CLCH QUALITY ACCOUNT 2023 – 2024

PART 1: ABOUT OUR QUALITY ACCOUNT

Welcome to the Central London Community Healthcare NHS Trust (CLCH) Quality Account for 2023 – 2024

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 information does the 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.

The strategy can be found here: https://clch.nhs.uk/about-us/quality

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 four 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:

- Community and district nursing.
- Specialist nursing including continence; respiratory, heart failure; tissue viability and diabetes.
- Children and family services including health visiting, school nursing, speech and language therapy and community paediatrics.
- 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.*

We have four core values and linked behaviours we aim to meet at all times when working with patients, partners and colleagues:

- 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 2024. Acknowledging the leadership changes on the board in the last year – including the appointment of our new chairman Tom Kibasi in November 2023 - our organisation has remained resilient and has maintained its position as a good system partner in PLACE, delivering high quality care to the local populations we serve. I am proud that we have received improved overall feedback from our staff through the staff survey, with the highest response rate in the organisation's recent history. We have continued to engage in wider partnerships across London and West Hertfordshire, achieving immense value for our partners, patients and other key stakeholders that continue to enhance the overall quality and efficiency of our services.

We have been successful in delivering on a majority of quality key performance indicators (KPIs) and have achieved good outcomes for our patients, carers, and staff. We continue to challenge ourselves in setting zero tolerance measures for preventing pressure ulcers and falls with harm in our bedded services. Although unfortunately these KPIs have not been achieved this year, we have as a result of our full adoption of the Patient Safety Incident Response Framework (PSIRF), strengthened our quality improvement structures. This will ensure continued support for staff to deliver expected improvements in these areas in next and future years.

I am delighted that we have successfully retained a good rating from the Care Quality Commission (CQC) in a recent unannounced inspection of our sexual health services in Southwest London and Hertfordshire. This is the first time that sexual health services have had a standalone rating. The CQC published their inspection report on 28 February 2024 which rated the services as 'Good' overall and 'Good' in all five domains (safe, effective, caring, responsive and well-led). We are pleased that the CQC did not identify any action that the Trust needed to undertake in order to improve and the Trust retained its overall rating of 'Good.'

We are extremely proud that our teams have continued to showcase their outstanding work and have been recognised in national award schemes. In a commendable feat, Merton Community Nursing recently earned distinction as one of the top contenders in the prestigious Self Care Innovation Awards 2023. The Trust has been accredited as Veteran Aware; the accreditation was conducted by the Veterans Covenant Healthcare Alliance (VCHA). Our Outer Northwest division has been awarded three Brent health and adult social care awards. The awards bring together inspirational keyworkers from the NHS, council, and care homes across the borough to celebrate and recognise their outstanding achievements. CLCH was also shortlisted for three prestigious Nursing Times awards this year and our health visiting service in inner northwest successfully retained their UNICEF baby friendly gold sustainability award.

Finally, my heartfelt thanks to all our staff, volunteers, and system partners for their continued commitment in supporting us to deliver 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

Welcome to the 2023 – 2024 version of our Quality Account. We are now in the fourth year of delivering our quality strategy 'Improving Quality in Everything We Do' and continue to see the fruit of our investment in the strategy, as evidenced in the high quality of services we provide. The Quality Committee has met quarterly throughout 2023 - 2024, reviewing and constructively challenging the delivery of our strategic priorities. We have received regular updates through the quarterly quality report which includes our quality dashboard, bedded scorecard, patient stories and progress against our agreed key performance indicators. I am again pleased to report that we have successfully delivered on our four quality campaigns as set out in our strategy, reaffirming our commitment to put quality at the heart of all we do

We have continued to receive outstanding feedback from our patients, with over 99% of patients who completed our experience survey reporting they felt that they were treated with respect and dignity by our staff and 97% rating their overall experience as very good or good. We have successfully transitioned away from using root cause analysis to investigate serious incidents and have fully adopted the Patient Safety Incident Response Framework (PSIRF), with key staff receiving systems training to support new processes that enhance opportunities to learn from patient safety events. We have strengthened the sharing of learning from patient safety events through the use of a 7-minute briefing report which we believe has resulted in improved patient care, as evidenced in the proportion of reported clinical incidents that did not cause moderate or severe harm, which was above target at 98%.

In order for our staff to remain safe as they undertake their roles, I am pleased to report that we have maintained high levels of statutory and mandatory training compliance. The CLCH Academy has maintained its close working relationship with the North West London primary care training hub as well as the Northwest London health and social care academy. As part of this the Academy continues to support a wide range of training programmes, such as primary care network development, clinical skills training and nursing associate implementation.

Our rate of volunteer recruitment continues to increase steadily; there are now over one hundred volunteers supporting fifty-eight teams across the trust to improve patient experience. CLCH has also been successful in its international recruitment of professional staff, with one hundred and three international nurses and three International allied health professionals in the recruitment pipeline. Last year we welcomed our first new chief allied health professional (Patsy Fung) who successfully spearheaded the work to enhance our recruitment into our allied health professional posts (AHPs). She achieved this through her focus on the return to practice recruitment, with six AHPs successfully onboarded and two returned onto the health and care professions' council register to date. This work has been recognised and featured as an NHS England case study, as CLCH was the only organisation in the UK to offer such an attractive support package for AHP returnees.

Further information about the Academy, our volunteers and our AHPS, as well as about numerous other quality projects, can be found in the Quality Account.

As I write this introduction to our Quality Account, I am aware it will be my last; I will shortly be standing down after serving as committee chair for most of my ten years at the Trust. I consider it a privilege and a pleasure to have been able to work with such dedicated and professional colleagues to enhance the safety and effectiveness of our services and the experiences of our patients and staff and would like to take this opportunity to thank every member of the committee for their unwavering commitment and support in delivering high quality care throughout CLCH. The Trust should be rightly proud of all that has been achieved.

Dr Carol Cole
Chair of Quality Committee

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

PRIORITIES FOR IMPROVEMENT 2024 - 2025

Our four quality campaigns for 2024 – 2025 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 and these are described in the tables below. 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 is reported to the quality committee on a quarterly basis as part of our comprehensive quality report. Additionally 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 quality campaigns, their key outcomes and associated measures of success for July 2023 to April 2024 are as described in the tables below. It should be noted that as the strategy is a five year one, the measures of success have been divided up and split across different financial years.

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

In January 2020 we refreshed and updated our quality strategy and sent it to all our external stakeholders for their comments. During the consultation we confirmed that the quality priorities described in the strategy would be the same as the quality priorities in our Quality Account. As part of this original consultation, the Trust facilitated engagement events across each of our divisions, these allowed us to engage with both staff and patients asking them for their views on the updated quality strategy. Additionally, we held meetings with staff, patients and other stakeholders, requesting their input into our updated quality strategy and reminding them that the quality priorities in the strategy would be mapped to our Quality Account. Following this in January 2024 we wrote to our stakeholders and asked if they had any further comments on our quality priorities. We also took the opportunity to confirm that, as in previous years, the priorities as outlined in our quality strategy would be taken forward as our quality priorities in our Quality Account.

CAMPAIGN ONE: A POSITIVE PATIENT EXPERIENCE

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

KEY PRIORITY / OUTCOME	MEASURES OF SUCCESS APRIL 2024 – 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 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 continue to be maintained at 95%
	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 85%
	We will continue to embed the volunteer roles across the trust and to focus on volunteer community outreach projects
	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 SUCCESS APRIL 2024 – MARCH 2025
Feedback from patients, carers and families is taken seriously and influences improvements in care	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 complex complaints within the agreed deadline
	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 evaluate the *Always Events* implemented
	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)**	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 APRIL 2024 – 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 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 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 actions will continue to be completed on time in accordance with locally agreed timescales
Enhance the embedding of a safety culture in the trust ensuring learning from adverse events and compliance with national best practice	There will be evidence of continued improvement from baseline
	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
	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

CAMPAIGN THREE: SMART, EFFECTIVE CARE

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

KEY PRIORITY / OUTCOME	MEASURES OF SUCCESS APRIL 2024 – 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
	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 ≥ 20%
	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 APRIL 2024 – MARCH 2025
Implementing reverse mentoring for all staff ensuring career opportunities are accessible to all	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 %
Staff receive appropriate education and training to ensure they have the right skills 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
Ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times	We will introduce the Apprentice Nursing Associate (ANA) role to specialist services e.g., WICs/ specialist nursing teams We will continue to evaluate
	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.

STATEMENTS OF ASSURANCE FROM THE BOARD

Review of services

During 2023-2024 CLCH provided 110 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 2023–2024 represents 100% of the total income generated from the provision of NHS services by CLCH for 2023-2024.

