to improve the core service's *safe domain.* Individual plans to address the actions were written and assigned to responsible owners who undertook the necessary work. Progress was 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

High quality data is a key component of information governance. It is essential for both the effective delivery of patient care and enabling continuous improvements in care provision. We are fully committed to improving the quality of data across all our services. We recognise the importance of

our duties with personal data - keeping it accurate and up to date, treating it with the strictest confidence, managing it securely, and sharing it only in full compliance with the Caldicott principles. During 2021/22 we have taken the following actions to improve data quality:

- Developed a Data Quality Plan and undertaken a wide range of data improvement tasks set out therein. The plan has sought to improve the accuracy of the Trust's reporting data, make more data available for scrutiny by relevant stakeholders, and place a greater emphasis on reconciliation. The plan has been overseen and delivered by members of the Trust's data forum with clinical and operational input.

- Migrated Trust information reporting to Power BI. This provides activity and performance reporting refreshed daily, including contacts, referrals, ethnicity recording completeness, and outcome timeliness. All current reporting has been migrated from QlikView to Power BI and additional functionality is in the pipeline. Power BI enables more intuitive and detailed analysis of data and allows Trust activity data to be shared with a much wider corporate and clinical audience. This has, for example, allowed greater scrutiny of waiting times by operational teams and more rapid resolution of outliers, thus aiding data quality improvement and patient care.

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

- Continued with an initiative to increase the completeness of patient ethnicity recording, which resulted in an improvement from 84% to 90% over the 2021 calendar year. This has involved creating new reporting, amending systems templates, and mapping, and engaging with front line staff 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 2022/23:

- 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 with all divisions, corporate services, and other 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.

We will also be taking the following actions in 2022/23 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, including 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 data collection and reporting.

- Using Power BI as the platform for the Trust's Self-Service Business Intelligence portal, expanding its user base to the whole Trust, and adding to its functionality, in particular data quality monitoring tools

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

LEARNING FROM DEATHS: 2021 – 2022

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 because 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.* It was updated in January 2020 and is now fully embedded for adults across our services. All deaths within the Trust are reported via the incident reporting system - Datix. As part of the LfD process, Service Team Leaders and Directors of Nursing & Therapies 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 / Divisional Medical Directors from the relevant divisions and discussed at the Trust's bi-monthly Resuscitation and Mortality Group.

CLCH is engaged in the multiagency statutory review of deaths of children and young people. In 2020, considering the changes introduced by Working *Together to Safeguard Children 2018* we 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.

The internal processes relating to the overview of deaths of people with learning disabilities in the Trust were also revised in 2020/21. All deaths of people with learning disabilities have been reported to the learning disabilities mortality review programme (LeDeR) since 2017. From March 2021, the learning disability teams also started presenting an overview of deaths of people with learning disabilities biannually to the Trust's Resuscitation and Mortality Group. 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.

	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 2021 – Mar 2022, 2894, CLCH patients died as follows (includes expected hospice deaths): • 666 in Q1 • 749 in Q3 • 687 in Q2 • 792 in Q4 Of this number, the following number were in-patients: 2 in the first quarter, 3 in the second quarter, 2 in the third quarter and 5 in the fourth quarter.
2.	The number of deaths included in item	From Apr 2021 to Mar 2022, 10 case reviews were completed, 9 were case record, (PRISM)

	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.	reviews and 1 incident review were completed in relation to the 2894 of the deaths included in item 1. In 3 cases, the deaths were subjected to both a case record (PRISM) review and an investigation (Case 6: 2021 – 2022, Case 7: 2021 – 2022, Case 8: 2021 – 2022). The number of cases in each quarter for which a case record review or an investigation was carried out was: • 3 in Q1 • 2 in Q3 • 3 in Q2 • 2 in Q4
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.	1 representing 11% 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 Q1 • 1 in Q3 • 0 in Q2 • 0 in Q4
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 19 (2020 – 2021)** a) All Divisions need to regularly ensure that they have sufficient staff members nominated to enter relevant patient deaths onto the CPNS register. b) All divisions need accountable senior clinician who will ensure that all relevant deaths are entered onto the CPNS register within a reasonable time frame. **Case 1 (2021 – 2022)** a) Importance of early discussion of resuscitation with patients to allow advance decision making. b) Importance of staff being familiar with enhanced PPE needed for resuscitation in bedded area (which is likely to be different to their usual PPE). c) Importance of debrief and emotional support for staff after a patient death, particularly if this was unexpected/ involved a resuscitation attempt. **Case 2 (2021 – 2022)** No action points relating to Learning from Death or the clinical management of the patient were noted. **Case 3 (2021 – 2022)** In cases where a ceiling of care is agreed, more careful documentation needed if patient deteriorates to record that consideration has

		been given to escalation in medical management but has been ruled out. **Case 4 (2021 – 2022)** No action points relating to Learning from Death or the clinical management of the patient were noted. **Case 5 (2021 – 2022)** a) All ward staff need to be aware of protocols in relation to treatment of hypoglycaemia. b) All ward staff need to comply with protocols for recording of fluid balance. c) Medication reviews need to be repeated if patients' renal function deteriorates to stop nephrotoxic drugs if indicated. d) Family meetings should be documented in specific section rather than in shared contemporaneous records. e) Although the patient deteriorated throughout the course of the admission, this was not reflected in discussions at MDT or in Family meetings. **Case 6 (2021 – 2022)** a) Patient was not suitable for admission onto a rehabilitation unit and should have been transferred back to the acute hospital for investigation. b) Nursing staff need to be given clearer guidance re: calculating and recording of NEWS scores in patients on supplemental oxygen. c) Medical team failure to recognize deteriorating patient and escalate appropriately, and senior members of medical team failed to review junior doctor decision making, (This case is currently being investigated as an External Serious Incident). **Case 7 (2021 – 2022)** a) Patients' Resuscitation status needs to be discussed during the weekly Consultant ward round and in the weekly MDT meeting. b) The weekly Consultant ward round proforma to have a record of resuscitation status of each patient. c) Learning from the case to be summarized in a "7-minute Learning tool" and discussed within the division and at the Trust's Patient Safety & Quality Group. d) The Standard Operation procedure for the management of the deceased patient needs to be reviewed and updated as the patient died within 28 days of a positive PCR for

