CLCH QUALITY ACCOUNT 2022 – 2023

* Page nos. etc will be finalised when all the information has been received.

PART 1: ABOUT OUR QUALITY ACCOUNT

Welcome to the Central London Community Healthcare NHS Trust (CLCH) Quality Account for 2022-2023

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 district nursing, community matrons and case management.
- Specialist nursing including continence; respiratory, heart failure; tissue viability and diabetes.
- Children and family services including health visiting, school nursing, community nursing, speech and language therapy, blood disorders and occupational therapy.
- Rehabilitation and therapies including physiotherapy, occupational therapy, foot care, speech and language therapy.
- End of life care, supporting people to make decisions and to receive care at the end of their life.
- Long-term condition management supporting people with complex and substantial ongoing health needs caused by disability or chronic illness.
- Specialist services including delivering parts of long-term condition management for people living with diabetes, heart failure, Parkinson's and lung disease, homeless health services, community dental services, sexual health and contraceptive services and psychological therapies.
- Walk-in and urgent care centres providing care for people with minor illnesses, minor injuries and providing a range of health advice and information.
- A lymphedema service in Hertfordshire providing support and management for cancer related lymphedema and for those with complex oedema at end of life.

Vision mission and values:

Our vision is 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 2023. This year has been an opportunity to re-establish the processes that we had paused during the pandemic and strengthen our work with partners to deliver safe care across the communities we serve. I'm proud to note that our staff have also remained resilient, regardless of the pressures they have faced this year, with the increasing cost of living and industrial action that they have had to navigate.

This year we have once again successfully delivered on our quality key performance indicators (KPIs) and have achieved good outcomes for our patients, carers, and staff. We have continued to report excellent feedback from our positive patient experience campaign, with nearly 100% of patients responding to our surveys rating their overall experience as good or very good. We have also worked to ensure that over 97% of our clinical incidents did not lead to moderate or severe harm. We will however be looking to stretch ourselves further going forward, as we review and update our quality strategy in 2023/24.

We are extremely proud that our teams have continued to excel, with some being recognised in national award schemes. Our Merton tissue viability nursing team was crowned winner of the student placement of the year (community) award at the student nursing times awards. In September 2019, our health visiting service in inner northwest was the first in London to achieve the UNICEF baby friendly gold sustainability award. The team has achieved gold reaccreditation every year since, including most recently in January 2023.

We also celebrated a year since welcoming Brent services into our outer northwest division and have recently invested in the clinical environment to enhance patient experience by refurbishing the Furness ward. We have also worked with partners in PLACE to increase the number of rehabilitation beds at our Willesden centre for health location.

Finally, my heartfelt thanks to all our staff, volunteers and system partners 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 Chief Executive Officer

STATEMENT OF THE CHAIR OF THE QUALITY COMMITTEE

We are in the third year of delivering our refreshed quality strategy '*Improving Quality in Everything We Do'.* The Quality Committee has continued to meet quarterly throughout 2022/2023 and has monitored and scrutinised the delivery of the quality priorities. As in previous years the committee has received monthly updates, including a quality dashboard, bedded score card, patient stories and reports on progress against our targets. I am pleased to report that once again we have been successful in delivering on our campaigns despite the pressures that our staff have had to navigate.

The Trust has maintained strong performance against its quality key performance indicators (KPIs). We have achieved excellent levels of engagement with our patients, with over 98% of patients who completed our experience survey, reporting they felt that staff had taken time to find out about them and 99% reporting that they were treated with respect and dignity. We have also maintained improvements in our preventing harm indicators with 100% of our serious incident investigations being completed on time. We enhanced how we share learning from serious incidents and launched an internal patient safety alert process to ensure greater vigilance when clinical risk has been identified. For our staff to remain safe as they undertake their roles, we are happy to report that we have also maintained high levels of statutory and mandatory training compliance.

As we continue to recruit into our vacant posts, we have managed to increase the number of people volunteering in our services. Over the last 12 months, we have been growing our volunteer offer and working to embed a culture of volunteering at CLCH. There are now over 100 volunteers, which is a four-fold increase since this time last year.

To ensure we maintain safe staffing levels across all our clinical services, I am pleased to report success in our international recruitment processes, where we have successfully onboarded 262 overseas professionals since September 2020. Our CLCH Academy has continued to support our existing staff with meeting their education needs, primary and social care staff with identified training and development requirements and our new staff as they transition into working in the UK. We have also enhanced our pastoral support by recruiting an international recruitment practice and pastoral support allied health professional to welcome and support our international recruits into their new role and the UK.

I am happy to also note the growth of our clinical research function in CLCH with the research and development team successfully promoting their work through roadshows. the team have also been successful in achieving 100% for its target response rate for the participant in research experience survey (PRES). Of the PRES respondents, 100% either agreed or strongly agreed that the information they received before taking part prepared them for their experience in the study.

In the last year we have continued to enhance our quality monitoring and assurance processes through embedding the e-core standards self-assessment process. There was a total of 216 teams/services who completed the audit with a 100% compliance rate and a majority reporting high levels of compliance. Our service improvements initiative, through quality councils and shared governance, remains in place, with 250 staff involved in 60 quality councils.

As we have returned to full operational service delivery over the year, we have worked closely with system partners, our staff, and patients to deliver services that provide high quality care to our local community. 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 delivering high quality care at every level of the organisation

Dr Carol Cole
Chair of Quality Committee

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

PRIORITIES FOR IMPROVEMENT 2023 – 2024

Our four quality campaigns for 2023 – 2024 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 July 2023 to August 2025 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 and March 2023 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 DEC 2021- JULY 2023	MEASURES OF SUCCESS AUGUST 2023 – MARCH 2025
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 maintained at 95%	The proportion of patients who felt staff took time to find out about them will continue to be maintained at 95%
	We will ensure that 80% of patient/ user/ carer feel involved in each service change	We will maintain 80% of patient/ user/carer feeling involved in 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 80%	Staff, friends and family test – percentage of staff recommending CLCH as a place for Treatment will be 85%
	We will increase volunteer numbers by 50% from 2020/21 baseline in services where volunteer participation improves patient experience	We will continue to embed the volunteer roles across the trust and to focus on volunteer community outreach projects
	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	We will continue to share you said we did stories to share volunteers' experiences and to complete an annual volunteer survey to understand their impact on services and their experience

KEY PRIORITY /OUTCOME	MEASURES OF SUCCES DEC 2021 – JULY 2023	MEASURES OF SUCCESS AUGUST 2023 – MARCH 2025
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	We will continue to respond to 100% of patients' concerns (PALS) within 5 working days We will continue to respond
	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 transfer the learning from each *always event* across the trust	We will evaluate the Always Events implemented
	We will review the impact and learning from quarterly projects on the overall patient experience	We will continue to deliver and 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)**	50% of health visiting services will have achieved level 2 breast feeding accreditation or greater	All services will have achieved level 3 breastfeeding accreditation or gold or have a plan in place to achieve this within a year.

CAMPAIGN TWO: PREVENTING HARM

Keeping our patients, their families, and our staff safe.

KEY PRIORITY / OUTCOME	MEASURES OF SUCCESS DEC 2021- JULY 2023	MEASURES OF SUCCESS AUGUST 2023 – MARCH 2025
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 2020/21	Maintain or improve on the proportion of clinical incidents that did not cause harm reported in 2021/22
	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 continue to 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 continue to 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 DEC 2021- JULY 2023	MEASURES OF SUCCESS AUGUST 2023 – MARCH 2025
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	There will be evidence of continued improvement from baseline
	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	Each division will assess the impact of learning from each shared incident learning examples using the 7-minute learning tool in divisional boards and patient safety risk group
	90% of teams will have undertaken a core standards annual health check assessment and identified action plans that are completed on time	We will assess the level of improvements in the quality of services in findings from the core standards annual health check assessment
	No outstanding 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 DEC 2021- JULY 2023	MEASURES OF SUCCESS AUGUST 2023 – MARCH 2025
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 evaluate the use of MECC link with our clinical staff	MECC will be embedded in clinical practice
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%	We will increase the number of research projects involving/led by clinical staff within the Trust by ≥ 20%
	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%	We will use an electronic survey tool to measure the impact of communication with a target of ≥ 60% of clinical staff inspired to undertake clinical improvements.