Secondary use services

CLCH submitted records during 2023 – 2024 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% and which included patient's valid General Medical Practice Code was 96%

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 2023-2024

Data security and protection (DSP) toolkit

The DSP submission is not due until **30 June 2024.**

This information will be included later as it won't be available until 26 June 2024.

PARTICIPATION IN CLINICAL AUDITS

National audits.

CLCH has actively participated in eight out of ten relevant national audits in the year 23/24. Of the remaining audits the clinical effectiveness team are supporting clinical teams to participate in the national obesity audit and the trust has also registered for the 2024 national audit of care at the end of life (NACEL).

The list of Trust national audit reports can be found below. Not all divisions participate in every audit because of the specific mix of clinical services offered in each division. Where appropriate, the clinical effectiveness team is supporting participation from additional relevant teams.

Please note that in some cases the data collection process spans two financial years. For example with regard to the NACEL audit, data collection began in quarter 4 of 2023-2024 but this will continue until the end of quarter 3 in 2024-2025.

The national clinical audits that CLCH participated in during 2023 – 2024 are as follows below:

National clinical audit	Participation	Outcomes
The falls and fragility fracture audit programme (FFFAP) National audit of inpatient falls (NAIF)	The falls and fragility fracture audit programme (FFAP) is a national clinical audit programme. the NAIF is one part of FFAP, which audits the delivery and quality of care for patients over 60 who fall and sustain a hip or thigh bone fracture in acute, mental health, community and specialist NHS trusts / health boards. The NAIF reviews the care the patient received before their fall and post-fall care. **Services taking part in 2023/24:** Hertfordshire (inpatient units) Inner northwest (inpatient units) Outer northwest (inpatient units) North central (inpatient units)	Data collection is in progress for 2023/2024.
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	The National LeDeR program reports on the deaths of people aged four and above with a learning disability. The organisation aims to learn lessons from the deaths of people with LD and to use this learning to make changes to health and social care practices to prevent inequalities in the future. **Services taking part in 2023/24:** Inner North West (Tri-borough learning disability team) North Central (Barnet learning disability service)	*** Please see detailed outcome described below.**
National adult diabetes audit (NDA)	The NDA measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards, in England and Wales. It collects and analyses data for use by a range of stakeholders to drive changes and improvements in the quality of services and health outcomes for people with diabetes. **Services taking part in 2023/24:** Outer North West	Data collection is in progress for 2023/24.

National clinical audit	Participation	Outcomes
National audit of cardiac rehabilitation (NACR)	NACR collects comprehensive audit data used to quality-assure programmes, support improvement, and monitor cardiac rehabilitation services regarding their uptake, quality, and clinical outcomes. **Services taking part in 2023/24:** South West (Merton cardio-respiratory service) Hertfordshire (cardiac rehabilitation service) Outer north-west	Data collection is in progress for 2023/24.
National diabetes footcare audit (NDFA)	This national audit enables all services that treat diabetic foot ulcers to measure their performance against NICE guidance, monitor patient outcomes and benchmark against peer units. **Service taking part in 2023/24:** Outer North West (podiatry service)	Data collection is in progress for 2023/24.
National obesity audit	This will bring together comparable data from the different types of adult and children's weight management services across England to drive improvement for those living with being overweight and obesity. Inner North West (specialist weight management service) will be participating. The data for this audit is collected through the community services dataset (CSDS), and CLCH is a registered member.	Data collection is in progress for 2023/24.
National respiratory audit programme (NRAP)	The NRAP aims to improve the quality of respiratory care, respiratory services, and patient clinical outcomes. **Services taking part in 2023/24:** Outer north west (community respiratory service) North central (Barnet community respiratory service) Hertfordshire (community respiratory service) .	Data collection is in progress for 2023/24

National clinical audit	Participation	Outcomes
Sentinel Stroke National Audit Programme (SSNAP)	SSNAP measures the processes of care (clinical audit) provided to stroke patients and 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 provided to patients. **Services taking part in 2023/24:** South West (neuro therapies service) North Central (early stroke discharge team and Barnet Stroke support service) Hertfordshire (early supported stroke discharge service)	Data collection is in progress for 2023/24.
UK Parkinson's Audit	The UK Parkinson's Audit is a recognised quality improvement tool for Parkinson's services. It measures the quality of care provided to people with Parkinson's against various evidence-based guidelines. **Services taking part 2023/2024:** Inner North West (Parkinson's Tri-borough Service) North Central	Data collection is in progress for 2023/24.
National audit 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 audit aims to improve the quality of care at the end of their life. **Services taking part 2023/2024:** All divisions across the Trust have registered for the audit in 2023/24, which the Trust's End-of-Life Care Group manages: Inner north west Outer north west South west North central Hertfordshire	Registration completed and ready for 2023/2024 submission.

* **Learning from deaths – Outcomes and improvements**

Change in Practice/ Improvement measures

Barnet:

- Work is ongoing with the CLCH improving access to healthcare services for PLD and ASD Project group.
- Roll out and training of 'Stop and Watch' guidance to identify the early signs of ill health in those with a learning disability.
- Barnet learning disabilities services (BLDS) now operates a complex care pathway. BLDS is also progressing with introducing the decision support tool for physical health to our LD clients.
- A health pathway for BLDS health teams was created on Mosaic, the case recording system used by BLDS CLCH and BEH staff. This will aim to enable better demand tracking and support the development of MDT approaches.
- Most BLDS health staff have now received bespoke training to understand their role in safeguarding enquiries.
- Learning events continue to be delivered through the Safeguarding Adults Partnership.

Developments in BLDS:

- A newly funded dementia practitioner is now in post to work specifically with people with learning disabilities. BLDS recently procured specialist high-precision wheelchair weighing scales to enable additional advice and support to people with learning and physical disabilities about weight management issues.
- We continue supporting local GPs to offer improved access to quality annual health checks through the quarterly DES training, which is still delivered virtually, to return to partial or complete face-to-face sessions soon. GPs who have signed up are sent the DES Training package to pre-read it before attending a live Q&A session via MS Teams.
- We continue to work with GPs, carers/families, and care providers to find alternative ways of support for service users that reduce the use of medication.

Tri borough learning disability (LD) team (Hammersmith and Fulham, RBKC, Westminster):

- CLCH LD nursing team developed stronger links with palliative care teams and district nursing through, e.g. community/primary care MDT meetings.
- The CLCH Team have updated knowledge on Hospital Passports and Purple Pathway via team meetings.
- The CLCH team have strengthened links with acute LD Leads.
- The CLCH team rolled out an education programme to GP colleagues to improve the uptake of annual health checks. Uptake is monitored at the monthly LD health and social care health facilitation development group. Significant improvements made in the past six months; now targeting individual underperforming practices.
- CLCH LD nursing team to strengthen health facilitation function, in this case, supporting individuals to screening appointments. The team are working with GP link workers to facilitate.

Local and trust wide clinical audits

During 2023/24, 61 local and trust-wide audits were conducted.

Out of these, 31 audits have been completed, and reports and posters for 16 of those have been finalised and returned to the clinical effectiveness team. Reports are still be worked on for the remaining 15 projects. The findings from the trust-wide audits have been shared with all teams. Clinical teams are regularly updated with feedback from clinical audit activities through divisional quality governance processes. This helps services to identify areas where they can improve their performance and monitor their progress.

The areas of excellence in performance are shared with staff via the hub, in divisional quality forums and monthly smart effective care meetings. The table below provides five examples of how clinical audit results have been used to improve patient care, safeguarding, quality and patient safety, and provide assurance. 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	Key impact:	Summary
Urinary catheter documentation audit	**Trust-wide**	**Patient Safety**	**Aim:** The audit aimed to evaluate standards around catheterisation documentation and catheter-associated urinary tract infections. **Key findings:** The overall completion rate across relevant teams within the Trust was 98%, and the overall compliance score across all teams against the standards audited was 93%. 56% of patients with catheters were catheterised in acute hospitals. Patients are actively trialed without catheter in CLCH and catheters are discontinued where appropriate. **Recommended actions:** All teams have been reminded that clinicians must continue to monitor catheter use and that catheters must be removed as soon as their use is no longer required. The UTI Prevention Group agreed that a re-audit will occur next year to monitor improvement levels. All patients with an indwelling catheter must have a completed catheter passport and a record of changes completed at each catheter change. The audit lead will liaise with leads in the acute hospitals in North West London ICS where the catheter passport has been launched to ensure patients are discharged to the community with a catheter passport.
Re-Audit of justification for antibiotic prescribing in CLCH community dental services	**Inner North West, specialist dental services**	**Patient safety and assurance**	**Aim:** This re-audit reviewed care against best practices for safe and correct antimicrobial prescription use and assessed the prescribing profile of CLCH CDS dentists. Dentists contribute nationally to 10% of antibiotic prescriptions in primary care. A known consequence of inappropriate antibiotic use is microbial resistance. **Key findings:** 100% documentation of antibiotic justification in prescription log and clinical notes. 70% of prescriptions were for appropriate antibiotic prescribing. Individual prescribing profiles varied between CDS dentists, and staff were informed of their profile by email. **Recommended actions:** Audit findings were shared within the team and awareness of antimicrobial resistance was reinforced. All CLCH dentists received an update on current guidelines regarding antibiotic prescribing.