		COVID-19 but they were not entered on the CPNS register. **Case 8 (2021 – 2022)** No action points relating to Learning from Death or the clinical management of the patient were noted. **Case 9 (2021 – 2022)** 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 19 (2020 – 2021)** a) Senior management team from each Division have identified accountable clinician who will be responsible for ensuring relevant deaths are entered onto the CPNS register. Each Division has identified either the Divisional Nursing Director (ONW, SW, Herts) or the Divisional Medical Director (INW and NC) who will be responsible for checks and hold ultimate accountability within the Divisions. **Case 1 (2021 – 2022)** a) Learning described in section 4 disseminated to the service level teams by the Divisional Nursing Directors and Divisional Medical Directors. b) PPE guidance has been reviewed to clarify guidance and emphasis will be given to use of PPE during Resuscitation attempts during Annual Resuscitation training for staff. As clinical staff who would participate in a Resuscitation attempt have now been vaccinated, a review of PPE is taking place. c) Divisional Nursing Directors and Divisional Medical Directors have cascaded this information back to the Service level clinical leads and managers. **Case 2 (2021 – 2022) - N/A** **Case 3 (2021 – 2022)** Divisional Nursing Directors and Divisional Medical Directors have cascaded this information back to the service level clinical leads and managers. **Case 4 (2021 – 2022) - N/A** **Case 5 (2021 – 2022)** a) Trust Mortality Lead will present this case in an upcoming multi-professional ward team

		meeting and will emphasise need to follow Hypoglycaemia protocol. b) Trust Mortality Lead will present this case in an upcoming multi-professional ward team meeting and will emphasise importance of recording fluid balance in fluid balance charts. c) Trust Mortality Lead will present this case in an upcoming multi-professional ward team meeting and will emphasise importance of regular medication reviews and ad hoc medication reviews if a patient's condition changes in order to check whether medication is contraindicated. d) Ward manager will feedback to ward staff re: the importance of documenting medical and nursing records in the specified sections of the records rather than recording them as one narrative in the shared contemporaneous records. e) Trust Mortality Lead will present this case in an upcoming multi-professional ward team meeting and will emphasise need for reviewing management plans if a patient's condition changes and for documenting that the management plan has been reviewed in the clinical records. f) The Clinical Directors and Nursing Directors are meeting to discuss whether the clinical environment in our community rehabilitation wards, current staffing levels and staff training is currently suitable to care for patients with the higher clinical acuity we have been admitting from our acute hospital partners since the pandemic began. This discussion will include an assessment of changes to training and the environment which need to be made to care for these higher acuity patients safely. **Case 6 (2021 – 2022)** This case is being investigated as an External Serious Incident. **Case 7 (2021 – 2022)** a) This has been fed back to the Consultant and the Divisional Board will monitor this in the Divisional Quality forum by auditing the Consultant ward round proforma documentation on resuscitation status. b) Learning from the case to be summarized in a "7-minute Learning tool" and discussed within the division and at the Trust's Patient Safety & Quality Group. c) The Head of Nursing will review Standard Operation procedure for the management of the deceased patient.

		Case 8 (2021 – 2022) - N/A **Case 9 (2021 – 2022) - N/A**
6.	An assessment of the impact of the actions described in item 5 which were taken by the provider during the reporting period.	**Case 19 (2020 – 2021)** No impact as yet. **Case 1 (2021 – 2022)** No impact as yet. **Case 3 (2021 – 2022)** No impact as yet. **Case 5 (2021 – 2022)** No impact as yet. **Case 6 (2021 – 2022)** No impact as yet. **Case 7 (2021 – 2022)** No impact as yet.
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.	1 case record reviews and 0 investigations completed after 2020 -2021 which related to deaths which took place before the start of the reporting period **(Case 19 (2020 – 2021 – please see sections 4, 5 & 6 of this document).**
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 2020 – 2021 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 year 2021/22, 15,040 patient safety incidents were reported within CLCH. Of these incidents, nine (0.06%) resulted in severe harm. This is a reduction in the number of incidents that caused harm from the previous year (2020/21) when we reported that thirteen incidents from 10,723 resulted in severe harm (0.12%).

There is no information available for this reporting period from the National Reporting and Learning System (NRLS) about the rate of patient safety incidents, so this information is not available. The most recent report from NRLS covers the period April 2020 to March 2021.

There were no incidents that resulted in a death. The patient safety incidents reported that resulted in severe harm consisted of four category 4 pressure ulcers, two falls, one unexplained injury, one unwell illness/sepsis, one treatment problem.

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

- The Patient Safety Team work closely with clinical colleagues across all divisions to raise awareness of timely incident reporting, and the prompt review and approval of reported incidents by managers. This ensures improved classification of incidents and logging of the level of harm.

- We have enhanced our quality assurance monitoring and reporting arrangements with the appointment of a data analyst who checks and verifies the quality of our reported data

- Regular feedback to teams is provided through communication channels such as the Hub (Trust intranet), divisional quality forums, the Spotlight on Quality e-newsletter, as well as direct feedback to relevant staff about reported incidents.

- Using early warning triggers to identify when levels of reporting drop below what is expected based on historical data, size and activity of any given team.

- Supporting a fair safety culture that is improvement focused and does not seek to apportion blame.

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

- The continued review all the incidents, with a particular focus on inpatient falls, and pressure ulcers. This enables the early identification of emerging issues that may require urgent follow up.

- The continued monitoring of reported incidents to ensure the early identification of serious incidents that require a 48-hour review and explore the need for further in-depth investigation.

- Meeting weekly with a group of senior clinicians to review all community acquired pressure ulcers, and monthly to review of all category two inpatient pressure ulcers.

- Reviewing all reported podiatry incidents monthly. This has continued to strengthen collaborative working in the multi-disciplinary teams. This approach has been shared to help improve communication between teams across the trust.

- The continued use of root cause analysis (RCA) methodologies to investigate and share learning across the Trust.

- Implementing action plans following the completion of investigations to prevent reoccurrence.

- Ensuring Ward Matrons/Manager Network Meetings take place each month. They meet virtually to share learning, best practice, review their bedded scorecard, and identify targeted areas for improvement.

- Providing additional Datix training sessions for staff who have recently joined CLCH particularly members of our new Outer North West London Division.

- Ensuring our Patient Safety Risk Group, and Quality Committee remain focused on providing the correct level of scrutiny to drive safety.