CAMPAIGN FOUR: MODELLING THE WAY

Providing innovative models of care, education, and professional practice

KEY PRIORITY / OUTCOME	MEASURES OF SUCCESS DEC 2021- JULY 2023	MEASURES OF SUCCESS AUGUST 2023 – MARCH 2025
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 Mentoring opportunities will be publicised for staff Trust wide	80% of clinical staff at band 8b or above will have undertaken training Reverse mentorship will positively influence decision making by senior clinical leaders
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	Each professional group will have development portfolios to support staff having the right skills and knowledge to support new models of care	Each professional group will have identified education and training to support their career development
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	All community nursing and bedded services will have 1/2 ANAs in place	We will introduce the ANA role to specialist services e.g., WICs/ specialist nursing teams We will continue to evaluate
	We will evaluate safe staffing models for AHP workforce, and any new roles developed	We will continue to evaluate safe staffing models for AHP workforce, and any new roles developed
	We will continue to develop Professional networks and deliver / events to be delivered for all staffing groups across the Trust and primary care	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 2022-2023 CLCH provided 109 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 2022 – 2023 represents 100% of the total income generated from the provision of NHS services by CLCH for 2022-2023

Secondary use services

CLCH submitted records during 2022 – 2023 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 98.38% and which included patient's valid General Medical Practice Code was 96.04%

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 2022-2023

Data security and protection (DSP) toolkit

The Trust last submitted a 'standards met' for the 2021-2022 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 2023.

PARTICIPATION IN CLINICAL AUDITS

Clinical Outcome Reviews: During 2022-23, 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 **eight** eligible national clinical audits as detailed below:

National clinical audits		
National Clinical Audit	**Participation**	**Outcomes**
1. National Audit of Cardiac Rehabilitation (NACR)	NACR collects comprehensive audit data used to quality assure programmes, support improvement and monitoring of cardiac rehabilitation services in terms of their uptake, quality and clinical outcomes. Services taking part: • South West (Merton cardio-respiratory service) • Cardiac rehabilitation service (Hertfordshire)	Data collection is in progress. The audit report will be published in December 2023.
2. National Asthma and COPD Audit Programme (NACAP) Pulmonary Rehabilitation Audit	The NACAP aims to improve the quality of respiratory care, respiratory services and patient clinical outcomes. Services taking part: • Outer north west (respiratory service) • North central (Barnet community respiratory service) • Hertfordshire (respiratory service) .	Data collection is in progress
3. National Audit of Inpatient Falls (NAIF)	The NAIF audits the delivery and quality of care for patients over 60 who fall and sustain a fracture of the hip or thigh bone in acute, mental health, community and specialist NHS trusts/health boards. The NAIF reviews the care the patient has received before their fall as well as post-fall care. Services taking part: • Inner north west inpatient units (Alexandra unit and Athlone house) • Outer north west Inpatient Units (Robertson Ward) • South West inpatient units (Merton) • Hertfordshire inpatient units (Langley House unit) • North central (corporate)	For 2022, we registered new inpatient areas across Brent and Hertfordshire.

4. National adult diabetes audit (NDA) national diabetes foot care audit workstream	This national audit enables all services that treat diabetic foot ulcers to measure their performance against NICE guidance, to monitor patient outcomes and to benchmark against peer units. Services taking part: • Outer north west (podiatry service) • South west (podiatry service) • North central (podiatry service)	Data collection is in progress. The NACAP has not yet published the Audit Report for the 2022-23 period.
5. National Audit of Care at the End of Life (NACEL)	The NACEL is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute hospitals, community hospitals and mental health inpatient providers. The aim of the audit is to improve the quality of care at the end of their life. All divisions across the Trust have registered for the audit which is managed by the End-of-Life Care Group in the Trust. • Inner north west • Outer north west • South west • North central • Hertfordshire	Registration completed and ready for 2023-24 submissions.
6. National obesity audit	The national obesity audit will bring together comparable data from the different types of adult and children's weight management services across England in order to drive improvement for the benefit of those living with overweight and obesity. Services taking part: • Inner north west (weight management service)	Data collection is in progress.

7. Sentinel stroke national audit programme (SSNAP)	SSNAP measures both the processes of care (clinical audit) provided to stroke patients, as well as the structure of stroke services (organisational audit) against evidence-based standards. The overall aim of SSNAP is to provide timely information to clinicians, commissioners, patients, and the public on how well stroke care is being delivered so it can be used as a tool to improve the quality of care that is provided to patients. • South west (neuro therapies service) • North central (early stroke discharge team and Barnet stroke support service) • Hertfordshire (early supported stroke discharge)	Data collection is in progress.
8. UK Parkinson's audit	The UK Parkinson's audit is the recognised quality improvement tool for Parkinson's services. The audit measures the quality of care provided to people living with Parkinson's against a range of evidence-based guidance. • Inner North West (Parkinson's tri-borough) • Outer North West (community neurorehabilitation) • North Central (Parkinson's: Barnet)	Data collection is in progress.

LOCAL AUDITS

The reports of **six local clinical audits** that were reviewed by CLCH in 2022-2023 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.

Title	Division	Service	Actions:
1. Service review of safeguarding supervision across sexual health services	**South west**	**London and Hertfordshire sexual health service**	**Audit aim:** • To gather attendees' views of the current model of safeguarding supervision within sexual health services and to ascertain whether any changes needed to be made. This will inform future versions of CLCH's Safeguarding Supervision Policy Relating to Children and Adults at Risk. **Key findings:** • Appropriate cases were being discussed at the safeguarding supervision meetings and respondents were happy with the format of the meetings. • 7/40 (18%) respondents across the services said they did not know how to get hold of the safeguarding team, despite this information being readily available. • The desire for more emotional support in relation to more traumatic cases was highlighted. This is due to the nature of the cases that practitioners are dealing with, such as sexual assault. Specialised support is outside the expertise of the safeguarding team. **Recommended actions:** 1. Liaise with the senior health advisor to clarify timescale for introduction of therapeutic supervision for staff and to liaise with CSU and senior health advisors to ensure that staff are aware of therapeutic sessions available to them. 2. Arrange for safeguarding information and contact numbers to be put up on notice boards in all clinic rooms and add to Microsoft Teams backdrops, including notices in clinic rooms to make this information more widely known among sexual health teams. 3. To liaise with senior sexual health staff and health advisors about carrying out safeguarding supervision face to face, with the opportunity to participate via Microsoft Teams, as required.

2. An audit to compare the current prescribing practices of Brent dietitians, within nursing homes, against the London oral nutritional supplement (ONS) formulary	**Outer north west**	**Brent and Harrow specialist nutrition and dietetics services**	**Audit aim:** • To assess the use of the nutritional supplement formulary within the nursing home population. • To evaluate to what extent the advisory committee on borderline substances (ACBS) criteria are being adhered to. • To see if a food first approach is being promoted. • To evaluate the appropriate use of first line products and the prescription of compact supplements. **Key findings:** • Compact supplements were prescribed to 40% of patients • 90% of patients met the ACBS criteria. • Food first advice was provided to all the patients. • In 62% of cases, a first line ONS product was not prescribed. **Recommended actions:** 1. Distribute the generated leaflet of what to include in assessments with nursing home patients to all staff members and future new members of staff. 2. Distribute OD food first, nourishing drinks and smoothie alternatives to all staff members and future new members of staff. 3. Distribute Hydration Advice leaflet to all staff members and future new members of staff.