Title	Division/ Service	Key impact:	Summary
0-19 Health Visiting and school nursing Movement in / movement out Audit 2023	**Trust-wide (Health visiting teams)**	**Patient safety and assurance**	**Aim:** The audit aimed to review client records to ensure the process of clients moving in and out of boroughs is clinically robust and timely. It also aimed to ensure that staff comply with the CLCH Movement in / Out policy. This is an annual audit and relates to families/children moving in and out of health visiting and school nursing caseloads. **Key findings – Strengths:** Reasonably robust and timely communication from the admin hub to the clinical teams. Vulnerable families were offered face-to-face contact. Forwarding addresses were generally documented. Advice to parents to register with a GP was recorded. **Improvement areas:** Clients under 1 were not routinely risk assessed to determine their level of need. There were gaps in robust care plans using the assessment of need framework. Movement in record templates were not fully completed. The recording of the child's allergies and sensitivities /or 'no known allergies', continues to be a gap. Recommended actions: The importance of recording LCON levels and using the assessment framework to assess the level of need was reinforced at the divisional / borough level. The need to complete the relevant movement in record templates to include relevant medical information was reinforced at divisional / borough level. The allergy template on S1 / EMIS will be reviewed to explore whether a mandated field can be introduced, and associated staff training and allergy template crib sheet will be developed. Next year's audit will have separate audit questions for health visiting and school nursing – with a crib sheet for guidance.

Title	Division/ Service	Key impact:	Summary
Assessing appropriate prescribing of oral nutritional supplements (ONS) for domiciliary patients	**Outer North West, Brent and Harrow nutrition and dietetic services**	**Clinical standards and quality**	**Aim:** Interventions to combat malnutrition include ONS, which leads to better care and saves money. To assess whether ONS prescriptions are appropriate to formulary and clinically beneficial to domiciliary patients in the five localities within Brent. **Key findings:** 73% of patients were referred to the service already on ONS, of which 27% did not meet advisory committee on borderline substances (ACBS) criteria, and only 18% were first-line formulary. 100% were given food-based advice on 1st appt by community registered dietitians (RDs). 60% of patients were prescribed ONS during the package of care with community RDs, of which 80% met ACBS criteria and 70% had a first-line formulary item prescribed. **Recommended actions:** A team update on ACBS criteria and formulary items led by the Nutrition Support lead is being planned. The North West London (NWL) formulary has been distributed to local GPs and prescribing healthcare professionals. The clinical systems team are planning to agree on the Trust's electronic prescription service (EPS) plan.

Title	Division/ Service	Key impact:	Summary
Domestic abuse safeguarding advisor	**Outer North West (Ealing and Brent)**	**Safeguarding**	**Aim:** To provide an understanding of the 0-19 teams' confidence, knowledge and barriers to making routine enquiry and managing domestic violence and abuse (DVA) disclosures in the five localities within Brent. **Key findings:** The responses which were received were of good quality. However, the responses were largely from experienced staff, 56% from Band 7 and above More junior members of the team and those new to the 0-19 team (international nurses) indicated that they needed more knowledge and did not feel as confident with these processes. The default for most practitioners was to contact the safeguarding team or make a children's social care referral. Whilst this is appropriate, we should encourage staff to take responsibility for the risk. Best practice would be to make our own independent domestic advisor (IDVA) referrals, undertake domestic abuse, stalking and honour based violence (DASH) risk assessments and refer to local multi agency risk assessment committee (MARAC) - expediating safety planning for families. **Recommended actions:** The safeguarding team will ensure that all colleagues within the 0-19 service access the Responding to Domestic Abuse Training. The safeguarding team are developing shorter / adapted training for the adult and remaining children's workforce. The team are also supporting champions to be a visible support and resource for their teams. There will be further training and support / bitesize learning sessions for “skill mix 0-19 team.” The safeguarding team will offer support to staff to initiate their own DVA referrals to IDVA’s / MARAC, thus expediting real-time safeguarding / safety planning.

Examples of ongoing audits and projects forming part of the clinical effectiveness programme of work include the following:

FP10 prescription audit
Antimicrobial prescribing audit on the bedded units
Safe management and use of controlled drugs - bedded areas
Omitted medicine bedded units
Patient group direction audit
Child protection conference reports audit
Trust-wide clinical record-keeping audit
Pressure ulcer audit
Bedded units nutrition audit
Malnutrition Universal Screening Tool (MUST) audit
Compliance against the movement in/out policy
Assessing the usefulness of diet sheets used to provide information to patients
Implementation of capital AHP fair share placement model for practice placements
Diabetes kidney disease
Service delivery regarding domestic abuse and routine enquiry
Hand hygiene and glove audit
Validation tool for IPC nurses
Quality of referrals to mash re-audit
Urinary catheter documentation audit
E core standards self-assessment
LD/autism checklist
Handover audit
Advance care planning
Palliative/ End of life (EOL) care
Diabetes foot patients' access to psychological services
Scaphoid fractures in Walk in Centre (WiC)
Practitioner and patient perspectives of patient-centred care- health visiting.
South west deferrals policy audit
Supplemental fluoride use for learning disability patients with increased caries risk
Justification for antibiotic prescribing: re-audit
Was not brought policy implementation within CLCH paediatric dental service – service re-evaluation
Efficacy of managing frail and elderly housebound patients with type 2 diabetes, using a once-daily basal and pre-mixed insulin regimen
Harrow physiotherapy smart setting
Improving the delivery of care to domiciliary patients
Knowledge, attitude and practice of nurses from bedded unit on dysphagia
Respiratory specialist review
Assessing appropriate prescribing of oral nutritional supplements
Documentation audit for Robertson and Furness ward
Privacy and dignity audit

List of abbreviations:

BLDS	Barnet learning disabilities service
CBP	Cancelled by patients
CDS	Community dental services
CR	Cardiac rehabilitation
DASH	Dash tool (domestic abuse, stalking, harassment and honour-based violence assessment)
DNA	Did not attend
EQ-5D	Euroqol group – 5dimensions
ESD	Early supported discharge
H&F, RBKC	Hammersmith and Fulham, Royal borough of Kensington and Chelsea
ICSS	Integrated community stroke service
IDVA	Independent domestic violence advocacy
LCON	London continuum of need
MARAC	Multi-agency risk assessment co-ordinator
MUST	Malnutrition universal screening tool
NICE	The national institute for health and care excellence
Reach	Rehabilitation enablement in chronic heart failure
TOM	Therapy outcome measure
PLD and ASD	People with learning disability and autism spectrum disorder
STOMP	Stopping over medication of people with a learning disability, autism or both

PARTICIPATION IN RESEARCH

Since the implementation of its strategy in 2021 research at CLCH continues to develop and embed across the Trust. All clinical divisions are now participating in research activity or a study. CLCH continues to maintain its quality measures under the 'smart effective care' pathway by increasing the number of research projects involving, or led by clinical staff, by 20%. The Trust remains committed to creating an inclusive research culture and creating equity of opportunity for both patients and staff.

There were 114 CLCH patients recruited during 2023 – 2024 to participate in research approved by an ethics committee. This exceeds last year's figure of 89 CLCH patients recruited into studies during 2022-2023.

Participant recruitment across studies 2023-2024.		
IRAS Ref	Full title	Recruitment
316986	CADET: Multicentre trial of the clinical and cost-effectiveness of a novel urinary catheter design in reducing catheter-associated urinary tract infection compared with the traditional Foley design for adults requiring long-term catheterisation	3
279691	AND-PD: Anxiety and depression in Parkinson's disease	4
301408	DM PAD: Diagnostic tools to establish the presence and severity of peripheral arterial disease in people with diabetes	26
326566	A clinical study to compare the performance of AQUACEL® Ag+ Extra™ and Cutimed® Sorbact® dressing in the management of patients with Venous Leg Ulcers over a 12-week period	12
291746	BabyBreathe Trial: A randomised controlled trial of a complex intervention to prevent return to smoking postpartum.	5
320940	A qualitative study of a Hospital at Home service in South-West London	21
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 3)	10
294372	Live Well with Parkinson's (as part of the program Personalised care for people with Parkinson's Disease: PD-Care WP4)	4
306756	Cognitive Stimulation Therapy for people with Intellectual Disabilities and Dementia (CST-IDD). A mixed methods feasibility study.	3
332580	Respricorder Study-Assessing user acceptability of Respicorder device in varied settings	10
323576	UPBEAT-A randomised feasibility trial to evaluate a digital system for UPper limB rEhabilitation After sTroke	15
308114	IMPROVE- Improving life quality in chronic obstructive pulmonary disease (COPD) by increasing uptake and completion of pulmonary rehabilitation with lay health workers: a cluster randomised controlled trial	1
Total:		114

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 work in a psychologically safe environment where they feel 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.