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	2021/22 TARGET	PERFORMANCE	
			Previous year 2020-2021	2021-2022
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 %	97.7 %	97.0%
	Proportion of patients who were treated with respect and dignity	95.0 %	98.8 %	99.3%
	Friends and family test - Percentage of Staff recommending CLCH as a place for Treatment	80.0 %	NA*	
	Patient Friends and family test - Proportion of Patients rating their overall experience as very good or good	92.0 %	96.9 %	96.8%
	Proportion of patients' concerns (PALS) responded to within 5 working days	95.0 %	100.0 %	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 Staff FFT.

QUALITY CAMPAIGN	KEY PERFORMANCE INDICATOR	TARGET	PREVIOUS YEAR 2020-2021	2021-2022
Preventing Harm Incidents and Risk	Proportion of clinical incidents that did not cause harm (moderate to catastrophic categories)	97.0 %	99.2 %	99.2%
	Zero tolerance to falls in bedded units with harm (moderate or above)	0	9	8
	Zero tolerance of new (CLCH acquired) category 3 and 4 pressure ulcers in bedded units	0	4	3
	Zero tolerance of new (CLCH acquired) category 2 pressure ulcers in bedded units	0	43	24
	Zero tolerance on the number of patients in our bedded areas who have reported a CAUTI	0	New KPI in 2021/22	1
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 %	0.25 %	1.4%
	Percentage of Central Alerting System (CAS) alerts including Patient Safety Alerts (PSAs) due, and responded to, within deadline	90.0 %	94.6 %	90.5%
	Percentage of hand hygiene episodes observed across CLCH bedded areas that are compliant with policy	97.0 %	100.0 %	99.8%
	Percentage of staff trained at Making Every Contact Count level one. Non – Clinical	95%	95.7 %	95.9%
	Percentage of staff trained at Making Every Contact Count level two. Clinical	95%	92.9 %	93.1%
Modelling the Way	Statutory and Mandatory training - Non-Clinical*	95 %	96.2 %	96.5%
	Statutory and Mandatory training – Clinical*	95 %	94.1 %	95.8%

QUALITY CAMPAIGN	KEY PERFORMANCE INDICATOR	TARGET	PREVIOUS YEAR	2021-2022
Workforce *	Staff Turnover rate – 12 month rolling (Clinical)		12.9 %	14.1%
	Sickness absence rate - 12 month rolling (Clinical)		5.5 %	5.6%
	Percentage of staff who have an appraisal		78.9 %	77.4%
	Staff Vacancy rate (Clinical)		13.9 %	18.3%

* 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 Jan 2022-July 2023	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 2021/22. The year-end position is 99.3%
	We will maintain the proportion of patients reporting their overall experience as very good or good at 95%	This KPI has been achieved throughout 2021/22. The year-end position is 96.8%
	The proportion of patients who felt staff took time to find out about them will be maintained at 95%	This KPI has been achieved throughout 2021/22. The year-end position is 97%
	We will ensure that 80% of patient/user/carer feel involved in each service change	The action plan for patient and carer involvement has now been signed off at PEG, we will be working with the transformation and QI teams to establish SMART milestones in 22/23 to reach our 80% target. The action plan includes the first draft of the Patient Representative Policy, and the milestones which will allow us to advertise for new patient representatives in April 2022. Patients continue to report a high level of involvement in their care through the monthly Patient Experience KPIs. Patient involvement in QI, Shared Governance, and Transformation Projects is improving. We continue to work with our divisions to

Key Priority / Outcome	Measures of Success Jan 2022-July 2023	Update
		ensure that patients are involved when a service is being changed.
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 80%	This target has not been achieved. The Q3 Pulse Survey (National Quarterly Pulse Check) only had a 3.6% (t=165) response rate and 57.1% of staff who responded would be happy to recommend CLCH as a place for treatment. The National Staff Survey (Q3 of 21/22), published in March 22, found that 70.2% of staff would be happy to recommend CLCH as a place for treatment. We are working to improve our score through: • Schwartz Rounds have continued to focus on *Caring through and living with COVID*. • The monthly Spotlight on Quality highlights best practice and exemplar teams. • The Patient Experience Team continue to collect staff and patient stories about caring through COVID.
	We will increase volunteer numbers by 50% from 2020/21 baseline in services where volunteer participation improves patient experience	We will not achieve this target. The main issues are changes to services due to COVID, the confidence of older volunteers to come forward, and low unemployment. We have 38 volunteers with a further 44 applications in progress and we are confident that we can recruit 100 more volunteers by October 2022. Recruitment is now online. This is faster, more user friendly, and enables us to advertise directly on many more platforms. In Q3 & Q4 we developed new working relationships with Brunel University, and Barnet and Southgate College as well as strengthening our existing relationships with Westminster University, and local high schools. Recruitment is easier when we have enough exciting opportunities. Over Q3 & Q4, we've added six new services who work with volunteers, taking us to eighteen with a further 28 in the pipeline. A detailed communications and engagement plan has also been

Key Priority / Outcome	Measures of Success Jan 2022-July 2023	Update
		developed to support recruitment and retention. The Volunteering Services Lead now attends the Divisional Management Boards and Quality meetings (DMBQ), and Quality Forums to identify volunteering opportunities.
	To continue to complete an annual volunteer survey to understand their impact on services and their experience	The final satisfaction survey of our 2020/21 volunteers showed: • 95% would recommend volunteering at CLCH • 85% feel well supported • 75% see the difference they're making • 65% have learned new skills in their role • 84% feel CLCH communicates well There was an improvement to volunteer communication. Areas for improvement in 22/23 are: • demonstrating the impact of the volunteer role • upskilling volunteers
	We will develop 'you said we did' stories to share volunteers experiences	We are collecting volunteer stories. Two have been shared in Spotlight on Quality and on Facebook, Twitter, and Instagram to promote the benefits of volunteering with CLCH. We have been able to demonstrate improvements for volunteers based on their feedback. These includes a monthly newsletter, and an online induction process, which is quicker and facilitates better communication and support for new volunteers.
Feedback from patients, carers and families is taken seriously and influences improvements in care.	We will continue to respond to 97% 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 2021/22.
	We will continue to respond to 100% of complex complaints within the agreed deadline	100% compliance was maintained throughout 2021/22.
	We will continue to acknowledge 100% of complaints within 3 working days	100% compliance was maintained throughout 2021/22.