3. Justification for Antibiotic prescribing in the CLCH community and specialist dental services	**Inner north west**	**Specialist dental services**	**Audit aim:** • Inappropriate antibiotic prescribing contributes to increased risk of antimicrobial resistance. Dentists contribute 10% of antibiotic prescribing nationally in primary care • To confirm that all antibiotic prescribing by CLCH Dentists is with a valid justification according to national guidance. • To assess that antibiotic prescription justification is recorded in the clinical notes and the prescription log. **Key findings:** • Prescribing of antibiotics in the CLCH Community and Specialist Dental Services was very low in the period January to September 2022: 204 prescriptions / 7968 patients (0.026%), which is to be commended and continued. • Of the antibiotics that were prescribed: 67% Appropriate prescribing of antibiotic, 8% inappropriate prescribing of antibiotic and 25% other (Minor Oral Surgery post-operative surgical prophylaxis). • 88% patients had recording of antibiotic justification in both the clinical notes and the Prescription log. **Recommended actions:** 1. To share the audit findings with the Dental team. 2. To increase awareness and update all Community and Specialist Dental Service dentists with current guidelines regarding prescribing of antibiotics. 3. Electronic Prescription Log is on shared drive and explore options for electronic prescribing by dental team. 4. Re-audit for 2023-24 cycle, with separate analysis for the Minor Oral Surgery team due to complexity of treatment.

4. Written consent for minor oral surgery	**Inner north west**	**Specialist dental services**	**Audit aim:** • To establish whether written consent for Minor Oral Surgery in the Oral Surgery department has been documented in the patients' records. • To establish whether a record of consent has been documented in the patients notes. • To identify whether consent has been reconfirmed before treatment. • To assess whether a copy of the consent form has been given to the patient. **Key findings:** • 88% of patients had a scanned copy of the signed consent forms uploaded onto their clinical records on R4. • 18% patients were given a copy of their signed consent form, and this was documented in the notes. • 22 patients had a record in their notes that consent had been obtained (it was not specified whether this was verbal or written. • 100% had their consent reconfirmed before treatment. **Recommended actions:** 1. Every patient attending the Oral Surgery department for treatment should have a signed consent form uploaded onto their clinical record. 2. A contemporaneous record of the consent process (covering risks & benefits of treatment and alternatives) should be documented in the patients notes. 3. Consent should be reconfirmed before treatment to ensure it remains valid. 4. Patients should be offered a copy of the consent form to review after the initial consultation. 5. All uploaded documentation should be reviewed by the clinician to ensure accuracy. 6. Spot-check audit notes per oral surgeon

5. FP10 Prescription Handling Audit	**Corporate**	**Medical Directorate**	**Audit aim:** • To assure the trust that prescribers and services are compliant with FP10 handling standards in line with CQC regulation 17, NHS counter fraud authority's "management and control of prescription forms: a guide for prescribers and health organisations" and the non-medical prescribing policy mm008. **Key findings:** • Nearly all prescribers and services stated that prescription pads were kept secure/locked when not in use (99.6% of personalised pads, 100% of service pads). • 94% of prescribers are aware of the correct reporting process when prescriptions are lost or stolen. • 93% of prescribers reported keeping and maintaining log sheets. 2% of prescribers had alternative arrangements for record keeping and 5% did not keep a log sheet. • 90% of services reported that access was restricted to the FP10 storage area/room **Recommended actions:** 1. Update prescriber education presentation based on major findings from this report. 2. To include FP10 handling compliance as part of the annual appraisal for prescribers. 3. Medicines management team to request copies of prescription log sheets for prescribers with low prescribing activity on an annual basis. 4. Develop an FP10 handling policy for the Trust. A working group has been established. 5. Medicines management team to meet with clinical systems team to agree the electronic prescription service (EPS) plan for the trust.

6. Management of opiates and gabapentinoids prescribed for acute pain: an evaluation of practice at an inpatient rehabilitation	**Outer north west**	**Athlone inpatient rehabilitation unit**	**Audit aim:** • To review the prescribing practices of opiates and gabapentinoids by clinicians in the Athlone Inpatient rehabilitation unit. • To assess how these drugs have been managed in the appropriate patients on the ward and how often this was actively done. **Key findings:** • Documentation regarding opiates and gabapentinoids can be improved. • Clinicians need to be more proactive in management of these drugs. **Recommended actions:** 1. Present the findings of the audit to the multidisciplinary team (doctors who work on the unit, the nursing and therapy staff). 2. Increase awareness in opiate and gabapentinoid stewardship amongst clinicians and staff to ensure good communication can improve the management of these drugs. 3. Re-audit using modified guidelines from the faculty of pain medicine and evaluate improvement.

Ongoing audits and projects forming part of the clinical effectiveness programme of work:

1. Trust-wide clinical record-keeping audit
2. Pressure ulcer audit
3. Bedded units nutrition audit
4. Bedded units malnutrition universal screening tool (MUST) audit
5. Compliance against the movement in movement out policy
6. Infection prevention and control (IPC) checklist on bedded units
7. Assessing the usefulness of diet sheets used to provide information to patients
8. Implementation of capital allied health professionals fair share placement model for practice placements
9. Diabetes kidney disease
10. Antibiotic prescribing in community and specialist
11. Implementation of the was not brought (WNB) and late cancellation policy in the paediatric dental service
12. Service delivery regarding domestic abuse and routine enquiry – staff confidence, barriers and knowledge
13. The role of community nursing in the early identification of frailty in housebound patients
14. To improve appropriate gloves usage and hand hygiene
15. Quality of referrals to multi-agency safeguarding hub (MASH) re-audit
16. Diagnosis and management of urinary tract infections
17. Safe management and use of controlled drugs in community services
18. Urinary catheter audit
19. Multiple service evaluation projects within local teams and services and/or linked to staff or student's study programmes

PARTICIPATION IN RESEARCH

Since the implementation of its strategy in 2021 research at CLCH continues to develop and embed across the Trust. The Trust remains committed to creating an inclusive research culture and creating equity of opportunity for both patients and staff. In August 2022 the Trust revised its research governance policy to provide guidance and direction on ensuring that quality and regulatory standards are implemented into safe effective research practice and delivery.

There were 89 CLCH patients recruited during 2022 – 2023 to participate in research apprvoed by an ethics committee.

Participant recruitment across studies 2022-2023.		
IRAS Ref	Full title	Recruitment
301144	geko™ cross therapy registry	30
279691	AND-PD: Anxiety and depression in Parkinson's disease	7
301408	DM PAD: Diagnostic tools to establish the presence and severity of peripheral arterial disease in people with diabetes	13
255684	Evaluating the home-based intervention strategy (his-uk) to reduce new chlamydia infection among young men aged 16-25 years by promoting correct and consistent condom use:	10
291746	BabyBreathe Trial: A randomised controlled trial of a complex intervention to prevent return to smoking postpartum.	17
275253	A case study in the use of avatar-based therapy utilising the externalisation of problems in an adult on the autistic spectrum	1
318255	DEMCON- Development, evaluation and provision of an intervention for primary and community NHS staff to help carers and homecare workers supporting people living at home with dementia with their continence (Phase 2 - interviews)	11
Total:		89

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 applies to anyone who undertakes work for the trust.

Speaking up should be part of the normal business practices of the Trust, and seen as gift, rather than a hindrance. Acknowledging each concern should be seen as a learning opportunity.

Information about FTSU is included within the Trust's welcome booklet; it is part of staff induction, and a handout given to bank workers and volunteers. Core FTSU training has been developed in line with national guidelines and it is also 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. Additionally, a FTSU module has been developed and included in the trust's leadership and people development programme.

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. The Trust encourages staff to raise concerns which is usually initially through their line manager. Where staff don't feel confident to do this they may wish to contact: a more senior manager; a clinical lead; the patient safety or safeguarding team; staff representatives; human resources; directors or the local counter fraud specialist. They can also contact the Freedom to Speak Up guardian. 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 the chair of the quality committee, Dr Carol Cole.

Staff can choose to raise their concern by name, confidentially or anonymously. Confidentiality maybe limited in certain circumstances, such as where the Trust is required to disclose information by law, for example by the police or if a patient is in immediate danger. In these situations, we will always work with the staff member who has raised the concern.

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. Staff are protected under the FTSU policy if they experience negative consequences for speaking up.