Four quarterly reports were submitted to the national guardian's office during the year.

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

Awaiting end of year information – this information wont be available until the middle of May.

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 2023 - 24. Furthermore, the Trust has not participated in any special reviews or investigations by the CQC during the reporting period that ended 31st March 2024. At our last inspection, during October and November 2023, the CQC inspected one of the Trust's core services – community sexual health services, when they inspected the services provided in South West London and Hertfordshire. The Trust has not had a well-led assessment element of inspection since October 2017.

In February 2024, CQC published their report which rated sexual health services as 'Good' overall, and 'Good' in each of the five domains. The Trust remains as 'Good' overall. The grids below reflect the Trust's current rating.

The Trust was not issued with any actions which it was required to take in order to improve

Last rated
28 February 2024

Central London Community Healthcare NHS Trust

Overall rating	Inadequate	Requires improvement	Good	Outstanding

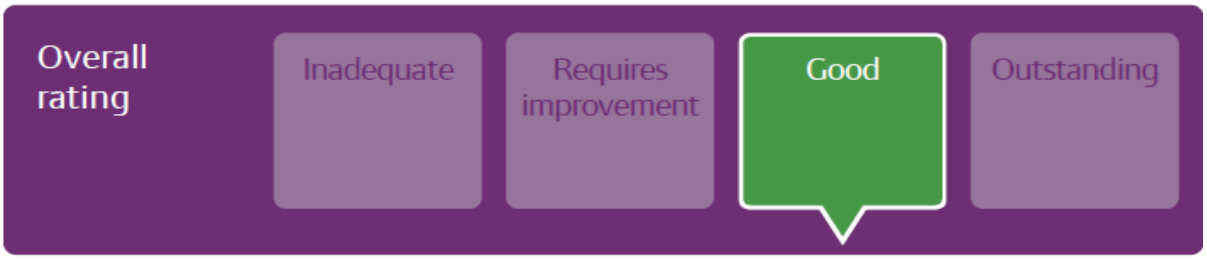
Are services

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

CareQuality Commission

Last rated
28 February 2024

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
Community health sexual health services	Good	Good	Good	Good	Good	Good

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

DATA QUALITY

High quality data is a key component of information governance. It is essential for both the effective delivery of patient care and enabling continuous improvements in care provision. We are fully committed to improving the quality of data across all our services. We recognise the importance of our duties with personal data - keeping it accurate and up to date, treating it with the strictest confidence, managing it securely, and sharing it only in full compliance with the Caldicott principles.

During 2023 - 24 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 Microsoft Power BI. Developments have included reports which scrutinise waiting lists for new and follow-up patients, more detailed reporting on contacts, and row level security to allow secure and compliant patient level data reporting. 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 information management and technology have been engaged with data quality initiatives encompassing clinical template and counting rules standardisation. A major review of counting rules took place in 2023/24 across all clinical systems, which has been implemented in a new data warehouse environment, and will improve the accuracy of reporting.

- Worked directly with Urgent Community Response services to supply latest data reports, to improve the reliability of recording and reporting of data scrutinised through 2 hour response time measurements.

- Enhancements to internal Service Line Mapping to better reflect the organisation structure, to add more granular information and properties, and assist the future organisational hierarchy transformation project.

The data forum, 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 heads of business and performance. This group has the following specific aims to improve data quality in 2023/24:

- 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 2024 - 25 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 improving data completeness and accuracy, using opportunities arising from recent standardisation and data warehouse upgrades, developing an innovative data quality tracking tool on the Azure platform, and pursuing national data standards for community services.

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

- Using Microsoft Power BI as the platform for the Trust's Self-service business intelligence portal, expanding its user base to wider trust staff, and adding to its functionality, in particular enhancing existing data quality monitoring tools to offer more detailed insights. This will extend to bespoke reporting to support specific services' needs.

- 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 2023 – 2024

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 2024 to being the Trusts LfD processes in parallel with the new patient safety incident response framework (PSIRF). 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. As part of the PSIRF process, deaths which occur in CLCH services which the divisional directors of nursing & therapies and divisional medical directors highlight as requiring further discussion and investigation are discussed in the weekly incident decision meeting. The case record reviews are completed by divisional medical directors from the relevant divisions and discussed at the trust's 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.

LEARNING FROM DEATHS

	Prescribed Information	Form of statement
1.	The number of in- patients who have died during the reporting period, including a quarterly breakdown of the annual figure.	From Apr 2023 – Feb 2024, CLCH patients died as follows (includes expected hospice deaths): • 852 in Q1 • 762 in Q2 • 809 in Q3 • 839 in Q4 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 Apr 2023 to Mar 2024, 11 case record reviews (PRISMs) were completed. 3 case reviews from the previous reporting period were also completed (see section 7 for details). In 6 cases, the deaths were subjected to both a case record (PRISM) review and an investigation (Case 8: 2022-2023, Case 3: 2023 – 2024, Case 5: 2023 – 2024, Case 6: 2023 – 2024, Case 14: 2023 – 2024, Case 11: 2023 – 2024) The number of cases in each quarter for which a case record review or an investigation was carried out was: • 2 in Q1 • 4 in Q2 • 6 in Q3 • 6 in Q4 *The case record reviews for Q4 are currently ongoing and conclusions will be included in the QA 2024 - 2025.
3.	An estimate of the number of deaths during the reporting period included in item 2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.	2 representing 11% of the deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter this consisted of: • 0 in Q1 • 1 in Q2 • 1 in Q3 • 0 in Q4 Case record reviews at Resuscitation & Mortality group meetings and Serious Incident investigations were used to assess this.

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 3 (2023 – 2024)** This patient was referred to a Rapid Response team, had significant comorbidities and exacerbation of an underlying medical issue. a) Treatment should be discussed with the patient so that they can make an informed decision particularly relating to ceilings of care. b) Decisions regarding ceilings of care need to be made by the MDT and not by one individual. c) If heart failure is managed at home daily reviews are needed to manage fluid balance and renal function. d) Where there is diagnostic uncertainty there should be a lower threshold for hospital admission. e) RR is a new service which manages patients who are too ill to be managed entirely in general practice, but who have not reached threshold for hospital. Therefore, clear protocols to manage conditions required. **Case 11 (2023 – 2024)** This patient under the care of the Community Nursing team also had multiple agencies involved in her care due to multiple comorbidities. a. When patients refuse treatment/ intervention, a detailed record of the discussion should be documented in the clinical record and a capacity assessment regarding the specific decision should be completed b. Divisional medical directors have disseminated the learning above within their divisions.

4.	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 3. Contd.	**Case 14 (2023 – 2024)** This patient under the care of a rapid response team, had significant comorbidities and was referred for worsening shortness of breath. a) There was some evidence of joint decision making with the patient's family during the patient's admission, however this requires improvement particularly relating to decisions relating to ceilings of care. b) Where there is diagnostic uncertainty there should be a lower threshold for hospital admission. If patients live alone, and clinical deterioration cannot be monitored by a carer/ family member, this should also trigger a lower threshold for hospital admission. **c)** All patients admitted to the service on the day need to be discussed in the daily MDT meeting regardless of the status of the patients' clinical investigation results - Patients whose investigation results have not been received should have a provisional management plan agreed.
5.	A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 4).	**Case 3 (2023 – 2024)** a) Discuss at the bimonthly trust deteriorating patient group meeting with a focus on education, learning from deaths /incidents, including effective escalation of deteriorating patients. b) Service to create protocols for management of common conditions and standard operating procedures to standardise practice across the trusts RR teams. **Case 11 (2023 – 2024)** a) Discuss at the bimonthly trust Deteriorating Patient Group meeting with a focus on education, learning from deaths /incidents, including effective escalation of deteriorating patients. b) Divisional Medical Directors have disseminated the learning above within their divisions.