Key Priority / Outcome	Measures of Success Jan 2022-July 2023	Update
The patient and the public voice are integral in the decision-making process when making changes to services or care delivery	We will transfer the learning from each Always Event across the Trust	The Always Event projects that were paused during the pandemic, are now under review at Divisional Quality Forums. Each division will start an Always Event in 2022/23. The original District Nursing Always Event is under consideration by a Shared Governance Quality Council. They are reviewing the leaflets that have been used to inform patients about their team, and their visits. Despite the pausing of Always Events, the EOL Always event has continued to develop. A working group has been meeting and is exploring getting feedback from staff, patient representatives as well as the public. The Health Equalities Programme Manager has developed a poster which will be used to start promoting the project. The Outer NW Division (& originally CHD) Always Event produced leaflets that provide general information about the School Nursing Service such as contact details, location, and services available. The leaflets were produced in multiple languages and widely distributed to all special schools. Now that it is complete leaning from this project has been shared.
	We will review the impact and learning from quarterly projects on the overall patient experience	Quarterly projects continue across each clinical division. The impact of the projects and the learning from their success are shared at divisional boards, QSRG meetings with external stakeholders, and monthly at PEG.
Transforming healthcare for babies, their mothers and families in the UK (UNICEF Baby Friendly Initiative, BFI)	50% of health visiting services will have achieved level 2 breast feeding accreditation or greater	The Inner North West services have successfully maintained UNICEF BFI Gold Baby Friendly Accreditation, following submission of their Annual Report and Audit in January 22. UNICEF BFI noted that they were "*delighted to see the quality of work that is being implemented within CLCH and the positive outcomes being achieved as a result*". All other boroughs have successfully reached stage 2 BFI accreditation. Brent: stage 3 BFI accreditation, working towards stage 3 re accreditation in 2022

Key Priority / Outcome	Measures of Success Jan 2022-July 2023	Update
		Ealing: stage 2 BFI accreditation, working towards stage 3 in 2022 Merton: stage 3 BFI accreditation, working towards stage 3 re accreditation in 2022 Wandsworth & Richmond: stage 2 BFI accreditation, working towards stage 3 in 2023

CAMPAIGN TWO: PREVENTING HARM

Key Priority / Outcome	**Measures of Success Jan 2022-July 2023**	**Update**
Robust, effective systems and processes in place to deliver harm free care all the time	Maintain/ or improve on the Proportion of clinical incidents that did not cause harm reported in 2021/22	As reported in section 3.3, the year-end figure for 2021/22 is 99.2%. This is a slight improvement from 99.1% in 2020/21.
	100% of patients in bedded units will not have a fall with harm (moderate or above)	As reported in section 3.5, one fall with harm was reported in Q4 and a total of eight falls with harm were reported during 2021/22.
	100% of patients in bedded units will not have a NEW (CLCH acquired) category 2-4 pressure ulcer	In Q4, one category three and six category two pressure ulcers were reported. In total 24 category 2-3 pressure ulcers were reported during 2021/22. No category four pressure ulcers were reported this year.
	100% of all Serious Incident investigations will be completed on time in accordance with national guidance	In Q4, 66.7% (2 out of 3) of External Serious Incident Root Cause Analysis (RCA) reports were completed on time in Q4. For 2021/22, 89% were submitted on time. Details in Section 3.12.
	100% of all Serious Incident actions will be completed on time in accordance with locally agreed timescales	92 incident actions were due in Q4 (taken from Datix actions module) and 14 remain open. Action plan meetings are arranged to ensure actions are completed so that action plans can be closed. Both PSRG and Patient Safety Managers continue to emphasise the importance of timely closure. During 2021/22, 409 Incident actions were logged and 16 (3.9%) remain open.

Key Priority / Outcome	Measures of Success Jan 2022-July 2023	Update
Enhance the embedding of a safety culture in the trust ensuring learning from adverse events and compliance with national best practice	There will be evidence of an improvement in the safety culture compared to baseline	An assessment of safety culture will be undertaken using results from the 2021 NHS Staff Survey, published in Spring 2022, together with feedback from the Accreditation Audit and E-Core Standards process. Data sources will be reviewed to identify what is working well, and opportunities to enhance our safety culture in line with the NHS National Patient Safety Strategy.
	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	A total of thirteen 7-minute learning tools were submitted in Q4. In 2021/22, 57 7-minute learning tools were shared at PSRG. Patient Safety Managers continue to work across all services to identify incidents where learning would be beneficial.
	90% of teams will have undertaken a core standards annual health check assessment and identified action plans that are completed on time	100% of teams have now completed the Core Standards self-assessment: • 86% RAG rated green • 11% RAG rated amber • 3% RAG rated red. All red and amber teams will need to repeat the assessment in 6 months' time along with Implementing an action plan to address non-compliant areas.
	No outstanding actions from risks on the register	62 individual risk actions were due in Q4, 9 remain open. A summary and detailed report of overdue Incident and Risk actions is circulated bi-weekly, and members of the safety team work closely with risk owners to review and close actions within the given timeframe.

CAMPAIGN THREE: SMART EFFECTIVE CARE

Key Priority / Outcome	Measures of Success Jan 2022-July 2023	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 we achieved our target for training non-clinical staff but not for our clinical teams where we achieved 1.9% below target.
	We will evaluate the use of MECC link with our clinical staff	The MECC link was circulated in 2019 and launched by the Medical Director and Chief Nurse: (https://www.mecclink.co.uk). In Q1 22/23, we will evaluate this with staff when we launch the new population health training.
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 ≥ 15%	The Trust has achieved this with an increase in the number of research projects involving or led by clinical staff. Nine recruiting studies opened in 21/22 compared to seven in 20/21. Commercial study recruitment has also increased from one participant in 19/20 to 23 participants in 21/22.
	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%	Of the clinical audits, service evaluations, and QI projects registered in Q4 by services, 20% presented clinical improvement posters during service/team meetings. The Clinical Effectiveness Team is working with the Deputy Chief Nurse (Director of Quality & Safety) to improve this performance.