The FTSU guardian 2022/23 reports have been completed and returns submitted for those periods to the national guardian's office.

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

TOPICAL CONTRACTING ISSUES ACROSS CLCH – CQUIN Q3

It should be noted that although payment for CQUINs is included in block contracts, it is possible that some claw back to reinvest into system savings is contractually possible if there is failure to report, or there is underachievement. CQUIN achievement must be uploaded onto the NHSE website by 25 May 2023 and will also be shared individually with commissioners in respective divisions. All CQUINs contribute to 1.25% of each NHS block contract.

Forecast summary at year end: CLCH expect to fully achieve all CQUINs by the end of 2022/2023.

	CQUIN Achievement Summary for Q4 2022-23	CQUIN Goal	Herts	SW	NC	NWLI	NWLO	Trust Total
CCG 1	Description: Achieving 90% uptake of flu vaccinations by frontline staff with patient contact. ***	90%	47.47%	38.9%	37.24%	39.16%	24.62%	35.10 %
CCG 13	Description: Achieving 70% of community hospital inpatients having a nutritional screening that meets NICE Quality Standard QS24 (Quality statements 1 and 2), with evidence of actions against identified risks	70%	99%	92%	90%	100%	64%	94%
CCG 14	Description: Achieving 50% of patients with lower leg wounds receiving appropriate assessment diagnosis and treatment in line with NICE Guidelines	50%	52%	80%	56%	92%	81%	70%
CCG 15	Description: Achieving 60% of community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks	60%	99%	92%	96%	100%	96%	98%

The Trust wide average data for other CLCH departments are as follows:
Finance, contracts and performance = 14.61% improvement = 34.69%,
Medical = 55.88%,
Partnership and integration = 50.00% , people = 39.66%,
Quality and learning = 57.75%,
Trust management/hosted = 57.45

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 2022/23. Furthermore, the Trust has not participated in any special reviews or investigations by the CQC during the reporting period that ended 31st March 2023. At our last inspection, in October 2022, the CQC inspected one of the Trust's core services- community health services for adults, when they inspected the Harrow community nursing service. The Trust has not had a well-led assessment element of inspection since October 2017.

In December 2022, CQC published their report which rated the Trust as 'Good' overall, with a change to the 'safe' rating in the core service inspected from 'good' to 'requires improvement'. The grids below reflect the Trust's current rating.

CareQuality Commission

Last rated
30 December 2022

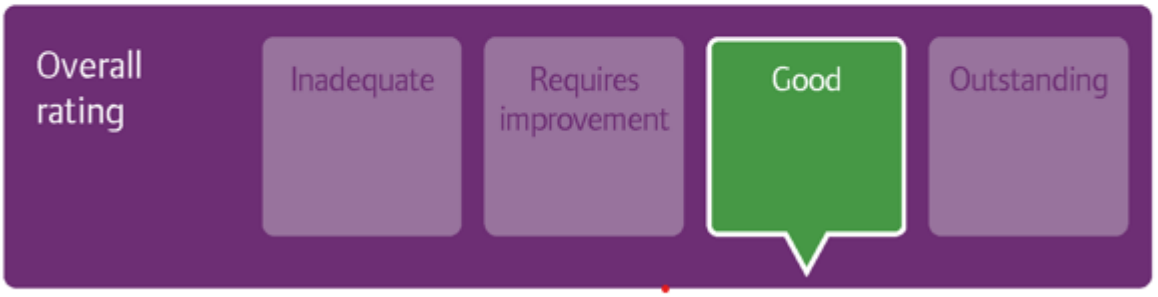
Central London Community Healthcare NHS Trust

Are services

Safe?	Good
Effective?	Good
Caring?	Good
Responsive?	Good
Well-led?	Good

Last rated
30 December 2022

Central London Community Healthcare NHS Trust



	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires Improvement	Good	Good	Good	Outstanding ☆	Good
Community health services for children, young people and families	Requires Improvement	Good	Good	Good	Good	Good
Community dental services	Good	Good	Good	Good	Good	Good
Community health inpatient services	Good	Good	Good	Good	Good	Good
Community end of life care	Good	Good	Good	Good	Good	Good
Community urgent care services	Good	Good	Good	Good	Good	Good

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 adults, at the 2022 inspection. Areas of improvement were identified by the CQC, and the Trust had put extensive plans in place to address these.

The Trust was issued with two 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 to undertake the necessary work. Progress is monitored through the Trust's monthly patient safety and risk group and compliance steering 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 recognize 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 2022/23 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.

- Continued with a programme to migrate Trust information reporting to Power BI. This provides activity and performance reporting refreshed daily, including contacts, referrals and outcome timeliness. Power BI enables 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 operational and corporate teams, staff in IM&T have been engaged with data quality initiatives such as clinical template and counting rules standardization. A major review of counting rules took place in 2022/23 which was implemented during Q4.

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 2023/24 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 taking opportunities to improve data completeness and accuracy arising out of recent standardization and data warehouse upgrades, developing more granular data quality reporting, and pursuing 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 2022 – 2023

From April 2017, all trusts are 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 currently being updated again. 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 and therapies triage each case to ascertain whether a case record review should be carried out using a modified PRISM2 (preventable incidents, survival, and mortality study 2) form. The case record reviews are completed by 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 associate medical director for children's services 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. For example 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.

There is a theme noted in 8/11 cases in the tables below. This relates to the medical optimisation of patients being admitted to the ward.

Since the advent of covid there has been a change in the nature of medical optimization of patients admitted to bedded rehabilitation units. In particular, during peak periods of covid, admission criteria to bedded units have been flexed to aid system flow which has meant some admitted patients have been less optimally medically optimised compared with previously admitted cohorts and are thus less able to functionally engage with rehabilitation and also present a higher risk of deterioration.

	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 April 2022 – Feb 2023, 3146 CLCH patients died as follows (includes expected hospice deaths): Q1 - 790 Q2 – 751 Q3 – 967 Q4 - 929 Of this number, the following number were in-patients: Q1 =1 Q2 = 2 Q3 = 3 Q4 = 2
2.	The number of deaths included in item 1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.	From April 2022 to Mar 2023, 6 case record reviews (PRISMs) were completed. 5 case reviews from the previous reporting period were also completed (see section 7 for details). In 2 cases, the deaths were subjected to both a case record (PRISM) review and an investigation (Case 4: 2022 – 2023, Case 6: 2022 – 2023) The number of cases in each quarter for which a case record review or an investigation was carried out was: Q1 – 1 Q2 – 2 Q3 – 3 Q4- 2* The case record reviews for Q4 are currently ongoing and conclusions will be included in the 2023-2024 quality account.

3.	An estimate of the number of deaths during the reporting period included in item 2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.	0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: Q1 – 0 Q2 – 0 Q3 – 0 Q4 – 0
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 10 (2021 – 2022)** This patient was admitted to a rehabilitation unit for rehabilitation, but medical issues hindered **rehabilitation**. They deteriorated after admission and died. Review noted that due to the high dependency and high clinical acuity of the patient, there were issues around staff resource, training, and skillset which affected patient care.
		Case 11 (2021 – 2022) This patient was admitted to a rehabilitation unit for rehabilitation, but they deteriorated shortly after admission and died. There is evidence that staff were responsive to the patient and the carer's request that the patient was not moved again and arranged end of life care including referral to the specialist palliative care team. The review noted that due to the high dependency and high clinical acuity of the patient, there were issues around staff resource, training, and skillset.