		Case 14 (2023 – 2024) This case was investigated as a serious incident. a. Divisional rapid response teams to develop Trust wide Protocols for all major conditions treated by Rapid Response Teams b. Divisional clinical/medical directors to collaborate on a Trust wide SOP for all Senior decision makers in Rapid Response Teams which outlines the expectations of the senior decision-maker in the team, in terms of roles and responsibilities, communication and MDT working. c. Set up case discussion/ learning for rapid response teams so that they can learn from clinical cases and keep up to date with guidance –at Trust level. d. Implement training for the team regarding 'Managing abnormal results' so that the team feel empowered when it comes to reviewing and actioning blood results. e. Organisational development work to be done with the team so they feel able to clinically challenge more senior clinicians. – through use of role play scenarios and support is being sought from in-house psychologist to address barriers to challenging more senior members of the team.
6.	An assessment of the impact of the actions described in item 5 which were taken by the provider during the reporting period.	**Case 3 (2023 – 2024)** Impact not assessed at present. **Case 11 (2023 – 2024)** Impact not assessed at present. **Case 14 (2023 – 2024)** Impact not assessed at present.
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.	3 case record reviews and 0 investigations were completed after 2022-2023 which related to deaths which took place before the start of the reporting period **(Cases 7-9 (2022-2023) – 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 deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This was assessed by review of case records by the resuscitation and mortality group.
9.	A revised estimate of the number of deaths during the previous reporting period stated in item 3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 8.	0 representing 0% of the deaths during 2022 – 2023 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 are 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 2023/24 18,597 patient safety incidents were reported within CLCH. Of these incidents, zero resulted in severe harm. This is an increase n the total number of incidents that caused severe harm from the previous year (2022/23) when we reported that ten incidents from 17,971 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 2022 to March 2023.

There were no incidents that resulted in a death.

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

- The patient safety team continues to 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 (the trust intranet), divisional quality forums, the *spotlight on quality and people 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 patient safety incidents through the daily the daily incident review huddle and the weekly incident review meeting, with particular focus on inpatient falls, pressure ulcers, deteriorating patients, lower limb ulcers and medicines management. This is enabling the early identification of emerging themes, which may require monitoring through the above relevant working groups.

- Introduction of the incident decision meeting, which includes the senior management team, deputy chief medical officers, deputy directors nursing and therapies, as well as quality improvement (QI) and patient safety team representation. Patient safety incidents escalated to the Incident decision meetings are discussed, and decision made on the learning response required proportionate to the patient safety incident, if necessary.

- Weekly meetings with senior clinicians to review all community acquired pressure ulcers, and monthly to review all category 2 inpatient pressure ulcers.

- All incidents relating to podiatry and children's services are reviewed monthly. This has continued to strengthen collaborative working in the multi-disciplinary teams. This approach has been shared to shared to improve communication between teams across the Trust.

- The patient safety incident response framework (PSIRF) has been successfully implemented across the trust. PSIRF learning response methodologies have been rolled out to investigate and share learning across the Trust.

- Implementing improvement plans in collaboration with QI leading to service improvements 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 and Risk Group (PSRG) and quality committee remain focused on providing the correct level of scrutiny to drive safety improvements across the organisation.

- Successfully recruited patient safety partner, in line with NHS requirements.

- The Trust patient safety incident response plan and patient incident response policy were approved by the integrated care board (ICB) in March 2024.

PART 3: OTHER INFORMATION - QUALITY PERFORMANCE AND PROGRESS AGAINST OUR QUALITY PRIORITIES 2023 – 2024

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	2023-2024
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%	98.5%	98.1%
	Proportion of patients who were treated with respect and dignity	95%	99.8%	99.5%
	Friends and family test - Percentage of Staff recommending CLCH as a place for Treatment.	85%		
	Patient Friends and family test - Proportion of Patients rating their overall experience as very good or good	95%	98.1%	98.0%
	Proportion of patients' concerns (PALS) responded to within 5 working days	100%	100.00%	100.0%
	Proportion of complaints responded to within 25 days	100%	100%	100.0%
	Proportion of complaints responded to within agreed deadline	100%	100%	100.0%
	Proportion of complaints acknowledged within 3 working days	100%	100%	100.0%
Preventing Harm Incidents & Risk	Proportion of clinical incidents that did not cause harm (moderate to catastrophic categories)	97%	99.2%	99.3%
	Zero tolerance to falls in bedded units with harm (moderate or above)	0	10	13
	Zero tolerance of new (CLCH acquired) category 3 & 4 pressure ulcers in bedded units	0	1	5
	Zero tolerance of new (CLCH acquired) category 2 pressure ulcers in bedded units	0	31	39
	Zero tolerance on the number of patients in our bedded areas who have reported a CAUTI	0	3	7

Trust wide performance scorecard - continued.

Quality campaign	Key Performance Indicator	Target	Performance	
Smart, Effective Care	Percentage of Central Alerting System (CAS) alerts including Patient Safety Alerts (PSAs) due, and responded to, within deadline	90%	100%	91.7%
	Percentage of hand hygiene episodes observed across CLCH bedded areas that are compliant with policy	97%	99.1%	94.8%
	Percentage of staff trained at Making Every Contact Count level one- Non clinical	95%	95.3%	95.7%
	Percentage of staff trained at Making Every Contact Count level two -clinical	95%	93.7%	92.6%
Modelling the Way	Statutory & Mandatory training - non-clinical	95%	96.7%	96.8%
	Statutory & Mandatory training - clinical	95%	96.2%	96.5%
People	Staff Turnover rate – 12-month rolling (clinical)		17%	12.4%
	Sickness absence rate - 12 month rolling (clinical)		5.4%	4.9%
	Percentage of staff who have an appraisal		85.1%	89.8%
	Staff Vacancy rate (Clinical)		17.6%	14.2%

PROGRESS AGAINST OUR QUALITY PRIORITIES 2023-2024

CAMPAIGN ONE: A POSITIVE PATIENT EXPERIENCE

Key Priority / Outcome	Measures of Success	Update
Services are designed and care delivered in a way that involves patients, carers, and families as partners in care	We will maintain the proportion of patients who felt that they were treated with respect and dignity at 95%	This KPI has been achieved- 99.5% at year end. This has been achieved at both trust and divisional level.
	We will maintain the proportion of patients reporting their overall experience as very good or good at 95%	This KPI has been achieved – 98.0% at year end. This has been achieved at both trust and divisional level.
	The proportion of patients who felt staff took time to find out about them will be maintained at 95%	This KPI has been achieved – 98.1% at year-end. This has been achieved at both trust and divisional level.
	We will ensure that 80% of patient/user/carer feel involved in each service change	This KPI has been achieved in year: 85% Throughout the year, we have worked with each of the QI project leads. Projects that have been paused or did not reflect the level of patient involvement in place were updated. Cleansing and engagement with the leads will continue.
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%	72.1% was achieved in the quarter 4 pulse survey results and at year end. Although the target has not been achieved, significant improvements have been made.
	We will increase volunteer numbers by 50% from 2020/21 baseline in services where volunteer participation improves patient experience	This has been achieved with a 55% increase since this time last year. We are continuing to see an increase in volunteer numbers (an increase from 105 in Q1, 112 in Q2 and 110 in Q3 and 143 in Q4). Work continues with teams across the Trust to develop exciting and engaging roles. We currently have 61 services who are seeking or currently have volunteers in their team. This is up 47 from Q1, 51 in Q2, 58 in Q3.

Key Priority / Outcome	Measures of Success	Update
Staff work in services that they believe are delivering the best positive outcomes - contd.	To continue to complete an annual volunteer survey to understand their impact on services and their experience	Our annual survey in October 2022 saw 35% of volunteers respond as follows: • 76% are satisfied or very satisfied with their role (vs 73% last year) • 71% feel they have learned a new skill in their role. • 64% would recommend volunteering at CLCH. • 71% say they see the difference their volunteering is making. Volunteers rate their experience of each shift. 2023/24 has seen an average score of 4.3 versus 4.2 last year.
	We will develop 'you said we did' stories to share volunteers' experiences	Through 2023/24 we have worked hard to raise the profile of volunteering internally with: • Monthly case studies or retrospectives on volunteering in Spotlight on volunteering • Quarterly social media activity around volunteer case studies • Video content created for Volunteers' Week celebrations. • Video content created for end of year celebrations
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 KPI has been achieved– 100% at both divisional and trust levels at year-end.
	We will continue to respond to 100% of complaints within 25 days	This KPI has been achieved– 100% at both divisional and trust levels at year-end.
	We will continue to respond to 100% of complex complaints within the agreed deadline	This KPI has been achieved– 100% at both divisional and trust levels at year-end.
	We will continue to acknowledge 100% of complaints within 3 working days	This KPI has been achieved– 100% at both divisional and trust levels at year-end.