CAMPAIGN FOUR: MODELLING THE WAY

Key Priority / Outcome	Measures of Success Jan 2022-July 2023	Update
Implementing Reverse Mentoring for all staff ensuring career opportunities are accessible to all	60% of clinical staff at band 8b or above will have undertaken training	The Trust began reverse mentorship in 2020 and cohort five starts in May 2022. With a dedicated lead now in place, there is a robust plan to offer cohorts bimonthly.
	Mentoring opportunities will be publicised for staff Trust wide	Details were publicised in the monthly Spotlight on Quality, and the Trust wide communications bulletins.
All staff have the core identified statutory and mandatory skills for	We will continue to maintain Statutory and Mandatory Training compliance at 95%	At year-end the Trust exceeded our 95% target for both clinical and non-clinical staff.
Staff receive appropriate education and training to ensure they have the right skills to support new models of care	Each professional group will have development portfolios to support staff having the right skills and knowledge to support new models of care	The Academy submitted a finalised Continuing Professional Development (CPD) Investment Plan to HEE, which accounted fully for the monies allocated. The Academy has also delivered against the Workforce Funding Plan submitted to the NWL ICS. The annual learning needs process has started with templates sent to all divisions for review and completion as part of business planning for 2022/23. The Academy is looking to develop a multi professional band 7 and 8a clinical leadership programme.
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 review all proposed establishment changes monthly before QIA. Extra panels have been held to ensure that any QIPP workforce proposals are reviewed prior to QIA.

Key Priority / Outcome	Measures of Success Jan 2022-July 2023	Update
Ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times	All community nursing and bedded services will have 1/2 ANAs in place	The ANA role has been implemented across all community nursing and bedded services except Brent where it is being phased into the establishments as part of their agreed staffing levels. In 2022/21, the Trust met its target for ANA training for both NWL and Hertfordshire. The target for 2022/23 has been set and we plan to exceed it as part of our continued commitment to supporting this role.
	We will evaluate safe staffing models for AHP workforce, and any new roles developed	Work has started on the required AHP safe staffing levels for inpatient areas. Our new AHP Lead is in post, and we are reviewing regional and national work on best practice for AHP staffing levels. This work will be undertaken in Q1 and discussed at the Clinical Staffing Panel. We continue to report AHP Care Hours Per Patient Bed Day for our Inpatient areas monthly.
	We will continue to develop Professional networks and deliver/events to be delivered for all staffing groups across the Trust and primary care	Several conferences have been delivered though 2021/22 – see section 5.3 and the 2022/23 Conference dates have been agreed. Professional Networks are now being reviewed as part of the Clinical Workforce Group with the aim of implementing them across the Trust where there are gaps.

SHARED GOVERNANCE PROJECTS

Division	Quality Campaign	Project	Number of staff involved	Project progress
North Central Division	Positive Patient experience	Improving family involvement in the patients' care	6	This quality council started in Q3 with the aim to improve the updates and information shared with family members of patients across the bedded units. Feedback from PALs data were included in the change ideas. The project was on pause in Q4 due to staff capacity but will be restarted in Q1.
	Modelling the Way	Improving the MDT meeting	6	The quality council was on hold during Q4 due to staff capacity. In Q1 this will be restarted using the data gathered previously regarding the positives, negatives and improvements of the processes involved with the MDT.
	Modelling the Way	Improving staff retention on the bedded units (new)	4	This quality council are presently collecting data regarding staff morale. This will be analysed in Q1, and change ideas tested taken forward.
	Positive Patient Experience	Improve the uptake of 6-8 week maternal mood contacts with the Health Visiting Service in Barnet.	6	The quality council devised an allocation sheet for all due Maternal Mood Assessments of clients who initially had a New Birth Visit carried out by a bank/agency Health Visitor. The sheet was utilised by allocating out the assessments accordingly by the Team Leader to permanent Health Visitors within the Barnet 0-19 Team. This had a huge impact on our KPI's, as clients were not then being missed from receiving a Maternal Mood Assessment, and they were also being completed within the given timeframe. The council have completed and will be showcasing their work on Spotlight on Quality.
Inner North West Division	Positive patient experience	Improve access to mainstream service for LD clients	5	The quality council added a referral prompt to the falls assessment plan. The prompt is to help clinicians identify if the mainstream services would be appropriate to action out the treatment plan. The council will collect feedback regarding the outcomes of this change and will be collecting patient/carers feedback regarding the service.
	Positive patient experience	Raising the voice of the Child with health conditions	5	A quality council is working in collaboration with a Primary school, 3 children with diabetes and their parents. The aim is to improve children's awareness of diabetes from a child perspective. The three children voices have been made into a video regarding how it feels to have diabetes, and what they would like their friends to know about their condition. The council are also putting a comic strip together which will be tested as a training tool.

Division	Quality Campaign	Project	Number of staff involved	Project progress
	Preventing Harm	Improving the communication of safeguarding information between Social Care Services, Health Visitors and School Nurses	4	In Q3 the QC paused whilst waiting for the result of the H&F tender. Feedback from Social Care has indicated the project is integral for communication and information sharing at safeguarding meetings. In Q1 the ideas from this quality council will be shared across other Boroughs and incorporated into the work carried out as part of the "Time to Shine".
	Positive patient experience	To increase the number of women supported to breastfeed in the Inner Boroughs and improve rate of data recording of infant feeding in the Inner Boroughs	4	The last part of the data required is still being analysed, presently it is heading towards 95%, the required level to submit the data to Public Health England. The next steps to ensure the data collected will continue at this level of 95%.
	Modelling the way	To improve staff morale and retention of staff in the Speech and Language therapists ELT and dysphagia. (new)	7	A new quality council who would like to make improvements in their working environment with regards to involvement in decisions and how that effects their morale. They have met three times and have themes linking to change ideas which they will start in April.
Outer North West Division	Modelling the way	Improve continence guidelines and training to complete bladder and bowel assessments in Brent.	4	In Q3 the training slides and information were prepared by the Clinical Lead Specialist. The training has started to be shared with patient facing staff in NWLH and the outcome of this will continue to be reviewed through data collection of staff confidence of assessment completion prior to leaving the hospital.
	Modelling the Way	Tackling bullying and harassment in Harrow	6	The QC met at the end of Q3 and are revisiting their change ideas. In Q1 their ideas will be heard and supported to be taken forward by the bullying and harassment task force group.
	Positive patient experience	SG/QI Use data to compare areas of deprivation with breastfeeding rates and see if we give targeted support to improve rates of breast feeding where it is needed (14 days and 8 week)	5	The quality council in Brent have continued to collate the data from PHE (Public Health England) with the Data Analyst. Data is still being analysed and comparing this with the Trusts breast feeding uptake. Gaps have been identified; next steps are to ensure the varied cultural needs of service users in Brent are met.
	Positive Patient Experience	Improve the communication and uptake of e-red book between CLCH and the Families in Ealing.	5	Process maps have been created around the E-Redbook process for both Admin Staff, and the process that a parent needs to complete. Feedback from the parents and admin staff around how they find the process around the activation of the E-Redbook has been analysed. The findings so far are that the process is long, not all services acknowledge the e red book and other areas of the Trust are not involving admin staff in the process. This has been escalated. Next steps ideas to promote e red book and streamline process.