4.	Contd.	**Case 12 (2021 – 2022)** This patient was admitted to a rehabilitation unit for rehabilitation, but medical issues hindered rehabilitation. They deteriorated shortly after admission and died. There is evidence that staff were responsive to the patient's deteriorating condition and provided a balance of intervention and conservative care. Good communication with the family was noted. The review noted that due to the high dependency and high clinical acuity of the patient, there were issues around staff resource, training, and skillset.
		Case 13 (2021 – 2022) This patient was admitted to a rehabilitation unit for rehabilitation. on admission to the unit, they were assessed to be "borderline" suitable for rehabilitation from a physical perspective, however a previously identified medical issue caused deterioration on the ward so they couldn't make functional progress with rehabilitation due to confusion. There was evidence of joint decision making with the patient's family during the patient's admission, including the end-of-life phase. review noted that due to the high dependency and high clinical acuity of the patient, there were issues around staff resource, training, and skillset. **Case 14 (2021 – 2022)** This patient was admitted to a rehabilitation unit for rehabilitation, but a deterioration in known medical issues hindered rehabilitation and the patient died. It was noted deterioration in the patient's mental health also hindered rehabilitation. There was evidence of joint decision making with the patient's family. The review noted there was no documentation of mood assessment or psychological input and that the patient did not receive liaison psychiatry as the team had been redeployed due to COVID-19.

4.	Contd.	**Case 1 (2022 – 2023)** This patient was admitted for rehabilitation and initially engaged with some aspects of rehabilitation although they were physically frail. However, their physical and mental health deteriorated and they died. There was evidence of good communication and joint decision making with the patient's family. The review noted there was no documentation of mood assessment or psychological input and that the patient did not receive liaison psychiatry as the team had been redeployed due to COVID-19. The review advised better documentation is needed of any consideration of medical intervention, even if the decision is to not pursue that medical intervention.
		Case 2 (2022 – 2023) This patient was admitted to a rehabilitation unit for rehabilitation. On admission to the unit, they were assessed to be "borderline" suitable for rehabilitation from a physical perspective but deteriorated after admission and died. There was evidence that staff were responsive to the patient and the carer's request that the patient was not moved again and arranged end of life care including referral to the specialist palliative care team. There was evidence of joint decision making with the patient's family during the admission including the end-of-life phase. The review noted that due to the high dependency and high clinical acuity of the patient, there were issues around staff resource, training, and skillset.

4.	Contd.	**Case 3 (2022 – 2023)** This patient was referred for rehabilitation but had an underlying previously diagnosed Medical issue meant that symptoms limited engagement with rehabilitation. There was evidence of early recognition that the patient needed palliative care input for symptom control and evidence that the patient's psychiatric condition was diagnosed and treated. There was evidence of joint decision making with the patient's family during the patient's admission including the end of life phase. The review noted that due to the high dependency and high clinical acuity of the patient, there were issues around staff resource, training, and skillset.
		Case 4 (2022 – 2023) This patient engaged in rehabilitation but deteriorated during admission and died. There was evidence of joint decision making with the patient's family during the patient's admission including the end-of-life phase. The multi-disciplinary review did not identify further learning.
		Case 5 (2022 – 2023) This patient engaged in rehabilitation but deteriorated during admission and died. There was evidence of joint decision making with the patient's family during the patient's admission including the end-of-life phase. The multi-disciplinary review did not identify further learning.
		Case 6 (2022 – 2023) This patient was referred for rehabilitation but was frail with multiple comorbidities including having poor oral intake. Prior poor functional ability in advance of acute admission had not been communicated. The patient deteriorated during admission and died. Review noted that due to the high dependency and high clinical acuity of the patient, there were issues around staff resource, training, and skillset.

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 10 (2021 – 2022)** The divisional director of nursing and therapies and the divisional medical director in one division have set up clinical summits where learning from deaths and incidents is discussed and this learning is disseminated across all staff in the division. there are discussions regarding whether this could be rolled out across all divisions in the trust. A bimonthly trust deteriorating patient meeting has been set up with a focus on education, learning from deaths /incidents including effective escalation of deteriorating patients. Discussions taking place in medical directorate between the senior medical leadership team with a focus on medical oversight in the bedded units where the patients with higher clinical acuity are cared for, and increasing resource and training rehabilitation team staff, including a review of the skillset of staff. **Case 11 (2021 – 2022)** Please see Case 10 (2021 – 2022) for actions. **Case 12 (2021 – 2022)** Please see Case 10 (2021 – 2022) for actions. **Case 13 (2021 – 2022)** Please see Case 10 (2021 – 2022) for actions.

5.	Contd.	**Case 14 (2021 – 2022)** a) Please see case 10 (2021 – 2022) for actions. b) Divisional medical director and divisional director of nursing & therapies fed back to the team that documentation needed improvement. c) This case and the case below (case 1, 2022 – 2023) will be discussed at the deteriorating patient meeting in a themed discussion regarding the importance of addressing and documenting psychological symptoms.
		Case 1 (2022 – 2023) a) Divisional medical director and divisional director of nursing & therapies fed back to the team that documentation needed improvement. b) This case and the case above (case 14, 2021 – 2022) will be discussed at the deteriorating patient meeting in a themed discussion regarding the importance of addressing and documenting psychological symptoms. **Case 2 (2022 – 2023)** Please see Case 10 (2021 – 2022) for actions. **Case 3 (2022 – 2023)** Please see case 10 (2021 – 2022) for actions. **Case 4 (2022 – 2023)** No action points relating to learning from death or the clinical management of the patient were noted. **case 5 (2022 – 2023)** No action points relating to learning from death or the clinical management of the patient were noted. **Case 6 (2022 – 2023)** Please see case 10 (2021 – 2022) for actions.

6.	An assessment of the impact of the actions described in item 5 which were taken by the provider during the reporting period.	**Case 10 (2021 – 2022)** The first deteriorating patient meeting was held in February 2023. The membership of this group includes service level clinical managers and the CLCH academy as well as the deputy chief nurse responsible for quality and safety, the deputy chief medical officers and the associate medical directors. **Case 11 (2021 – 2022)** Please see case 10 (2021 – 2022) for impact. **Case 12 (2021 – 2022)** Please see case 10 (2021 – 2022) for impact. **Case 13 (2021 – 2022)** Please see case 10 (2021 – 2022) for impact. **Case 14 (2021 – 2022)** Please see case 10 for impact. Actions b) and c) have had no impact as yet.
		Case 1 (2022 – 2023) No impact as yet. **Case 2 (2022 – 2023)** Please see case 10 for impact. **Case 3 (2022 – 2023)** Please see case 10 for impact. **Case 4 (2022 – 2023)** Not applicable. **Case 5 (2022 – 2023)** Not applicable. **Case 6 (2022 – 2023)** Please see case 10 for impact.

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.	5 case record reviews and 0 investigations completed after 2021 -2022 which related to deaths which took place before the start of the reporting period **(cases 10 - 14 (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.	1 representing 7% of the patient deaths during 2021 – 2022 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 2022/23, 17,970 patient safety incidents were reported within CLCH. Of these incidents, 11 (0.06%) resulted in severe harm. This is an increase in the total number of incidents and equal to the proportion of incidents that caused harm from the previous year (2021/22) when we reported that nine incidents from 15,040 resulted in severe harm (0.06%).

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 2021 to March 2022.

There were no incidents that resulted in a death. The patient safety incidents reported that resulted in severe harm consisted of ten category 4 pressure ulcers, and one fall resulting in fracture.

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.

- Quality assurance monitoring and reporting is overseen by 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:

- Continued review of all reported 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 all category two inpatient pressure ulcers.

- Reviewing all incidents relating to podiatry and children's services 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. Working towards fully adopting the Patient Safety Incident Response Framework (PSIRF).

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

- Clinical summits and learning events held to support dissemination of best practice and learning from patient safety incidents, including pressure ulcer prevention and lower limb awareness, falls, catheter management, and recognition of the deteriorating patient in the community setting.

- Providing routine and ad hoc Datix training sessions for new and existing staff.

- 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 2022 – 2023

The following trust wide scorecard describes Trust performance against the quality campaign key performance indicators (KPIs). Performance against our quality strategy measures of success is incorporated into the relevant tables below.