Key Priority / Outcome	Measures of Success	Update
The patient and the public voice are integral in the decision-making process when making changes to services or care delivery	We will transfer the learning from each Always Event across the trust	The 2023/24 Always Events across the trust have progressed well throughout the year. Work continues with the following projects with progress shared at several forums including the patient experience group, the newly launched carers involvement group, and the end-of-life care steering group: The end-of-life care project is gathering feedback from ethnic minorities looking at how we can make our care culturally inclusive whilst encouraging access. The focus is with Hertfordshire, and a working group with Hospice staff meets monthly. A large population health piece of work has been completed, and wider staff engagement has now taken place. Carer engagement in Hertfordshire and how we can better work with our families and carers. The project has now moved to a trust wide project. A carers engagement group has launched and is refreshing the carers charter. They are also focussing on developing the project alongside the carers training offer to staff and signposting options for our patients.
The patient and the public voice – contd.	We will review the impact and learning from quarterly projects on the overall patient experience	The 2023/24 quarterly project highlights have been: Sickle cell mobilisation of the new 5 borough southwest haemoglobinopathy service in conjunction with NHSE. Positive feedback has been collected from parents involved and shared at the patient experience group and the trust board. The inner North West division professional nurse advocates (PNAs) on a project to involve patients with lived experience of service users receiving care from a nurse who is having support from a professional nurse advocate. Feedback of experience received will be used to evaluate the hypothesis that by supporting staff, patient experience and patient safety will be improved. Each of the 5 clinical divisions have been working with their respective SPA teams to ensure we are asking about our carers ensuring that they are being offered the support they require when accessing our services.

Key Priority / Outcome	Measures of Success	Update
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	Achieved. Wandsworth and Richmond achieved full/stage 3 Accreditation in December 2023. Inner Northwest: Confirmation that we can keep the gold sustainability award after 4-year reaccreditation in January 2024. A quality improvement (QI) project has been selected to present a poster at the BMJ international forum for quality and safety in healthcare in April about analysis of breastfeeding rates and drop off rates in wards in each borough in relation to deprivation and ethnicity. The team are also working with public health in Kensington, Chelsea and Westminster (KCW) to create a crisis infant feeding pathway for Voluntary sector partners). Merton: Gold assessment booked for April 2024 (mothers audits) and June (staff/service assessment) 2024. Ealing: Stage 3 follow up assessment for Ealing 0-19 and Ealing Children's Centres took place in January 2024. Both services did very well, and UNICEF noted the progress made since the last assessment. The services still require a little more work in a few areas to be awarded stage 3. Brent: Stage 3 follow assessment for Ealing 0-19 and Ealing Children's Centres in January 2024 – awaiting report

CAMPAIGN TWO: PREVENTING HARM

Key Priority/ Outcome	Measures of Success	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 2023/24	The year-to-date figure is 99.3% which is just marginally behind the previous year's value of 99.6%. As the most recently incidents are reviewed, this value is likely to increase beyond 99.3%.
	100% of patients in bedded units will not have a fall with harm (moderate or above)	There has been a total of 13 reported harmful falls in our bedded units this financial year, which is an increase on the ten reported last year. Improvement work now supported by the Inpatient falls prevention group.
	100% of patients in bedded units will not have a NEW (CLCH acquired) category 2-4 pressure ulcer	There have been 44 reported category 2 – 4 pressure ulcers in our bedded units this year, which is an increase on the 38 reported last year. But calculated as a proportion of total reported incidents, the value remains consistent at 6%.
	100% of all proportionate response processes will be completed on time in accordance with national guidance and agreement with affected parties where relevant.	In January 2024, there was one externally reported patient safety incident investigation (PSII). In 2023/2024, 100% of external serious incidents (7/7. 100% of internal serious incidents (15/15) and 100% of after-action reviews (15/15) were completed within timeframes
	100% of all proportionate responses will be completed on time in accordance with locally agreed timescales.	In quarter 4, 82% of our actions were closed on time. There is targeted work in place with divisions to ensure improvements are delivered in meeting this measure. The deputy chief nurse (director of quality and safety) held root cause analysis closure meetings to ensure all agreed actions form the pre-patient safety incident response framework (PSIRF) processes are closed.
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	The culture improvement work which was part of the Patient Safety Improvement Programme has now been merged with the work underway in Organisational Development to ensure greater alignment with trust wide work on this agenda
	Each division will assess the impact of sharing from each shared incident learning examples using the 7-minute learning tool in divisional boards and patient safety risk group.	The patient safety and risk group continues to review and discuss presented learning. These are now being added to the Hub for wider sharing of learning. A focused divisional 7-minute learning presentation now takes place at PSRG monthly. In summary sharing of learning through the 7-minute tool has made a positive impact across all Divisions by ensuring faster sharing of learning.

Key Priority/ Outcome	Measures of Success	Update
Enhance the embedding of a safety culture – contd.	We will assess the level of improvements in the quality of services in findings from core standards annual health check assessments.	It has been agreed by the compliance steering group that the core standards annual health check assessment will be postponed until Q1 2024/25. Further to this we will assess the level of improvements required in our services.
	No outstanding actions from risks on the register	There has been a reduction in the number of outstanding risk actions on the register with 91.5% reported as being in date. The improvement is due to the enhanced approach to reviewing and managing risk actions on Datix with support of the Trust corporate risk manager and greater oversight at the patient safety and risk group and at the executive leadership team.

CAMPAIGN THREE: SMART EFFECTIVE CARE

Key Priority / Outcome	Measures of Success	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	95.7% staff have been trained at level 1, and 92.64% at level 2 QI project identified to review and support improvement in Level 2 MECC compliance (as of March 24)
	MECC will be embedded in clinical practice	Training continues to be delivered and through population health training as well
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 ≥ 20%	Five studies were approved year-to-date, and we are on track to maintain a 20% increase. 13 studies will be open by July 2024.
	We will share learning from completed clinical audit and service evaluation projects across the Trust, including via divisional quality forums, SEC group meetings, and/or on the Hub. Target >80% of projects to be shared.	Since Q1 2023/24, all 16 clinical audits/service evaluation projects (where reports have been completed) have been shared at the SEC Group or other appropriate clinical quality forums. They have also been shared at other specialist groups, and/or on the Hub.

CAMPAIGN FOUR: MODELLING THE WAY

Key Priority / Outcome	Measures of Success	Update
Implementing Reverse Mentoring (RM) for all staff ensuring career opportunities are accessible to all	80% of clinical staff at band 8b or above will have undertaken training	67 % of clinical staff bands 8b+ are trained mentees. We are on track to achieve our target by July 2024. Further training dates are available until September 2024. These are being publicised at Quality Forums and Divisional forums across the Trust.
	Reverse mentoring will positively influence decision making by senior clinical leaders	An impact assessment has been completed to assess the impact of the programme on both mentors and mentees with a comprehensive report due to be published in May 2024. Feedback is being reviewed to determine the positive influence of the programme including increase in uptake of 360-degree feedback, learning from the results of this intervention.
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%	This KPI has been achieved in both quarter 4 and It has also been achieved throughout 2023/24.
Staff receive appropriate education and training to ensure they have the right skills to support new models of care	Each professional group will have identified education and training to support their career development.	The annual learning needs analysis (LNA) has been used to inform the education and training delivered for our staff. The practice development nurses and AHPs continue to support clinicians in practice.
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.	This has been completed in Q4 and throughout the year 2023/24.

Key Priority / Outcome	Measures of success	Update
Ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times	We will introduce the apprentice nursing associate (ANA) role to specialist services e.g., Walk in Centres / specialist nursing services	The ANA role has been introduced into children's services and will be recruited into in 2024. Work to introduce ANA and Nursing Associate roles into our walk-in services is underway with discussions as part of the clinical staffing panel and clinical workforce group.
	We will continue to evaluate safe staffing models for the allied health professional workforce, and any new roles developed	This work has continued in quarter 4 and throughout 2023/24 through the clinical staffing panel. We have also aligned this work with the Trust service review programme so that any staffing models or workforce changes are looked at alongside demand and capacity modelling.
	We will continue to develop professional networks and deliver/events to be delivered for all staffing groups across the trust and primary care.	This KPI has been achieved in quarter 4 and throughout the year, a programme of successful conferences and networking events have been undertaken.

TRUST QUALITY PROJECTS AND INITIATIVES

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

The Academy: The academy continues to increase its portfolio of education, training, research and development throughout 2023 - 24. Highlights for 2023 - 24 include:

- Statutory and mandatory training compliance, has met or exceeded the Trust target throughout the year with particular effort noted by staff and managers in the re-introduction of face to face Resuscitation training.
- Delivering the clinical multi-professional leadership programme to two cohorts which has had a significant impact in developing the leadership capabilities of our clinicians across the system.
- Introducing and growing the practice development allied health professional (AHP) role within the Trust which has had a demonstrable impact on AHP and AHP support worker development and support. The team won award for their hard work at the CLCH staff awards in 2023.
- Growing the clinical apprenticeship offer within an increase in numbers for both Nursing Associates and Registered Nurse degree top ups as well as an exciting expansion of AHP apprenticeship opportunities. We also successfully promoted our apprenticeship offer on national and regional TV news and radio.
- Delivering a series of high-quality hybrid conferences and professional networking opportunities
- Successfully completing the specialist community public health nurses (SCPHN) cohort in July 2023 and recruiting a further 40 SCPHN students for Sept 2023.
- Developing postgraduate programmes in Health Equalities, Homeless Health and Advanced Assessment alongside our academic partner London Southbank University (LSBU).