Division	Quality Campaign	Project	Number of staff involved	Project progress
South West Division	Positive Patient Experience	Improving communication through information folders for patients in the Community in Merton.	5	Over 200 folders have been distributed by the Chair and members of her team. The feedback from patients, carers and professionals has continued to be positive. The inserts have been translated into 5 different languages and these will be saved in a shared drive to be used for all staff. Two other divisions are now taking forward ideas from the folders. The learning and outcomes of this council will now be showcased across the Trust.
	Preventing harm	Improving pathways and competencies in pressure ulcer awareness.	6	This is a new Quality Council presently recruiting nurses to the council to work together with AHPs regarding awareness and management of Pressure ulcers. The pathways will be reviewed and ideas to improve collaboration of both AHPs and nursing staff in the prevention of and management of PUs.
	Modelling the way	Creating a CLCH E-Learning module on Tongue Tie Training	5	This quality council is chaired by a School Nurse in Merton. In Q3 a quick survey was sent out across the Trust to HVs identify the gaps in staff knowledge and training regarding babies with tongue tie. Key themes for training were identified. In Q4 this information will be used to help plan the content of the training carried out by a Lactation consultant and Infant Feeding Lead in Merton. The Academy are supporting with the process of the ILearn module being created once the content has been devised. Indira is still currently putting the content together. QC Liaising with the academy around this.
	Modelling the Way	Improving staff morale in the Brocklebank, Bridge Lane and Roehampton Team in Wandsworth	6	The council have tested their first change idea of informal coffee and chats within their teams to get to know each other and feel part of the team. The feedback from this was analysed and changes made in 2 areas around the name of the get together and the time. Christmas get togethers also trialled within each area and this was reviewed in Q4. Meeting with CBU Managers arranged for the middle of March to share progress and barriers facing in hope of gaining their support with pushing the project forward.
	Positive patient experience	Improving the environment of the clinical room for Children and young people.	5	In Q3 this quality council of paediatric physiotherapists have collected staff and service user feedback to improve the clinical room they use for consultations. The feedback has identified ideas for decoration which have been shared with estates who have offered support to commence with the design ideas. The work is due to start at the end of December. In Q4 due to Omicron the project had to be paused. The QC are now

Division	Quality Campaign	Project	Number of staff involved	Project progress
				awaiting a new date for work to commence in Q1.
Herts	Positive patient experience	Reducing PALs complaints in Planned Care in Herts regarding deferred/missed appointments.	7	The quality council used staff and patient feedback to change the process regarding deferred/missed appointments. The messaging service and waiting list reminders tested resulted in reduction of complaints regarding deferred and missed appointments. This streamlined process which will now be shared across other areas of the Trust.
	Positive patient experience	Increase the number of virtual consultations in Hertfordshire Planned Community Therapy Teams.	6	In Q4 the council continued to test their triage flow chart and support service users using virtual consultations. In Q1 the learning from this project will be shared and the triage template continue to be used.
	Smart Effective care	Improving the process of inputting S1 using handheld devices.	6	A new quality council, the staff have collected feedback regarding the positives and negatives of a handheld device. Research into devices used across other Trusts will be carried out and clinical systems will be integral as a stakeholder in the council. The plan is to pilot the use of handheld devices in one service in Herts and review the feedback.
	Modelling the way.	Increasing the support of research in the Long Covid service.	6	This is a new council, who have been part of the Joy in Work collaboration to improve patient satisfaction in the long covid service. In Q4 they have been incorporating support of research into their service to develop their rehab pathways and improving the MDT meeting. The QC are currently devising a resource book for patients to aid self-management. Redesigning and launching their referral forms once agreed with CCG and looking into the inequality of access to the Long Covid Service.
	Modelling the Way	To improve staff wellbeing and connectedness in Dacorum and Watford Planned Therapy Care Teams.	6	The council have identified the effect on staff due to lone working and no social contact due to covid. The council have been collecting more information through a quick survey through MS teams and the results showed 50% feel less connected. Virtual coffee mornings started as change idea and a review questionnaire of this idea showed an increase in peoples wellbeing by 0.5 in score. In Q1 coffee mornings will continue but with a focus and will be reviewed.
	Smart Effective care	To improve processes between the Herts SPA and Specialist Services (New)	8	A new quality council who are brainstorming the improvements required around workload, understanding of new services and communication between SPA and Specialist services. They will start their change ideas in Q1.

Division	Quality Campaign	Project	Number of staff involved	Project progress
Trust wide	Modelling the Way	Improving development opportunities and raise morale in the finance department.	8	The council reviewed their survey in Q3 in line with the new way of working. The work was paused due to capacity but will be restarted in Q1 alongside staff morale project for the senior members of this team.
	Positive patient experience	Improving the continence service across the Trust	7	In Q3 and Q4 evidence had started to be collected regarding what is going well and where the gaps and improvements can be made across the Trust. This highlighted that there are differences in suppliers and processes across the Trust. Due to this moving forward in Q1 it will be divided back into divisions to map the processes being carried out, recruit patient representatives and start testing change ideas.
	Smart effective care	Improving the duty HV process	12	This was a Trust wide QI/SG from the HV reimagining. The processes of all the tasks coming into 'duty' were mapped. Issues were highlighted from this regarding admin vs clinical task and staff capacity to carry out duty due to the decreased number of HVs. Ealing is now piloting change ideas regarding the role of the CNN and Community staff nurse in the Duty rota and reduction of admin tasks to clinical staff through the duty line.
	Modelling the way	Supporting research across the Trust	6	The shared governance team has highlighted research support across the QCs which has been supported by the research team. In Q1 staff will be meeting to share their ideas regarding the access to and time to utilise research support.
	Modelling the Way	Tackling bullying and harassment in the workplace by staff	10	In Q4 the QC was on hold due to staff capacity but their ideas continued to be fed into the Bullying and Harassment Steering group by the SG Lead and the animation highlighted in the anti-bullying week. In Q1 there will be a recruitment drive to gain more members to restart the council.
	Positive patient experience.	Charity donations through the shared governance model	5	The shared governance model was used regarding the practical use of Charity money donated to Athlone ward was carried out using staff and service user feedback through the shared governance model. Phase 1: Ideas shared include the garden area to be redesigned for staff and the possibility of large, mounted TVs for patients and relatives. This work is due to start in April 22. Phase 2 will take forward further ideas including Team development – away days, radios, and a coffee machine.
	Modelling the Way	Improving opportunities for career development of Administrators and making staff feel valued	10	The quality council have continued to work on their first admin newsletter with a survey regarding value and career opportunities in non-clinical staff.