TRUST WIDE PERFORMANCE SCORECARD

Quality campaign	Key performance indicator	Target	Performance	
			Previous year 2021 – 2022	2022/ 23
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%	97.00	98.5%
	Proportion of patients who were treated with respect and dignity	95%	99.30	99.8%
	Friends and family test - Percentage of Staff recommending CLCH as a place for Treatment.	80%	NA	N/A
	Patient Friends and family test - Proportion of Patients rating their overall experience as very good or good	92%	96.8	98.1%
	Proportion of patients' concerns (PALS) responded to within 5 working days	97%	100.00	100.0%
	Proportion of complex complaints responded to within 25 days	100%	100.00	100.0%
	Proportion of complaints responded to within agreed deadline	100%	100.00	100.0%
	Proportion of complaints acknowledged within 3 working days	100%	100.00	100.0%

Quality campaign	Key performance indicator	Target	Performance	
			Previous year	2022-2023
Preventing harm Incidents and risk	Proportion of clinical incidents that did not cause harm (moderate to catastrophic categories)	97%	99.2	99.2%
	Zero tolerance to falls in bedded units with harm (moderate or above)	0	8	10
	Zero tolerance of new (CLCH acquired) category 3 & 4 pressure ulcers in bedded units	0	3	1
	Zero tolerance of new (CLCH acquired) category 2 pressure ulcers in bedded units	0	24	31
	Zero tolerance on the number of patients in our bedded areas who have reported a CAUTI	0	1	3
Smart, effective care	Percentage of central alerting system (CAS) alerts including patient safety alerts (PSAs) due, and responded to, within deadline	90%	90.5	100.0%
	Percentage of hand hygiene episodes observed across CLCH bedded areas that are compliant with policy	97%	99.8	99.1%
	Percentage of staff trained at making every contact count level one- non – clinical	95%	95.9	95.3%
	Percentage of staff trained at making every contact count level two -clinical	95%	93.1	93.7%
Modelling the way	Statutory and mandatory training - non-clinical	95%	96.5	96.7%
	Statutory and mandatory training - clinical	95%	95.8	96.2%
People	Staff turnover rate – 12 month rolling (clinical) *		14.1	17.0%
	Sickness absence rate - 12 month rolling (clinical)		5.6	5.4%
	Percentage of staff who have an appraisal, *		77.4	85.1%
	Staff vacancy rate (clinical) *		18.3	17.6%
* This is the previous months data				
. This data is from two months ago				

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 target has been achieved with 99.8% of our patients reporting that they felt they were treated with dignity and respect.
	We will maintain the proportion of patients reporting their overall experience as very good or good at 95%	This target has been achieved with 98% of patients reporting their overall experience of CLCH services as very good or good. CLCH continues to be one of the highest rated NHS community trusts in the country with a consistently high response rate.
	The proportion of patients who felt staff took time to find out about them will be maintained at 95%	This target has been achieved with 98.5% of patients reporting that they felt staff took the time to find out about them.
	We will ensure that 80% of patient/user/carer feel involved in each service change	At year end, 30.85% of QI projects have had a level of patient involvement in them. Although this number seems low, it does not take into consideration the projects that perhaps do not require patient feedback or insight (i.e., staff related projects). The QI and PE team will be undertaking a deep dive into this data to establish a greater degree of accuracy in reporting.

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 (FFT) – percentage of staff recommending CLCH as a place for Treatment will be 80%	69.2% of staff would recommend CLCH as a place for treatment. Work continues on promoting CLCH as a place for treatment through Spotlight, Feedback Friday, and monthly divisional board meetings, helping to raise awareness of our service offers and areas of best practice. The PE team will be working with HR in the new financial year at ways to improve staff FFT response rates.
	We will increase volunteer numbers by 50% from 2020/21 baseline in services where volunteer participation improves patient experience	The team have seen an increase in volunteer numbers (an increase from 45 in Q1, 60 in Q2 and 69 in Q3 and now 94 by end of Q4) Work continues with teams across the Trust to develop exciting and engaging roles. We currently have 36 services who are seeking or currently have volunteers in their team (up 8 from Q1, 30 in Q2, 36 in Q3 and 45 in Q4). Over the past 12 months, we have seen volunteers record 2323 hours of volunteering hours (to date), assist 7299 patients, make driving visits to 409 patients, and collect 2 patient stories. This is the first full year of data we have and are excited to build on this.
	To continue to complete an annual volunteer survey to understand their impact on services and their experience	Our annual survey in October 2022 saw 36% of volunteers respond. 73% are satisfied or very satisfied with their role, 69% feel volunteering has increased their confidence and 55% think volunteering has a positive impact for staff. Volunteers rate their experience of each shift out of 5. This quarter has seen an average score of 4.1 stars out of five (versus 4.3 in Q1 and 4.1 in Q2, 4.3 in Q3). Our annual average score is 4.2/5 One area of feedback from volunteers which would improve their experience is for volunteer resources to engage patients. As a result, we have ordered several activities and games and we will monitor their impact.

	We will develop *'you said we did'* stories to share volunteers' experiences	This year, the team have worked hard to raise the profile of volunteering internally with monthly case studies or retrospectives on volunteering in Spotlight on volunteering and quarterly social media activity around volunteer case studies. We have also developed video content for Volunteers' Week celebrations and have created video content around volunteer motivations and impact for the Quality Conference in May 2023.
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	This target has been met with 100% of PALS concerns being responded to within 5 working days throughout 2022/23.
	We will continue to respond to 100% of complaints within 25 days	This target has been met with 100% of complaints having been responded to within 25 working days throughout 2022/23.
	We will continue to respond to 100% of complex complaints within the agreed deadline	This target has been met with 100% of complex complaints having been responded to within an agreed deadline throughout 2022/23.
	We will continue to acknowledge 100% of complaints within 3 working days	This target has been met having successfully completed the 22/23 financial year at 100% of complaints having been acknowledged within 3 working days.
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 most recent Always Event is one that looks at improving the patient, family and carer experience of our end-of-life service users. With support of the Promoting Access team a huge amount of outreach and engagement work has been undertaken with several faith and community groups to start to learn about their wants and needs. The next step is for the team to collaborate with Islamic community leaders to run a workshop in April 2023 at the Dar Al-Islam Centre, Cricklewood. The workshop will ask members of the mosque about their experiences of engaging with NHS care around the end-of-life care.

		Always Events have also started in 2022/23 across Heathlands Court and Robertson Ward focusing on frailty and a focus on Carers in Hertfordshire, will be scaled up across the trust.
	We will review the impact and learning from quarterly projects on the overall patient experience	The divisional quarterly projects have been delivered across the trust throughout the year. Performance has been regularly scrutinised to ensure they are having an impact on improving the overall patient experience and shared across the trust. Quarterly projects continue to be reported against at divisional board meetings and at the monthly PEG meetings. Quarterly Project highlights include: **Patient Diaries** piloted at Heathlands Court, now being rolled out across all bedded units. **SPA feedback project with volunteers:** bespoke survey designed to capture the patient experience of those contacting the trust through SPA. **Learning from Young Carers** through feedback and patient stories to think about identification of children in schools that are young carers and improving the 'patient/child experience' via the school nursing service. **FFT refresh:** A pan trust quarterly project developing QR codes, posters, lanyards and badges to encourage a greater FFT response rate.
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	All health visiting services have achieved level 2 breast feeding accreditation or greater. Breast Feeding Accreditation update: **Wandsworth & Richmond:** BFI assessment for stage 3 due: July 2023. **Ealing:** Stage 3 assessment completed February 2023. HV areas to improve: Safe prep of formula + responsive bottle feeding. **Merton:** Stage 3 accredited Summer 2022 - planning for Gold 2023. **Inner London:** BFI update: re-submitted Gold annual audit and re-accredited Feb 2023. External assessment for Gold Jan 2024 **Brent:** Working towards re-accreditation Stage 3 in Oct 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	The end-of-year figure is 99.2%. This is subject to change as incidents progress through the review process and harm levels are updated.
	100% of patients in bedded units will not have a fall with harm (moderate or above)	Six falls with harm were reported in quarter 4. The end-of-year figure for 2022/23 is 10, compared to eight during 2021/22.
	100% of patients in bedded units will not have a NEW (CLCH acquired) category 2-4 pressure ulcer	One category 3 pressure ulcer was reported in quarter 4. The end-of-year figure for 2022/23 is one, compared to three during 2021/22. 14 category 2 pressure ulcers were reported in quarter 4. The end-of-year figure for 2022/23 is 31, compared to 24 during 2021/22.
	100% of all serious incident investigations will be completed on time in accordance with national guidance	In quarter 4, 100.0% (5/5) of external SIs were completed on time, and 100.0% (17/17) of Internal SIs were completed on time.
	100% of all serious incident actions will be completed on time in accordance with locally agreed timescales	In quarter 4, 84.7% (72/85) of SI actions were completed on time. A weekly report of open actions is circulated to all action owners, and the patient safety team continue to work with divisions to design SMART actions and emphasize the importance of timely closure.