Some further highlights from the Academy include the following:

Advanced practice: The advanced practice lead started in July 2023 and since then has met with internal and external stakeholders to review and address areas of focus in line with the NHS England (NHSE) centre of advancing practice's governance maturity matrix. The six workstreams are based on the eight titles of the matrix and the working groups are made up of a variety of quality and operational leads and advanced practitioners from across the trust's breadth of services and professions. These working groups have enabled an overall change on the governance maturity matrix from 29% at initial assessment in July 2023 to 56% as of end of February 2024. As work progresses, update reports are provided to both modelling the way and the clinical workforce group ensuring divisions are engaged and information can be cascaded to services

Professional nurse advocate (PNA): The roll out and implementation of the PNA role has been successful and by March 2024 we will have 84 PNAS with the ambition to have a PNA to support each of the 9 protected characteristics networks and FTSU champions. There have been several successful quality improvement (QI) projects supporting the embedding of PNA including 'Itchy feet clinics' and 'pathway to excellence'. Two of our PNA QI projects have been successfully shortlisted as abstracts for the British Medical Journal (BMJ) which reflect the success of the role itself.

The emerging AHP leadership programme (EAHPL): This is a new five-day course aimed at band 6 and new band 7 AHPs to enhance their leadership skills across all four pillars of practice. This interactive programme provides AHPs with the skills and knowledge required to build networks, confidence, and competence as a leader. A successful pilot cohort with representation from every CLCH division and four AHP groups took place in Autumn 2023. fantastic feedback was received from the 15 attendees on the pilot cohort, and cohort 1 will commence in spring 2024 with 25 attendees.

AHP summer school programme: As part of widening access and participation in AHP careers, the Academy will be launching an innovative CLCH AHP Summer school programme in August 2024. This will deliver a two-week programme to 16-18 year olds to introduce the seven AHP groups at CLCH - dietetics, occupational therapy, orthoptics, paramedics, physiotherapy, podiatry and speech and language therapy

Allied health professionals (AHP) quality projects and initiatives. We are proud that CLCH has:

- Hosted an AHP conference on AHP day in October 2023 at the Royal College of Nursing - this was delivered hybrid and was attended by over 200 participants
- Led the way nationally with the introduction of Practice Development AHP roles to support education, learning and career development for Registered and Non-Registered AHPs - this has been formally recognised by NHS England
- Piloted a new band 5 AHP support worker coordinator role to lead on the NHS England AHP support workforce framework across CLCH
- Introduced a podiatry refreshers programme for band 6 podiatrists to enhance their clinical skills in musculoskeletal disease, diabetes, vascular podiatry and surgery and podiatric surgery and nail surgery
- Piloted *Evolve AHP* in Brent, an innovative digital learning tool for AHPs providing instant access to Continuing Professional Development with a built-in e-Portfolio

Bedded units: A band 7 physiotherapy lead has been awarded a 12 month fellowship with the Royal College of Physicians to support the national audit of inpatient falls. This will support our existing trust wide falls prevention group activity.

Breastfeeding support clinics: A mapping exercise in inner North West was undertaken where the uptake by the mother's place of residence was compared with the location of the breastfeeding support clinics. The location of clinics was changed in order to meet the greatest need.

Blossom project: This project in inner North West provided speech, language and communication needs (SLCN) training to key workers in targeted early years settings to enable them to run more language/communication learning opportunities for children in deprived areas that were known to be at higher risk of developing SLCN.

Care Home Befrienders: The Merton Care Homes team has been working with our volunteer services to introduce a new service for residents with dementia in Merton care homes. Volunteers typically meet with three to four patients weekly and the feedback from both the volunteers and the care home managers has been very positive.

Carers: A three-year strategy has been agreed with the goal to improve the support we provide to unpaid carers at the Trust. This includes a digital signposting tool broken down into local services available to carers across each of the boroughs that CLCH covers and how to access a carers assessment within these. We are also reaching out to local partners to collaborate and refer carers as they come into our services. The parent and carers network continues to involve carers in our strategy and we continually work towards a workplace which is confidently caring for carers.

Chat to Pat : As part of a joint digital transformation project the sexual health services in Hertfordshire and South West London have implemented a chatbot into their service based website. This automated bot has been designed in conjunction with clinicians to support service users by guiding them though set questions relating to common reasons for presenting at clinic. It provides support with health promotional messaging and signposts service users to areas of the website that provide information about basic queries. It also supports them with online booking access. Safety netting is provided throughout with patients being directed to clinic or to the single point of access to speak to someone directly.

Clear catheter project: The South West division has been working with NHS England and St. George's to improve care and clinical outcomes for patients with catheters. The teams have been reviewing clinical data from the two providers to understand the patient's experience and to look at how we can support this population better.

Community nursing: A number of projects were set up in the south west 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.

Deaf service for sexual health The South West London sexual health service is setting up a completely unique service for the d/Deaf community. It will be run monthly from Falcon Road for d/Deaf patients and will run as a pilot for 12 months hopefully starting in April 2024. This will be the only service of its kind in the country. It will be run by a doctor proficient in level 6 British sign language (BSL). The clinic proposes to offer a fully accessible clinic to seek advice support and treatment for any non-urgent sexual health issues where they will be able to communicate directly with the doctor In BSL. There will also be BSL interpreters present to facilitate the whole of the patients' journey and to allow them to have consultations with health advisors for psychosexual, social and sex-educational support matters

Dementia team: The 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.

Deteriorating patient project: Following implementation of deteriorating patient training for all adult clinical services in the trust, south west division held several quality councils to support multidisciplinary training and support for staff. The team is now reviewing the training package and will be working with the academy to co-produce further educational materials for staff.

Developing digital pathways: Digital pathways were developed in Brompton Health primary care network to promote frailty management via multi-disciplinary teams. Frailty training has been added to CLCH's i learn.

District nursing monthly staff awards in Hammersmith and Fulham: These staff awards are an excellent initiative to recognise and celebrate the outstanding contribution and overall commitment of staff members. By acknowledging the hard work and dedication of the staff, the monthly staff awards not only boosts morale but also inspires others to strive for excellence in their own roles. The certificate, medal, and other gifts awarded to the staff members are tangible symbols of appreciation and serve as a reminder of their exceptional contributions.

Engagement with our future staff in South West London: A number of south west division staff, academy staff and patient and patient experience staff have met with local colleges in Merton, Kingston, Lambeth and Wandsworth and a secondary and sixth form school to highlight the career and training opportunities in community services at CLCH. This included attending apprenticeship events at the colleges and speaking events with health and social care students.

Health innovation network project: This project aims to support improved treatment and clinical outcomes of lower limb wounds. South West division was successful in being appointed as a pilot site by the Health innovation network for South London to look at improving the care for patients with lower limb wounds. Merton teams , including community nursing, tissue viability and podiatry have taken an interdisciplinary approach to implementing the new national wound care strategy pathway for lower limb wounds with project support from the health innovation network. This has resulted in a new pathway with a clearer structure for timelines for treatment. This in turn has resulted in faster evidence based treatment plans and improved clinical outcomes such as faster wound healing times.

Learning disability service users: The Triborough learning disability service has been running a monthly patient forum since November 2022 to hear the voices of service users and to ensure that the service is tailored to meet their needs. The attendees have named the forum service users speak up. The forum has been a place to share health care user experiences.

Learning Disabilities in South West division: Although the division does not have a specific learning disabilities service commissioned, the clinical quality lead has worked with the local authorities of Merton and Wandsworth to establish a learning disability working group for community services. This group has been looking at access to services and reviewing how we work with service users with learning disabilities in our clinical services.

Merton care home team: The team has worked with the volunteering team to set up a group to provide individual cognitive stimulation therapy to patients. The volunteers have been provided with a bespoke training backage by the nurse consultant to provide cognitive stimulation therapy. The volunteers are currently working with eight residents on an individual basis in three care homes.

Patient diaries: These have been used to support a positive patient experience across the South West bedded units. Over the past year the Heathland's rehabilitation team looked at codesigning and piloting a patient diary to enrich the patient's experience, receive real time feedback and as a tool to support service improvements. Following their success across the South West division, patient diaries have been rolled out across the bedded units and division is now using a co-design approach to implementing a diary for children and young people as well as for learning disabilities service users and dementia service users.

Period poverty: Staff within sexual health in South West London, led by Dr Plaha, have been providing practical support to patients with the provision of free sanitary wear in the toilets and washrooms of their sexual health clinics. The clinic's efforts aim to reduce the financial burden associated with menstrual hygiene and create a supportive environment, where patients feel comfortable discussing private issues.