Division	Quality Campaign	Project	Number of staff involved	Project progress
				Members of the QC presented at the non-clinical conference and in Q1 further staff will be recruited to push forward with the admin forum for 2022.
	Modelling the Way	Raising the profile of Allied Health Professionals	7	This quality council are looking at staff development. The last meeting highlighted that staff are not aware of the resources available to them such as career development clinics, mentorship programmes, and secondment opportunities. In Q1 next steps will be decided how to improve staff awareness of these opportunities.
	Modelling the Way	Improving communication across AHPs	7	This Quality Council have highlighted the issues regarding communication across the Trust and would like to pilot the change idea of Communication Champions within the Trust. This was discussed with Comms team who were receptive to this, and next steps are to decide how to take this idea forward.
	Preventing harm	SG/QI Improve accessibility of safeguarding resources for HV staff and evaluate the content and change as needed	7	The team have been testing the change ideas of review links, one policy per page, QR codes, leaflets and posters for safeguarding resources. There is now a policy on a page completed and the feedback regarding this was very positive during safeguarding week.
	Positive patient experience	Improving the understanding of the views of BAME communities for end of life and palliative care. (new)	6	This a new quality council who are presently recruiting staff and have designed a poster with a QR code to collect information regarding the views of BAME communities for end of life and palliative care. These findings will be taken forward to decide change ideas and to shape trainings for staff to give best patient and family care.
	Smart effective care	Improving completion of the S1 new birth templates	4	Previously started pre covid this quality council are regrouping to continue their collection of data around the barriers and learning needs of staff completing the S1 template.

TRUST QUALITY PROJECTS AND INITIATIVES

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

Volunteers and Patient Representatives: Our **volunteers** are a vital and welcome resource who proved invaluable during the pandemic. Volunteer recruitment is now online. This is faster, more user friendly, and enables us to advertise directly on many more platforms. Over Q3 & Q4, we've added six new services who work with volunteers, taking us to eighteen with a further 28 in the pipeline. Induction has also moved online to make starting at the Trust more efficient and welcoming too. Our volunteer survey this year showed that 95% would recommend volunteering at CLCH, 85% feel well supported and 84% feel CLCH communicates well.

To better hear from our patients and involve them in our services we have reviewed our **Patient Representative** Policy, and job description. We began advertising for the new role in April 2022.

Always Events: The Outer NW Division (& originally Child Health Division) **Always Event** produced leaflets that provide general information about the School Nursing Service such as contact details, location, and services available. The leaflets were produced in multiple languages and widely distributed to all special schools. Now that it is complete, leaning from this project has been shared.

Breastfeeding BFI Accreditation: The Inner North West services have successfully maintained UNICEF BFI Gold Baby Friendly Accreditation, following submission of their Annual Report and Audit in January 22. UNICEF BFI noted that they were "*delighted to see the quality of work that is being implemented within CLCH and the positive outcomes being achieved as a result*." All other boroughs have successfully reached stage 2 BFI accreditation:

- Brent: stage 3 BFI accreditation, working towards stage 3 re accreditation in 22
- Ealing: stage 2 BFI accreditation, working towards stage 3 in 22
- Merton: stage 3 BFI accreditation, working towards stage 3 re accreditation in 22
- Wandsworth & Richmond: stage 2 BFI accreditation, working towards stage 3 in 23

The Health Equalities team initiatives: Leading campaign One (Access to Services) of our **Equalities Strategy**, the Health Equalities Team has driven projects and investigated ways to achieve equity of access to CLCH services with respect to protected characteristics of our patient population that the Trust routinely collects (i.e., age, sex, and ethnicity). Achievements to date include:

- **Improving access to our Diabetes Service** through a co-production project between CLCH staff, and people with lived experience of diabetes, to design a survey, asking critical questions about access to healthcare and diabetes services.
- **Redesign of the Equality and Health Inequalities Impact Assessment (EHIA)** to ensure consideration is given to the impacts of service changes on people with protected characteristics, and low socioeconomic status.
- **Digital Inclusion:** We supported the Homeless Health Service to acquire ten mobile devices with three months connectivity. These enabled users to reconnect with friends, family, and support services.
- **Health Equalities Dashboard**: The Health Equalities Dashboard, an interface enabling staff to view CLCH activity, waiting times and DNA rates with respect to age, sex, ethnicity, and deprivation, is in the closed testing stage. The Dashboard has been developed to operate on Power BI and will enable staff to view health inequalities within specific service reporting lines.
- **Ethnicity Recording:** The Health Equalities Team has achieved improvements in the ethnicity recording completion rates. In February 2021, the ethnicity completion rate was 83% and it has reached and stayed consistently at approximately 90% over the past nine months. This has been achieved through the publishing of materials to empower staff to ask about ethnicity and to educate both staff and service users about the importance and use of this information.
- **Website Accessibility:** The Trust's external website is now more accessible by integrating *Recite Me*. Beyond simple text translation, the software offers language, sight, and hearing adjustments by reading text aloud, amending fonts, and altering the colour scheme amongst further features.

7-minute learning: A total of 57 **7-minute learning tools** were shared across the Trust in 2021/22. This quick easy way to share learning from incidents and best practice will continue to expand in 2022/23.

E-Core Standards self-assessment: Every team in the Trust has now completed the **E-Core Standards self-assessment**. 86% were RAG rated green. This forms the basis for more teams starting the journey to become **Quality Development Units** (QDU). Five services have achieved QDU status. The Herts Podiatry Service is the latest team to do so, despite the challenges of redeployment during the pandemic.