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	This quality strategy measure has been met and achieved. Summary analysis of results from the CLCH culture of care barometer survey in comparison with the NHS staff survey 2021 was approved via quality committee in October 2022. Further analysis will be undertaken following publication of the NHS staff survey 2022 results.
	Each division will share at least 4 incident learning examples in divisional boards using the 7-minute-learning tool through divisional board and patient	In quarter two, 38 seven-minute learning templates were submitted to the PSRG. The patient safety team are collaborating with other teams across the organisation to increase the total number of submissions.
	90% of teams will have undertaken a core standards annual health check assessment and identified action plans that are completed on time	All teams have completed their initial assessment and 80% of those required to re-audit have done so.
	No outstanding actions from risks on the register	In quarter 4, 83.3% (75/90) of risk actions were completed on time. A weekly report of open actions is circulated to all action owners, and the patient safety team continue to work with all divisions to design SMART actions and emphasize the importance of timely closure.

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 the end of quarter four the year-to-date target for MECC Level One was achieved
	We will evaluate the use of MECC link with our clinical staff	This action was completed in 2019 when the MECC link was circulated (https://www.mecclink.co.uk)
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 already 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 and is on track to maintain a 20% increase in 2022-2023 with 11 studies to be opened.
	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%	All teams have been notified of the requirement to submit a report and poster. A new poster format has been created and has started to be used in Q4.

CAMPAIGN FOUR: MODELLING THE WAY

Key Priority / Outcome	Measures of Success Jan 2022-July 2023	Update
Implementing reverse mentoring (rm) for all staff ensuring career opportunities are accessible to all	60% of clinical staff at band 8b or above will have undertaken training	Currently 40% of staff have been trained. Additional training dates have been circulated to ensure remaining Senior Leaders have undertaken training
	Mentoring opportunities will be publicized for staff trust wide	Roadshows are underway across divisions. Additional training sessions delivered by the Reverse Mentoring Lead are available to book via iLearn:
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%	Statutory and mandatory training compliance has met or exceeded the Trust target throughout the year with the exception of October where there was a small dip contributed to by the launch of the new Statutory training booklets. In quarter 4, compliance has remained above the Trust compliance target of 95%.
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 first cohort of the band 7 and 8a multi professional clinical leadership programme was completed in March 2023 with excellent feedback cohort 2 is now underway. Work is in progress in relation to competency development for rapid response teams and school nursing services across the divisions. Competencies portfolios are in place for Community Nursing, Inpatient beds, Health Visiting, Therapies and Walk-in Centers.
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	Throughout 2022/23, 100% of clinical staffing establishment changes have been discussed in the monthly clinical staffing establishment panel prior to a quality impact assessment where required.

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 apprentice nursing associate role has been incorporated into the bedded services and community nursing clinical staffing model and in place.
	We will evaluate safe staffing models for AHP workforce, and any new roles developed	AHP apprenticeships are being implemented
	We will continue to develop Professional networks and deliver/events to be delivered for all staffing groups across the trust and primary care	The Academy have delivered a programme of conferences throughout 2022/23 and will continue to deliver conferences through 2023/24. Role specific professional networks have been implemented across physiotherapy, SLT, occupational therapy, dietetics, community nursing, looked after children, health visiting (for team leads), inpatients (for matrons).

TRUST QUALITY PROJECTS AND INITIATIVES

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

Academy: The CLCH Academy has increased its portfolio of education, training and development throughout 2022/23 as COVID restrictions have eased, enabling a greater depth and breadth of opportunities for our staff. Key highlights for 2022/23 include:

- Statutory and mandatory training compliance, has met or exceeded the Trust target throughout the year with the exception of October where there was a small dip contributed to by the launch of the new Statutory training booklets
- Continuing to build and embed professional nurse advocate (PNA) principles and training which has been supported with the appointment of a new PNA lead, increasing PNA capacity across the Trust
- Developing and delivering the new healthcare support worker development programme which has supported 42 individuals into their new roles
- Developed and delivered the clinical multi-professional leadership programme which has had a significant impact in developing the leadership capabilities of our clinicians across the system
- Continuing to grow the research agenda at pace within CLCH
- Introducing and growing the practice development AHP role within the Trust
- Growing the apprenticeship offer and the first four nursing associates completing the registered nursing degree apprenticeship, two of whom have achieved band 6 roles in the Trust
- Delivering a series of high-quality conferences and professional networking opportunities
- Implementation of the equality, diversity and inclusion (EDI) book club enabling a safe place for staff to consider their behaviours considering contemporary EDI literature
- The delivery of Academy roadshows across each of the divisions to engage with staff locally, ensure staff know about the opportunities available to them and help them meet key members of the team

Carers' listening event: A face to face listening event was held with carers of people who had been on the hospital at home caseload to understand what matters to them. Themes were identified and feedback will be reviewed to see what improvements they can make.

Citizen engagement: The Trust has been working collaboratively with citizens to better understand barriers to accessing services across a number of projects including end of life care for black and minority ethnic members of the community. We have been exploring barriers to accessing podiatry with Westminster Healthwatch as well as delivering digital skills sessions in Barnet with Age UK

Community skills event. In the SW division, continual professional development skill sharing events were set up to provide insight on the unique skill set required by healthcare professionals working in the community. topics included community skills in physiotherapy and occupational therapy, breast feeding & lactation support and the post-covid assessment service.

Community nursing: There were a number of projects set up in the SW division to review and improve processes, led by community nurses. Projects included: Mapping and standardising the triage process across all teams and developing a handbook with information that staff felt would be useful to support them at triage; developing a handover process and action log with team leads that helps structure handover and ensure all actions are captured and managed; creating a clear process map for referrals from community nursing to the diabetes specialist team – this ensured clear communication and reduced adverse incidents.

Equity of access dashboard: This is now live and enables staff to view CLCH activity, waiting times, and did not attend (DNAs) rates. This information can then be split according to various demographics – age, sex, ethnicity and deprivation to understand how accessible our service is for different community groups. Work is ongoing to embed utilisation of this tool consistently across the Trust. Additionally training videos on the equity of access dashboard have been published on the Hub to aid staff in using the platform for their investigation of potential health inequalities.

Equality delivery system: The health equalities team delivered the review of CLCH commissioned services as part of the equality delivery system 2022 (EDS3). The EDS3 is a collaborative approach that invited participants (including patient representatives and voluntary sector) to examine some of CLCH commissioned services and make recommendations for improvement. Publication of this work, including the action plan, is due soon.

Improving access for people with learning disability and autism: In collaboration with the Edgware walk-in-centre, CLCH has developed a project to support identification of hidden disabilities for our patients, using the sunflower lanyard scheme. We have supported the training of members of staff with respect to supporting reasonable adjustments for our patients. Feedback has been very positive so far and following completion of the pilot, we are planning to roll the scheme out across the Trust.

Long covid team: In Hertfordshire, a long covid team is now established. Starting from one nurse and one newly qualified occupational therapist and being predominantly a sign posting service and receiving feedback, the team now has nine members. These include a GP; physiotherapists, occupational therapists and rehabilitation support workers and the team is now receiving 100% positive feedback. Additionally, a weekly clinic is up and running at Marlowes health clinic. This also receives excellent feedback.