Personalised care training package: Following a successful quality improvement project in Merton community nursing to improve offering and uptake of self-management and shared care plans, a training animation video is being developed to share learning with other services. This will be available on iLearn.

Planned care: Planned care have started a *hand therapy* shared governance council. This started in one locality as a pilot and now covers all planned care therapy teams. The aim is to support hand mobility and strength as part of a rehabilitation programme to ensure patient dexterity and independence for managing daily tasks.

Post-covid assessment service (PCAS) in Merton and Wandsworth – co production focusing on inequities. The service initiated a project to look at the equity of access for service users last year. This= included educating primary care networks in the Merton and Wandsworth boroughs with a particular focus on areas with under-serviced populations. The main aim was to increase the uptake of referrals and collaborate with public health to generate co-produced self-management materials. This collaboration included working with Healthwatch to understand and capture the lived experience of people with post covid syndrome. The team built on this work to co-produce patient educational literature for service users to recognise post-covid symptoms, empower service users to take control of their health outcomes, set expectations of post –covid syndrome recovery and explain what the service provides. After the final design was created, the focus group evaluated and fed back before final changes. The literature is now being shared across communities in collaboration with public health and community post-covid syndrome community champions.

Post covid syndrome: It was noted that data from the north west London post-covid service showed minority ethnic groups not accessing the post-covid service as much as other cohorts. Engagement with these groups showed that there was a lack of understanding of post-covid and both where and how to get help for this. In response to this and educational animation was created and the communications team have been involved in promoting the video.

Public health fellowship project: Due to the national shortage of health visitors this project has been initiated to attract health visitors to come and work for us getting back to the core tenants of health visiting seeking out the health needs of the community. The health visiting role will be for four days of clinical time and one day a week will be dedicated to working within a structured six to nine month work based programme that will be supervised by a trust public health nurse consultant. This is being piloted in Westminster, Royal borough of Kensington and Chelsea and Hammersmith and Fulham. The project aims to identify, design and manage a project focusing on health at a population level, looking at ways to make communities and environments healthier, reducing ill health and tacking health inequalities.

PURPOSE T pressure ulcer risk assessment tool: This year we implemented the use of PURPOSE T which is the only evidence-based pressure ulcer risk assessment tool. The tool can be used in the community setting as well as within the bedded units and is recommended for use by NHS England. The mandatory training on the tool was built by the working group and delivered on ilearn to all clinical staff in quarter 2. Following this all-other pressure ulcer risk assessment tools were removed from use in quarter 3. This has moved the Trust from having four pressure ulcer risk assessment tools to one.

Record keeping project in community nursing: The community nursing teams in South West division have been looking at ways to improve the quality of record keeping in their teams. They are working on a quality improvement initiative to look at innovative ways of capturing information whilst out on community visits. This included initiating a review of the clinical record keeping tools which is now being carried out trust wide. The services have brought in external speakers to discuss the importance of record keeping and implications for practice.

Reducing skin tone bias in wound care project: Best practice guidance was implemented in inner North West so that skin tone is to be documented as part of every wound assessment. Additionally training materials will be updated to cover skin tone bias.

Research and development: CLCH continues to maintain its quality measures under the 'smart effective care' pathway by increasing the number of research projects involving, or led by clinical staff, by 20%. All clinical divisions are now participating or undertaking research activity.
The research and development team secured funding to hold a community engagement event in March 2024 to enable insight into understanding any barriers or challenges of the impact of dementia on LGBTQ+ populations. To further support our communities the team have been supporting the Age UK Barnet memory days to enable the teams to engage with the dementia community and raise awareness of research.

CLCH in collaboration with London South Bank University (LSBU) was shortlisted and interviewed for funding to create the NIHR HealthTech Research Centre. Although unsuccessful at the final funding stage, the funding panel commended CLCH's application on its unique focus on community that addressed a clear area of unmet need.

Quality development unit (QDU) accreditation: This year we have 4 teams now holding QDU accreditation status, one re-accreditation and one more team going for accreditation in March . Teams and services that have been awarded QDU accreditation status continue to be celebrated and held up as centres for quality excellence. All successful teams are awarded £1,000 to spend on developing their team further by using funding for external training, team building, or purchasing items such as books to enhance their service provision. Additionally teams receive lapel badges and QDU lanyards to mark their achievement. QDU accredited teams are at the forefront of driving new and innovative ways of working, offering advice to other teams.

Shared governance: Shared governance supported the development of a short animation film using the voice of the child to teach their peers about medical conditions. Both the project and animation were shortlisted for two categories at the Nursing Times awards. The animation was the innovative idea of a school nurse who enhanced understanding using the voices, imagery and lived experience of three children with type 1 diabetes. The responses and feedback were extremely positive and a second animation regarding children with allergies will be entered this year.

Supporting patients closer to home: The Heathland court rehabilitation unit reviewed its rehabilitation offer to the residents of Merton. Following a review of inequalities data and access of the service and outcomes, the team and the division supported changing the model from a bed based inpatient unit to a home-based rehabilitation model. Service users were involved in the planning and implementation of the service.

Tackling unacceptable behaviour: 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 security site visits in response to security concerns and reported incidents, with identified actions monitored at divisional estates groups

- Multi-provider security improvement project at St Charles Centre for Health & Wellbeing and another at Edgware Community Hospital to improve access to security support and to streamline requests for assistance

- Continuation of the weekly online 'Skyguard Surgery' drop in clinics for users to receive a refresher about how to use the functions on their lone worker devices effectively, with almost 100 people receiving a personalised session

- Upgrade of Skyguard devices issued to ensure that staff have access to the latest technology

- Lone working and tackling unacceptable behaviour sessions provided to services and to staff attending the Trust induction day, with over 750 people attending a session

- Tailored response and procedural guidance sent to reporters and handlers of every incident of violence and aggression against staff logged on the Trust's incident management system

Time to shine: In 2021, a project was commissioned by our Chief Nurse of Central London to review existing mainstream school health provision across all six boroughs where school health was delivered; to propose a revised clinical model to meet the needs of the service; to ensure the voice of children and young people was incorporated and to ensure wide staff involvement in the development of the future model. At the end of the project a new skill mix clinical model, based on a demand and capacity tool, was agreed. A new approach to case conference attendance was introduced and a complexity tool was developed to support allocation of staff to schools. Additionally training requirements for community school staff nurses were identified and provided and a children and young people's forum was established.

Toothbrushing pilot in Hammersmith and Fulham: The trust received Integrated Care Board (ICB) funding for a pilot of supervised tooth brushing once a day in primary schools in the most deprived areas of the borough.

Volunteering: We are delighted to have seen continued growth in the volunteering department. We now have over 140 volunteers which is a 60% increase on the previous year and there are now over 50 teams at the Trust working with volunteers in their service. We continue to measure the impact our volunteers' time has and for 2023-2024 we have recorded over 5,000 hours of activity, supporting over 25,000 patients. Furthermore we have launched 3 volunteer projects to enhance particular areas across the Trust. Volunteer to Career has seen us recruit 10 volunteers to support them in a role which gives them an insight into a healthcare career and also supports them to obtain employment or education to pursue a career in the NHS. Our *Butterfly* volunteer project has seen us recruit 3 volunteers in Merton to support palliative residents in care homes across the borough. Our third project has seen us recruit and train 16 new volunteers to become breastfeeding supporter volunteers at breastfeeding clinics across the Trust.

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

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

The directors are required under the Health Act 2009 and the National Health Service (quality accounts) regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:

➢ board minutes and papers for the period April 2023 to March 2024

➢ papers relating to quality reported to the board over the period April 2023 to March 2023

➢ feedback from commissioners dated xxxx 2024.

➢ feedback from local Healthwatch organisations dated xxxx 2024.

➢ feedback from overview and scrutiny committees dated xxx 2024

➢ 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:

Tom Kibasi

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
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Ealing Healthwatch
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Hertfordshire Healthwatch
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Hounslow Healthwatch
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Merton Healthwatch
Vestry Hall, London Road
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Richmond Healthwatch
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Tel: 020 8099 5335
https://www.healthwatchrichmond.co.uk/

Wandsworth Healthwatch
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89 Bickersteth Road
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INTEGRATED CARE SYSTEMS (ICSs)

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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.

A**fter action review (AAR):** is a method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future.

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 Resolution: This is an arm's length body of the Department of Health and Social Care that provides expertise on resolving concerns and disputes fairly. It also shares learning for improvement and preserving outcomes for patient care.

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

PSIRF: Patient safety incident response framework. Further information can be found regarding this can be found at the following link: NHS England » Patient Safety Incident Response Framework

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.

COMPLAINTS REPORT

This will be made published when it has been approved by the board. It will be attached to the quality account as an appendix.