Tackling unacceptable behaviour campaign: In 2021/22 the following actions were taken to manage and minimise violence and aggression towards staff as part of our **Tackling unacceptable behaviour campaign:**

- Completion of a pilot project to provide assurance on the robust implementation of staff and patient emergency alarm systems at Trust sites. Following the pilot, a Standard Operating Procedure was approved for rollout in Q1 22/23.
- Reports were circulated to all divisions on the use of Skyguard personal safety devices.
- The second *'Tackling Unacceptable Behaviour Week'* took place in April 2021, to shine a spotlight on this important issue and how we can all work together to manage and minimise incidents of violence and aggression.
- Production of four training videos to help staff address and challenge unacceptable behaviour.
- *'Violence and Aggression at Work'* and *'Lone Worker'* policies updated.
- Introduction of a standard operating procedure and visual flowchart to support incident handlers in addressing unacceptable behaviour against staff with the perpetrators.
- Publishing of case studies covering examples of the application of sanctions to tackle unacceptable behaviour against staff.
- Distribution of new materials for the public-facing *"I'm not a target"* campaign featuring staff from across the Trust.
- Introduction of newsletter aimed at helping lone workers to stay safe and to manage and minimise the risk of violence and aggression while undertaking their duties.
- Collaborative learning sessions with partner organisations to ensure best practice.
- Continuation of security site visits in response to security concerns and reported incidents, with identified actions monitored at divisional estates groups.
- Targeted conflict resolution training provided to inpatient units and walk-in centres

The CLCH Academy: The Academy has continued to deliver essential clinical skills training across the Trust. Key highlights of 2021/22 include:

- The Tissue Viability Team in Merton won the Student Nursing Times Award for Community Placement of the Year
- Introduction of the Professional Nurse Advocate (PNA) Role across the Trust
- Appointment of Dr Chris Flood as Professor of Healthcare Practice in conjunction with London Southbank University
- Launch of the Long COVID Introductory Module on E-Learning for Health (ELfH)
- Continued provision of training for the Northwest mass vaccination centres
- The Research and Development Department was integrated into the Academy, and launched the CLCH Research Strategy 2021
- Introduction of the 0 – 19 Practice Development Nurse (PDN) role across the Trust
- Leadership and People Development (LPD) programme

The Academy has risen to the challenges presented by limited face to face contact to support the delivery of an exciting range of virtual conferences this year:

- International Nurses Day (May 2021)
- Promoting Equality and Tackling Inequality (May 2021)
- Learning Disability (June 2021)
- Disability and Wellbeing (Sept 2021)
- Safeguarding (Sept 2021)
- Race and Equality (Oct 2021)
- Allied Health Professionals Day (Oct 2021)
- Non-clinical (Nov 2021)
- Health Visiting (Nov 2021)

NHSEI commissioned the CLCH Academy to develop two Long Covid training packages. The first, a basic awareness of Long Covid was successfully launched in 2021. This has now been updated to ensure it is more interactive and new sessions on Living with Long COVID and Managing Symptoms of Long COVID have been launched on 1 April. Each of the e-learning sessions takes approximately 30 minutes to complete and a certificate is available to download on completing each session.

Research: To support our vision to become leaders in community-based research, in July 2021, the Trust launched its new Research Strategy 2021-2024. Delivery of the strategy is being managed through agreed annual implementation plans (AIPs) that monitor the progress and effectiveness of strategic actions and deliverables are overseen by the Trust Research Governance Committee, Modelling the Way Group and Quality Committee. The Trust has achieved its quality measures under the 'Smart effective Care' pathway by increasing the number of research projects involving, or led by clinical staff, by 20% against an initial target of 10%, with 9 recruiting studies opened in year 2021-2022 compared to 7 studies in 2020-2021. Commercial study recruitment has also increased from 1 participant in 2019-2020 to 23 participants in 2021-2022.

The Trust was proud to become a member of the North West London Clinical Research Trials Alliance. As the only community provider partner this creates a valuable opportunity to showcase our expertise, capabilities, and services.

School Engagement: A dedicated **School Engagement** Steering Group is now managing and monitoring our school engagement workstream. It has created a series of videos which schools and students can access to explore the different professions available at CLCH. Students even have the chance to undertake **virtual work experience** placements on our website.

Overseas recruitment: Our overseas recruitment campaign continues with new staff recruited and on-boarded every month. In the last 12 months, we have completed 226 interviews, offered 128 positions, and onboarded 105 international recruits. We continue to support our new recruits with the OSCE Preparation Programme and 100% of our staff have passed. We also continue to offer the OSCE Preparation Programme to other Trusts. We have shared some of our recruitment successes at the **Queen's Nursing Institute** and across London.

Funding from NHS England has allowed us to recruit three OSCE Preparation Practice Development Staff for a fixed period. They were all themselves international recruits from earlier years able to draw on their own lived experience to provide invaluable training and pastoral support to our new recruits. Over the last year, they developed two guides - one for our international recruits to support their induction into the Trust and their migration to the UK, and one for managers and teams welcoming an international recruit into their service.

In Q4, we have joined the new Capital AHP International Recruitment Programme as an early adopter. This programme will mirror the Capital Nurse International Recruitment programme ensuring best practice and consistent recruitment is undertaken across London. We have increased our AHP international recruitment plans for all AHPs, and our agency has launched a Speech and Language Therapists Campaign in Australia, New Zealand and South Africa.

Quality Improvement: 121 active and 63 completed **Quality Improvement** projects were registered at the end of 2021/22, including **The Joy in Work Improvement Collaborative**. Twenty-one teams (eighty-five members of staff) from clinical and corporate divisions joined the Improvement Collaborative and set up improvement projects with the common purpose of improving their joy in work. Through six learning sets, participants learned quality improvement tools and methods, and shared their progress and learning. In between learning sets each team was supported by an improvement coach.

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

This will be completed after receipt of stakeholder comments

We would like to thank those who reviewed and provided comments on our 2021-2022 Quality Account. We have considered the comments received and where appropriate the comments were responded to.

ANNEX 2: STATEMENT OF DIRECTORS' RESPONSIBILITIES FOR THE QUALITY REPORT

This will be completed after it is signed off, and receipt of stakeholder comments

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 2021 to March 2022
    - papers relating to quality reported to the board over the period April 2021 to March 2022
    - feedback from commissioners dated xxxx
    - 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
- CQC inspection reports

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

James Benson

Interim 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 organisations.

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 the 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 when published