Health inequalities became really apparent in covid, and this was reflected in the referral data. The team was keen to look at ways to improve access and are at the beginning of a research project to look at this. The team was selected to be part of CLCH's equality, delivery system project.

Merton dementia team developed a leaflet to support carers of people living with dementia to undertake risk assessments at home, to identify any hazards, with information to support in the process. This was well received by other teams across the Trust.

The post-covid service in Merton and Wandsworth created a project looking at equity of access. This included educating PCNS across the boroughs to increase uptake and referrals; working with public health to generate co-produced self-management materials and participating in the Healthwatch review of the lived experience of people with long covid.

Quality Improvement (QI): The Trust continued to develop the use of QI with 97 active and 105 completed quality improvement projects being registered at the end of 2022/23. In 2022 we ran our second Joy in Work improvement collaborative. Thirteen teams participating from clinical and corporate services 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. We will be launching a new improvement collaborative in March 2023 to focus on reducing health inequalities.

The Trust won funding from the q-community to lead on the co-design of the quality coach development programme, a collaboration of QI experts from across the country to develop a training programme to build QI expertise in front line services. The 6–9-month programme was shortlisted for the HSJ Partnership Award for best NHS education programme. the programme is due to be released as a free of charge product for the whole NHS in early 2023/24. Currently 25 trusts/ICS regions have indicated an intention to run this programme in the next 12-18 months.

Research: The Trust has already 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 also increased from to 23 participants in 2021-2022 to 30 participants in 2022-2023. This is the highest commercial recruitment at CLCH over the last 4 years.

The research and development team and the cardio-respiratory team lead in Merton have been successful in being awarded a national Innovate UK funding grant in collaboration with a biotech company to support the development of a respiratory diagnostic monitoring at home use device. The grant will provide funding to support a full-time research nurse to coordinate the study and time for the cardio-respiratory team lead to lead the study programme.

The Trust has embarked on an ambitious funding bid to become a NIHR HealthTech Research Centre (HRC). The Trust has been successful at stage one of the application process and has been invited to submit for stage two in 2023-2024. The head of research and development, in collaboration with Central and North West London NHS Foundation Trust , has been leading a national working group to develop models to enable researchers from the NHS and higher education institutes, access to out of hospital care settings such as Care homes, hospices and schools to conduct studies. Additionally, CLCH and London South Bank University (LSBU) have been collaborating to support clinical academic pathways for staff at CLCH. Through this joint working, a podiatrist from the outer north west division was successfully awarded a Health Education England (HEE) non-medical clinical academic internship, to enable them to access postgraduate research programmes.

Tackling unacceptable behaviour campaign: In 2022/23 the following actions were taken to manage and minimise violence and aggression towards staff as part of our tackling unacceptable behaviour campaign/

There was a:

- Continuation of quarterly newsletter to help lone workers stay safe and to manage and minimise the risk of violence and aggression while undertaking their duties.
- Continuation of security site visits in response to security concerns and reported incidents, with identified actions monitored at divisional estates groups.
- Launch of weekly 'Skyguard Surgery' clinics for users to receive a refresher about how to use the functions on their lone worker devices effectively
- Launch of monthly reporting of Skyguard device usage, with comparisons on previous months to track variations in usage by division
- Review of the physical security guard provision at locations across the Trust's geography
- A tailored lone working and tackling unacceptable behaviour sessions provided to services across the Trust

Additionally, work was undertaken with the improvement team and the Trust onboarding project to ensure timely access to lone worker devices for new starters . Improvements were made to 'outcome of

investigation' field on Datix to better track incident where sanctions from the Violence and Aggression at work policy were not issued to include the reasons why not.

Volunteering: Over the last 12 months, we have been growing our volunteer offer and working to embed a culture of volunteering at CLCH. Now with over 90 volunteers, there has been a four-fold increase since this time last year in the number of volunteers giving their time routinely. There are now over 40 teams at the Trust working with volunteers in their service, again representing a significant increase from 18 this time last year. With a now fully online application process. In 2022/23, we recorded over 15,000 hours of activity, supporting over 5,000 patients.

The patient experience team have successfully secured funding for the volunteer to career programme. This will see the volunteering, organisational development, recruitment and academy teams work together to identify appropriate employment opportunities with high vacancies and develop volunteer roles to give candidates a feel for what the role would be like. After a set period of volunteering hours, candidates would then be eligible to interview for the role, with a view to starting a career at the CLCH. Additionally, from quarter 3, the team have focused on our work experience offer at the Trust and we have been working with the Academy to develop a package of support for teams to host work experience placements.

ANNEX 1: STATEMENTS FROM COMMISSIONERS, LOCAL HEALTHWATCH ORGANIZATIONS AND OVERVIEW AND SCRUTINY COMMITTEES

Feedback will be included post consultation.

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

This will be completed after draft approval at the May Board.

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 2022 to March 2023
  - papers relating to quality reported to the board over the period April 2022 to March 2023
  - feedback from commissioners dated xxxx
  - feedback from local Healthwatch organisations dated xxx
  - feedback from 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.
  - 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

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

HEALTHCARE ORGANISATIONS

Care Quality Commission
Tel 03000 61 61 61
www.cqc.org.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: 020 3869 9730
www.healthwatchbrent.co.uk/

Central West London Healthwatch
For Hammersmith and Fulham, Kensington, 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
45 St. Mary's Road
Ealing
W5 5RG
Tel: 0203 8860830
www.healthwatchealing.org.uk/

Hertfordshire Healthwatch
Kings Court, London Road.
Stevenage
Hertfordshire,
SG1 2NG
01707 275978
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
82 Hampton Road. Twickenham.
TW2 5QS
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

INTEGRATED CARE SYSTEMS (ICSs)

NORTH WEST LONDON ICS
nhsnwl.communications.nwl@nhs.net
Tel: 020 3350 4000

NORTH CENTRAL LONDON ICS
Email: nclccg.enquiries@nhs.net
Tel: 020 3198 9743

NORTH EAST LONDON ICS
elhcp.enquiries@nhs.net
Tel: 020 3688 2300

SOUTH WEST LONDON ICS
hello@swlondon.nhs.uk
Tel: 020 3880 0308

SOUTH EAST LONDON ICS
contactus@selondonics.nhs.uk
Post: PO BOX 64529, London SE1P 5LX

HERTFORDSHIRE AND WEST ESSEX INTEGRATED CARE SYSTEM
hweicbenh.communications@nhs.net
Tel: 01707 685 000

GLOSSARY

15 Steps Challenge: This is a tool to help staff, service users and others to work together to identify improvements that can be made to enhance the service user experience. The idea is to see the ward through a service user's eyes. Members of the 15-step challenge team walk onto a ward or residential unit and take note of their first impressions.

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

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

Baseline data: This is the initial collection of data which serves as a basis for comparison with the subsequently acquired data.

Being Open: Being Open is a set of principles that healthcare staff should use when communicating with patients, their families and carers following a patient safety incident.

Care Quality Commission (CQC): The CQC is the independent regulator of health and adult social care services in England. It ensures that the care provided by hospitals, dentists, ambulances, care homes and home-care agencies meets government standards of quality and safety.

Catheter: A catheter is a thin flexible tube which is inserted into the body, usually along the tube through which urine passes (the urethra) or through a hole in the abdomen. The catheter is then guided into the bladder, allowing urine to flow through it and into a drainage bag.

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

CSU: Clinical service unit

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

Geko: The geko™ W neuromuscular electrostimulation device is indicated for use to promote wound healing and can be used as part of current standard care given to patients for wound management.

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.

IRAS- Integrated Research Application System. This is the national application system we use for research, which provides study specific identifiers.

Integrated care board (ICB): An integrated care board is a statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area.

Integrated care partnership (ICP): A statutory committee jointly formed between the NHS integrated care board and all upper-tier local authorities that fall within the ICS area. The ICP will bring together a broad alliance of partners concerned with improving the care, health and wellbeing of the population, with membership determined locally.

Integrated care system (ICS): Integrated care systems are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in the area.

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.

Patient safety alerts (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.

This will be reported separately to the quality committee and attached when approved. .